

# Diabetes and Dyslipidemia Master Decision Path

## At Presentation

### Labs:

#### 1. Fasting lipid profile

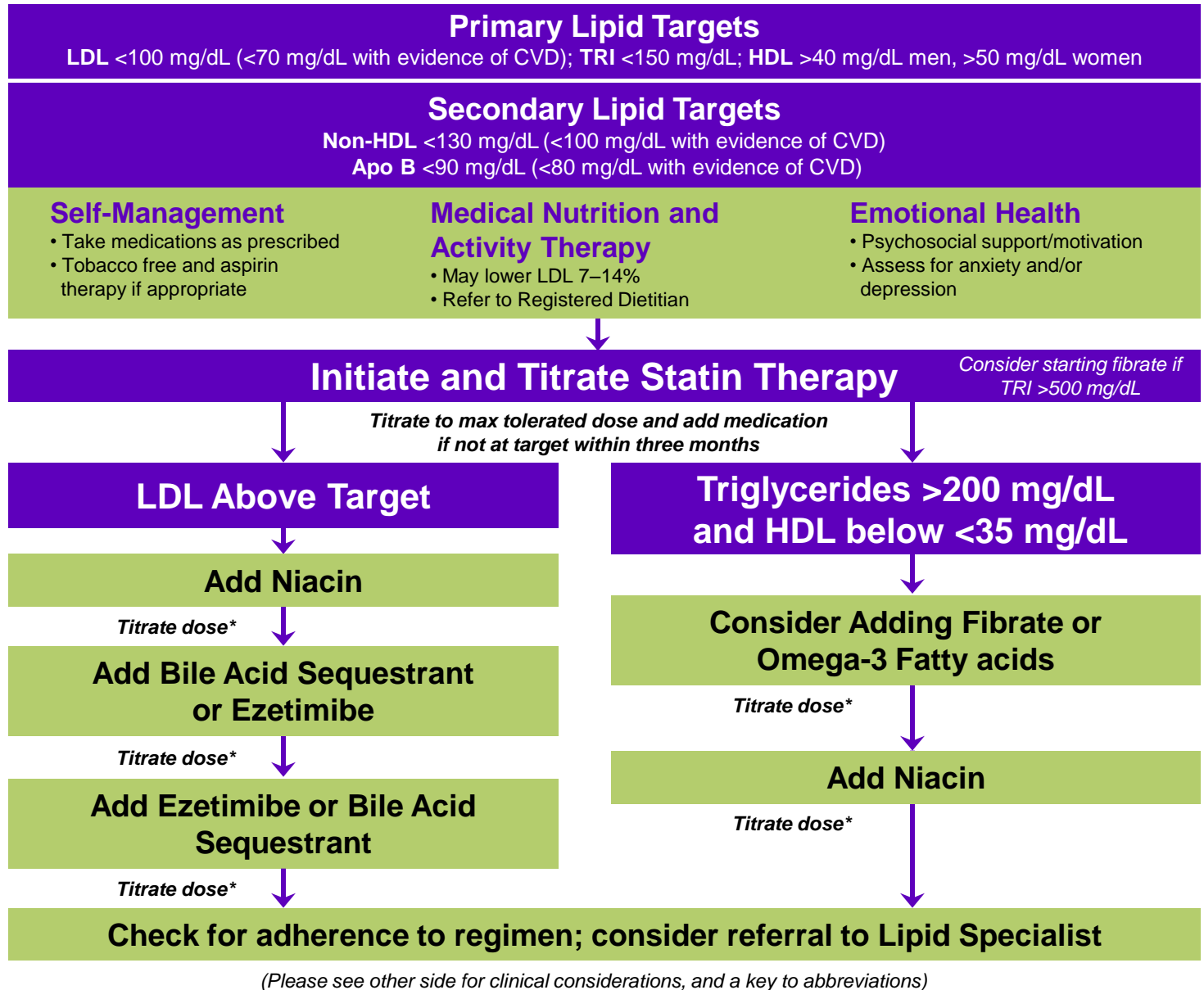
(May consider using nonfasting sample when measuring non-HDL cholesterol)

#### 2. ALT

#### 3. CK

(Consider if muscle pain, history of elevated CK, and/or muscle disease)

*\*Titrate dose; add medication if not at target within three months, or stop if not tolerated*



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## Abbreviations and Clinical Considerations

### Abbreviations

<b>ApoB:</b>	Apoprotein B
<b>CVD:</b>	Cardiovascular disease
<b>DM:</b>	Diabetes mellitus
<b>HDL:</b>	High-density lipoprotein
<b>LDL:</b>	Low-density lipoprotein
<b>Non-HDL:</b>	Non-high-density lipoprotein
<b>TRI:</b>	Triglyceride

### Clinical Considerations for Statin Therapy

- Titrate statin dose to lower LDL 30–40% regardless of baseline LDL
- Statin therapy should be considered in all patients with type 2 diabetes and evidence of CVD, and those >40 years of age with additional CV risk factor(s)
- Determine ALT and CK level at baseline; do not initiate statin or consider discontinuing therapy if >3 times upper limit of normal; consider alternate statin (pravastatin or low dose rosuvastatin) or reduced dose for statin associated myalgia
- Statin and fibrate combination therapy (especially with gemfibrozil) increases risk of myopathy and rhabdomyolysis

### Other Clinical Considerations

1. Non-HDL = total cholesterol – HDL; reflects cholesterol in all atherogenic lipoproteins.
2. High ApoB associated with CVD; represents a large number of small, dense oxidized LDL particles.
3. Reinforce importance of glycemic control if persistently elevated triglyceride level; reinforce need for moderating carbohydrate and alcohol intake; consider 2 gm/day plant stanols/sterols for elevated triglycerides.
4. Flushing is a concern with niacin therapy; frequency diminishes with repeated, consistent dosing; consider taking aspirin 30–60 minutes prior to dose and/or use of extended release niacin; beneficial because raises HDL, lowers triglycerides and LDL.
5. Bile acid sequestrant contraindicated when triglycerides >500 mg/dL; colestevlam recommended because of better tolerability and impact on lipid panel (may have modest beneficial effect on lowering blood glucose).
6. Ezetimibe well tolerated; modest benefit on lowering LDL when added to statin; no additional reduction in carotid intima-media thickness when added to statin.
7. Fibrate lowers triglycerides and raises HDL; trend towards CV protection when triglycerides >204 mg/dL and HDL <35 mg/dL; suggested benefit in men and possible harm in women; consider baseline CK when starting fibrate with statin.
8. Omega-3 fatty acids lower triglycerides; limited outcome data on CV protection; prescription grade omega-3 fatty acids available.