



Expert Clinical Consensus Treating Hypercholesterolemia in Patients Aged 75 and Older Without Established Atherosclerotic Cardiovascular Disease

Overview:

Risk of atherosclerotic cardiovascular disease increases with advancing age and cholesterol levels remain predictive of incident atherosclerotic cardiovascular events among individuals 75 years and older. Risk prediction in these older individuals is less certain because many current risk calculators lack specificity in those 75-year-old and older and do not adjust for comorbidities, life expectancy, functional status, frailty, and cognition which significantly impact prognosis in this age group.

Data on the benefits and risks of cholesterol-lowering with statins in older individuals without prevalent atherosclerotic cardiovascular disease are also limited, since most primary prevention trials have focused on younger individuals. Available data suggest that statin therapy, for the purpose of primary prevention of cardiovascular events in older people, reduces atherosclerotic cardiovascular events and that benefits from statins outweigh potential risks such as statin-associated muscle symptoms, incident type 2 diabetes mellitus, and cognitive impairment.

Online calculators, such as ePrognosis (ePrognosis.ucsf.edu), can help clinicians incorporate evidence-based information about life expectancy for older people into decisions about preventive therapies, such as statins.

Key Points:



2024 NLA/AGS: Expert Clinical Consensus Treating Hypercholesterolemia in Adults ≥ 75 of Age Without Established ASCVD

... LDL-C plasma level is associated with incident ASCVD.

... in those with high LDL-C and additional risk factors, use of ezetimibe for reduction of LDL-C and ASCVD risk can be considered.

... aged 76-80 years with LDL-C 70-189 mg/dL with clinical uncertainty about statin initiation, it is reasonable to measure CAC and withhold statin therapy if CAC score is 0.

... aged 76-80 years with LDL-C 70-189 mg/dL with a CAC score of ≥ 100 or $\geq 75^{\text{th}}$ compared with age, sex, and race-matched individuals, it may be reasonable to engage in shared decision-making regarding initiation of statin therapy.

... in those treated with statins, ongoing monitoring of LDL-C every 3 to 12 months is recommended if consistent with life expectancy and patient goals and priorities.

... shared decision-making should be used when making decisions regarding initiation, monitoring and intensification of statin therapy.

... statin discontinuation may increase risk of ASCVD events, but the incremental risk may be acceptable to some clinicians and patients.

... integrating screening for frailty, dementia, and functional

impairment into decisions about primary prevention statin therapy can be useful.

... in select adults in whom statin deprescribing is considered, shared decision-making between the clinician, patient, and/or caregiver is recommended.

... it is reasonable to discontinue statins for those who are nearing their end of life (<1 year to live) or receiving palliative care.

... the utility of traditional risk equations to assess 5 or 10-year risk of ASCVD is uncertain.

... clinicians may use models adjusted for competing risks to estimate ASCVD risk and potential benefit of primary prevention statin therapy.

... tools such as life tables and validated mortality indices that include comorbid conditions and functional status are commended to help clinicians incorporate the patient's remaining life expectancy into decision making about primary prevention statin therapy.

... benefits of statin therapy outweigh the risks of SAMS.

... benefits of statin therapy outweigh the risks of T2DM.

... benefits of statin therapy outweigh the risks of cognitive impairment.

