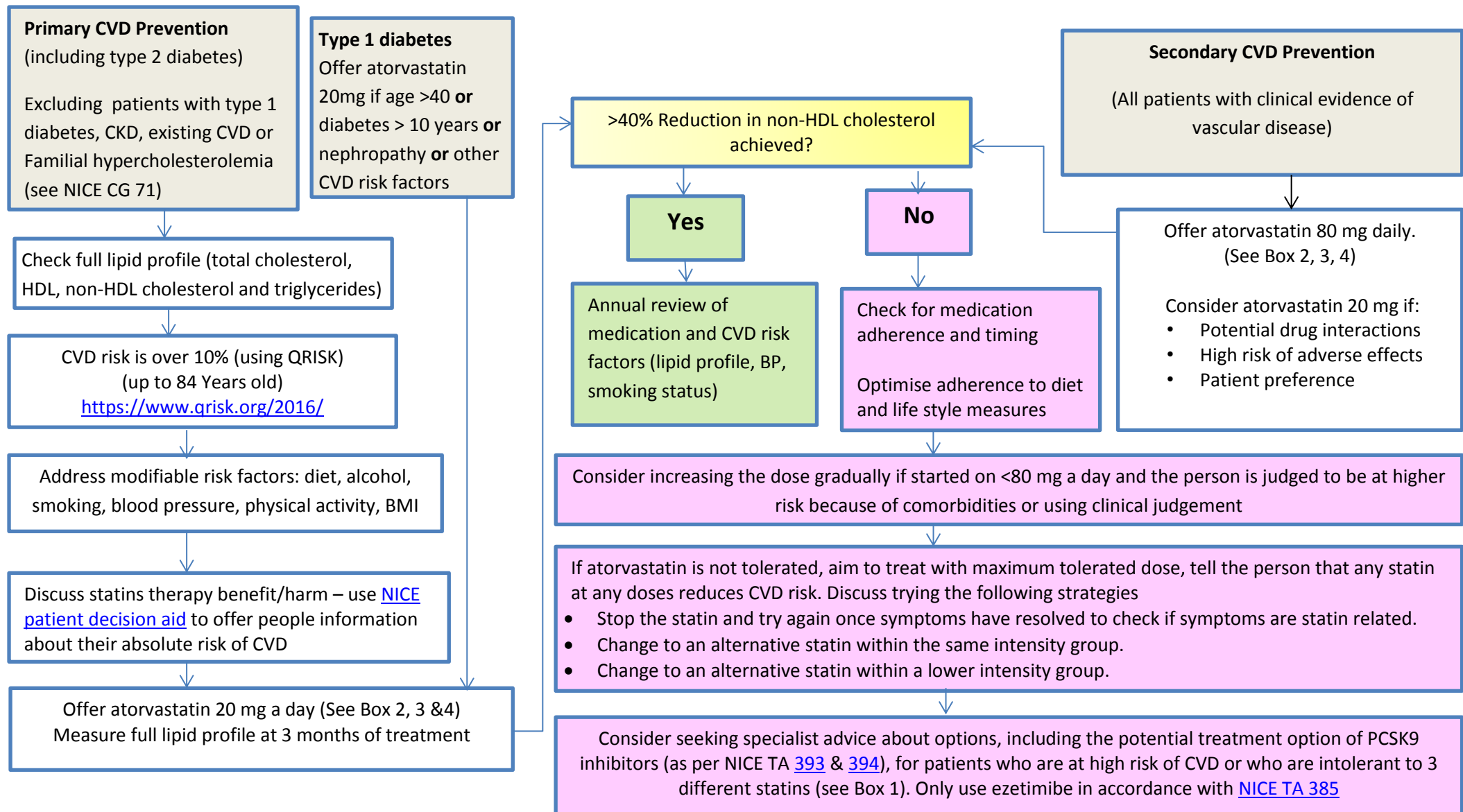


Management of Hyperlipidaemia in Primary Care: Clinical Guidelines



Box 1: Consider referral to lipid clinic if:

- Total Cholesterol > 9 mmol/L or non-HDL Cholesterol > 7.5 mmol/L
- Familial Hypercholesterolemia or other genetic dyslipidaemia is suspected
- Fasting TG persistent > 10 mmol/L
- Urgent if fasting TG > 20 mmol/L (and not due to excess alcohol or poor diabetes control)
- Side effects or contraindications to statins
- Failure to achieve treatment aims despite maximal tolerated lipid-lowering therapy, for the consideration of PCSK9 inhibitor treatment (in line with NICE TA [393](#) & [394](#))

Box 3: Statins and creatinine kinase (CK)

- Before offering statin, ask the person if they have had persistent generalised unexplained muscle pain. If they have, measure CK level. If CK levels are more than 5 times the upper limit of normal (ULN), re-measure after 7 days. If CK is still 5 times ULN, **do not** start statin treatment. If CK levels are raised but less than 5 times ULN, start statin at a lower dose.
- Consider seeking specialist advice if patients develop muscle pain
- Do NOT measure CK levels in asymptomatic people who are being treated with a statin.

Box 5: Chronic Kidney Disease:

- eGFR >30 or albuminuria : Offer atorvastatin 20 mg a day. Seek specialist advice before increasing the dose
- eGFR < 30: Seek specialist advice before starting atorvastatin

Box 7: The following treatments are not recommended for routine use in the modification of CVD risk:

Fibrates, Nicotinic acid, Bile acid sequestrant or Omega 3 fatty acid compounds

Please note management of raised triglycerides sits outside of this guidance. See separate [Hypertriglyceridaemia guidelines](#). Consider discussing individual cases with the specialists, if required.

Box 2: Drugs safety:

- Statins interact with other medications. Please refer to the current BNF for up-to-date list
- Statins should be avoided in pregnancy (discontinue 3 months before attempting conceive) and in breast feeding
- Statins should be used with caution in patients at risk of myopathy or rhabdomyolysis
- Statins should be discontinued if ALT is > 3 times upper reference range
- Patients with hypothyroidism should receive adequate thyroxine replacement before starting them on statins

Box 4: Statins and liver transaminase (ALT/AST)

- Measure baseline ALT/AST before starting a statin, within 3 months of starting and at 12 months, but not again unless clinically indicated
- Do not routinely exclude people who have raised ALT/AST but are less than 3 times ULN from statin therapy

Box 6: Grouping of statins:

- Atorvastatin 10 mg², 20 mg³, 40 mg³, 80 mg³
- Simvastatin 10 mg¹, 20 mg², 40 mg²
- Pravastatin 10 mg¹, 20 mg¹, 40 mg¹
- Rosuvastatin 5 mg², 10 mg³, 20 mg³, 40 mg³

1. low intensity, 2. medium intensity, 3. high intensity

Following the MHRA report of increased risk of myopathy associated with 80 mg simvastatin. The use of simvastatin at this dose is not routinely recommended. Consider discussing individual cases with the specialists, if required.

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References:

1. NICE [CG181](#) (July 2014); Lipid Modification
2. NICE [TA385](#) (February 2016): Ezetimibe for treating primary and non-familial hypercholesterolemia
3. NICE [TA393](#) April 2016; Alirocumab for treating primary and mixed dyslipidaemia
4. NICE [TA394](#) April 2016: Evolocumab for treating primary and mixed dyslipidaemia