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Integrating EPA in CV risk reduction strategies: Practical experience and guidance

Dr. Zaman:
I'm going to talk today about integrating icosapent in cardiovascular risk reduction. You've heard all of the evidence and the trial data showing the benefit of this agent in patients with elevated triglycerides.

These are my conflicts of interest that are relevant to this talk.

So I'm going to talk about the guidelines, how they've developed from the evidence base that you've heard from, and then about how we can disseminate the information about triglycerides locally and try to apply the guidelines into regular practice. And what I will talk about, essentially, is the guidelines-to-practice gap and how this can be overcome by establishing a specialist clinic.

Relevant to the UK, we have the NICE guidelines which recommended icosapent ethyl for the secondary prevention of cardiovascular risk. And the criteria are that patients with a fasting triglycerides of greater than equal to 1.7 mmol/L, already on statins, and importantly, with an additional cardiovascular disease, so whether that's acute coronary syndrome, previous arterial revascularization, coronary heart disease, ischemic stroke, or peripheral arterial disease. And importantly, in addition to statins that they should have an LDL cholesterol level of above 1.04 mmol/L.

What about international guidelines? If we look beyond the UK, we have the European Society and we have the American College of Cardiology. Essentially, they are similar. What they state is that we can start treatment with icosapent ethyl if patients have clinical cardiovascular disease and with triglyceride levels above a certain level. While the 2 guidelines differ in terms of the levels, the principle is the same. You can see that there is benefit, independent of the baseline LDL cholesterol level.

The mechanism, I think, is most important when you look at the EVAPORATE study that shows a change in beneficial plaque morphology, and this might be the reason why you get reduced ischemic events following therapy. And this is supported by this graph, which tells you about the time to first event in patients with a recent acute coronary syndrome, ie, acute coronary syndrome within the first 12 months. You see cumulative events on the y-axis and time since randomization, up to 5 years. And it's very clear the difference between the patients who were treated with icosapent ethyl, where there is a 37% reduction in events out to 5 years. Really impressive data in patients post ACS.

So what did we do? How did we try to bridge this guideline-to-practice gap? Because certainly in our practice, I know that we're not prescribing icosapent ethyl according to the guidelines. So we've established a clinic run by a senior pharmacist and a consultant. We've identified high-risk patients based on those criteria, and we see these patients at 3 months, and their lipid profile is repeated on the standard recommended discharge medication, which for our unit in the UK, is atorvastatin 80. So the secondary prevention of cardiovascular disease, we identified patients who were on maximally tolerated statins with a baseline triglyceride of greater than equal to 1.7 mmol, in line with the NICE guidelines. And these were the patients that we've seen since June 2023, so baseline of 825, of which we had bloods in 769. I'm just going to focus you on the changes post discharge, when we see these patients at 3 months and then at time two, after 6 months, after pharmacy intervention. And you can see that we achieved 73% of patients are at target after time two.

Let's look at this data in more granular detail. So what happens with the LDL-C in this clinic? You can see that from baseline to time two, there's a significant reduction with a mean drop in LDL cholesterol of 1.07. What happens to triglyceride levels? Even without treatment, just with optimally managed lipid therapy with statins, you can see that there is a drop in triglycerides from admission to time two at 6 months. And this is significant even from time one to time two.

Let's once again look at it in detail. Between the diabetic patients in the dark blue and the nondiabetic patients, you can see that whilst triglycerides do come down, even the mean levels at time two, 6 months, remains above the guideline-recommended levels.

So from our clinic, we know that high-risk ACS patients have elevated LDL cholesterols and triglycerides. Both respond to maximally tolerated lipid-lowering therapy. But after treatment, over 53% of patients remain with a triglyceride level above the NICE recommendation of 1.7 mmol/L. What our data shows is that an ACS-focused clinic facilitates guideline-recommended treatment of LDL cholesterol, and it allows identification of patients with elevated triglycerides.

So in summary, ladies and gentlemen, cardiovascular disease we know has multiple pathophysiological mechanisms. We know from large meta-analysis that even those patients optimally treated with standard secondary prevention medication have an 18% recurrent ischemia event rate within 1 year of their initial event. All of us are aware that the known risk factors should be optimized according to guideline levels. And what our clinic has shown is that there is a clear guideline-to-practice gap. Trial data shows that even if LDL cholesterol is optimized, integrating icosapent ethyl in cardiovascular risk reduction strategies helps to further reduce recurrent ischemic events after an acute coronary syndrome. And what I hope my talk has shown you is that establishing a dedicated acute coronary syndrome clinic facilitates identification and treatment of high-risk ACS patients.

Thank you for your attention.