Background Document – Dyslipidaemia Protocol

Working Group:
Dr Kaspar Willson (Physician Registrar, Broome Hospital)
Dr Sarah Woodland (GP, KAMS)
Dr Nitya Malhotra (GP Registrar, KAMS)
Dr Casey Barnes (GP Registrar, KAMS)

Case Definition

The screening/case definition sections were switched as the working group felt this was easier to interpret.
Mention of non-fasting bloods (aacc https://www.aacc.org/publications/cln/cln-stat/2016/may/19/international-panel-recommends-non-fasting-lipid-tests) as this is no longer required.
Mention early of CVD risk as this determines whether it is important to act on an abnormal result.

Screening

This section has been considerably altered. It has been based on the RACGP Red Book (https://www.aacc.org/publications/cln/cln-stat/2016/may/19/international-panel-recommends-non-fasting-lipid-tests) for non-indigenous and on the NACCHO guidelines http://www.naccho.org.au/wp-content/uploads/1.National-guide-to-a-preventive-health-assessment-for-Aboriginal-and-Torres-Strait-Islander-people-2.pdf) for Indigenous patients.

The risk categories have also been defined clearly. The very high risk patients are based off the PBS general statement for lipid lowering therapy.

Assessment

The working group felt necessary to add "full lipid profile (fasting not required)" as a reminder that fasting is not required.
CVD risk calculation was also added as this is apart of a thorough assessment.

Management

This has been split into non-pharmacological and pharmacological sections for ease of reading. This section has been changed considerably due to new guidelines being available as well as for easy use at the point of care

Non Pharmacological

More detail has been added in regards to diet. This was adapted from the Australian Heart Foundation and the Queensland Chronic Conditions Manual 1st Ed.

Pharmacological

In regards to treatment targets this section has been removed. Current data suggests (and also discussed with cardiologist Dr John Tan) that patients should not be treated according to targets, however focus should be placed more so on risk and treatment dose and tolerability. References include UTD article "Treatment of Lipids (including hypercholesterolemia) in primary prevention) 2016 and "ACC/AHA Release updated guidelines on the treatment of blood cholesterol to reduce ASCVD risk" American Family Physician 2014.

It is mentioned in the pharma section that lifestyle should be trialled first in patients for primary prevention, unless they are very high risk. This is consistent with the PBS statement.

In the primary prevention section there is reference to risk as well as PBS category in making this decision.
In the very high risk patient group the dosing has not changed from the previous protocol. There is also mention that if LDL does not reach target ezetimibe can be considered. This statement was made as it can be considered and will lower the LDL that there is no proven reduction in cardiovascular risk.

The statements on types of cholesterol derangement have been removed as the decision to treat is not affected. A statement in regards to hypertriglyceridemia has been made however.

There is also a statement made in regards to the use of other statin therapies outside of the Kimberley Std Drug List. This is as simple as assessing why the patient is on the medication and using this information to determine the dose of atorvastatin required.

Treatment contraindications and the “Caution” statement remain unchanged.

Follow Up
The duplication of the caution statement has been removed
The working group were happy with this section. It has been simply re-formatted

Women of Childbearing age
Minimal changes made here

Refer/Discuss
Minimal changes made in wording