Riesgo cardiovascular: ¿tratamos pacientes o números?

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Los pros y contras de los scores

Step 1

Age		
Years	LDL Pts	Chol Pts
30-34	-9	[-9]
35-39	-4	[-4]
40-44	0	[0]
45-49	3	[3]
50-54	6	[6]
55-59	7	[7]
60-64	8	[8]
65-69	8	[8]
70-74	8	[8]

Step 2

LDL - C		
(mg/dl)	(mmol/L)	LDL Pts
<100	<2.59	-2
100-129	2.60-3.36	0
130-159	3.37-4.14	0
160-190	4.15-4.92	2
≥190	≥4.92	2

Cholesterol		
(mg/dl)	(mmol/L)	Chol Pts
<160	<4.14	[-2]
160-199	4.15-5.17	[0]
200-239	5.18-6.21	[1]
240-279	6.22-7.24	[1]
≥280	≥7.25	[3]

Step 3

HDL - C			
(mg/dl)	(mmol/L)	LDL Pts	Chol Pts
<35	<0.90	5	[5]
35-44	0.91-1.16	2	[2]
45-49	1.17-1.29	1	[1]
50-59	1.30-1.55	0	[0]
≥60	≥1.56	-2	[-3]

Step 4

Blood Pressure					
Systolic (mm Hg)	Diastolic (mm Hg) <80	80-84	85-89	90-99	≥100
<120	-3 [-3] pts				
120-129		0 [0] pts			
130-139			0 [0] pts		
140-159				2 [2] pts	
≥160					3 [3] pts

+ Note: When systolic and diastolic pressures provide different estimates for point scores, use the higher number

Step 5

Diabetes		
	LDL Pts	Chol Pts
No	0	[0]
Yes	4	[4]

Step 6

Smoker		
	LDL Pts	Chol Pts
No	0	[0]
Yes	2	[2]

(sum from steps 1-6)

Step 7

Adding up the points	
Age	_____
LDL-C or Chol	_____
HDL - C	
Blood Pressure	_____
Diabetes	_____
Smoker	_____
Point total	_____

Key	
Color	Relative Risk
green	
white	
yellow	
rose	
red	

(determine CHD risk from point total)

Step 8

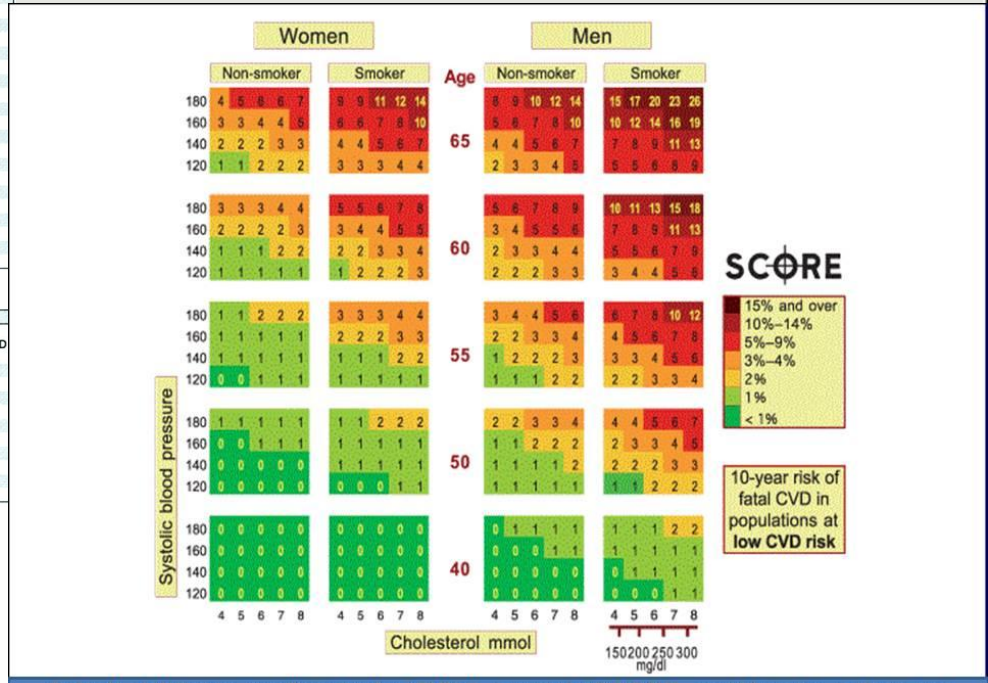
CHD Risk			
LDL Pts Total	10 Yr CHD Risk	Chol Pts Total	10 Yr CHD Risk
≤-2	1%	[≤-2]	[1%]
-1	2%	[-1]	[2%]
0	2%	[0]	[2%]
1	2%	[1]	[2%]
2	3%	[2]	[3%]
3	3%	[3]	[3%]
4	4%	[4]	[4%]
5	5%	[5]	[4%]
6	6%	[6]	[5%]
7	7%	[7]	[6%]
8	8%	[8]	[7%]
9	9%	[9]	[8%]
10	11%	[10]	[10%]
11	13%	[11]	[11%]
12	15%	[12]	[13%]
13	17%	[13]	[15%]
14	20%	[14]	[18%]
15	24%	[15]	[20%]
16	27%	[16]	[24%]
≥17	≥32%	[≥17]	[≥27%]

(compare to average person your age)

Step 9

Comparative Risk			
Age (years)	Average 10 Yr CHD Risk	Average 10 Yr Hard* CHD Risk	Low** 10 Yr CHD Risk
30-34	<1%	<1%	<1%
35-39	<1%	<1%	1%
40-44	2%	1%	2%
45-49	5%	2%	3%
50-54	8%	3%	5%
55-59	12%	7%	7%
60-64	12%	8%	8%
65-69	13%	8%	8%
70-74	14%	11%	8%

* Hard CHD events exclude angina pectoris



Calculo del riesgo cardiovascular (RCV), proyecto SCORE, versión para países con ...do Colesterol total

PROCAM Score

Alter (Jahre)		LDL-Cholesterin (mg/dl)		Systolischer Blutdruck (mm Hg)	
35-39	0	<100	0	<120	0
40-44	6	100-129	5	120-129	2
45-49	11	130-159	10	130-139	3
50-54	16	160-189	14	140-159	5
55-59	21	>189	20	>=160	8
60-65	26				
Triglyzeride (mg/dl)		**HDL-Cholesterin (mg/dl)**		**Raucher**	
<100	0	<35	11	Nein	0
100-149	2	35-44	8	Ja	8
150-199	3	45-54	5		
>199	4	>54	0		
		Diabetiker		**Positive Familien-anamnese**	
		Nein	0	Nein	0
		Ja	6	Ja	4

Assmann, Cullen, Schulte; Circulation, 105: 310-315; 2002

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Razones para evaluar el riesgo global

- La estimación de la probabilidad de que un individuo desarrolle un acontecimiento coronario a partir de sus factores de riesgo es una estrategia valiosa para prevenir eventos vasculares.
- La prevención coronaria basada en una evaluación del riesgo global permite tomar decisiones más eficientes que mediante el abordaje de sus componentes aislados.

Problemas en las estimaciones de riesgo global

- Hay que tener en cuenta el desenlace clínico que emplea el score
- Variabilidad regional del riesgo: calibración local
- No incluyen BMI, sedentarismo, antecedentes fliares, triglicéridos.
- No dan cuenta del tratamiento corrector.
- Emplean categorías: fuma o no; DBT sí o no. Se pierde el impacto de gran fumador, DBT mal controlada, etc

El beneficio de cualquier intervención en prevención cardiovascular es más alto cuanto mayor riesgo basal tenga el paciente.

.

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Como regla general

- Mayor “agresividad” en el tratamiento a mayor riesgo de padecer un evento

Con algunas cosas nos pasamos de revoluciones

- Diabéticos como equivalentes coronarios
- Aspirina en el agua corriente
- Metas de TA “durísimas”
- Estatinas a demasiada gente….
- Modificar perfil lipídico caiga quien caiga en DBT

Statins and Primary Prevention

Statins Have No Benefit on All-Cause Mortality in High-Risk Primary Prevention

Ray KK, Seshasai SR, Erqou S, et al. Statins and all-cause mortality in high-risk primary prevention: a meta-analysis of 11 randomized controlled trials involving 65,229 participants. Arch Intern Med. 2010;170:1024-31. [PMID: 20585067]

Data Do Not Support Lower Systolic Blood Pressure Targets for Diabetic Persons

Cushman WC, Evans GW, Byington RP, et al; ACCORD Stud Group. Effects of intensive blood-pressure control in type 2 diabetes me litus. N Engl J Med. 2010;362:1575-85. [PMID: 20228401]

Nilsson PM. ACCORD and risk-factor control in type 2 diabetes N Engl J Med. 2010;362:1628-30. [PMID: 20228405]

A More Favorable Lipid Profile Is Not Necessarily Associated With Reduced Cardiac Events In Persons With Diabetes

Ginsberg HN, Elam MB, Lovato LC; ACCORD Study Group. Effects of combination lipid therapy in type 2 diabetes mellitus. N Engl J Med. 2010;362:1563-74. [PMID: 20228404]

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Hipertensión arterial

- Selección de droga (monoterapia)
  - El mejor predictor de disminución riesgo es la reducción de la TA
    - IECA-ARA ll
    - Bloqueantes cálcicos
    - Tiazidas

IECA

- No parecen tener un efecto protector más allá del descenso TA en pacientes de alto riesgo vascular
  - Sí: en insuficiencia cardíaca, diabetes proteinúrica, IAM

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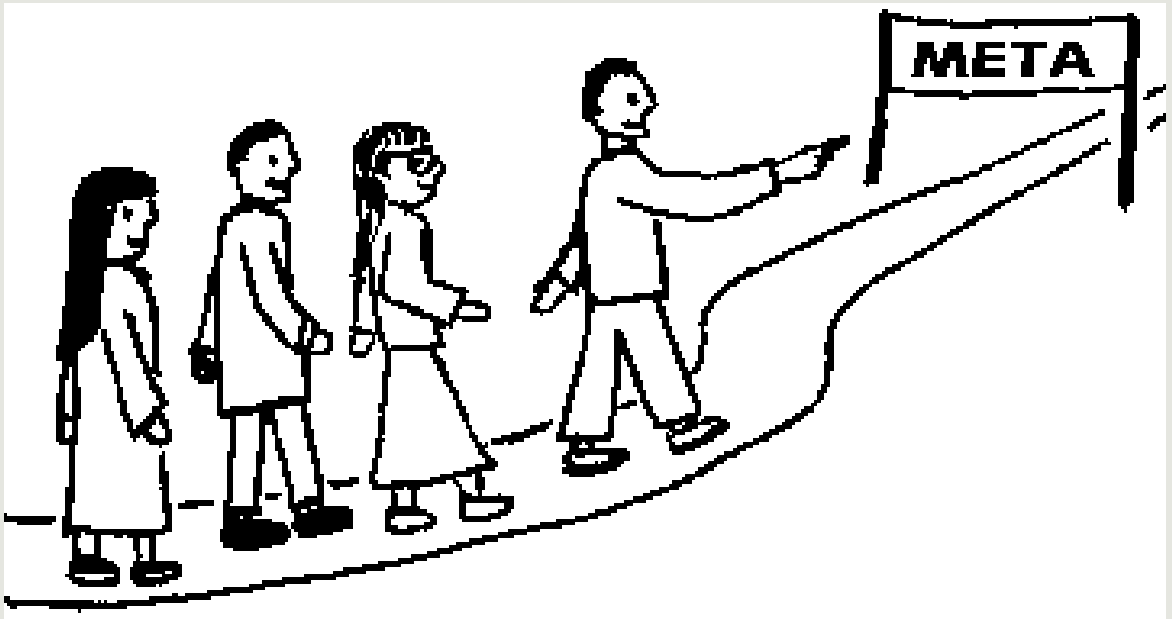
META

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¿Qué hay del furor bajandis?

- Sístólica 130 ??¿¿¿ en diabéticos sin producir efectos adversos
- Menos de esto…tal vez en proteinuria > 500 mg/día

Annals of Internal Medicine | REVIEW

Systematic Review: Blood Pressure Target in Chronic Kidney Disease and Proteinuria as an Effect Modifier

Ashish Upadhyay, MD; Amy Earley, BS; Shana M. Haynes, DHSc; and Katrin Uhlig, MD, MS

Background: The optimal blood pressure target in patients with chronic kidney disease (CKD) is unclear.

Purpose: To summarize trials comparing lower versus higher blood pressure targets in adult patients with CKD and focus on proteinuria as an effect modifier.

Data Sources: MEDLINE and the Cochrane Central Register of Controlled Trials (July 2001 through January 2011) were searched for reports from randomized, controlled trials with no language restriction.

Study Selection: Authors screened abstracts to identify reports from trials comparing blood pressure targets in adults with CKD that had more than 50 participants per group; at least 1-year follow-up; and outcomes of death, kidney failure, cardiovascular events, change in kidney function, number of antihypertensive agents, and adverse events.

Data Extraction: Reviewers extracted data on study design, methods, sample characteristics, interventions, comparators, outcomes, number of medications, and adverse events and rated study quality and quality of analyses for proteinuria subgroups.

Data Synthesis: Three trials with a total of 2272 participants were included. Overall, trials did not show that a blood pressure target of less than 125/75 to 130/80 mm Hg is more beneficial than a target of less than 140/90 mm Hg. Lower-quality evidence suggests that a low target may be beneficial in subgroups with proteinuria greater than 300 to 1000 mg/d. Participants in the low target groups needed more antihypertensive medications and had a slightly higher rate of adverse events.

Limitations: No study included patients with diabetes. Trial duration may have been too short to detect differences in clinically important outcomes, such as death and kidney failure. Ascertainment and reporting of adverse events was not uniform.

Conclusion: Available evidence is inconclusive but does not prove that a blood pressure target of less than 130/80 mm Hg improves clinical outcomes more than a target of less than 140/90 mm Hg in adults with CKD. Whether a lower target benefits patients with proteinuria greater than 300 to 1000 mg/d requires further study.

Primary Funding Source: Kidney Disease: Improving Global Outcomes (KDIGO).

Ann Intern Med. 2011;154:541-548. www.annals.org

For author affiliations, see end of text.

This article was published at www.annals.org on 15 March 2011.

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Microsoft PowerPoint ...

www.pagina12.com.ar/diario/sociedad/3-145809-2010-05-17.html

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Lunes, 17 de mayo de 2010 | Hoy

INGRESAR | REGISTRARSE | EDICIONES ANTERIORES | BUSQUEDA AVANZADA | CORREO | KIOSC

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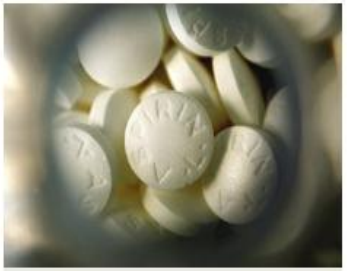
SOCIEDAD › SEGUN UNA PUBLICACION MEDICA, NO SE DEBEN USAR PARA PREVENIR ATAQUES CARDIACOS

Una advertencia por las aspirinas

El prestigioso British Journal of Medicine, órgano de la Asociación Médica Británica, llamó a desalentar el uso continuado en bajas dosis de este medicamento para prevención primaria. Sostiene que los datos disponibles no lo justifican.

Por Pedro Lipcovich

"No use aspirina para prevenir ataques cardíacos." Así, en imperativo, está escrito el título de un artículo en el British Journal of Medicine, órgano de la Asociación Médica Británica, que procura desalentar en profesionales y pacientes el uso continuado de este medicamento en bajas dosis con aquel propósito: el problema –verificado por distintos trabajos científicos en los últimos meses– es que las propiedades anticoagulantes de la aspirina, que



Las propiedades anticoagulantes de la aspirina al mismo tiempo aumentan el riesgo de hemorragias graves.

Imagen: AFP

SUBNOTAS

» "Ya no se sostiene la recomendación"
Por Pedro Lipcovich

MIS RECORTES: 0 [0%]

SOCIEDAD | INDICE

MOVILIZACION EN OLAVARRIA A FAVO
DE UN ACUSADO DE VIOLACION
El ejemplo de General Villegas
Por Mariana Carbajal

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BMJ 2010;340:c1805 doi:10.1136/bmj.c1805 (Published 21 April 2010)
Cite this as: BMJ 2010;340:c1805

Practice

Change Page

Don't use aspirin for primary prevention of cardiovascular disease

Helen Barnett, associate editor[1], **Peter Burrill**, specialist pharmaceutical adviser for public health[2], **Ike Iheanacho**, editor[1]

+ Author Affiliations

Correspondence to: H Barnett hbarnett@bmjgroup.com

Accepted 15 March 2010

All patients currently taking aspirin for primary prevention should be reviewed individually to reconsider whether such treatment is justified

The clinical problem

Cardiovascular disease accounted for around two million deaths in the

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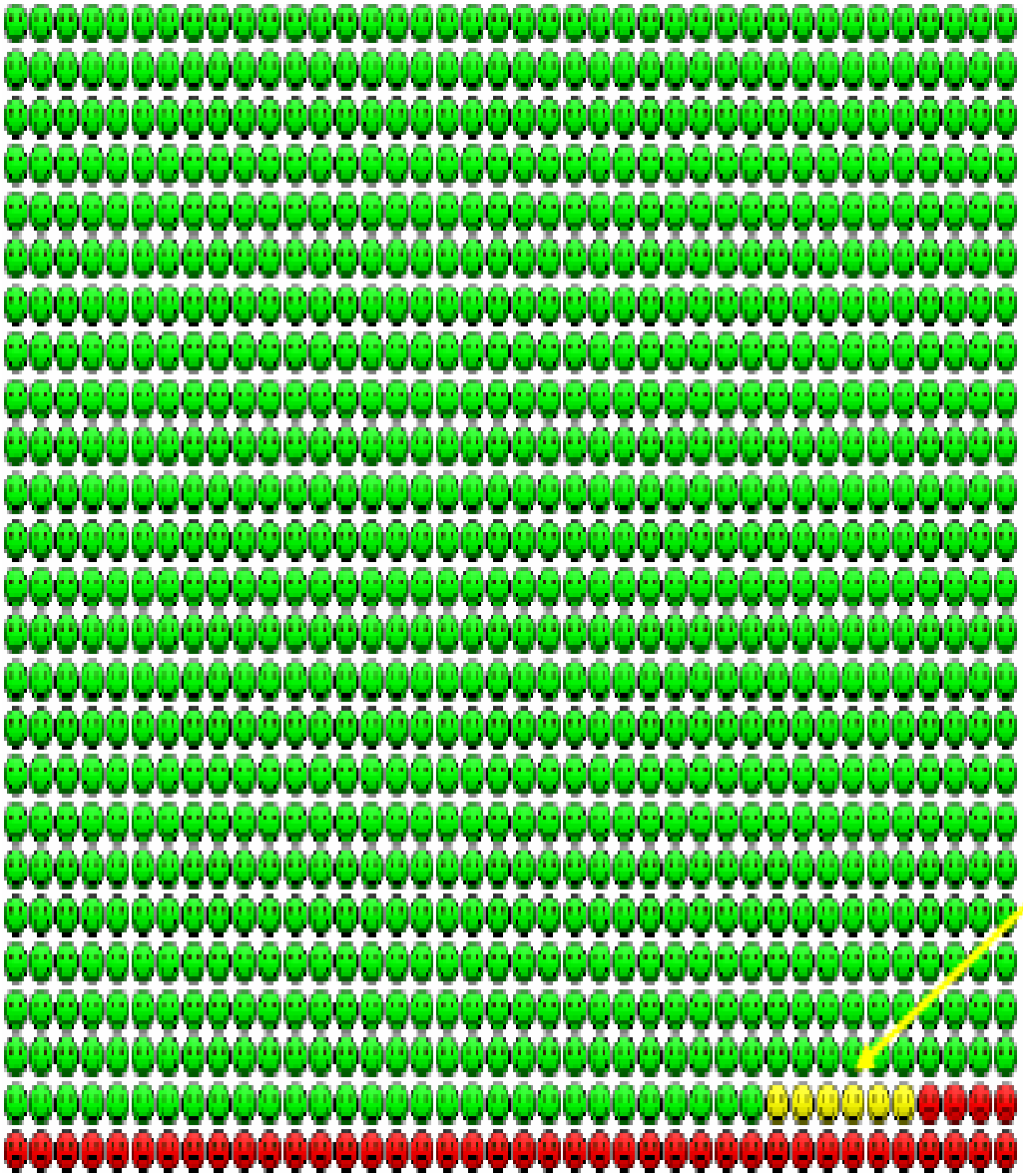
- David Kerr: The new prohibition (24 Jun 2011)
- Research highlights – 24 June 2011 (24 Jun 2011)

Aspirina en prevención primaria

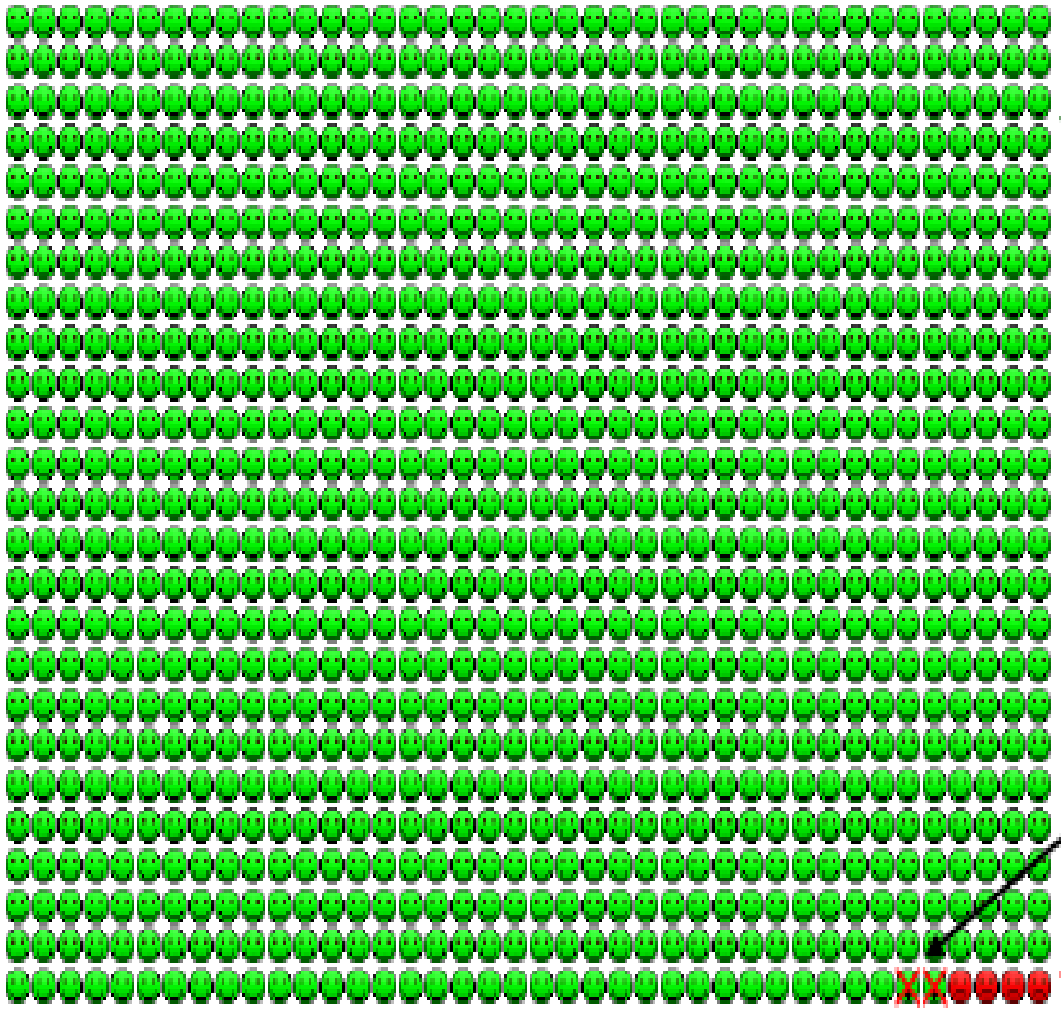
- La decisión debe ser individualizada
- Incluye balance entre riesgos y beneficios
  - Bajo riesgo: beneficios no equiparan los riesgos
  - Para moderado y alto riesgo, los datos de los ensayos son escasos.
  - Toma de decisiones compartidas



These 950 people will not die, have a non-fatal MI or a stroke whether or not they take aspirin

These 6 people will be saved from dying, having a non-fatal MI or a stroke by taking aspirin

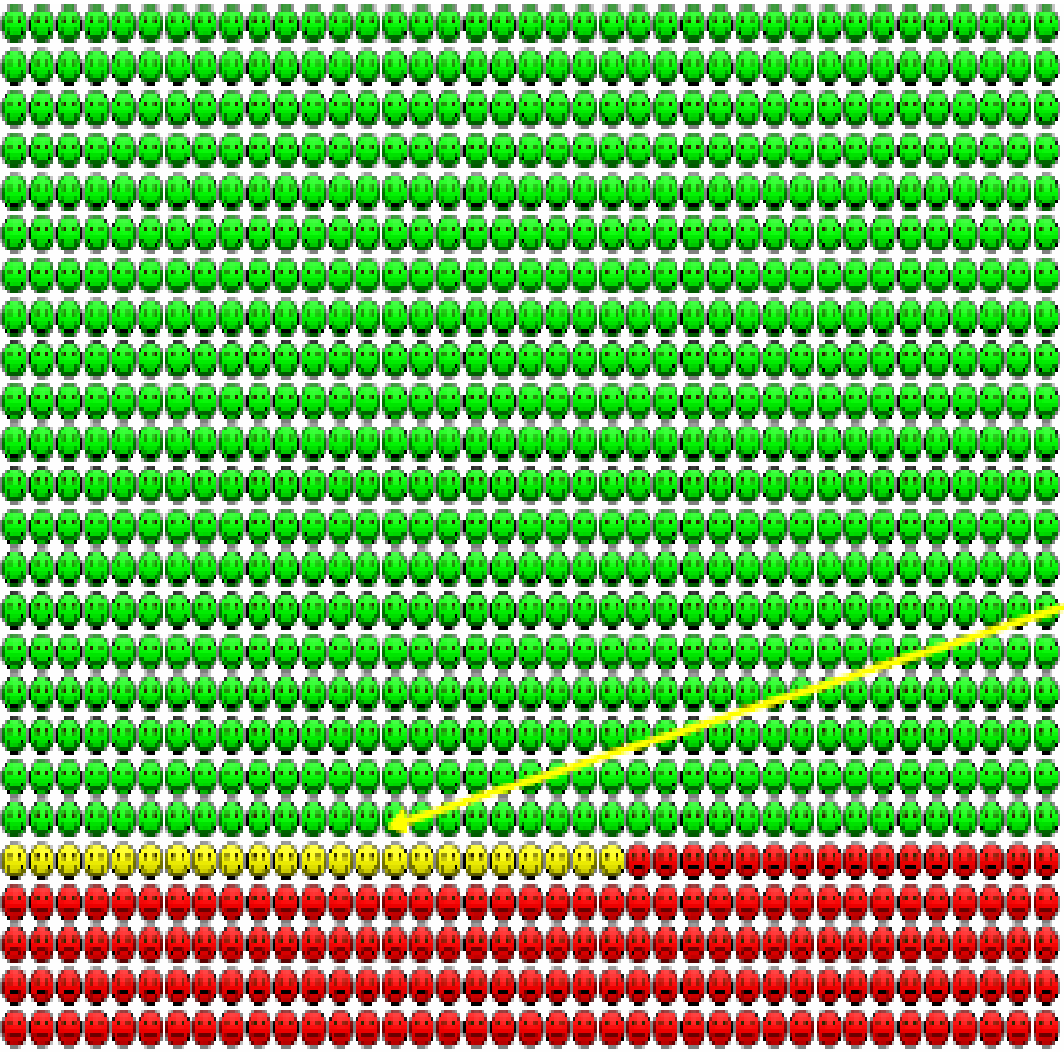
These 44 people will die or have at least one non-fatal MI or stroke, whether or not they take aspirin



These 994 people will not have a major bleed whether or not they take aspirin

These two people will have a major bleed because they take aspirin

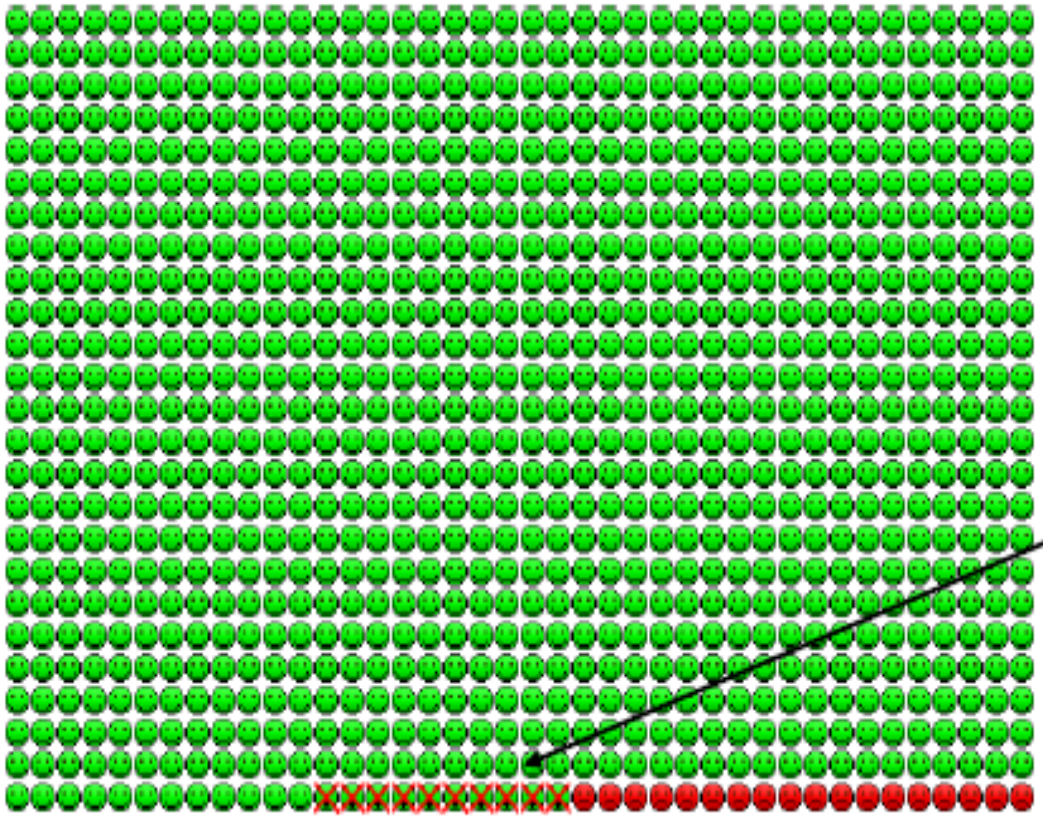
These four people will have a major bleed whether or not they take aspirin



These 800 people will not die, have a non-fatal MI or a stroke whether or not they take aspirin

These 24 people will be saved from dying, having a non-fatal MI or a stroke by taking aspirin

These 176 people will die or have at least one non-fatal MI or stroke, whether or not they take aspirin

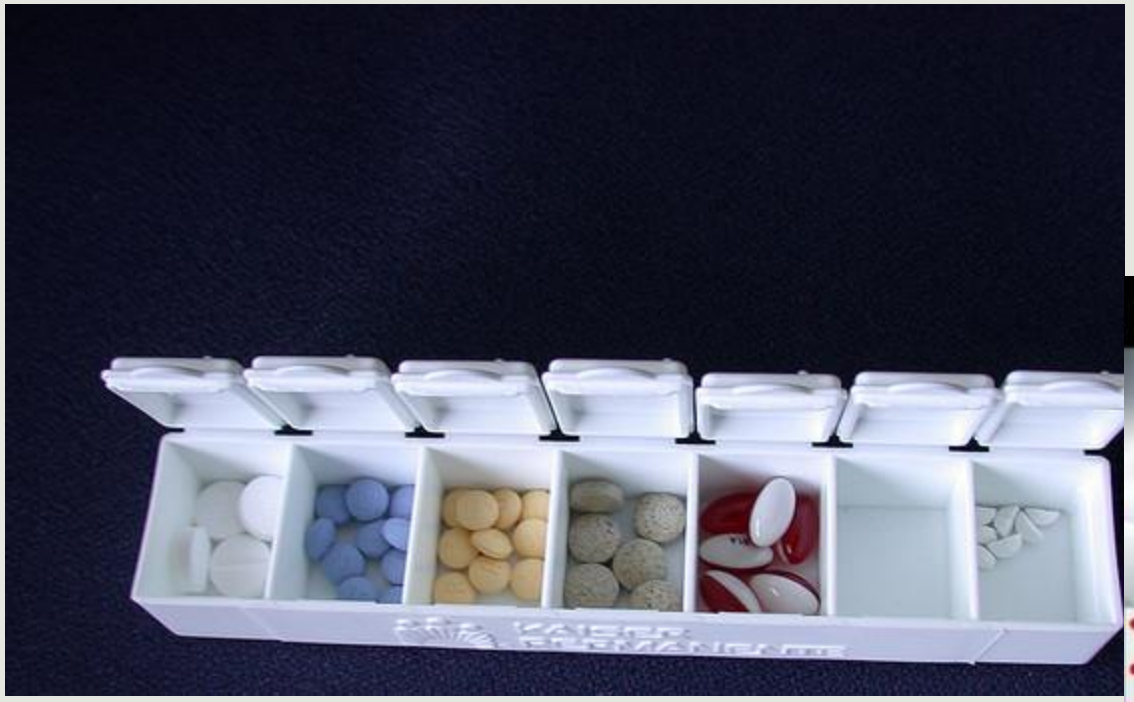


These 972 people will not have a major bleed whether or not they take aspirin

These 10 people will have a major bleed because they take aspirin

These 18 people will have a major bleed whether or not they take aspirin

La polypill



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- Es un desafío de la investigación…

Colesterol

National Cholesterol Education Program

Adult Treatment Panel III (ATP III) Guidelines

CATEGORIA DE RIESGO	Meta de C-LDL	Inicio de Tratamiento No Farmacológico	Inicio de Fármacos
EQUIVALENTE CORONARIO	< 100 mg/dl	≥ 100 mg/dl	≥ 130 mg/dl
≥ 2 FACTORES DE RIESGO	< 130 mg/dl	≥ 130 mg/dl	≥ 160 mg/dl
≤ 1 FACTOR DE RIESGO	< 160 mg/dl	≥ 160 mg/dl	≥ 190 mg/dl

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Decidiendo a quién tratar…

- Hay que ver a las estatinas como una medida que reducen 20-30% riesgo cardiovascular independientemente LDL basal
- El beneficio en términos absolutos sí depende del riesgo global

The effects of lowering LDL cholesterol with statin therapy in people at low risk of vascular disease: meta-analysis of individual data from 27 randomised trials

Cholesterol Treatment Trialists' (CTT) Collaborators*

Summary

Background Statins reduce LDL cholesterol and prevent vascular events, but their net effects in people at low risk of vascular events remain uncertain.

Methods This meta-analysis included individual participant data from 22 trials of statin versus control (n=134 537; mean LDL cholesterol difference 1·08 mmol/L; median follow-up 4·8 years) and five trials of more versus less statin (n=39 612; difference 0·51 mmol/L; 5·1 years). Major vascular events were major coronary events (ie, non-fatal myocardial infarction or coronary death), strokes, or coronary revascularisations. Participants were separated into five categories of baseline 5-year major vascular event risk on control therapy (no statin or low-intensity statin) (<5%, ≥5% to <10%, ≥10% to <20%, ≥20% to <30%, ≥30%); in each, the rate ratio (RR) per 1·0 mmol/L LDL cholesterol reduction was estimated.

Interpretation In individuals with 5-year risk of major vascular events lower than 10%, each 1 mmol/L reduction in LDL cholesterol produced an absolute reduction in major vascular events of about 11 per 1000 over 5 years. This benefit greatly exceeds any known hazards of statin therapy. Under present guidelines, such individuals would not typically be regarded as suitable for LDL-lowering statin therapy. The present report suggests, therefore, that these guidelines might need to be reconsidered.

www.thelancet.com Published online May 17, 2012 DOI:10.1016/S0140-6736(12)60367-5

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- Y los muy jóvenes???????
- Y los viejos?????

Decidiendo con qué y como tratar

- Qué se usó en ensayos en prevención primaria (dosis bajas a moderadas) y altas
  - Prava 40, atorvastatina 10
  - Rosu 20

Nunca se testearon diferentes intensidades ni metas en prevención primaria

Por lo tanto

- Si decidió tratar, el monitoreo de LDL es sólo para adherencia
- No hay indicación, usando la estrategia de dosis moderadas, de llevar a ninguna meta

Y si no tolera estatinas

NADA!

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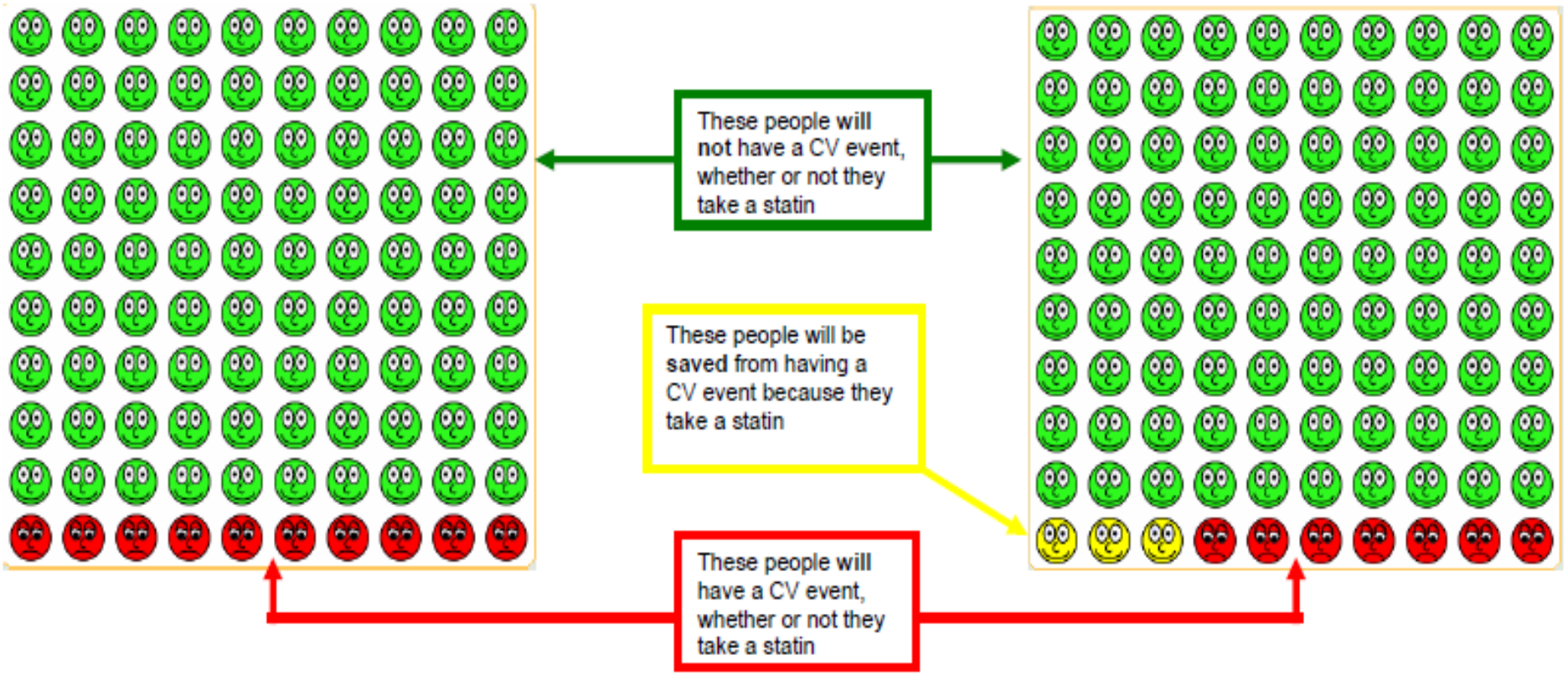
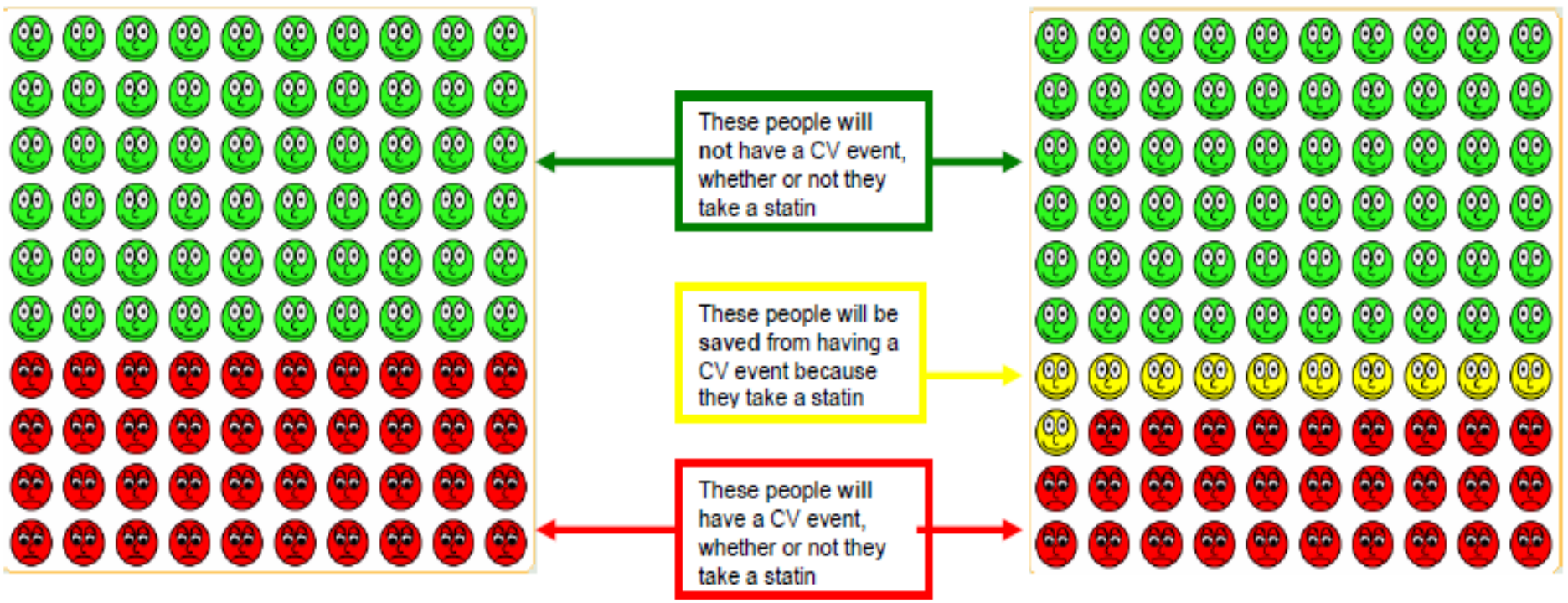
But remember

- It is impossible to know for sure what will happen to each individual person.
- All 100 people will have to take the statin for 10 years.





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¿A quién tratar?

- Riesgo mayor 20% a 10 años (si no puede bajarse por otros medios)

- Niveles colesterol extremos

Algunas alertas

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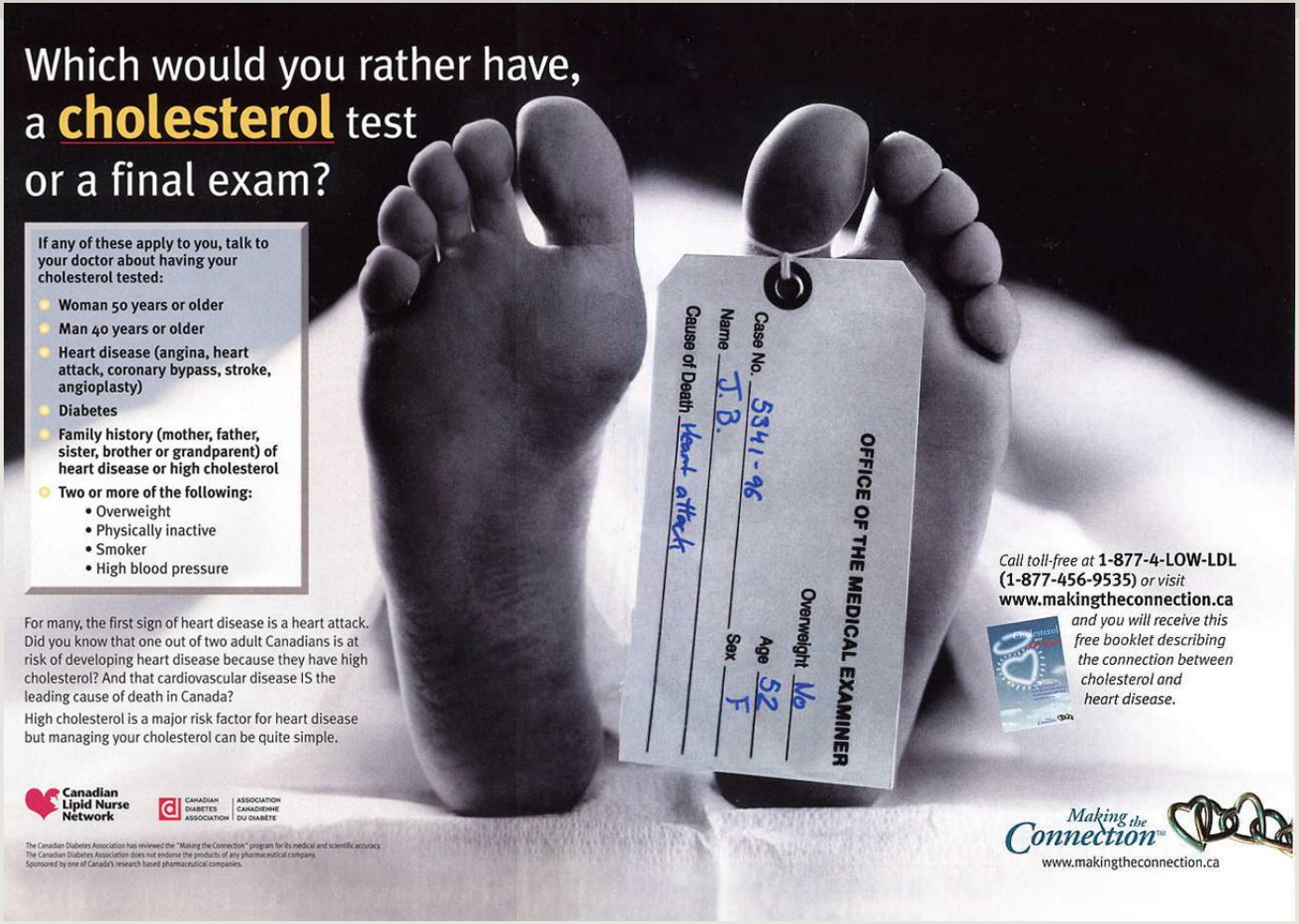

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Scan for Author Audio Interview

Lipid-Related Markers and Cardiovascular Disease Prediction

The Emerging Risk Factors Collaboration*

Context The value of assessing various emerging lipid-related markers for prediction of first cardiovascular events is debated.

Objective To determine whether adding information on apolipoprotein B and apolipoprotein A-I, lipoprotein(a), or lipoprotein-associated phospholipase A_2 to total cholesterol and high-density lipoprotein cholesterol (HDL-C) improves cardiovascular disease (CVD) risk prediction.

Design, Setting, and Participants Individual records were available for 165 544 participants without baseline CVD in 37 prospective cohorts (calendar years of recruitment: 1968-2007) with up to 15 126 incident fatal or nonfatal CVD outcomes (10 132 CHD and 4994 stroke outcomes) during a median follow-up of 10.4 years (interquartile range, 7.6-14 years).

Main Outcome Measures Discrimination of CVD outcomes and reclassification of participants across predicted 10-year risk categories of low (<10%), intermediate (10%-<20%), and high (≥20%) risk.

Results The addition of information on various lipid-related markers to total cholesterol, HDL-C, and other conventional risk factors yielded improvement in the model's discrimination: C-index change, 0.0006 (95% CI, 0.0002-0.0009) for the combination of apolipoprotein B and A-I; 0.0016 (95% CI, 0.0009-0.0023) for lipoprotein(a); and 0.0018 (95% CI, 0.0010-0.0026) for lipoprotein-associated phospholipase A_2 mass. Net reclassification improvements were less than 1% with

ROUTINELY USED RISK PREDICTION scores for cardiovascular disease (CVD) contain information on total cholesterol and high-density lipoprotein cholesterol (HDL-C) and several other conventional risk factors.[1,2] There is considerable interest in whether CVD prediction can be improved by assessment of various additional lipid-related markers either to replace, or supplement, traditional cholesterol measurements in these scores.[3]

Proposals to replace information on total cholesterol and HDL-C with single parameters, such as the total cholesterol:HDL-C ratio or non–HDL-C

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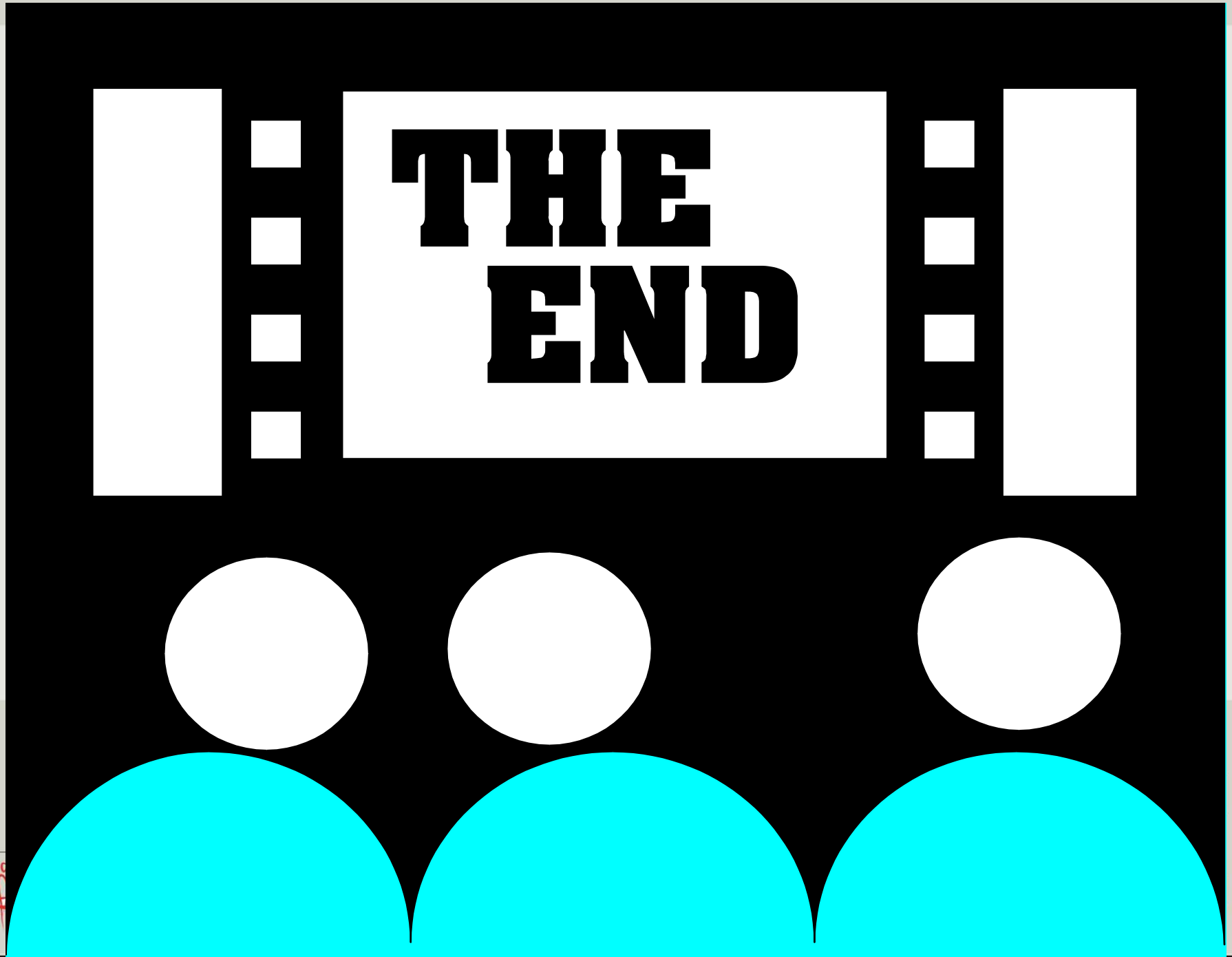
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