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Leadoff Hitter – Spotting High-Risk Players

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Dr. Englert:
I'm Dr. Randy Englert. Today I'll be discussing how to identify patients that are at very high risk for recurrent ASCVD events.

So ASCVD stands for atherosclerotic cardiovascular disease. This is an umbrella term that includes coronary artery disease, including myocardial infarction, ischemic stroke, and peripheral artery disease. Our 2018 lipid guidelines introduced this concept of being at very high risk for recurrent events through the introduction of these criteria. To meet criteria for being of very high risk for recurrent events, you had to have 2 of these major ASCVD events or 1 major event and 2 of these high-risk conditions.

When you look through these criteria, you can recognize that a 65-year-old patient with hypertension and a prior history of myocardial infarction is at very high risk. This is a very common patient to see in clinical practice. For patients that are considered of very high risk for recurrent ASCVD events, they have 3 times the event rate than patients that have known atherosclerotic cardiovascular disease but are not considered to be at very high risk for recurrent events.

Based on the 2022 ACC/AHA Consensus Pathway, the LDL goal for patients considered at very high risk is to achieve an LDL target of less than 55. The goal is also to reduce the LDL by 50% compared to baseline. For patients that are not considered to be at very high risk, the LDL goal remains at less than 70.

Despite this clear guidance for identification of patients who are considered at very high risk for recurrent events and a clear target of less than 55 for the LDL, less than 40% of our patients actually receive a high-intensity statin with known ASCVD.

Additionally, receiving a high-intensity statin does not necessarily equate to a patient achieving an LDL goal. To achieve these low LDL targets, patients often require additive therapies such as ezetimibe, PCSK9 inhibitors, bempedoic acid, and inclisiran.

Despite our undertreatment with statin therapy in the general population, there are certain populations that also have further disparity: women, noncoronary ASCVD manifestations, and patients with lower socioeconomic status. For women, I believe this starts with an inherent bias from the public as well as with physicians. Think about on a TV show, if there is a character that's going to have a myocardial infarction, that's typically going to be represented by the male character. For physicians, we recognize that men have the onset of cardiovascular disease about 10 years earlier than women, and so this earlier onset of disease can be translated into cardiovascular disease as a male problem when, in fact, it's the leading cause of death for both men and women.

It's also more reported that women have statin-associated side effects. So women are more likely to decline statin therapy, swap statins, leading to longer time to LDL goal, or decline therapy due to the statin side effects.

There's also noncoronary ASCVD manifestations. In this population, which includes peripheral artery disease and ischemic stroke, these groups are often undertreated compared to patients that have coronary artery disease. Peripheral artery disease is the most undertreated group, and when you add on racial and ethnic disparities, this only compounds the discrepancy.

Patients that have lower socioeconomic status have multiple barriers to optimal ASCVD treatment. In this population, there are substantial income-dependent disparities after an ASCVD event, including being less likely to receive guideline-recommended therapy, including statins. There's less participation in cardiac rehabilitation. There's worse cardiometabolic profiles, lower blood pressure control, and higher rates of persistent smoking. Additionally, these patients have structural barriers and unmet social needs. The structural barriers can include things like high medication costs, limited healthcare access, and lower rates of insurance coverage. And some of these social needs that are unmet include food insecurity, transportation challenges, lack of health literacy, and higher rates of comorbid mental illness. Addressing these unmet social needs will be crucial in the management of these patients.

So hopefully I've convinced you that there remains a significant gap in care for our patients with a known ASCVD. Awareness of this treatment gap is the first step to developing an action plan to improve the outcome for our patients. This is the end of the talk. Thank you for joining me today.

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