

Generic/TRADE	LDL <sup>2,7</sup> (dose effect)	HDL <sup>2</sup>	TG <sup>2</sup>	SIDE EFFECTS /CONTRAINDICATIONS (CI) /COMMENTS/MONITOR (M)	DRUG INTERACTIONS	THERAPEUTIC BENEFITS/USES	USUAL Dose Range (Max dose/day) Studied doses in 1 <sup>o</sup> or 2 <sup>o</sup> prevention	\$ /Month	
<b>STATINS / HMG</b>	<b>Atorvastatin</b> <b>LIPITOR</b> ATO (10,20,40,80 mg tablet)	↓ 35 - 60%			SE≤10%; Generally better tolerated than other agents Common: upper GI disturbances, muscle pains, headache, rash & sleep disturbances Rare: peripheral neuropathy, lupus like Sx, impotence <sup>9</sup> ↑ LFT (AST & ALT >3X Normal in <2%) <sup>4,7</sup> ; dose dependent; reversible if statin stopped Myopathy <sup>10</sup> ; <1%; rhabdomyolysis <0.2% <sup>6</sup> (CK>10x) -if muscle pain & weakness, monitor CK ↑ creatinine kinase (CK) & darkened urine. -risk ↑ 10 fold <sup>11</sup> with combinations/DI's (<1%) ↓ CNS SE: ATO,FLU,PRA due to ↓ CNS penetration CI: Active Liver Dx, ↑ alcohol intake & Pregnancy M: Routine LFT's & CK not indicated for all pts <sup>22,30</sup> (LFT: 0,3,6,12 months & annually if high dose/combo or at risk) ROS:new; most potent statin; appears to ↑ HDL even at high dose; ↑ levels in Asians, lacks outcome data <sup>12,13</sup>	↑ effect of: digoxin <sup>ATO</sup> ↑ 20%, warfarin <sup>FLU,LOV,SIM</sup> FOR: LOV, SIM, ATO ↑ toxicity with HMG &: amiodarone, amprenavir, clarithromycin, cyclosporine, danazol, diltiazem, ethinyl estradiol, erythromycin, fenofibrate, fluoxetine, fusidic acid, gemfibrozil, grapefruit juice, ketoconazole, indinavir, itraconazole, nelfinavir, niacin, nefazodone, ritonavir, telithromycin & verapamil. ↓ effect of HMG by: cholestyramine & colestipol (space by ≥ 2hr); carbamazepine, phenytoin, pectin, phenobarb., St. Johns Wort & rifampin. PRA & ROS: appears to have few interactions	↓ Cholesterol ATO,FLU,LOV,PRA,SIM,ROS ↓ Atherosclerosis ATO,FLU,LOV,PRA,SIM ↓ Coronary Heart Disease ATO,FLU,LOV,PRA,SIM ↓ Stroke PRA,SIM Pediatric FDA approval ATO,LOV,PRA,SIM Effective in secondary causes such as diabetes & in nephrotic syndrome	10mg po hs ASCOT, CARDS, TNT 20mg po hs (80mg/d \$87) 40mg po hs AVERT,MIRA,CL,PROVE IT,TNT 20mg po hs 40mg po hs 40mg po bid cc LIPS (80mg/d) 20-40mg po hs AFCAPS 40mg po bid cc → 40-80mg/d POST CABG (cc=with meals ↑ absorption) (80mg/d) 20mg po hs (80mg/d) 40mg po hs WOSCOPE; → CARE,LIPID,PROSPER {Adjust for severe renal impairment <sup>7</sup> } 10mg po od 20mg po od 40mg po od (40mg/d) 20-40mg po hs <sup>2,4S</sup> 40mg po hs <sup>9</sup> MRC/BHP: HPS 80mg po hs A to Z (80mg/d)	67 81 87 35 46 84 34 - 79 151 38 44 56 68 78 46 46 46
	<b>Fluvastatin</b> <b>LESCOL</b> FLU (20 & 40mg capsule)	↓ 20 - 35%							
	<b>Lovastatin</b> <b>MEVACOR</b> LOV (20 scored & 40mg tablet)	↓ 25 - 40%	↑ 5 - 15%	↓ 7 - 30%					
	<b>Pravastatin</b> <b>PRAVACHOL</b> PRA (10,20 & 40mg tablet)	↓ 20 - 35%	ROS & SIM	ATO, ROS & SIM					
	<b>Rosuvastatin</b> <b>CRESTOR</b> ROS (10,20,40mg tablet)	↓ 40 - 65%	may ↑ HDLs most <sup>8,12</sup>	may ↓ TGs most <sup>3,12,14</sup>					
	<b>Simvastatin</b> <b>ZOCOR</b> SIM (5,10,20,40, 80 rectable mg tab)	↓ 35 - 50%							
Pravastatin & Rosuvastatin few DIs-some transplant meds like cyclosporin & GEM. Fluvastatin less DIs→ still with glyburide, phenytoin,rifampin & warfarin. Atorvastatin similar DIs but less dramatic. {Primary Mechanisms <sup>21</sup> of DI: PRA⇒sulfation; ATO/LOV/SIM⇒CYP-3A4; FLU⇒CYP-2C9}									
<b>FIBRATES</b>	<b>Bezafibrate</b> <b>BEZALIP</b> BEZ (200mg tab;400mg SR tab)	LDL shifts to larger more buoyant forms <sup>3</sup> ↓ 5-20%			Common: GI upset, rash & abdominal pain Less common: headache, pruritis, ↓ libido, dizzy, drowsy, arthralgia, ↑ glucose, sleep/vision changes Rare: ↓ renal fx, anemia, ↑ LFT's, myopathy, reversible impotence & gallstones ↑ by 1-2% <sup>3</sup> CI: severe hepatic & renal Dx & ?smoking (↑ in cardiac events in smokers + gemfibrozil <sup>VA-HIT</sup> ) M: CBC,Scr (↓ dose if ↑ Scr),Glucose, LFT's (?CK's) Criteria: if gemfibrozil/fenofibrate intolerance or ineffective → bezafibrate	↑ toxicity/levels with: cyclosporin, furosemide, MAOI's, probenecid, & statins. ↓ effect by: cholestyramine & colestipol (space by ≥ 2hrs); rifampin ↑ effect of: chlorpropamide, furosemide, repaglinide, rosiglitazone, sulfonyleureas & warfarin.	✓ ↓ Cholesterol & ↓ TG; ↑ HDL ✓ Combo with HMG/Niacin (to ↑ HDL & ↓ TG) ↓ Atherosclerosis ✓ Type III dyslipidemia May be useful if: ♦ TG >2.3mmol/l BIP, HHS -virtually all clinical benefits in patients with diabetes & ↑ insulinemia <sup>7</sup> -lack all-cause mortality ↓	200mg po bid cc 200mg po tid cc (600mg/d) 400mg SR po od <sup>2</sup> BIP 200mg MICRO po od cc DAIS (200mg/d) 160mg SUPRA po od cc (160mg/d) 300mg po bid ac (ac=before meals) 600mg po bid ac HHS, VA-HIT (1500mg/d)	70 102 64 46 52 21 42
	<b>Fenofibrate</b> <b>LIPIDIL MICRO</b> & 200mg cap <b>LIPIDIL SUPRA</b> (X → 100 & 160mg tab)	↑ 10-20% ↓ 20-50%							
	<b>Gemfibrozil</b> <b>LOPID</b> GEM (300mg cap, 600mg tablet)	-fenofibrate may ↓ LDL & ↓ TG more than GEM <sup>3,7</sup> -current outcome evidence best with gemfibrozil -clofibrate was associated with ↑ mortality <sup>WHO</sup>							
<b>RESINS</b>	<b>Cholestyramine</b> <b>QUESTRAN</b> CME (4gram regular,4gram light)	Option:mix with metamucil & orangejuice/lemonade the night before; refrigerate & give next day, ½ before breakfast & ½ before supper (shake well)			Common(<30%): constipation, nausea & bloating Rare:hyperchloremic acidosis <sup>CME</sup> in peds/↑renal fx <sup>3</sup> CI: biliary obstruction, dysbetalipoproteinemia, TG >4.6 mmol/l (Caution TG >2.3 mmol/l); phenylketonurics ("light" & "orange granules") ↑ fluid & bulk in diet → metamucil may be required Mix → juice/milk/water/applesauce M:LFT's,TGs	Space other meds (by ≥ 2hrs) with resins since ↓ absorption of: amiodarone, cyclosporin, digoxin, diuretics, fat soluble vitamins (A,D,E,K), folate, HMG's, l-thyroxine, methotrexate, NSAIDs, propranolol, steroids, sulfonyleureas, valproate, warfarin, mycophenolate	✓ ↓ Cholesterol & ↓ LDL (Questran:pregnancy & age >2yr) ✓ Combo with HMG (to ↓ LDL) ✓ Pruritus esp. with certain biliary/liver dx ✓ Bile acid induced diarrhea	4g po bid ac → +/- 8g/day POST CABG 8g po bid ac (16-24g/d) Start 4g od-bid to ↑ tolerability 2g po bid ac 4g po bid ac (20-30g/d) Start 2-5g od-bid to ↑ tolerability	53 99 42 77
	<b>Colestipol</b> <b>COLESTID</b> (5g granules; 7.5g orange granules; 1gm tab)	↓ 15-30%	↑ 3-5%	NO Change or Possible INCREASE					
<b>OTHER</b>	<b>Ezetimibe</b> <sup>15</sup> <b>EZETROL</b> 10mg tablet ⊗	↓ 17%	↑ 1.3%	↓ 6%	↓ intestinal cholesterol absorption; synergistic ↓ in LDL when added to statin CI: hepatic M:LFT's	• levels ↑*d by cyclosporine, fibrates • resins interfere with absorption	✓ ↓ Cholesterol (+/- Statin) -lacks outcome data	10mg od (with or without meals) {when added to statin, may allow ↓ statin dose}	⊗ 64
	<b>Nicotinic acid</b> <sup>16,17</sup> <b>NIACIN</b> (50,100,500mg tab); SR / No-flush niacin: non-Rx in Canada,less effective?; better tolerated?; ↑ hepatic SE?	↓ 5-25% -shifts to larger buoyant forms <sup>3</sup> -2g niacin/day helps HDL & TG, but only higher doses affect LDL <sup>3,7</sup> NICOTINAMIDE-NOT EFFECTIVE !!	↑ 15-35%	↓ 20-50%	Flushing (↓ by ASA/Advil 1/2hr pre),dry eyes, pruritis, headache,GI upset,↑ LFT's,↑ uric acid & ↑ glucose CI: severe peptic ulcer Dx, chronic liver Dx, overt diabetes & severe gout M: LFT's, glucose, uric acid	• Low dose or 325mg/d ASA: useful on initiating/↑ niacin dose to ↓ flushing; some pretreat X3d. ASA may also ↑ niacin levels. HMG's: ? ↑ myopathy if with lovastatin <sup>18</sup>	✓ ↓ Cholesterol & ↓ TG; ↑ HDL ✓ Combo with HMG/Fibrate (to ↑ HDL & ↓ TG) ✓ Niacin deficiency (Pellagra)	Start 50-100mg bid-tid (↑ tolerability) (increase weekly by ~100mg/week) 500mg po tid with meals 1500mg po bid ADMIT 1g po tid cc CDP (3-6g/d)	12 16 16

Major RISK Factors<sup>1,2,22</sup>: Diabetes,Smoking,Hypertension(≥140/90/BP meds),Low HDL≤ 1, Family history<sup>1-1.5x Risk</sup> premature (Age: ♂<55, ♀<65)CHD, Age(♂ ≥45, ♀ ≥55); MODIFIABLE ↑BP, ↑Cholesterol/LDL, Obesity: BMI >25, Waist(♂>102cm,40"; ♀>88m,35"), Smoking, Diet, Alcohol & sedentary lifestyle. Screen: pts with CAD/PVD/carotid atherosclerosis, diabetes, xanthomata or other stigmata of dyslipidemia; family history of dyslipidemia/CAD; adults with 2 or more risk factors; other pts (♂ ≥40, ♀ ≥50).

DRUG INDUCED HYPERLIPIDEMIA<sup>19,20</sup>: amiodarone, beta-blockers non ISA, carbamazepine, clozapine, cyclosporin, danazol, contraceptives esp. levonorgestrel, phenytoin, phenobarbital, protease inhibitors, progestins, retinoids, steroids & thiazides ≥50mg/d.

CHOICE OF AGENT: ↑↑ LDL ⇒ HMG +/- resin; ↑↑ LDL & ↑ TG ⇒ HMG; ↑↑ LDL & ↓ HDL ⇒ HMG +/- fibrate/niacin; Normal LDL & ↑↑ TG ⇒ fibrate/niacin/?fish<sup>05,21</sup> or combo; Normal LDL & ↓ HDL ⇒ fibrate/niacin or combo

TARGETS 2003 <sup>22</sup> :	HIGH RISK (10yr CAD risk ≥20%)	LDL <2.5 & Total Chol/HDL <4	+Apo B <0.9	{High risk → ALL pts with CAD / DIABETES <sup>adult</sup> -incl. chronic renal dx / any atherosclerotic dx (eg. CVD,PAD)}
for patients at:	MODERATE RISK (10yr CAD risk 11-19%)	LDL <3.5 & Total Chol/HDL <5	+Apo B <1.05	High risk pts: treat medication & lifestyle changes concomitantly.
	LOW RISK (10yr CAD risk 6-10%)	LDL <4.5 & Total Chol/HDL <6	+Apo B <1.2	Lower risk pts: treat with meds after 3-6 months of lifestyle changes if targets not met.
	VERY LOW RISK (10yr CAD risk <5%)	LDL <5	--	♦ Lifestyle changes for DIET, EXERCISE, moderate alcohol use & stop SMOKING! Consider ASA <sup>81mg/d</sup> . Highest risk benefit most!

⊗ EDS Sask. ✗ Non-formulary SK ⊗ not covered by NIHB ▼ covered NIHB ✓ Indication/Use DI=Drug Interaction Dx=disease dysfx=dysfunction GI=gastrointestinal HDL=high density lipoprotein HMG CoA reductase inhib→STATINS LDL=low density lipoprotein SE=side effect TG=triglycerides If >10mmol/l → risk of pancreatitis  
It is unclear whether benefit derived is solely from achievement of targets eg. ↓ LDL alone. Ⓢ = ↓ dose for renal dysfx +Apo B: a useful marker, particularly if metabolic syndrome or on statin therapy. Optimal TG <1.7 mmol/l

**New 2003 Canadian & USA - NCEP Working Group<sup>2</sup> -10yr risk of CAD in patients without diabetes or clinically evident heart disease.**

RISK*	MEN										WOMEN															
	20-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	20-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79						
AGE points	-9	-4	0	3	6	8	10	11	12	13	-7	-3	0	3	6	8	10	12	14	16						
<b>TOTAL CHOL</b>																										
<4.14 mmol/l	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						
4.15-5.19	4	3	2	2	1	1	1	1	0	0	4	3	2	2	1	1	1	1	1	1						
5.2-6.19	7	5	3	3	2	2	2	1	0	0	8	6	4	4	3	3	2	2	1	1						
6.2-7.2	9	6	4	4	3	2	2	1	1	1	11	8	5	5	4	3	3	2	2	2						
≥7.21	11	8	5	5	4	3	3	2	1	1	13	10	7	7	5	4	4	3	2	2						
<b>HDL mmol/l</b>																										
<1.04	1.04-1.29		1.3-1.54			≥1.55					<1.04	1.04-1.29		1.3-1.54			≥1.55									
	+2	+1	0	0	0	0	0	0	-1	-1	+2	+1	0	0	0	0	0	0	-1	-1						
<b>SYSTOLIC BP mmHg</b>																										
	Not Treated					Treated					Not Treated					Treated										
<120	0					0					0					0										
120-129	0					1					1					3										
130-139	1					2					2					4										
140-159	1					2					3					5										
≥160	2					3					4					6										
<b>SMOKER</b>																										
No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						
Yes	8	5	3	3	3	1	1	1	1	1	9	7	4	4	4	2	2	2	1	1						
<b>TOTAL POINTS</b>																										
<b>POINTS</b>	MEN: actual 10yr CAD risk %												WOMEN actual 10yr CAD risk %													
<0-4	5-6	7	8	9	10	11	12	13	14	15	16	≥17	<9	9-12	13-14	15	16	17	18	19	20	21	22	23	24	≥25
1% (10yr % Risk→)	2	3	4	5	6	8	10	12	16	20	25	≥30	<1% (10yr % Risk→)	1	2	3	4	5	6	8	11	14	17	22	27	≥30

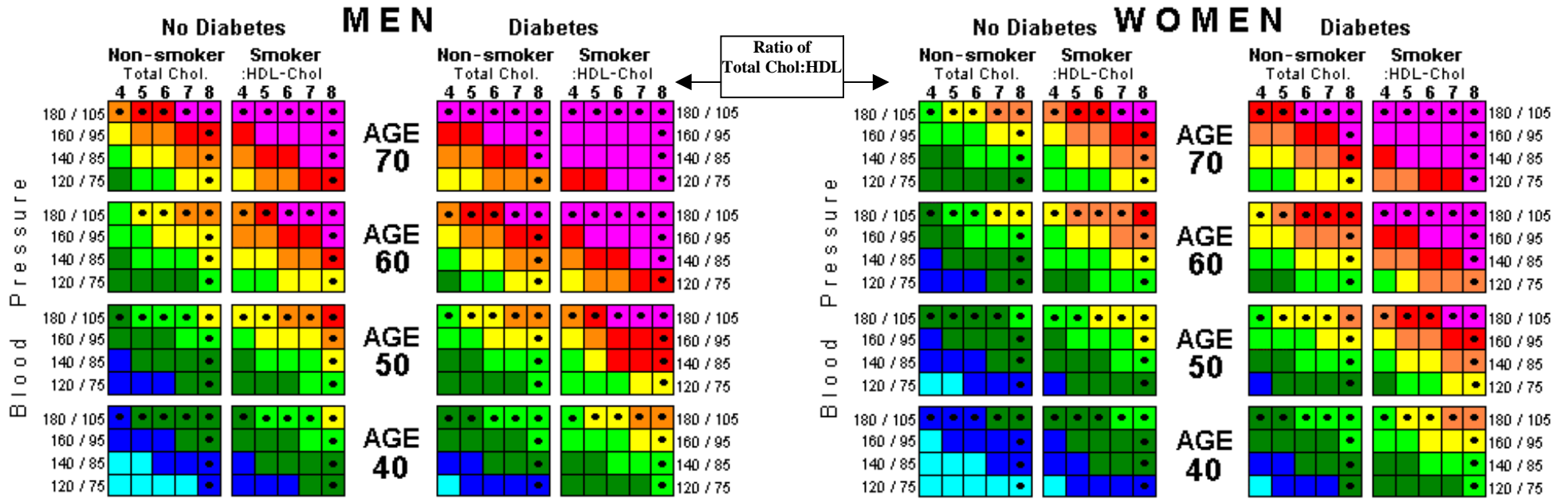
\*Risk assessments based on Framingham data; other risk factors such as family history of CAD, physical inactivity, obesity & left ventricular hypertrophy should also be considered.

Patients with **CAD / DIABETES** <sup>adult</sup> -incl. chronic renal dx / any atherosclerotic dx (eg. CVD,PAD) are **“high risk”** regardless of risk score.

Cardiac Risk Tools: 1) [www.statcoder.com](http://www.statcoder.com) 2) [www.nhlbi.nih.gov/guidelines](http://www.nhlbi.nih.gov/guidelines)

For suggested lipid targets, see bottom of page 10.

Comparative 10yr CAD % risks by AGE		30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74yr
Males	Low risk % →	2%	3	4	4	6	7	9	11	14
	Average risk % →	3%	5	7	11	14	16	21	25	30
Females	Low risk % →	<1%	<1	2	3	5	7	8	8	8
	Average risk % →	<1%	<1	2	5	8	12	12	13	14



**Key to Risk Tables**

RISK	Prognosis: 5 year CVD risk (non-fatal & fatal)	Benefit 1: CVD events prevented per 100 treated for 5 years *	Benefit 2: NNT for 5 years *	Suggested starting point for discussion with patient about drug treatment.
	Very High	> 30% 25-30% 20-25%	> 10 per 100 9 per 100 7.5 per 100	
High	15-20%	6 per 100	16	
Moderate	10-15%	4 per 100	25	
Mild	5-10%	2.5 per 100	40	
	2.5-5% < 2.5%	1.25 per 100 < 0.8 per 100	80 > 120	

• Cells with this marker indicate that in patients with very high levels of cholesterol (> about 8.5-9 mmol/L) or blood pressure (> about 170 / 100 mmHg), the risk equations may underestimate the true risk. **Therefore it is recommended that treatment be considered at lower absolute CVD risks than in other patients.**

\* Assumes BP reduction of about 12 / 6 mmHg in patients with BP > 140-150 / 90, or cholesterol reduction of about 20% in patients with total cholesterol > 5.0-5.5 mmol/L, produces an approximate 30% reduction in CVD risk, whatever the pre-treatment absolute risk.

**Also assess family history (↑ risk up to 50%), physical inactivity, obesity & LVH.**  
**Risk Factors** INTERHEART.CDN.JNC7: ↑ApoB/ApoA1 ratio, Smoking, Diabetes, ↑BP, Obesity: waist/hip ratio (♂ ≥0.95; ♀ ≥0.9), BMI >25, Waist (♂ >102cm/40inch, ♀ >88cm/35inch), stress & depression; lack of vegetables, fruits, exercise & alcohol; Low HDL ≤1, Family hx of premature heart dx (Age: ♂ <55, ♀ <65), Age (♂ >55, ♀ >65) & Microalbuminuria.

**NZ-CVD-5yr Risk Tool:** quick/easy way to estimate risk of CHD and stroke; the Framingham 10yr risk assessment may also be used to estimate CHD risk. Antihypertensive benefit greater in those at highest risk!

BLOOD PRESSURE <sup>2004, 26</sup>	Consider Treatment	Target	
		LDL	T.Chol/HDL
<b>NO RISK FACTORS</b> or target organ damage	≥160/100	<140/90	<140/90
<b>ISOLATED SYSTOLIC HTN (ISH)</b>	SBP >160	<140/90	<140/90
<b>MODERATE-HIGH RISK Patient</b>	≥140/90	<135/85	<135/85
♦ If HOME BP Measurement	≥135/85	<130/80	<130/80
<b>DIABETES or RENAL Disease</b>	≥130/80	<125/75	<125/75
♦ If PROTEINURIA >1g/d	≥125/75		

LIPID <sup>2003, 22</sup>	Risk (often based on Framingham 10yr CAD risk)		
	LDL	T.Chol/HDL	Apo B
<b>HIGH *</b> (10yr CAD ≥20%)	<2.5	<4	<0.9
<b>MODERATE</b> (10yr CAD 11-19%)	<3.5	<5	<1.05
<b>LOW</b> (10yr CAD 6-10%)	<4.5	<6	<1.2
<b>VERY LOW</b> (10yr CAD <5%)	<5	--	--

\*High Risk includes ALL pts with CAD / DIABETES adult incl. chronic renal dx / CVD / PAD. HIGH Risk: Treat with medication & lifestyle changes concomitantly. LOWER Risk: May try lifestyle changes for 3-6 months before drug therapy if targets not met.

BLOOD GLUCOSE <sup>2003, 27</sup>	Target for most	Normal range	→consider achieving if can be done safely without hypoglycemia etc..
	A1C q3-6 mon (calibrate meter qyr)	≤7	≤6
FPG (mmol/L)	4-7	4-6	
PPBG (mmol/L) 2hr post	5-10	5-8	

**Individualized Target Treatment Goals:** consider age<sup>28</sup>, life expectancy, co-morbidity and risk of hypoglycemic side effects. **Monitor:** A<sub>1c</sub> q3-6 months; calibrate meter yearly.

A<sub>1c</sub>=glycosolated hemoglobin A<sub>1c</sub> BP=blood pressure CAD=coronary artery disease CVD= cardiovascular disease Dx=disease FPG=fasting plasma glucose HDL=high density lipoprotein Hx=history LDL=low density lipoprotein PAD=peripheral arterial disease PPBG=postprandial (2hr) blood glucose TG=triglycerides ♂=male ♀=female

Table 8: TARGETS Canadian

- <sup>1</sup> Fodor JG, Frohlich JJ, Jacques JG et al. **Canadian** Recommendations for the management and treatment of dyslipidemia. *CMAJ* **2000**;162:1441-7.
- <sup>2</sup> NCEP Expert Panel. Executive summary-3<sup>rd</sup> national cholesterol education program on detection, evaluation and treatment of high blood cholesterol in adults (**Adult Treatment Panel III**). *JAMA* **2001**;285:2486-97. Implications of Recent Clinical Trials for the NCEP ATP Panel III Guidelines July **2004** [http://www.acc.org/clinical/adoptions/ncep\\_report.pdf](http://www.acc.org/clinical/adoptions/ncep_report.pdf)
- <sup>3</sup> Knopp RH. Drug treatment of lipid disorders. *N Eng J Med* 1999;341:498-511.
- <sup>4</sup> Davidson MH. Safety profiles for the HMG-CoA Reductase Inhibitors. *Drugs* 2001;61:197-206
- <sup>5</sup> Link N, Tanner M. Hyperlipidemia: Part 1. Evaluation and dietary management. *WJM* 2001;175:246-250.
- <sup>6</sup> Link N, Tanner M. Hyperlipidemia: Part 2. Pharmacologic management. *WJM* 2001;175:396-401.
- <sup>7</sup> Anonymous. Choice of lipid-regulating drugs. *Med Lett* 2001;43:43-48.
- <sup>8</sup> **Treatment Guidelines: Drugs for Lipid Disorders. The Medical Letter:** August, **2003**; (12) pp. 77-82 & March, **2005**; (3;31) pp. 15-22.
- <sup>9</sup> Rizvi K, Hampson JP, Harvey JN. Do lipid-lowering drugs cause erectile dysfunction? A systematic review. *Fam Pract* 2002;19(1):95-8.
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- <sup>11</sup> Herman, RJ. Drug interactions and the statins. *CMAJ* 1999;161:1281-6.
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- <sup>13</sup> Rosuvastatin--a new lipid-lowering drug. *Med Lett Drugs Ther*. 2003 Oct 13;45(1167):81-3.
- <sup>14</sup> Jones P, et al. Comparative dose efficacy study of atorvastatin versus simvastatin, pravastatin, lovastatin and fluvastatin in patients with hypercholesterolemia (The **CURVES** study). *Am J Cardiol* 1998;81:582-7.
- <sup>15</sup> Three new drugs for hyperlipidemia. *Med Lett Drugs Ther*. 2003 Mar 3;45(1151):17-9.
- <sup>16</sup> Grundy SM, Vega GL, McGovern ME, Tulloch BR, Kendall DM, Fitz-Patrick D, Ganda OP, Rosenson RS, Buse JB, Robertson DD, Sheehan JP; Diabetes Multicenter Research Group. Efficacy, safety, and tolerability of once-daily niacin for the treatment of dyslipidemia associated with type 2 diabetes: results of the assessment of diabetes control and evaluation of the efficacy of niaspan trial. *Arch Intern Med*. 2002 Jul 22;162(14):1568-76.
- <sup>17</sup> Elam MB, Hunninghake DB, Davis KB, Garg R, Johnson C, Egan D, Kostis JB, Sheps DS, Brinton EA. Effect of niacin on lipid and lipoprotein levels and glycemic control in patients with diabetes and peripheral arterial disease: the ADMIT study: A randomized trial. *Arterial Disease Multiple Intervention Trial*. *JAMA*. 2000 Sep 13;284(10):1263-70.
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- <sup>23</sup> New Zealand Guideline Group. [http://www.nzgg.org.nz/library/gl\\_complete/bloodpressure/table1.cfm](http://www.nzgg.org.nz/library/gl_complete/bloodpressure/table1.cfm) (access verified Jan 30/03).
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