ST. MICHAEL'S
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Questions & Answers with Dr. Beth Abramson

Guidelines for Lipid Lowering: Canadian, eh?

1. Why have the Canadian Guidelines ignored TGs over the past many years

   Answer: There is controversy as the "causality" of TG in ASHD Vs the association it has with other risks (low HDL). Until recently there has been little evidence to support intervention with treating TGs.

2. People must die of something, and few make it to death without some significant health issues ....

   Answer: This comment suggests we should not be practising medicine to improve QOL or quantity of life. It flies in the face of what we are trying to do for those at future risk.

3. In Dr. Abrahamson's talk, what are the absolute outcomes for total mortality and/or freedom from disability? There are competing risks, after all.

   Answer: There were several studies discussed. In general most preventive strategies have a 25% relative risk reduction of MACE, but it depends on the event rate of the population studies. Post MI patients have greater short term absolute risk. NNTs range but very from 50-75 depending on the population and intervention. In Reduce It the NNT was 21, lower than many studies.

4. There is a popular documentary ,"Fat Fiction", on amazon prime that I find a lot of patients have seen. Its goal seems to be to discredit lipids as being a risk factor for CVD...It preaches propaganda style on how clinical trials in fact do not prove lipids are a risk factor. Do you have any advice on a reply to something like this? In a typical GP appt, there is inadequate time to present all of the evidence in an understandable way to patients affected by such propaganda documentaries? Thank you

   Answer: I take a personal approach and don't argue the science with these patients. The argument can't be won with science (just like anti-vaccers) – I tell patients I treat them as I would my family members.

5. Q for Dr Abramson - Is she able to comment on the decision/rationale for the US guidelines to abandon specific lipid targets as opposed to Canadian/European guidelines

   Answer: I was not on the guideline committee, but I think it stems from a reduction in events from a population perspective, and the concept that lower is better. Most trials do not have "dichotomous" endpoints, rather lower is better. To be fair, until recently our previous LDL target of 2 was not evidence based, rather easier to "translate" for the medical community. .

6. Are there also concerns for rosuvastatin for other east asian patients e.g. Chinese and also south asians as well?

   Answer: To my knowledge this is not a concern. It is specific to the Japanese population. I would treat others aggressively and monitor B/W.

7. Dr. Abrahamson: you referred to having to spend a great deal of time persuading people to take statins. Why? They are inexpensive now, so what do people not like about them? The CTT collaborationists deny statin muscle toxicity, but they DEFINE myopathy by requiring CK at least 10 times ULN ... What do your patients not like about these drugs?

Answer: Mostly they are worried re side effects and want to do things "naturally". Patient "hear" about things from friends. There are several academics who have published books/articles on line that fly in the face of evidence and science. They often respond to the correct information .

8. Why has Common Drug Review not yet reached a conclusion on icosapentethyl? Did their initial meeting of CDEC disapprove of the effectiveness, or cost-effectiveness of this treatment?

   Answer. I'm not sure as to the rationale specifically. From other examples in the past, cost has been an issue, regardless of effectiveness.