

CVD risk management – the New Zealand approach

Patient communication and joint healthcare practitioner–patient management decisions are critical components of the CVD risk assessment (CVDRA) and management process. Recommendations for interventions, goals and follow-up are based on results of a patient’s CVDRA, and whether the five-year risk of an event presents as:

- <5 per cent (low risk)
- 5–15 per cent (intermediate risk)
- >15 per cent (high risk; equivalent to having had a previous cardiovascular event).¹

It helps to inform and motivate a patient if the expected benefits of treatment have been explained, and when treatment has been shown to be successful (ie, targets met).

For patients with estimated five-year CVD risk of 5–15 per cent, the benefits and harms of lipid-lowering and blood pressure-lowering drugs should be presented and discussed – Ministry of Health 2018¹

To address inequity of CVDRA and management in Māori or Pacific peoples, and particularly in identifying younger adults, a number of questions arise:

- How many people younger than 40 years would have their risk calculated at >15 per cent or 5–15 per cent?
- Are risk estimations appropriate for these age groups?
- While trials show statins are effective for primary prevention, almost all participants were older than 40 years – to what extent can the results be extrapolated to younger adults?

Cardiovascular risk is on a continuum, meaning that anyone is potentially at risk, but some more than others. The overall goal is to reduce CVD risk for individuals through making shared decisions.¹ The balance of treatment benefit and risk will also differ for each patient. People at the highest CVD risk will benefit the most from taking a statin, with larger reductions in absolute risk, and any potential harms from statin treatment likely to be perceived as a lower risk. In contrast, people at a lower level of CVD risk receive less benefit from taking a statin but have the same risk of harms, so they may feel the risk of taking a statin outweighs the benefit.¹²

While there is no clear evidence statins would not be effective in younger people, trials are under way (ECAD trial; Eliminate Coronary Artery Disease) investigating statins for the primary prevention of CVD in young adults.¹³ Conclusive evidence may be hard to obtain given the participant numbers and study duration required.

Given the lack of data internationally on the efficacy of screening for or treatment of dyslipidaemia in adults younger than 40 years, the US Preventive Services Task Force Recommendation Statement encourages clinicians to use their clinical judgement for these patients.¹⁴ Bearing in mind the earlier onset (15 years) of CVD in Māori and Pacific peoples in New Zealand, this should be noted, and lifetime risk considered and communicated as well when cardiovascular health is discussed.

References are available with the online article

Resources

- Ministry of Health. 2018. Cardiovascular Disease Risk Assessment and Management for Primary Care. Wellington: Ministry of Health.
www.health.govt.nz/publication/cardiovascular-disease-risk-assessment-and-management-primary-care
- Heart Foundation. My Heart Check.
<https://myheartcheck.org.nz>

Module 3: Activity 1	Learning notes	Reflections on practice
<p>Refer to the section on “Management thresholds” and Table 5 in the Ministry of Health resource and:</p> <ul style="list-style-type: none">• ensure you can clearly communicate the recommendations for management based on risk level.	Write your notes here (editable text box)	Write your notes here (editable text box)

Module 3: Activity 2	Learning notes	Reflections on practice
<p>Refer to the sections “Supporting behaviour change”, “Lipid lowering” and “Blood pressure lowering” in the Ministry of Health resource and:</p> <ul style="list-style-type: none"> • ensure you can clearly communicate the expected primary prevention benefits in terms of relative risk reduction of a 1mmol decrease in LDL-cholesterol (LDL-C) and each 10mmHg reduction in systolic blood pressure • ensure you can clearly communicate the absolute benefit of a 40 per cent reduction in LDL-C in primary prevention (target for patients with 5–15 per cent risk), which should be calculated and presented using the electronic decision aid • ensure you are familiar with the targets, if pharmacotherapy is commenced, for LDL-C and office blood pressure for patients with 5–15 per cent and >15 per cent risk levels (allowing for individual medical considerations and personal circumstances eg, older age, diabetic neuropathy, postural symptoms). 	<p>Write your notes here (editable text box)</p>	<p>Write your notes here (editable text box)</p>

Module 3: Activity 3	Learning notes	Reflections on practice
<p>Once you are familiar with the Heart Foundation’s My Heart Check tool:</p> <ul style="list-style-type: none">ask your next three Māori and Pacific patients aged 30 to 40 years whether they would agree for you to take them through the Heart Foundation’s My Heart Check tool to assess their current “heart age” and future risk trajectory.	<p>Write your notes here (editable text box)</p>	<p>Write your notes here (editable text box)</p>