Editor’s message

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We are attuned to a new “call to action” for aggressive management of lipid levels and treatment of hypercholesterolemia. Although physicians have been managing lipids for more than a decade, hypercholesterolemia remains surprisingly undertreated. Equally troubling, a gap remains between guidelines and actual practice. The Third National Health and Nutrition Examination Survey (NHANES III)1 reported that of 1251 survivors of myocardial infarction, stroke, or both, fewer than half achieved target low-density lipoprotein cholesterol (LDL-C) levels. This finding is in face of the overwhelming evidence that substantiates the reduction in morbidity and mortality associated with aggressive management of lipid disorders.

The Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III [ATP III])2 maintains the importance of intensive treatment in patients with coronary heart disease (CHD). In addition, the panel underscores the importance of primary prevention in persons with multiple risk factors, because many in this patient population have a relatively high risk for CHD and can benefit from more intensive treatment for elevated LDL-C levels than previously recommended. Furthermore, diabetes has been identified as a CHD risk equivalent. The ultimate goal is to achieve an optimal LDL-C level of less than 100 mg/dL in these high-risk patient populations.

As you are aware, atherosclerosis progresses silently for many years before becoming apparent. Compelling evidence demonstrates that risk of acute coronary events is related not only to lipid levels, but also to inflammatory pathophysiologic processes that can increase the risk of plaque rupture. This evidence means that many more patients are at risk than were previously thought to be.

As documented in this supplement to JAOA, statins have proven ability to reduce not only LDL-C levels but also inflammation. On the horizon are new agents and approaches that may help to correct current treatment deficiencies. In particular, the newer statins have proven efficacy and can help the majority of patients at risk reach their optimal goal as outlined in the ATP III guidelines.

The many untreated patients and the suboptimal results in many treated patients represent an imperative for primary care physicians. The ATP III recommendations are achievable in the primary care setting and have the potential to vastly diminish the tremendous disability, death, and cost associated with heart disease.

References
