HAH Bulletin
ISSUE #12 APRIL 2022

He Ako Hiringa
Learning Always

# Is your CVD management aggressive enough?

Are all your patients with cardiovascular disease receiving appropriate and equitable pharmacotherapy?

The latest primary care CVD management guideline strongly recommends aggressive risk management and lifestyle modification in patients with pre-existing CVD or an equivalent CVD risk.[1]

Intensive pharmacotherapy for the secondary prevention of cardiovascular events currently comprises a statin, an antihypertensive and an antiplatelet – known as triple therapy.[1]

High-risk patients include those with a previous cardiovascular event; congestive heart failure; familial hypercholesterolaemia; chronic kidney disease or diabetes with overt nephropathy or other renal disease; and asymptomatic carotid or coronary disease.[1] Five-year CVD risk for these patients is >15 per cent, so using risk equations is not necessary.

## Opportunities to improve medicine use

CVD disproportionately affects Māori and Pacific peoples: 2.6–2.8 times more years are lost to cardiovascular events relative to non-Māori/non-Pacific peoples.[2] This is despite the availability in New Zealand of highly cost-effective medicines for CVD prevention.

New Zealanders of European ethnicity with CVD (as identified by hospital discharge codes) are more likely to be taking CVD medicines compared with other ethnic groups. After adjustment for comorbidities that may limit aggressive secondary CVD prevention, in 2019 more people of European/Other ethnicity were on at least one of the three groups of CVD medicines (91 per cent) compared with Māori (83 per cent) or Pacific peoples (84 per cent).[3]

Significant opportunities in improving CVD medicines use remain. People with CVD have very high contact rates with primary healthcare and PHO enrolment rates. The high proportions of CVD patients who had at least one primary healthcare consult (96.9 per cent) in 2019 or were currently enrolled in a PHO in 2020 (99.2 per cent) provide a valuable opportunity for proactive care, eg, system alert set-ups, for the management of secondary prevention in people with CVD.[3]

*References are available with the online bulletin*

aHAH MOMENT!

### Reality check: CVD inequity

Medicines for primary and secondary cardiovascular disease prevention are funded and available in New Zealand, yet there has been limited improvement in their use for a number of years.[3] These medicines could reduce the risk of recurrent CVD events by at least 50 per cent over five years.

One factor associated with lower dispensing of medicines is previous publicly-funded CVD hospitalisations not being recorded, and subsequently not being captured by general practice at the time of a patient's first CVD risk assessment.

This is more likely to occur in people of non-European ethnicities, women and people under the age of 55 years.[4]