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IMPA NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

FROM THE PEN OF THE PRESIDENT. . .

Dear Colleagues,

We have committed ourselves in the last month for several important activities which have far reaching implications.

First the IMPA is taking an active part in publishing and printing the Sri Lanka Drug Index for the current year. The Drug Index sub-committee of the IMPA met with the key resource persons on Friday 18th Jan 2019 at 4.00 pm at the IMPA office. All the matters pertaining to the publication were discussed in detail and consensus reached on most of the matters. IMPA also took a keen interest to make the Drug Index updated annually and to make it more user friendly. We will keep you updated in this column as the project unfolds and bear fruit.

Second we also made a commitment to partner with OPA for a project on drug addiction prevention after OPA accepted a protocol proposed by the IMPA on the subject. However the project is in very early stages of implementation still and we value the input from our membership for this project. Please contact Mrs Champa Nishanthi for further details and suggestions.

Third we are also planning to solve a yet another nationally important problem relevant very much for the vision and mission of IMPA as depicted by our forefathers who wrote the constitution. For the sake of ease of reference I would like to call this project the IMRS project which is an acronym for IMPA Morbidity Registration System project. This is proposed as a solution for a very sourly felt deficit of primary care in Sri Lanka. Have you noticed if you have ever gone through the Annual Health Bulletin of Ministry of Health that there is virtually no DATA ON PRIMARY CARE MORBIDITY in Sri Lanka ? Annual Health Bulletin has repeatedly informed the reader about this deficit in nearly every print. This is of course despite a whopping annual consultation rate of nearly 95,000,000 conducted by doctors in Sri Lanka in both private and public sectors. There will be a full article on this project in our next Newsletter where all of us can get together and continue to develop and implement this project of national importance.

As mark Twain once told 'We are all in the gutter... but some of us are looking at the stars'.

Dr Ananda Perera

Editor - Dr A L P de S Seneviratne

The Life Saving Treatment for Patents with CVD

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Awarded "Knight of St. John"
by Her Majesty the Queen.

Her Majesty The Queen, the Sovereign Head of the Most Venerable Order of the Hospital of St. John of Jerusalem, has been graciously pleased to sanction the promotion of Dr. Sarath Samarage, the Hony. Secretary of IMPA as a **Knight in the Order**, for the outstanding services he has rendered through the St. John Ambulance Association & Brigade of Sri Lanka.

The announcement of this honour appeared in the 'London Gazette' on 22 December 2018. https://www.thegazette.co.uk / notice / 3178740

Dr.Samarage joined the St John Ambulance in 1971 after following a certificate course in First Aid under Prof. Milroy Paul. Over the last 47 years he has served the organization as a Divisional Surgeon, District Commissioner, Director-Primary Health Care, Director-Training & Development, Commander and currently serving as its Chairman.

From Medscape

CHOLESTEROL MANAGEMENT CLINICAL PRACTICE GUIDELINES (2018)

Reviewed and summarized by Medscape editors
December 05, 2018

The recommendations on management of blood cholesterol were released in November 2018 by the ACC, AHA, and multiple other medical societies.

The guideline's top 10 key recommendations for reducing the risk of atherosclerotic cardiovascular disease through cholesterol management are summarized below.

- Emphasize a heart-healthy lifestyle across the life course of all individuals.
- In patients with clinical atherosclerotic cardiovascular disease (ASCVD), reduce low-density lipoprotein cholesterol (LDL-C) levels with high-intensity statin therapy or the maximally tolerated statin therapy.
- In individuals with very high-risk ASCVD, use an LDL-C threshold of 70 mg/dL (1.8 mmol/L) to consider the addition of nonstatins to statin therapy.
- In patients with severe primary hypercholesterolemia (LDL-C level ≥190 mg/dL [≥4.9 mmol/L]), without calculating the 10-year ASCVD risk, begin high-intensity statin therapy.
- In patients 40 to 75 years of age with diabetes mellitus and an LDL-C level of ≥70 mg/dL: Start moderate-intensity statin therapy without calculating their 10-year ASCVD risk.
- In patients aged 40 to 75 years evaluated for primary ASCVD prevention: Have a clinician–patient risk discussion before starting statin therapy.

In nondiabetic patients aged 40 to 75 years and with the following characteristics:

- LDL-C levels ≥70 mg/dL (≥1.8 mmol/L), at a 10-year ASCVD risk of ≥7.5%: Start a moderate-intensity statin if a discussion of treatment options favors statin therapy.
- A 10-year risk of 7.5-19.9% (intermediate risk): Risk-enhancing factors favor initiation of statin therapy.
- LDL-C levels ≥70-189 mg/dL (≥1.8-4.9 mmol/L), at a 10-year ASCVD risk of ≥7.5-19.9%: If a decision about statin therapy is uncertain, consider measuring coronary artery calcium (CAC) levels.

Assess patient adherence and the percentage response to LDL-C–lowering medications and lifestyle changes with a repeat lipid measurement 4-12 weeks after initiation of statin therapy or dose adjustment; repeat every 3-12 months as needed.

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Cardiovascular Disease Prevention and Management Clinical Practice Guidelines (2018)
Canadian Cardiovascular Harmonized National Guideline Endeavour (C-CHANGE)

Reviewed and summarized by Medscape editors
November 01, 2018

Body Habitus
Monitor daily morning weight in patients with heart failure, with fluid retention or congestion that is not easily managed with diuretic agents, or in individuals with significant renal dysfunction.

Diet, and Sodium and Alcohol Intake
For hypertension prevention and blood pressure (BP) reduction in hypertensive adults, reduce daily sodium intake toward 2000 mg (5 g of salt or 87 mmol of sodium).

Encourage all individuals to moderate energy (caloric) intake to achieve/maintain a healthy body weight and to adopt a healthy dietary pattern to reduce their CVD risk, such as the following:

- Mediterranean, Portfolio, or DASH (Dietary Approaches to Stopping Hypertension) dietary pattern
- Dietary patterns high in nuts (≥30 g/day), legumes (≥4 servings/week), olive oil (≥60 mL/day), total fiber (≥30 g/day), and whole grains (≥3 servings/day), as well as those rich in fruits and vegetables (≥5 servings/day)
- Low glycemic load or low glycemic index dietary patterns
- Vegetarian dietary patterns

Diabetes
Offer diabetic patients timely self-management education tailored to enhance self-care practices/behaviors.

Overweight/obesity
Include a dietary plan for health improvement as part of a weight-management strategy in obese adults.
A comprehensive healthy lifestyle intervention is recommended for overweight and obese patients.

Risk Factor Screening
Every 3 years, screen all individuals aged 40 years and older, or those at high risk, for diabetes using fasting plasma glucose (FPG) and/or glycosylated hemoglobin (A1C) levels, and a risk calculator. Test earlier and/or follow up more often (every 6-12 months) with either FPG and/or A1C, or consider a postload glucose (2hPG) in a 75 g oral glucose tolerance test (OGTT) in very high-risk persons, using a risk calculator, or in those with additional type 2 diabetes risk factors, including, but not limited to, the following:

- Age 40 years and older
- First-degree relative with type 2 diabetes
- Member of a high-risk population (African, Arab, Asian, Hispanic, Indigenous/South Asian descent; low socioeconomic status)
- History of prediabetes, gestational diabetes (GDM), or delivery of a macrosomic infant
- Presence of microvascular or cardiovascular (CV) end-organ damage associated with diabetes
- Presence of vascular risk factors (HDL-C <1.0 mmol/L in males, <1.3 mmol/L in females; triglycerides ≥1.7 mmol/L; hypertension; overweight; abdominal obesity; smoking) or associated diseases (history of pancreatitis, polycystic ovarian syndrome, acanthosis nigricans, hyperuricemia/gout, nonalcoholic steatohepatitis, psychiatric disorders [bipolar disorder, depression, schizophrenia], human immunodeficiency virus [HIV] infection, obstructive sleep apnea, cystic fibrosis)
- Use of medications associated with diabetes (glucocorticoids, atypical antipsychotics, statins, highly active antiretroviral therapy, antirejection drugs)

To identify individuals with impaired glucose tolerance (IGT) or diabetes, consider testing with 2hPG in a 75 g OGTT in those with an FPG of 6.1-6.9 mmol/L and/or an AIC of 6.0%-6.4%.

Use standardized BP measurement techniques and validated equipment for all methods (automated office BP [AOBP], non-AOBP, ambulatory BP monitoring, and home BP monitoring). Upper arm electronic (oscillometric) measurement devices are preferred over auscultation. Note the following:

- AOBP (preferred): The displayed mean BP is high when systolic BP (SBP) is ≥135 mmHg or diastolic BP (DBP) is ≥85 mmHg.
- Non-AOBP: The mean BP is high when the SBP is ≥140 mmHg or the DBP is ≥90 mmHg; it is high-normal when the SBP is 130-139 mmHg and/or the DBP is 85-89 mmHg.
- Ambulatory BP monitoring: Hypertension is diagnosed with a mean awake SBP of ≥135 mmHg or DBP of 85 mmHg, or with a mean 24-hour SBP of ≥130 mmHg or DBP of ≥80 mmHg.
- Home BP monitoring: Hypertension is diagnosed

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with a mean SBP of ≥135 mmHg or DBP of ≥85 mmHg.

Screen plasma lipids in men and women aged 40 years and older (or postmenopausal women). Screen earlier for those in ethnic groups at increased risk (eg, South Asian or First Nations individuals). Inform patients of their global risk to improve efficacy of risk factor modification.

Screen lipids at any age in patients with the following features:
- Clinical evidence of atherosclerosis
- Abdominal aortic aneurysm, diabetes mellitus, arterial hypertension, stigmata of dyslipidemia, chronic kidney disease, obesity, inflammatory disease, HIV infection, erectile dysfunction, chronic obstructive pulmonary disease, hypertensive disease of pregnancy
- Current tobacco use (regularly update patients' tobacco use; advise smoking cessation)
- Family history of CVD

Heart failure
Assess patients with known/suspected heart failure for multimorbidity, frailty, cognitive impairment, dementia, and depression; all of these may affect treatment, therapeutic adherence, follow-up, or prognosis.
Hypertension
Assess patients' global CV risk.
Overweight/obesity

Screen patients for eating disorders, depression, and psychiatric disorders, as appropriate.

Stroke
For those at risk of, or who have had, a stroke, evaluate for vascular disease risk factors, lifestyle management issues, and use of oral contraceptives or hormone replacement therapy.

Provide information and counseling to individuals at risk of stroke about possible strategies for lifestyle and risk factor modifications, and refer to appropriate specialists as needed.

Diagnostic Strategies
Diabetes
The diagnosis of diabetes is made with any of the following criteria:
- FPG ≥7.0 mmol/L
- A1C ≥6.5% (in adults, in the absence of factors affecting A1C accuracy; not for those with suspected type 1 diabetes)
- 2hPG in a 75 g OGTT ≥11.1 mmol/L
- Random plasma glucose (PG) ≥11.1 mmol/L

Heart failure
Measure levels of B-type natriuretic peptide (BNP)/ N-terminal pro BNP (NT-proBNP) to help confirm/ exclude a diagnosis of heart failure in an acute/ ambulatory care setting when the cause of dyspnea is in doubt.

Before initiating cancer therapy known to impair left ventricular (LV) function in patients receiving potentially cardiotoxic cancer treatment, evaluate their LV ejection fraction (LVEF).

Hypertension
Laboratory workup includes the following tests:
- Urinalysis
- Blood chemisty (potassium, sodium, creatinine)
- FBG and/or A1C
- Serum total cholesterol, LDL, HDL, non-HDL-C, TGs; lipids may be drawn fasting/nonfasting
- Standard 12-lead electrocardiography

Obtain echocardiography or nuclear imaging to assess LVEF in hypertensive patients with heart failure.

Consider regular home BP monitoring for hypertensive patients, particularly those with diabetes mellitus, chronic kidney disease, suspected nonadherence, demonstrated white coat effect, or masked hypertension (BP controlled in the office but not at home).

In patients whose large arm circumferences preclude use of standard upper arm measurement methods, use validated wrist devices for assessing BP.

Overweight/obesity
When appropriate, obtain additional investigations (eg, liver enzyme tests, sleep studies) to screen for and exclude other common overweight/obesity-related health issues.

Risk Stratification
Complete a CV risk assessment every 5 years for men and women aged 40-75 years, or whenever there is a change in a patient's expected risk status, using the modified Framingham Risk Score (FRS) or Cardiovascular Life Expectancy Model (CLEM) to guide therapeutic interventions for lowering major CV events.

Calculate and discuss a patient's “CV age” to improve their likelihood of achieving lipid targets and that

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poorly controlled hypertension will be treated. Share the results of the risk assessment with the patient for joint decision-making and improving their likelihood of achieving lipid targets.

Treatment Targets

Diabetes

All diabetic individuals should follow a comprehensive, multifaceted approach for CV risk reduction, including the following:

- An A1C of ≤7% implemented early in the course of diabetes (type 1 or 2)
- SBP <130 mmHg and DBP <80 mmHg
- Additional vascular-protective medications in most diabetic adults
- Achievement and maintenance of healthy weight goals
- Healthy eating, regular physical activity, and smoking cessation

Dyslipidemia

A target level of LDL-C consistently <2.0 mmol/L or a >50% LDL-C reduction in those who have initiated treatment is recommended for risk reduction of CVD events. Alternatively, target variables include an apolipoprotein B (apoB) level <0.8 g/L or non-HDL-C level <2.6 mmol/L.

For those with an LDL-C level >5.0 mmol/L who have initiated therapy, a >50% reduction is recommended for reduction of CVD events and death.

Hypertension

For nonhypertensive persons (to lower the risk of hypertension) or hypertensive patients (to lower BP), clinicians should prescribe the accumulation of 30-60 min of moderate intensity dynamic exercise 4-7 days each week in addition to the routine activities of daily living.

For high-risk patients aged 50 years or older with SBP levels of ≥130 mmHg, target an SBP level of ≤120 mmHg. Use AOBP measurements to guide intensive therapy; patient selection is recommended for intensive management, and caution is advised in certain high-risk groups.

Prescribe antihypertensive therapy for average DBP measurements of ≥100 mmHg, or average SBP measurements of ≥160 mmHg in those without macrovascular target organ damage or other CV risk factors. Strongly consider antihypertensive therapy for average DBP measurements of ≥90 mmHg, or for average SBP measurements of ≥140 mmHg in the presence of macrovascular target organ damage or other independent CV risk factors.

Obesity

Previously sedentary individuals initiating activity should begin with light activity and gradual increases. Encourage all obese individuals considering beginning a vigorous exercise program to consult their physician or healthcare team professionals.

Stroke

After the acute phase of a stroke, use BP-lowering therapy to target a consistent BP <140/90 mmHg.

Pharmacologic and Procedural Therapy for CVD Risk Reduction

Coronary artery disease or ischemic heart disease

For those with established CVD, use low-dose acetylsalicylic acid (ASA) therapy (81 mg) to prevent CV events.

Diabetes

Use statin therapy for CV risk reduction in adults with type 1 or 2 diabetes with any of the following features:

- Clinical CVD
- Age ≥40 years
- Age <40 years and one of the following: diabetes >15 years and age >30 years; microvascular complications; therapy warranted due to the presence of other CV risk factors (based on the 2016 Canadian Cardiovascular Society guideline for the diagnosis and treatment of dyslipidemia)

To reduce the risk of major CV events in adults with type 2 diabetes and clinical CVD in whom existing antiglycemic medication is not achieving glycemic targets, add an antihyperglycemic agent with demonstrated CV outcome benefit, such as empagliflozin, liraglutide, or canagliflozin. To reduce the risk of heart failure admission, a sodium–glucose cotransporter 2 (SGLT2) inhibitor with demonstrated reduction in inpatient heart failure admissions may be added.

Use an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin-receptor blocker (ARB), at doses with demonstrated vascular protection, for CV risk reduction in adults with type 1 or 2 diabetes with any of the following: clinical CVD, age ≥55 years with an additional CV risk factor or end-organ damage (albuminuria, retinopathy, LV hypertrophy), or microvascular complications.

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Dyslipidemia

Management should include statin therapy to reduce CVD events and death in high-risk conditions (eg, clinical atherosclerosis, abdominal aortic aneurysm, most diabetes mellitus, chronic kidney disease [age >50 years]) and those with an LDL-C level of ≥5.0 mmol/L.

For those not at LDL-C goal despite statin therapy, use a combination of statin therapy with second-line agents. Select the agent on the basis of the existing gap to the LDL-C goal.

Management should include statin therapy for those at high risk (modified FRS ≥20%) to reduce the risk of CV events.

Management should include statin therapy for individuals at intermediate risk (modified FRS 10%-19%) with an LDL-C level of ≥3.5 mmol/L to reduce the risk of CVD events. Consider statin therapy for those at intermediate risk with an LDL-C level <3.5 mmol/L but with an apoB level of ≥1.2 g/L or non-HDL-C level of ≥4.3 mmol/L, or in men aged at least 50 years and women aged at least 60 years with one or more CV risk factor.

Heart failure

Use triple therapy to treat most patients with heart failure with reduced ejection fraction (HFrEF). This regimen includes an ACEI (or an ARB for ACEI-intolerant patients), a

beta blocker, and a mineralocorticoid receptor antagonist (MRA) in the absence of contraindications. Use loop diuretics to control symptoms of congestion and peripheral edema.

New oral anticoagulants (NOACs) are the agent of choice for stroke prophylaxis in those with heart failure and nonvalvular atrial fibrillation (AF). The treatment dose should be guided by patient-specific characteristics (eg, age, weight, renal function).

Use an angiotensin receptor-neprilysin inhibitor (ARNI), rather than an ACEI or ARB, in persistently symptomatic patients with HFrEF despite therapy with appropriate guideline-directed medical therapy (GDMT) to reduce CV death, heart failure admissions, and symptoms.

Hypertension

Initiate therapy with either monotherapy or single-pill combination.

Recommended monotherapy selections are as follows:

- A thiazide or thiazide-like diuretic (longer-acting preferred)
- A beta blocker (patients aged <60 years)
- An ACEI (non-black patients)
- An ARB
- A long-acting calcium channel blocker (CCB)

Recommended single-pill combinations are those in which an ACEI is combined with a CCB, ARB with a CCB, or ACEI or ARB with a diuretic.

Avoid hypokalemia in patients on thiazide or thiazide-like diuretic monotherapy.

Either a beta blocker or a CCB can be used as initial therapy for patients with stable angina pectoris but without previous heart failure, myocardial infarction, or coronary artery bypass surgery.

Alpha-blockers are not recommended as first-line agents for uncomplicated hypertension; beta blockers are not recommended as first-line therapy for uncomplicated hypertension in patients ≥60 years; and ACEIs are not recommended as first-line therapy for uncomplicated hypertension in black patients. However, these agents may be used in patients with certain comorbid conditions or in combination therapy.

Stroke

Appropriate options, based on the clinical setting, include ASA (80-325 mg), combined ASA (25 mg) and extended-release dypridamole (200 mg), or clopidogrel (75 mg).

Administer oral anticoagulation to patients with transient ischemic attack or ischemic stroke and nonvalvular AF. Direct non-vitamin K anticoagulants (DOACs) are preferred over warfarin for most patients requiring anticoagulation for AF.

Consider patient-specific criteria when selecting oral anticoagulants.

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