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Current Guidelines Should be Taken into Consideration in the Management of Dyslipidemia

LETTER TO THE EDITOR

To the Editor,

I read the article entitled "Adherence to Current Dyslipidemia Guideline in Patients Utilizing Statins According to Risk Groups and Gender Differences: The AIZANOI Study" published by Şen et al,[1] in the Anatolian Journal of Cardiology with great pleasure. In the mentioned study, the authors aimed to assess the adherence to the European Society of Cardiology dyslipidemia guidelines recommendations, the ratio of reaching target values according to risk groups, and the reasons for not reaching LDL-cholesterol (LDL-C) goals in patients already on statin therapy in the cardiology outpatient population. In this study, a very important issue concerning the daily practice of cardiology was discussed. However, there were some points I was curious about:

1. The risk categories of the patients were determined according to the systematic coronary risk evaluation (SCORE) (2019 ESC/EAS Guidelines for the management of dyslipidaemias)[2] risk model. However, at the time the study data were collected and analyzed, an updated version of the SCORE risk model, "SCORE2 and SCORE2-OP" (2021 ESC Guidelines on cardiovascular disease prevention in clinical practice),[3] was available. SCORE and SCORE2/SCORE2-OP categorize patients without known atherosclerotic cardiovascular disease (ASCVD) differently. Although there is no change in the very high ASCVD risk category, it would be more accurate to use SCORE2 and SCORE2-OP, as there may be changes in defining other risk categories (low-to-moderate and high CVD risk categories).
2. My understanding is that statin contraindications may have been exclusion criteria for the current study. However, patients with renal failure and a glomerular filtration rate below 30 mg/dL were excluded from the study. Renal failure with a glomerular filtration rate below 30 mg/dL is one of the very high-risk category criteria and is not a contraindication to statin treatment. It should be noted that the ESC guideline[3] does not recommend starting statin therapy only in patients with dialysis-dependent chronic kidney disease without ASCVD. Therefore, randomly excluding patients with a GFR below 30 mg/dL caused bias in sample selection for the present work.
3. The authors' recommendation that combination therapy is necessary for the majority of patients is certainly justified. However, dyslipidemia combination treatment facilities within Türkiye's social security institution are not at a sufficient level. It should be kept in mind that ezetimibe is currently the most suitable molecule for combined treatment under Türkiye's conditions. It should also be remembered that it is reimbursed after 6 months of statin therapy. In this context, the regulations of the Turkish social insurance institution, in accordance with scientific norms, will be beneficial for national health. Furthermore, alternative preventive measures such as diet, exercise, and lifestyle changes should be advised.

In conclusion, current guidelines should be taken into consideration in the management of dyslipidemia.

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