Conclusions: In this subgroup analysis of patients ≥65 years of age with mixed dyslipidemia, combination therapy with FA + R 5, 10, or 20 mg for 12 weeks resulted in comprehensive improvements in the overall lipid profile, with no new or unexpected safety issues. Combination of FA + R may represent a useful therapeutic option for the treatment of mixed dyslipidemia in patients ≥65 years of age.

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Long-Term Efficacy of Adding Fenofibric Acid to Moderate-Dose Statin Monotherapy in Patients with Persistent Elevated Triglycerides

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Synopsis: NCEP ATP III recommends the addition of a fibrate or niacin to LDL-C lowering treatment to achieve the secondary non-HDL-C goal for patients with triglycerides ≥200 mg/dl who are at their LDL-C goal. Limited long-term efficacy and safety data exist concerning the addition of a fibrate to a statin in patients with mixed dyslipidemia.

Proportion of patients at optimal lipid levels at 52 weeks after addition of fenofibric acid to MDS monotherapy.

		Baseline*	52 weeks
Variable		(MDS) n = 72	(Fenofibric acid + MDS) n = 72
LDL-C	Median, mg/dl	81.8	85.5
	Proportion at target (<100 mg/dl)	100%	81.9%
Non-HDL-C	Mean, mg/dl	128.7	116.5
	Proportion at target (<130 mg/dl)	52.8%	66.7%
Triglycerides	Median, mg/dl	247.0	149.5
	Proportion at target (<150 mg/dl)	0.0%	50.0%
Apo B	Mean, mg/dl	91.2	81.9
	Proportion at target (<90 mg/dl)	41.7%	69.4%
LDL-C and non-HDL-C	Proportion at both targets simultaneously	52.8%	63.9%
LDL-C, non-HDL-C, triglycerides, and Apo B	Proportion at all targets simultaneously	0.0%	40.3%

MDS = moderate-dose statin (rosuvastatin 20 mg, simvastatin 40 mg or atorvastatin 40 mg).

*Baseline = start of open-label extension study after 12 weeks of MDS monotherapy.

Purpose: To evaluate the long-term (52 week) efficacy of adding fenofibric acid (135 mg) to moderate-dose statin monotherapy (MDS: rosuvastatin 20 mg, simvastatin 40 mg or atorvastatin 40 mg) in patients at LDL-C goal (<100 mg/dl) but with triglycerides above 200 mg/dl.

Methods: This is a post hoc analysis of a subset of patients with mixed dyslipidemia treated with MDS monotherapy for 12 weeks in 3 randomized, controlled trials who had achieved LDL <100 mg/dl but whose triglycerides remained >200 mg/dl and subsequently had fenofibric acid 135 mg added to the same MDS in a 52-week open-label extension study. Lipid and apolipoprotein values as well as the proportion of patients meeting ATP III and consensus recommended lipid targets were determined at the end of MDS monotherapy (baseline; start of the open-label extension study) and after 52 weeks of therapy with fenofibric acid + MDS.

Results: Of 364 patients treated with MDS monotherapy in the 3 controlled trials and who entered the 52-week open-label extension study, 72 (19.8%) had LDL-C <100 mg/dl and triglycerides >200 mg/dl at baseline and completed the extension study. The addition of fenofibric acid to MDS lowered non-HDL-C, triglycerides, and Apo B from baseline (Table). Following 52 weeks of therapy with fenofibric acid + MDS, 63.9% of patients achieved both LDL-C and non-HDL-C treatment goals, compared to 52.8% meeting these goals prior to the addition of fenofibric acid. Furthermore, while none of the subjects achieved simultaneous optimal levels of LDL-C, non-HDL-C, triglycerides, and Apo B at the start of open-label treatment, 29/72 patients (40.3%) did achieve those 4 optimal levels after 52 weeks of therapy with fenofibric acid + MDS. No new or unexpected adverse events were observed with long-term exposure to fenofibric acid + MDS in the overall study population.

Conclusions: The addition of fenofibric acid to MDS in patients with LDL-C <100 mg/dl and triglycerides >200 mg/dl led to additional improvements in non-HDL-C, triglycerides and Apo B that resulted in a greater proportion of patients attaining optimal levels of the individual parameters as well as simultaneously achieving optimal levels of these variables and LDL-C.

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A Multidisciplinary Approach to the Prevention of Cardiovascular Disease

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Synopsis: Cardiovascular disease, stroke, chronic kidney disease, metabolic syndrome, and diabetes are prevalent in the southeastern United States. The Consortium for Southeastern Hypertension Control (COSEHC), a nonprofit healthcare organization, is committed to reducing the disease burden through development and dissemination

of best practices and through Cardiovascular (CV) Centers of Excellence. Ideally, these Centers provide expertise in disease management by employing a multi-disciplinary care team. The American Board of Clinical Lipidology (ABCL) was created to recognize excellence in clinical lipid management. The American Society of Hypertension (ASH) has developed the Specialist in Clinical Hypertension designation recognizing clinical expertise in hypertension management. The usefulness of this training in clinical practice is of interest.

Purpose: This study evaluated the efficacy of the COSEHC CV Center of Excellence concept in clinical practice. As the lead physician is both an ABCL Diplomate and an ASH Hypertension Specialist, the study offers an opportunity to assess the clinical relevance of these curricula.

Methods: A retrospective chart review (n = 422) was conducted of consecutive patients (February 2006–February 2008) evaluated at the Center for Cardiovascular Disease Prevention at the Baton Rouge Clinic, a private, multi-specialty group practice. Data was analyzed using an unpaired t test (significance, $p < 0.05$).

Results: 65.6% of patients were referred for a diagnosis of hyperlipidemia. 27.3% were referred for hypertension, and 7.1% were referred for both. 96.8% were referred by physicians (IM 57.7%, FP 7.4%, cardiology 20%, other MD 11.6%) and 3.2% were self-referred. 85.5% of patients (n = 361) were seen at least two times. A majority of patients (71%) were seen four or fewer times. 15.3% had seven or more visits. Compared with the initial visit, there were statistically significant improvements at the last visit in total cholesterol (227.3 +/− 61.1 vs. 170.61 +/− 44.7 mg/dl), LDL cholesterol (136.3 +/− 54.0 vs. 89.6 +/− 35.8 mg/dl), triglycerides (268.5 +/− 370.1 vs. 179.4 +/− 204.5 mg/dl), systolic blood pressure (134.7 +/− 22.0 vs. 126.0 +/− 15.7 mmHg), and diastolic blood pressure (80.3 +/− 11.2 vs. 75.4 +/− 9.9 mmHg.)

Conclusions: The COSEHC CV Center of Excellence concept, led by a physician with ABCL and ASH Specialist in Clinical Hypertension training, is both efficient and effective in achieving important clinical improvements in a difficult patient population at significant risk for cardiovascular disease and stroke despite previous treatment.

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Physician Prompts and Chart Audits Improve Compliance with Preventive Guidelines in the Elderly

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Synopsis: Because of their high absolute risk for cardiovascular disease (CVD), strategies to control risk factors in the elderly are particularly effective. Unfortunately, recommended therapies are initiated in only approximately half of high-risk elderly patients. Chart audits, chart prompts, and performance reports have proven variably successful in increasing physician compliance with clinical guidelines in previous studies. Since the elderly receive the majority of their care from primary care providers, this study examined the impact of a simple reminder system on improving guideline-recommended preventive care in this setting.

Purpose: The goal of this pilot study was to determine whether a practice-based intervention could increase the rate at which 6 recommended preventive care measures were documented or implemented in high risk patients 65 years or older: annual blood pressure measurement; blood pressure measurement within 3 months in patients with DM and HBP; HbA1c measured within 6 months for diabetic patients; annual LDL measurement; diagnosis of hyperlipidemia documented for patients with LDL Cholesterol of >100 mg/dl; lipid lowering drugs prescribed for LDL Cholesterol > 100 mg/dl.

Methods: The seven primary care practices [5 solo practices, 2 multi-provider practices] underwent baseline chart audits of patients 65 and older to measure adherence to the six preventive practices. Audits were only performed on patients with documented coronary artery disease [46%]; other Vascular Disease [peripheral arterial disease 9%, cerebrovascular disease 20%, aortic aneurysm 7%]; or Diabetes [50%]. After randomization, the Intervention practices received their baseline audit results and underwent quarterly audits with linked physician feedback. Intervention practices with a paper medical record [3 out of 4 practices] had a chart prompt affixed to the records of all patients 65 and older with recommended preventive measures for cholesterol, hypertension, and diabetes management. Both Intervention and Control practices underwent a final chart audit which was compared to their baseline audit results.

Results: In the Intervention Group, the documented diagnosis of high cholesterol in patients with LDL >100 mg/dl increased from 91% to100% [p = 0.035], the prescription of cholesterol lowering medication for patients with high cholesterol increased from 83% to 98%, [p = 0.020], and the number of study measures with 100% compliance rose from 33% to 75% [p = 0.004] . There was no significant performance difference between the Control and Intervention groups at baseline audit or follow-up assessment.

Conclusions: A simple intervention involving a chart prompt and physician feedback substantially improved compliance with key preventive recommendations among high-risk elderly patients.

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Novel Web-Based Lipid Management Software and its Utility in the Lipid Clinic

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Synopsis: CVD evaluator is an expert system written in visual basic 6 and web.net. The system basically computes individual patient risk from clinical information, lipid profile and, if available, emerging risk factors including genetic factors to make specific diagnostic and therapeutic