**For further detail,** please refer to the **Cardiovascular Disease Risk Assessment and Management for Primary Care** (Ministry of Health, 2018)

https://www.health.govt.nz/publication/cardiovascular-disease-risk-assessment-and-management-primary-care

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# What's new in **Cardiovascular Disease Risk Assessment and Management for Primary Care clinicians?**

***Reviewed by:*** **Associate Professor Gerry Devlin, Cardiologist and Medical Director Heart Foundation, Dr Fraser Hamilton, GP, and Dr Joan Leighton, GP, Heart Foundation**

In February 2018, the Ministry of Health published a Consensus Statement on **Cardiovascular Disease Risk Assessment and Management for Primary Care** to update and refresh the CVD guidelines in the **New Zealand Primary Care Handbook 2012.**

The Consensus Statement references the New Zealand Primary Prevention Equations from the New Zealand PREDICT study. The Ministry of Health is looking at how to integrate the new equations into usual practice.

**Management recommendations can be applied now** using current CVD risk assessments identifying high, intermediate and low-risk individuals.

**Encouraging a healthy lifestyle** remains a key foundation to the management of everyone regardless of CVD risk. These include smoking cessation, healthy diet, regular physical activity, optimal weight.

Communicating risk to individuals as part of shared decision making and CVD risk management is recommended.

# Important changes

### *Start earlier*

For Māori, Pacific and South-Asian populations, screening should begin at **age 30 years for men** and **40 years for women**, 15 years earlier than other populations.

Individuals with severe mental illness (schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder) are a high-risk group and screening from age 25 years is recommended.

### *Annual reviews recommended for high-risk individuals*

Annual risk management reviews are recommended for all **high-risk individuals** and for **individuals at intermediate risk on pharmacotherapy**.

### *New clinical high-risk groups*

Individuals with Heart Failure, a Glomerular Filtration Rate (e GFR) less than 30 ml/min (chronic kidney disease) and where available, a diagnosis of asymptomatic carotid disease or coronary disease (including coronary artery calcium score greater than 400 or plaque identified on CT angiography) are regarded as high risk for CVD and require intensive risk management.

### *Lipid management*

Statins are the lipid-lowering agent of choice. For high-risk individuals a **LDL-C target of 1.8mmol/L or lower is recommended.**

For intermediate-risk individuals the benefits and harms of lipid-lowering drugs should be presented and discussed to allow an individualised informed decision about whether to start treatment.
**A target LDL-C reduction of 40% or greater is recommended if drug treatment is commenced**.

### *Blood Pressure*

For high-risk individuals with persistent office BP 130/80mmHg or greater, or an equivalent level from ambulatory or home blood pressure monitoring, drug treatment in addition to lifestyle changes, is strongly recommended.

For intermediate risk individuals with persistent office BP of 140/90mmHg or greater, or an equivalent level from ambulatory or home BP monitoring, the benefits and harms of BP-lowering drugs should be presented and discussed to allow an individualised informed decision about whether drug treatment is commenced.

**In all individuals if drug treatment is commenced, a target office BP less than 130/80mmHg is recommended.**

Caution is recommended in lowering BP in elderly and comorbid individuals who may be at particular risk of treatment-related harms.

### *Aspirin*

The benefits of the use of aspirin need to be carefully weighed up against the risks of bleeding and, in general, should only be considered in high-risk individuals under the age of 70 for primary CVD prevention alone.