

Management

Refer to the Croydon Diabetes Guidelines Primary Care management includes

- Awareness that **dyslipidaemia is very common** in diabetic patients especially those with type 2 diabetes and contributes strongly to their increased risk of cardiovascular disease.
- People with Type 2 diabetes often have moderately elevated circulating levels of triglycerides (TG) and small, dense low-density lipoprotein cholesterol (LDL-C) particles, together with reduced levels of high-density lipoprotein cholesterol levels (HDL-C). However, they can have normal levels of total cholesterol (TC) and LDL-C if glycaemic control is adequate.
- At diagnosis and at least annually thereafter, diabetic patients should have blood levels checked for TC, LDL-C, HDL-C and triglyceride (TG). TC and HDL-C can be determined from a non-fasting sample. LDL-C and TG require a **fasting sample** - so this is the most efficient option.
- Interpretation of the results: **TC greater than or equal to 5 mmol/l, or LDL-C greater than or equal to 3 mmol/l, or TG greater than or equal to 2.3 mmol/l = Dyslipidaemia.**
- If levels are raised, exclude other causes (listed in prodigy guidelines) then **repeat samples twice.**
- For diabetic patients with no existing features of coronary heart disease, **10-year CHD risk should be calculated** using the Joint British Societies risk assessment charts for people with diabetes (printed at the back of the BNF) or use the online calculator: <http://www.hyp.ac.uk/bhs/resources/guidelines.htm>. A diabetic patient with existing symptoms of coronary heart disease (CHD) should already be taking lipid lowering therapy, but the efficacy should be checked annually with blood testing and similar 'risk prediction' calculations.
- Croydon recommended drug of choice simvastatin.
- If cholesterol results are not available, use average values for age and sex.
- Use baseline blood pressure (BP) and lipid measurements for risk calculation if people are already taking antihypertensive or lipid-lowering drugs.
- The risk assessment charts will indicate those patients with a **10 year coronary risk > 15%, who therefore require initiation and titration of lipid lowering therapy** according to local / NICE guidelines. (there are also guidelines on Prodigy). As **dietary management** alone only results in small reductions in cholesterol levels (1-5%), it is generally most useful as an **adjunct** to drug treatment. Optimise glycaemic control and other risk factors for CHD such as BP, smoking cessation, BMI etc.

Specialist management includes

- Investigation of causes of significantly raised lipid levels: there are some rare inherited causes.
- Initiation of more complex lipid lowering drug combinations with appropriate monitoring advice.

When to refer

Urgent out-patient referral [liaise with specialist and copy to CAS]

- Patient with very high lipid levels: TG >10.

Refer to CAS

Diabetic patient with raised lipid levels ie TC > 5 or LDL > 3 or TG 2.5 - 10 who have had a 6 month trial of medication but are proving hard to lower.

Patient with complex interactions / intolerance of suggested medications yet warranting lipid lowering therapy.

Patient with positive family history of dyslipidaemia where optimal treatment is uncertain.

Refer to RARC

- if the patient does not meet the referral criteria above consider referral to CAS requesting a RARC appointment.