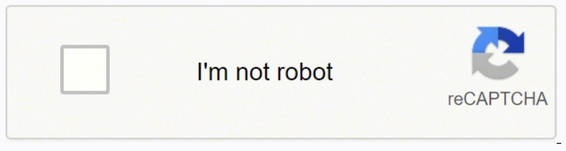


Next

Primary prevention of cardiovascular disease nice guidelines

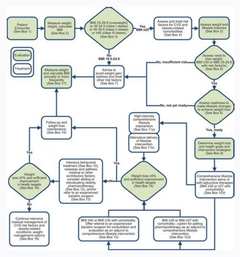


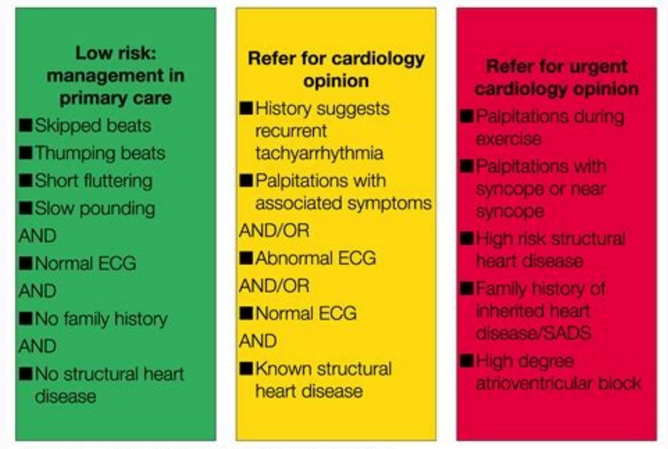
TABLE 4. Agents recommended for achieving lipid-lowering goals[4,5,24]

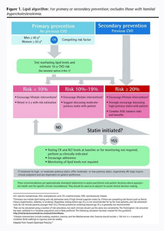
	Recommended lipid-lowering agents		
	2016 European Guidelines on Cardiovascular Disease Prevention in Clinical Practice[4]	2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults[5]	2014 NICE Clinical Guideline on Lipid Modification
Primary prevention	Statin	10-Year risk ≥7.5%: moderate*- to high†-intensity statin	10-Year risk ≥10%: atorvastatin 20 mg Age ≥85 years: consider atorvastatin 20 mg
Secondary prevention	Statin	≤75 Years: high-intensity statin† >75 Years: moderate statin*	Atorvastatin 80 mg
Familial hyper-cholesterolaemia	Statin	High-intensity statin†	Atorvastatin 20 mg Consider ezetimibe for FH
Diabetes	Statin	10-Year risk ≥7.5%: high-intensity statin† 10-Year risk <7.5%: moderate-intensity statin*	Type 1: consider atorvastatin 20 mg Type 2 and 10-year risk ≥10%: atorvastatin 20 mg
CKD	Statin	No specific recommendation	Atorvastatin 20 mg If non–HDL-C ↓ <40%: consider higher dose
Combination with non-statin	If target not reached with highest tolerated statin	If target not reached with highest tolerated statin	Do not offer fibrate, niacin, BAS, or omega-3 fatty acid

Abbreviations: ACC/AHA = American College of Cardiology/American Heart Association; BAS = bile acid sequestrant; CKD = chronic kidney disease; FH = familial hypercholesterolaemia; HDL-C = high-density lipoprotein cholesterol; LDL-C = low-density lipoprotein cholesterol; NICE = National Institute for Health and Care Excellence

* Moderate-to-high-intensity statin: Expected to reduce LDL-C by 30%-50%, eg atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg

† High-intensity statin: Expected to reduce LDL-C by ≥50%, eg atorvastatin 40-80 mg, rosuvastatin 20-40 mg





Your responsibility when using NICE advice Adults under the age of 85 with an increased estimated risk of cardiovascular disease (CVD) are offered a complete formal risk assessment using the QRISK2 tool. A formal assessment of total risk for adults who have been identified to have an estimated risk of increased DV ã© the most accurate mÃ©©all of direct prevention strategies to improve clinical results. QRISK2 is © the formal risk assessment tool recommended for assessing the risk of DV for early PREVENTION of DV in people over the age of 84. QRISK2 © an online assessment tool to estimate the 10-year risk of having a cardiovascular event, in people who no already have cardaca disease. A person's 10-year risk of CVD can be used to inform treatment decisions such as lifestyle advice or drug treatment. Adults 85 years of age and older and those with existing DV, type 1 diabetes, chronic kidney disease, or family hypercholesterolemia should be considered an increased risk of DV events without using QRISK2. For these people, a full formal assessment with QRISK2 does not provide any additional information and may underestimate their cvd risk, leading to inadequate treatment. Evidence of local arrangements to ensure that the QRISK2 tool is used to formally risk the evaluation of adults under the age of 85 when identifying an estimated risk of DV increase. Data source: Local data collection. Proportion of adults under 85 years of age with an increased estimated risk of CVD who have a complete formal risk assessment using the QRISK2 tool. Numerator â the number in the denominator that has a complete formal risk assessment using the QRISK2 tool. Denominator â the number of adults under 85 years of age with an estimated risk of CVD. Data source: Local data collection. Service providers (care ensure that systems are in place to offer adults less than 85 years old, with an estimated risk of increased CVT risk a complete formal risk assessment using the QRISK2 tool. Health Care Ensure that they offer a complete formal risk assessment, using the QRISK2 tool for adults under 85 years, with an estimated increased risk of CVD. Commissioners (NHS England area teams) ensure that they order services offering a complete formal risk assessment using the QRISK2 tool for adults in 85 years with an estimated increased risk of CVD. Adults less than 85 years old who may risk developing their CVD are subject to a risk assessment. The GP or nurse uses a computer program called QRISK2 to fully assess their risk of CVD development over the next ten years. This takes into account age, gender, smoking state, blood pressure and cholesterol levels, which may affect the risk of CVD development. It will help identify adults who need lifestyle advice and possibly treatment to reduce their risk. To estimate CVD risk, use CVD risk factors that are already recorded in mother records © Electronic primary care indicators using a strategy © systematic approach. [NICEJA]: Orientation for cardiovascular disease, recommendations 1.1.1 and 1.1.2]Adults aged 85 years and more, and people with a CVD on their own ©- existing or other classical conditions that increase the risk of CVD (such as type 1 diabetes, hypercholesterolation) © family disease or chronic renal disease) are already considered at high risk and should therefore be excluded from estimates of increased risk and formal risk assessment. [NICEJA]: The guideline on cardiovascular diseases, recommendations 1.1.9, 1.1.11, 1.15, 1.1.16, 1.1.1.21]This evaluation should use the QRISK2 online tool to assess the risk of developing a ten-year CVD for early CVD prevention in people of over 84 years old. The statement includes adults under 85 years of age, because this © the population in which the QRISK2 tool © Clear. Adults aged 85 and age should be considered at high risk only on the basis of age, especially those who smoke or have high blood pressure. As QRISK2 calculates a CVD risk for a person over the next ten years, its risk margins may underestimate the risk young people u women who have additional risks due to underlying medical conditions such as severe mental health problems u severe obesity (body mass index exceeding 40 kg/m2). when using a qrisk2 risk score to inform treatment decisions in these populations, particularly if it is close to the treatment threshold, take into account other factors that may predispose the person to a premature dcv that may not be included in the calculated risk scores. adults with a risk of cardiovascular disease (dcv) of 10 years u more are evaluated for secondary causes before any offer of statin therapy. various conditions may increase the risk of a person's dcv, which may also cause dyslipidemia (abnormal levels of lipids.) it is important that they be identified before the therapy with statins is started, which may cause side effects in adults with certain conditions. common secondary causes of increased risk of dcv u dislipidemia include uncontrolled diabetes, hypothyroidism, liver disease and nephrotic syndrome. evidence of local agreements to ensure that adults at a risk of 10 years u more dcv are evaluated for secondary causes before any offer of statin therapy. numerator - the number in the denominator that is evaluated for secondary causes before any offer of statin therapy. denominator - the number of adults with a risk of 10 years u more. data source: local data collection. service providers (primary care) must ensure that adults with a 10 year higher dcv risk are evaluated for secondary causes before offering statin therapy. health professionals evaluate adults with a risk of dcv of 10 years u more for secondary causes before offering statin therapyThe commissioning groups) ensure that GPS in their locality is aware of the need for adults with a 10-year risk of 10% or more DCV to be assessed for secondary causes before offering statistical therapy. The committees should include this requirement in any relevant local service specifications (e.g. cardiovascular) according to local arrangements. Adults with 1 in 10 or more chance of developing CVD in the next ten years (a 10-year risk of 10%or more) are checked to see if there are any underlying causes before being offered treatment with a medicine called Statin. This will indicate if there is another reason for the increased risk that may need a different treatment. The secondary causes of increased risk of DCV and dyslipidaemia include excessive use of alcohol, uncontrolled diabetes, hypothyroidism, liver disease and harm. An evaluation for the secondary causes of risk of VOC or dyslipidaemia should include: Smoking Status Weight consumption of body HBA1C renal function and estimated glomerular filtration rate (EGFR) Thyroid stimulation hormone. The statement includes adults with a 10%or more risk of DCV as determined by their QRisk2 score, if less than 85 years. Adults with 85 years old should be considered at high risk based on age alone, particularly those who smoke or have high pressure. As QRisk2 calcula t es the risk of a person's VOC over the next ten years, its risk scores may underestimate the risk in younger people or women who have additional risk because of conditions © underlying tips, as are © rivers mental health problems or severe obesity (body mass index higher than 40 kg/ m2). By using a QRisk2 risk score to inform drug treatment decisions in these populations, particularly if you are close to the threshold for take into account other factors that may predispose the person to premature CVD that cannot be included in the calculated risk scores. Adult Adults a 10-year risk of cardiovascular disease (CVD) of 10% or more receives advice on lifestyle changes prior to any offer of statin therapy. Lifestyle changes, such as quitting smoking, increasing physical activity, taking a healthy diet, managing weight and reducing alcohol consumption, can reduce the risk of CVD. Lifestyle changes should be made, if possible, before statin treatment is offered, because these can reduce a person's risk of CVD without the need for drug treatment. It is important that the benefits of lifestyle changes for primary prevention be discussed with adults at risk of CVD, to encourage the adoption of lifestyle interventions prior to any offer of statin therapy. Data source: Local data collection. Proportion of adults with a CVD risk of 10 years or more who receive advice on lifestyle changes prior to any offer of statin therapy. Numerator - the number in the denominator that receives advice on lifestyle changes before any offer of statin therapy. Denominator - the number of adults with a risk of 10 years or more. Data source: Local data collection. Service providers (primary care) ensure the existence of processes for adults with a 10-year risk of CVD of 10% or more receiving advice on lifestyle changes prior to any offer of statin therapy. Health professionals give advice on lifestyle changes to adults with a CVD risk of 10 years or more before offering statin therapy. Commissions (NHS England area teams and clinical commissioning groups) ensure that general practitioners are aware that adults at risk© of CVD of 10 years or older should receive lifestyle advice before offering statin therapy. The Comms can consider incorporating this discussion into SNS Health Checks and the specifications of improved local services. Collaboration with the local authorities (as commissioner ofAdults with a probability 1 in 10 or more of developing CVD in the next 10 years (a risk of 10 years or more) receive advice on lifestyle changes such as quitting smoking, losing weight, eating a healthy diet and exercising, before they are offered statin therapy. These changes can help reduce your chances of having a heart attack or stroke in the future. Lifestyle changes include: quitting smoking, eating a healthy diet, achieving and maintaining a healthy weight, increasing physical activity and reducing alcohol consumption. The statement includes adults with a 10-year or more CVD risk, as determined by their QRISK2 score, if they are under 85. Adults aged 85 years or older should be considered high-risk based only on age, particularly those who smoke or have high blood pressure. As QRISK2 calculates the risk of a person's CVD in the next 10 years, their risk results may underestimate the risk in younger people or women who have additional risks due to underlying medical conditions such as severe mental health or severe obesity (body mass index exceeding 40-kg/m2). By using a QRISK2 risk score to inform drug treatment decisions, particularly if it is close to the treatment threshold, take into account other factors that may predispose the person to a premature CVD that may not be included in the calculated risk scores. advice on the lifestyle given should be sensitive to the culture and faith of people, and adapted to their needs. An interpreter should be consulted if necessary for people whose first language is not English. Adults with a risk of cardiovascular disease (DCV) of 10 years or more for which lifestyle changes are ineffective or inadequate, discuss with their health professional the risks and benefits of starting therapy withPeople who are better informed and involved in decisions about their care are more likely to adhere to the chosen treatment plan, which improves improves experience and clinical results. Evidence of local provisions to ensure that adults with a CVD risk of 10 years or more, for whom lifestyle changes are ineffective or inadequate, discuss with their health professionals the risks and benefits of starting statin therapy. Proportion of adults with a 10-year risk of CVD equal to or greater than 10%, for whom lifestyle changes are ineffective or inadequate, with a registered discussion about the risks and benefits of initiating statin therapy.Numerator - the number in the denominator that has a record of a discussion about the risks and benefits of starting statin therapy.Denominator - the number of adults with a risk of CVD equal to or greater than 10%, for whom lifestyle changes are ineffective or inadequate. Data source: Local data collection. Service providers (primary care) ensure that adults with a CVD risk of 10 years or more, for whom lifestyle changes are ineffective or inadequate, have a documented discussion with their health professional about the risks and benefits of starting statin therapy. Health professionals discuss the risks and benefits of starting therapy with adults who have a CVD risk of 10 years or more for whom lifestyle changes have been ineffective or inadequate, and record the details of the person's discussion and decision. Commissions (NHS England area teams and clinical commissioning groups) ensure that adults at a risk of CVD of 10 years or more for whom lifestyle changes are ineffective or inadequate have a documented discussion with their health professional about the risks and benefits of starting statin therapy. The committees can do so by looking for evidence of practice, through © audits. Adults with a 1 in 10 or more probability of developing CVD in 10 years (a risk of 10 years or more) for which lifestyle changes have not helped or are inadequate, discuss with© their doctor the risks Benefits of initiating therapy with statins. This should include information about how therapy with statin can help reduce your hypotheses to have a cardacy attack or stroke in the future. Changes in lifestyle, such as smoking, increasing physical activity and changing diet that has not resulted in a reduction in DCV risk when qrisk2 is repeated, are considered ineffective . Use the clinical trial to determine how long wait before lifestyle changes are considered ineffective because this depends on the type of lifestyle changes and the desires and needs of the person. [Adapted from Nicea's Guideline on Cardiovascular Disease, Recommend 1.3.16] The discussion should include information on the risk of a person's DCV and on the benefits and damage of statin therapy during a 10 year period. Discussion and person's decision should be documented. This information must be in a way that: presents individualized risk and benefit scenarios presents the absolute risk of events using numerically appropriate diagrams and text. The declaration includes adults with a 10-year CVD risk greater than 10%, as determined by their QRISK2 score, if they have less than 85 years of age. Adults at the age of 85 or more should be considered high risk based only on age, particularly those who smoke or have high arterial tension. Because the QRISK2 calculates the risk of a person's DCV in the next 10 years, their risk results can underestimate the risk in younger people or women who have additional risks due to underlying tannic conditions such as serious problems mental health or serious obesity (body mass treating more than 40 kg / m2). When using a QRISK2 risk score to inform the decisions of medicated treatment, particularly if it is close to the treatment threshold, take into account other factors that may predispose the person to Premature DCV that may not be included in calculated risk scores. Discussion on the risks and benefits of initiating statin therapy should be sensitive to Culture and fan ©, and adapted to your needs. An intention should be consulted if it is not appropriate to use an employment-based patient's decision aid, for example, for people whose first language is not English. Adults who choose statin therapy for the primary prevention of cardiovascular disease (CVD) are offered atorvastatin 20 mg. High-intensity statins are the most clinically effective treatment option for the primary CVD prevention â € "this is, reducing the risk of first CVD events. After a discussion of risks and benefits of initial statin therapy with a health professional, a person can choose statin therapy as a suitable treatment to reduce the risk of CVD. When a person decides to have statin therapy, a high intensity statin and low cost must be offered. Atorvastatin 20 mg is recommended as the initial high intensity statin preferred to use because it is clinically and cost effective for primary CVD prevention. Evidence of local arrangements to ensure that adults choosing statin therapy for primary prevention are offered atorvastatin 20 mg. Data source: Local data collection. Proportion of adults choosing statin therapy for primary CVD prevention that are prescribed atorvastatin 20 mg. Numerator â € "The number in the prescribed denominator atorvastatin 20 mg. Denominator â € "The number of adults who choose statin therapy for the primary prevention of CVD. Data source: Local data collection. Service providers (primary care) ensure that adults choosing statin therapy for primary CVD prevention are offered atorvastatin 20 mg. Saúde Professionals offer atorvastatin 20 mg for adults by choosing statin therapy for primary CVD prevention. The commissures (England Equipment of England NHS and clinical commissioning groups) ensure that adults who choose the therapy For the primary prevention of DCV, atorvastatin 20 mg are offered. The commissioners can do this by seeking evidence of practices through © CLAN audits. Adults at risk from CVD who to have a statin to reduce your chances of CVD are offered a call atorvastatin a. This can help reduce your chances of having a heart attack or stroke in the future. Adults with recently diagnosed cardiovascular disease (CVD) are offered atorvastatin 80mg. High-intensity statins are the most clinically effective option for secondary prevention of CVD a priori@ i.e., reducing the risk of future CVD events in people who have had a CVD event, such as a heart attack or stroke. The evidence shows that atorvastatin 80 mg is the most profitable high-intensity statin for secondary CVD prevention, which can improve clinical results. Proof of local arrangements to ensure that adults with recently diagnosed CVD are offered 80mg atorvastatin. Data source: local data collection. Proportion of adults with recently diagnosed CVD that are prescribed atorvastatin 80mg. Numberer “ apron ” the number in the denominator prescribed atorvastatin 80mg. Denominator (“vador”) the number of adults with recently diagnosed CVD. Data source: local data collection. Service providers (primary care and secondary care) ensure that recently diagnosed CVD adults are offered atorvastatin 80mg. Health professionals offer atorvastatin 80mg to adults with recent diagnosis of DVC. Commissioners (HNS area teams England and clinical commissioning groups) ensure that adults with recently diagnosed CVD are offered 80mg atorvastatin. Commissioners can do so by seeking practical evidence through clinical audits. Adults who have recently been diagnosed with CVD are offered a statin called atorvastatin to help reduce their chances of other problems such as a heart attack or stroke. Adults with a high intensity statin that have side effectsa lower dose or an alternative statin. The use of high intensity statins can cause side effects, but to improve the clinical results is important that alternative strategies are tempted instead of stopping treatment. Any statin for any dose reduces the risk of Sickness (CVD). Evidence of local arrangements to ensure that adults in a high intensity statin are monitored for side effects and have offered a smaller dose or an alternative statin, if necessary. Data source: Local data collection. Adult proportion reporting side effects of a high intensity statin that receive a smaller dose or alternative statin. Numbers in the denominator where a lower dose or alternative statin is used © prescribed. Name: number of adult presentations reporting side effects of a high intensity statin. Data source: Local data collection. Adequate to statistical therapy. Data source: Local data collection. Service providers (primary care and secondary care) must ensure that adults in a high-intensity statin having side effects are offered a lower dose or an alternative statin. Service providers should consult Recommendation 1.3.42 in NICE Guidance on cardiovascular diseases to obtain more information. Healthcare professionals offer a smaller dose or an alternative statin for adults who have side effects of a high intensity statin. The commissioners (NHS equipment and traditional commissioning groups) must ensure that providers are aware that adults in a statin of high intensity having side effects should be offered a smaller dose or an alternative statin. Adults who take a statin that have side effects are offered a smaller dose or a different type of statin. The intensity of a statin © defined based on the low density lipoprotein (LDL) cholesterol percentage reduction that it can produce. A high intensity statin can produce a reduction above 40%. High intensity statins include: atorvastatin 20 mg to 80 mg of rosuvastatin 10 mg to 40 mg of simvastatin 80 Adults on a high intensity statin have a repeated measurement of lipids and hepamatic transaminases after 3 months of treatment. Repeat lipid profiles and measure the hepathic transaminases © important for the safety of the patient and ensure the from statin therapy. A repeated lipid profile can be used to determine whether the expected reduction of 40% in non-HDL cholesterol (non-high density lipoprotein) was achieved. Repeated measurement of liver transaminase is important to detect any increase in the levels of these enzymes, which may indicate problems with liver function. Proofs of local arrangements to ensure that adults with high intensity statin have a repeat of lipid and liver transaminases after 3 months of treatment. Data Source: Local Data Collection. Proportion of adults with high-intensity statins that had a repeated measurement of lipids and liver transaminases after 3 months of treatment. Numberer - the number in the denominator that had a repeated measurement of lipids and liver transaminases after 3 months of treatment. Denominator - the number of adults who prescribed high intensity statins for at least 3 months. Health professionals should make a new measurement of lipids and liver transaminases after 3 months of treatment of adults with high intensity statinosis. Commissioners (HNS England area teams and clinical commissioning groups) should monitor whether adults with high-intensity statinis have a new measurement of liver lipid and transaminases after 3 months of treatment. Commissioners may want to stipulate this in any improved local service specification. Adults taking a statin have a review 3 months after their treatment to see if statin is lowering their cholesterol levels and to see if it is not affecting their liver. The intensity of a statin is defined based on the percentage of low density lipoprotein cholesterol (LDL) reduction that can produce. A high-intensity statin can produce a reduction of over 40%.Statins include: atorvastatin 20 mg to 80 mg of rosvastatin 10 mg to 40 mg of simvastatin 80 mg. [NINE's guidance on cardiovascular diseases] A placeholder statement is © area of care that has been prioritized by the Quality Standards Advisory Committee, but for which no orientation of origin is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area. Cardiovascular disease (CVD) is © the most common cause of death in the UK, and is © the leading causes of disease, deficiency and quality of life. To improve primary prevention, people at higher risk of DV need to be identified and their risk factors managed in the most effective way. It is estimated that half of men over 50 and a fifth of women over 65 have a CVD risk of 20% or more. Current guidance recommends the use of a system©ically sensitive strategy using electrical records to identify people with an estimated increased risk of DV. However, the clarification of the strategies to prioritize people© for evaluation was not included in the recommendation©s of guidance. how often this identification should be made and which health professionals should perform it. Adults with, or at risk of chronic kidney disease (CKD) have eGFRcreatinine and albumin: creatine reason (ACR) tests on frequency agreed with their health professional. Monitoring the routine of key markers of renal function for adults with or at risk of CKD will allow early diagon and early adoption to reduce the risks of CKD progression, such as cardiovascular disease, end-stage renal disease, and mortality. The following measures can be used to assess the quality of the performance of These are examples of how the statement can be measured and can be adapted and used flexibly. EVIDENCE OF LOCAL SYSTEMS INVITING ADULTS or at risk of, CKD have eGFRcreatinine and ACR tests. Data source: Local data collection, for© example, through local protocols on markup reminders.Numerator is the number in the denominator that had eGFRcreatinine tests last year.Denominator is the number of adults with CKD.Data source: Local data collection, for example, auditing health records. The CKD National Audit reports the percentage of people with CKD encoded phases 3 to 5 with a repetition of the blood analysis of their funerals last year. b) Proportion of adults with CKD who have had ACR tests with the frequency agreed with their health professional. Numerator - the number in the denominator that has done ACR tests with the frequency agreed with your health professional. Denominator - the number of adults with CKD. Data source: Local data collection, e.g. auditing of health records. The CKD National Audit reports the percentage of people with CKD encoded phases 3 to 5 who had an ACR urinal test result in the previous year.c) Proportion of adults at risk of CKD who had eGFRcreatinine testing at the frequency agreed with their health professional.Numerator - the number in the denominator that had eGFRcreatinine test in the frequency agreed with your health professional.Denominator - the number of adults at risk of CKD.Data source: Collection of local data, for example, auditing health records. The CKD National

Audit reports the percentage of people with diabetes tested using saric creatinine© last year, and people at risk of CKD without diabetes tested in the last 5 years.d) Proportion of adults at risk of CKD who have had ACR tested at the agreed frequency with their health care professional.Numerator - the number in the denominator that had ACR tested at the agreed frequency. Denominator - the number of adults at risk of CKD. Data source: of local data, for example, health audit The CDC National Audit reports the percentage of people with diabetes tested using ACR last year, and people at risk of CKD without diabetes tests in the last five years. a) Prevalence of CKD not diagnosed. b) CKD phase in diagonic. Data source: local data collection, e.g. auditing of health records. Service providers (general practices and secondary care services, such as renal, cardiology, diabetes and rheumatological cell) ensure that systems are in place to identify adults with,© or at risk of, CKD, for© example through computerized research or manual medical records, and offer a appointment to discuss with them the frequency with which they should have eGFRcreatinine and ACR tests. They also © have systems in place to offer appointments for testing at agreed frequency. Health professionals (GPs, nephrologists, cardiologists, diabetologists, rheumatologists, nurses and pharmaceuticals) discuss and agree on the frequency of eGFRcreatinine and ACR tests with adults who have, or are at risk, CKD and offer tests on the agreed frequency. They can then agree to any appropriate treatment based on the test results. Commissions (clinical commissioning groups, integrated health care systems and NHS England) ensure that they order services in which adults with, or at risk of, CKD have eGFRcreatinine and ACR tests at the frequency agreed with their health professional. They can do this by verifying that the services have systems in place to identify adults with, or at risk of, CKD and offer commitments to discuss and agree on the frequency of eGFRcreatinine and ACR tests. Adults who have, or may be at risk of, CKD discuss and agree with their health professional how often they should have tests to check if their kidneys are functioning well. Blood and urine tests are offered at the agreed frequency for if your CKD is getting worse (progressing), or if they have kidney problems. The blood test is © at least once a year for adults with homework. Persons with homework homework have offered information and education relevant to the cause of kidney disease, how advanced it is, any complications they may have and the issues to worsen, to help fully understand and make informed choices about treatment. They © also be able to obtain psychological support if necessary for example, support groups, counseling or support from a specialized nurse.CKD © defined as abnormalities of the function or renal structure present for more than 3 months, with implications for health. This includes: all people with markers of kidney damage, including albuminâºria (ACR greater than 3 mg/mmol), urinary sediment abnormalities, electrolytes and other abnormalities due to tubular distÂºrbios, anomalies detected by histology, structural anomalies detected by imaging or a history of kidney transplantation of people with a glomerular filtration rate (GFR) of less than 60 ml/min/1.73 m2 on at least 2 occasions separated by at least 90 days (with or without markers of kidney damage). [NICEÂ¢s guideline on chronic kidney disease] Adults with any of the following risk factors: diabetes hypertension anterior episum ionof acute kidney disease cardiovascular disease (ischemic © disease, chronic heart disease, peripheral vascular disease or cerebral vascular disease) structural disease of the renal tract, recurrent renal cells or multi©human © adultprostatic hypertrophy with potential renal involvement for example, systemic ©, family history of end©stage renal disease (category GFR G5) or hereditary renal disease accidental detection of hematism or protein-rich drugs that can negatively affect renal function, such as calcineurin inhibitors (e.g., cyclosporine or tacrolimus), systems or non-inflammatory drugs (NSAIDs). An analysis to the blood estimating the glomerular filtration© rate (TFG) through the measurement of © creatinine. Ã as an estimate of renal function to identify kidney disorders and monitor the progression of CKD. CKD Laboratories should use the equation of the Epidemiological Patients'Epidemiological Collaboration of the Chronic Rins (CKD AheNS 145; EPI) to estimate the GFRcreatinine, using calibrated, screening creatinine tests for standard reference material. [Adapted from the NICE Ahenc standard on chronic renal disease, Recommendation 1.1.2]A test used to detect and identify proteins in the urine, which is © a sign of renal disease, and can be used to evaluate the progression of CKD. [Adapted from NICEJA to chronic renal disease, Recommendation 1.1.12 and full guidance]The frequency of monitoring should be discussed and agreed by the person and his/her health care professional. Table 2, NICE Ahem, indicates that the guideline on chronic renal disease should be used to guide the frequency of GFR monitoring. Adults with homework should be seen at least annually and adults at risk of DPC may be seen annually or with less frequency to monitor the eGFR. ACR need not be measured whenever the eGFR is © measured, except when evaluating the response to a treatment to reduce protein. The frequency of monitoring © determined by the stability of the renal function and the ACR level, and adapted to the individual according to: the underlying cause of CKD the deceleration rate of the eGFR or the increase of the ACR (but be aware that the progression of CKD © many times not linear) other risk factors, including cardholder insufficiency, diabetes and hypertension changes in their treatment (such as reninVirei Hah angiotensin apron Hah) aldosterone system [RAAS], antagonists, NSAIDs and diurnal © (c) intermittent disease (e.g. acute renal injury), whether they have opted for conservative CKD management. Adults with chronic renal disease (COPD) have their blood pressure maintained within the recommended range. People with BPD are at greater risk of high blood pressure. Keep the pressure on within a target range reduces the risk of cardiovascular disease, CDT progression and mortality. The following measures can be used to assess the quality of care or service provision specified: specified: The statement. They are examples of how the statement can be measured and can be adapted and used flexibly. (a) the existence of local systems to identify and invite adults with homework to have an arterial pressure reading. Data source: local data collection, for example through © (b) Evidence of the availability of equipment for reading the blood pressure of adults with homework. Source of data: local data collection, for example, service specifications. a) Proportion of adults with CPD with an ACR below 70 mg/mmol whose systemic blood pressure is between 120 and 139 Hg and their diastolic blood pressure below 90-Hg. Suggestor number in denominator whose systemic blood pressure © between 120 and 139 mHg and its diastolic arterial pressure under 90 mHg. Name (loudspeaker) the number of adults with CKD with an ACR below 70mg/mmol. Data source: local data collection, for example, audit of health records. The National Audit of CKD reports the percentage of people with CKD phases coded 3 to 5 with blood pressure below the recommended targets. (b) Proportion of adults with CPD whose systemic blood pressure is between 120 and 129 mHg and their diastolic blood pressure below 80-mHg. Number of denominator whose systemic blood pressure © between 120 and 129 mHg and its diastolic arterial pressure under 80 mHg. Title(a) the number of adults with CKD. Data source: local data collection, for example, audit of health records. The National Audit of CKD reports the percentage of people with CKD phases coded 3 to 5 with blood pressure below the recommended targets. (c) Proportion of adults with CKD and 70 mg/mmol ACR or more whose systemic arterial pressure is between 120 and 129 mHg and their diastolic arterial pressure below 80 mHg. Search number of number in whose systemic blood pressure © between 120 and 129 mHg and its chronic diastolic blood pressure below the 80-80 a) Number of adults with CKD and ACR of 70mg/mmol or more. Data source: local data collection, for example, auditing health records. The CKD National Audit reports the percentage of people with codified CKD phases 3 to 5 with blood pressure below the recommended targets. a) Prevalence of cardiovascular disease among people with CPD. Data source: local data collection, for example, auditing health records. The UK Renal Registry collects data on kidney patients' co-morability, including angina, heart failure, and atrial fibrillation. b) Incidence of cardiovascular events for people with PCTs. Data source: local data collection, for example, auditing health records. The UK Renal Registry collects data on renal patients' co-morability, including dates of heart failure, transient ischemic attack, stroke and myocardial infarction of the ST segment (STEMI). c) Cardiovascular mortality rates among people with CPD. Data source: local data collection, for example, auditing health records. The UK Renal Registry collects data on the cause of death of kidney patients. d) Incidence of terminal kidney disease. Data source: local data collection, for example, auditing health records. The UK Renal Registry collects data on the first date of renal replacement therapy or the start of the CKD 5 phase in renal patients. Service providers (general practitioners and secondary care services) ensure that systems are in effect for adults with PCT to maintain their blood pressure within the recommended range. This may involve having the equipment to do a blood pressure reading, using clinical IT systems to compare patients with the recommended range when introducing a blood pressure reading, or signaling when patients need a blood pressure reading. TheHealth care (GPs, nephrenologos, nurses and pharmacists) monitor the blood pressure of adults with PCC and are aware of the recommended intervals. They support people to keep their blood pressure within the recommended range, for example by or adjusting treatment, or advising on lifestyle changes. Commissioners (classical commissioning groups, integrated care systems and NHS England) ensure that they order services in which adults with CTBT have their blood pressure maintained within the recommended range. They work with service providers t o ensure that adults with CKD are identified, and have an arterial pressure reading and any support needed to keep it within the recommended range. Adults with BPD are supported to keep their blood pressure at a healthy level. If it is too high, your health care professional can offer medicines, or change the medicine you are taking, or suggest lifestyle changes, to help control it. THE CKD © defined a s renal function abnormalities or present structure for more than three months, with health implications. This includes: people with renal damage markers, including albumin (ACR over three mgs/mmols), urinary sediment abnormalities, Electronics and other anomalies due to tubular disturbances, anomalies detected by histology, Structural abnormalities detected by images or a history of renal transplantation with a glomerular filtration rate (GFR) of less than 60ml/min/1.73 m2 at least two locations separated by a period of at least 90 days (with or without renal damage markers). [NICEJA] Guidance for chronic renal disease]The blood pressure must be monitored and maintained within the following intervals: in people with CTC it is intended t o maintain systemic blood pressure below 140 mHg (target range 120 to 139 mHg) and diastolic blood pressure below m 90. In people with CKD with a 70mg/mmol ACR or more, the goal is to maintain systemic blood pressure below 130 mHg (target range 120 to 129 mHg) and diastolic blood pressure below 80 mHg. Adults with chronic renal disease (CKD) are atorvastatin 20 mg. There is a greater risk of cardiovascular disease (CVD) in people with CHD. We discuss the risks and benefits of Therapy with statin with a health professional, adults with CKD can choose statin therapy as adequate treatment to reduce their risk of first CVD events, or future CVD events in adults who have already had an event, such as a Card attack or an AVC. Statins are a clinically effective treatment for preventing DCV, and reducing the risks associated with DCV, for people who have DCV. Atorvastatin 20 mg is recommended as the preferred high intensity initial statin because it is clinically and economically effective for the primary and secondary prevention of DCV. The following measures can be used to assess the quality of the care or service of services specified in the declaration. Examples of how the declaration can be measured and can be adapted and used flexibly. a) Evidence of the availability of atorvastatin 20 mg in local service providers. Data source: Local data collection, for example, local forms. b) Evidence of local systems to verify that adults with CKD are taking atorvastatin 20 mg and inviting them to discuss the beginning of treatment if contrary. Data source: Collecting local data, for example, service specifications. Proportion of adults with CKD receiving atorvastatin 20 mg. CKD's national audit reports the percentage of people with CKD encoded phases 3 to 5 that are in a statin. health records. The United Kingdom renal registration collects data on reinforcement comorbidities, including angina, cardiac insufficiency and atrial fibrillation.b) Incidence of cardiovascular events for people with CKD. Data: audit of health records. The United Kingdom renal registration collects data on reinsparent comorbidities, including dates of isck attack © transient mimic, stroke and stroke of ST segment elevation myocardial infarction (STEMI). (c) Cardiovascular mortality rates among people with CKD. Source of data: Local data collection, e.g. health records audit. The UK Renal Registry collects data on the cause of death of kidney patients. (d) Proportion of people with CKD with a higher than 40%of lipoprotein cholesterol without high density. Data source: Local data collection, for example, Health records audit. Service providers (general and secondary care services, such as renal clinics, cardiology, diabetes and rheumatology) ensure the existence of systems for adults with CKD to be offered atorvastatin 20-mg. The health professionals (mother © family, nephrologists, cardiologists, diabeologists, rheumatologists, nurses and pharmacists) check that CKD adults are taking a statin, and discuss the risks and benefits of initiating therapy with statin, if not. They offer atorvastatin 20 mg and increase the dose if no adequate treatment response is reached and the eGFR © of 30 ml/min/1,73 m2 or more. If a person is unable to tolerate atorvastatin 20 mg or report adverse effects, alternative options such as stopping the statin or changing the dose or type of statin are discussed. The committees (traditional committee groups, integrated care systems and NHS England) ensure that they order services in which adults with CKD are offered wide range in 20-mg. The committees can do this by looking for proof of practice through © CLAN audits. Adults with CKD are at higher risk of heart attacks and stroke. To help reduce the risk ©- offered them a type of medicine called statin, which reduces the cholesterol level (sometimes called lipids) in the blood. If your cholesterol level does not decrease enough, they can change a higher level If the statin causes some side effect, your doctor may ask them to stop taking it for some time to check if they are caused by statin. Your doctor may discuss the reduction of the dose or the alteration of a different statin. CKD is defined as abnormalities of renal function or structure present for more than three months, with implications for health. This includes: people with renal damage markers, including albumin (albumin:creatinine ratio [ACR] more than three mg/mmol), anomalies in urinary sediments, electrolytes and other anomalies due to tubular disorders, anomalies detected by histology, Structural anomalies detected by images or antecedents of renal transplants with a rate of less than 1/73ml. [Niceman] Guidelines on chronic kidney diseases] Effective interventions in the library Effective interventions People have the right to engage in discussions and make informed decisions about their care as described in their care. Make decisions using guidelines NICE explains how we use words to show the strength (or certainty) of our recommendations, and has information on prescription medications (including off-label use), professional guidelines, rules and laws (including consent and mental ability), and safeguard. The recommendations contained in this guideline represent the viewpoint of the NICE, which came after careful consideration of the available evidence. By exercising your judgment, professionals and professionals are expected to take full account of this guideline, in addition to the needs, preferences and individual values of their patients or those who use their service. It is not obligatory to apply the recommendations, and the guideline does not annull the responsibility of making appropriate decisions to theof the individual, in consultation with them and their families. family. caregivers or guardians. Local Commissioners and health care providers have the responsibility to allow the guidelines line to be applied when individual professionals and people who use services wish to use it. They should do so in the context of local and national priorities in the field of service financing and development, and taking into account their obligations to take due account of the need to eliminate illegal discrimination, promote equal opportunities and reduce health inequalities. Nothing in this guideline should be interpreted in a way that is incompatible with the fulfillment of these functions. The recommendations of this interactive flow chart represent the NICE view, which came after careful consideration of the available data. By exercising your judgment, health professionals are expected to fully take into account these recommendations, along with the needs, preferences and individual values of their patients. The application of the recommendations in this interactive flow chart is at the discretion of health professionals and their individual patients and does not annull the responsibility of health professionals to make appropriate decisions to the circumstances of the individual patient, in consultation with the patient and/or their caregiver or guardian. Commissioners and/or providers have the responsibility to provide the necessary funding to allow recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They must do so in view of their obligations to take proper account of the need to eliminate illegal discrimination, promote equal opportunities and reduce health inequalities. The recommendations of this interactive flow chart represent the NICE view, which came after careful consideration of the available data. By exercising your judgment, you are expectedThe health professionals are fully into account these recommendations. However, interactive interactive flowchart not to overstep the individual responsibility of health professionals to make appropriate decisions within the circumstances of the individual patient, in consultation with the patient and/or guardian or caregiver. The Commissions and/or providers have the responsibility to implement the recommendations in their local context, taking into account their obligations to take due account of the need to eliminate illegal discrimination, promote equal opportunities and promote good relations. Nothing in this interactive flowchart should be interpreted in a way that is inconsistent with the fulfillment of these functions. (disadvantaged adults include (but are not limited to) those on low incomes (or who are members of a low©income family), those with benefits, those living in public or social housing, some members of black and minority ethnic groups, those with a mental health problem, those with learning disabilities, Those who are institutionalized (including those serving a prison sentence) and those who are homeless) (the following doses for statins are high intensity, based on the percentage reduction of low density lipoprotein cholesterol (LDL) they can produce: atorvastatin at 20© to 80mg; rosvastatin 10 to 40 mg; simvastatin at 80mg) (if someone has a 20% or greater risk of a first cardiovascular event in the next ten years, It is © considered to have a high risk of cardiovascular disease) (for the purposes of this orientation, statins are grouped into three different intensity categories according to the percentage reduction of low-density lipoprotein cholesterol: low intensity if the reduction is 20% to 30%; medium © intensity if the reduction is 31% to 40%; and high intensity if the reduction is greater than 40%) of low density lipoprotein Cholesterol Path created: July 2014 last update: November 2021