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What's new with the 6th Joint Task Force guidelines?

EAS President, Professor Alberico Catapano (University of Milan, Italy) overviewed what was new in the recently published Sixth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice,[1] in a special Congress session. He focused on key areas including risk assessment, goals and targets for important cardiovascular risk factors, recommendations for imaging, and lipid control, as well as intervention strategies.

Risk assessment: Risk assessment is recommended in individuals at increased risk, i.e. with a family history of premature cardiovascular disease or major risk factors, and this should be repeated at least every 5 years, more often in those with risk factors at levels close to targets for management. Systematic risk assessment may be considered in men aged >40 years or women >50 years or post-menopausal women with no known cardiovascular risk factors. Global risk estimation is based on the SCORE approach, with charts providing the 10-year risk of fatal cardiovascular disease, according to age, sex, smoking, systolic blood pressure and total cholesterol. In addition, relative risk charts, adapted from SCORE, may offer additional value in young individuals with risk factors.

Risk factors: Much of the focus of discussion was on lipids. While LDL-C goals remain unchanged across the spectrum of cardiovascular risk, the alternative goal of at least 50% reduction from baseline LDL-C levels for high risk and very high risk patients has been refined. This can be considered in very high risk patients with baseline LDL-C levels between 1.8 and 3.5 mmol/L (70 and 135 mg/dL), and high risk patients with baseline LDL-C levels between 2.6 and 5.1 mmol/L (100 and 200 mg/dL). While the Societies have recognized emerging evidence for high fasting triglycerides (>1.7 mmol/L or >~150 mg/dL) as a risk factor for cardiovascular disease, there is still no support for targets. Similarly, beyond recognition of low high-density lipoprotein cholesterol (HDL-C; (<1.0 mmol/L or 40 mg/dL in men and <1.2 mmol/L or <45 mg/dL in women) as a cardiovascular risk factor, there is no good evidence for targets for HDL-C.

Imaging: The guidelines consider coronary artery calcium scoring, atherosclerotic plaque detection by carotid artery scanning, and ankle brachial index as risk modifiers in cardiovascular risk assessment. Carotid intima-media thickness screening is not recommended for cardiovascular risk assessment.

As with all guidelines, the Sixth Joint Task Force guidelines place diet at the heart of prevention of cardiovascular disease. Lifestyle advice is recommended even for people at very low risk (SCORE <1%), with LDL-C levels <2.6 mmol/L or 100 mg/dL.

For lipid control, statins remain the first choice for treating elevated LDL-C. In patients at high or very high risk of cardiovascular events, who require further LDL-C lowering to reach goal, ezetimibe is the treatment of choice for combination with a statin. With respect to new therapies, the guidelines recognize that there is consistent support from clinical trials for up to 60% lowering of LDL-C with the new proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors. However, the results of ongoing outcomes studies are needed before any definitive recommendations on their use can be made. Overall, these Sixth Joint Task Force guidelines have provided alignment with the 2011 Joint European Society of Cardiology/European Atherosclerosis Society guidelines;[2] updates to these guidelines are expected at this year's European Society of Cardiology Congress in Rome.

The guidelines have highlighted the importance of adherence, and have provided specific recommendations for attaining and improving adherence. These include simplifying the treatment regimen, assessment of medication adherence, as well as reasons for nonadherence by clinicians, and considering combination therapies strategies – a polypill – to improve adherence.

Professor Catapano discusses the key changes in the guidelines in this **video**.

In a following presentation, **Professor Eva Bossano Prescott (Bispebjerg Hospital, Denmark)**, a member of the Task Force, commented that the guidelines have been generally well received. However, inclusion of a section on how to intervene at the population level to prevent cardiovascular disease was more contentious. Indeed, one reviewer recommended that such an issue should be more comprehensive, given important societal implications, including the potential for reducing health inequalities at the individual level, as well as reduction in healthcare costs, an important issue with ever increasing financial restraints across the globe.

References

1. European Guidelines on cardiovascular disease prevention in clinical practice. European Heart Journal. doi: 10.1093/eurheartj/ehw106
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2. Reiner Z, Catapano AL, De Backer G et al. ESC/EAS Guidelines for the management of dyslipidaemias: the Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and the European Atherosclerosis Society (EAS). Eur Heart J 2011;32:1769-818.