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Closing the Loop: Practical Strategies for Timely Lipid Panel Follow-Up

Announcer:
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Dr. Gluckman:
Welcome to CME on ReachMD. I'm Dr. Ty Gluckman.

Dr. Wadhera:
And I'm Dr. Rishi Wadhera.

Dr. Gluckman:
In this episode, we're going to talk about practical strategies to improve lipid monitoring. And maybe unknown to many of you is the fact that there can be heterogeneity in treatment response to statin and, for that matter, non-statin therapy. When we talk about statin intensity and different statin LDL cholesterol-lowering regimens, we think about an average treatment response, and that's actually how we classify individuals as being on low-, intermediate-, or high-intensity statin therapy. But the reality is that there could be wide variability in a population in terms of the magnitude of LDL cholesterol lowering associated with a given treatment regimen. And this is a major reason why guidelines have historically recommended routine surveillance monitoring of lipid parameters, of lipid test results to at least inform some of this. In short, you can't actually treat what you don't measure.

So as it relates to measurement of lipids, it really falls into sort of two broad groups. For individuals that are being initiated on lipid-lowering therapy, they're having a change in the dose of a lipid-lowering regimen, they're having additional lipid-lowering therapy added to baseline statin therapy, the recommendation is to measure a lipid panel 4 to 12 weeks after any change, principally to understand what was the patient's response to that lipid-lowering regimen or that change. Thereafter, once someone has achieved their LDL cholesterol goal, the guidelines recommend every 3 to 12 months thereafter checking a lipid panel, and now the goal in this case, is to monitor adherence and ensure that patients are consistently maintaining their LDL cholesterol level in the desired range.

And so this brings up the question overall, and, Rishi, I may turn to you about this is, what happens if this patient has trouble getting to clinics to get their labs drawn? What are the options that are available? How do you think about that, in particular in rural settings?

Dr. Wadhera:
Yeah, I think it's such a great point, Ty. And we have to remember that people living in rural communities may not have a car and certainly don't often have access to public transportation that makes it easy to go in and get labs checked or to visit a healthcare provider. So what are the options? And I actually think the options are limited, but this is a challenge that we need to be cognizant of as clinicians. One option is to plug patients that live in rural communities in with social workers who can help facilitate transportation for these patients, or community-based services that are oriented around enhancing access to in-person healthcare services for these patients.

Dr. Gluckman:
That's really helpful. And in my local area, even though I'm in a more urban/suburban area, even there are some people who have transportation issues and even sending people into the home or trying to find where you can best meet patient needs, meet patients where they need to be met. I think you've illustrated this nicely, and those challenges are even that much greater in rural settings.

I do want to just end on one thing that may be not as well understood, is we historically have thought about asking everybody to fast for a lipid panel. And the reality is, A, that creates its own challenges. Someone shows up in clinic at 2:00 PM, they've already eaten breakfast and lunch, it doesn't fit with their schedule, and to come back on another day, and you're in a conundrum. Or you expect people to come back on another day by asking them to fast. And the reality is that most individuals who are getting either initial or surveillance lipid panels do not have to fast for it. LDL cholesterol is not particularly affected by fasting or non-fasting state. Triglycerides are the most affected by this. There are circumstances where someone's had a non-fasting lipid panel and will have to come back for a fasting panel as a result of either results that can't be adequately interpreted. There are individuals, if you're screening for a family history of genetic hyperlipidemia or premature atherosclerotic cardiovascular disease, those are individuals in whom you want to fast outright. But the vast majority of individuals, both secondary and, in many cases, primary prevention, do not require fasting as a matter of routine in this patient population.

With that, unfortunately, we have to wrap up our brief discussion. I want to thank you all for listening.

Announcer:
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