Roadmap

Hoja de ruta

The Argentine Society of Cardiology (SAC) and the Argentine Federation of Cardiology (FAC) are organizing the first Cholesterol Roadmap of the World Heart Federation (WHF) in Argentina.

Roadmaps have been designed as a strategy to identify barriers and suggest possible solutions on the way to achieving the global goal of reducing premature cardiovascular disease (CVD) mortality by at least 30% by 2030. They are also intended to improve the prevention, detection and management of CVD and provide a generic global framework available for local adaptation.

It is in this context that we are planning a conference with representatives of the main medical societies of different specialties and health decision-makers at both the public and private levels. The aim of the meeting will be to identify the main difficulties in the management of hypercholesterolemia in our country so that the benefits of evidence-based medicine reach patients. The challenge is to translate science into policies that generate solutions.

First, we will discuss how to manage a silent disease and reinforce the importance of prevention. For this purpose, we will attempt to dialog with the representatives of the Ministries of Health throughout the country, in order to carry out educational and detection programs, and with the Ministries of Education, to raise awareness of the relationship between high cholesterol levels and other risk factors in the development of CVD since childhood. We will propose to implement a requirement for healthy foods available in schools and school stores. University curricula should also address these issues.

General screening of children and adolescents will be another proposal. Working with medical societies, chambers of commerce, industries, trade unions and all types of workers could contribute to expand screening in adults. It will undoubtedly help to connect patients with their families and provide guidance to the community where they live. We should take advantage of traditional media by means of radio and television interviews to raise awareness on the issue among the population. It is often useful to use patient testimonials on social networks and to conduct "Do you know your cholesterol numbers?" campaigns, similar to the "Know your numbers" campaign for hypertension and diabetes. The importance of maintaining adherence to hygienic, dietetic, and pharmacological measures should be emphasized. While this is a long-standing difficulty, it may have been exacerbated by the pandemic and by the worsening of the economic situation, which has increased the barriers to healthcare access. Undoubtedly, the significant increase in the price of medicines in the last year, even above inflation and salary updates in a country with high social marginalization and high level of workers out of the system, has worsened the situation.

We should facilitate professionals' access to continuing medical education programs and encourage them to follow the guidelines, which should have simple treatment algorithms developed in few steps. In this aspect, the scientific societies play a fundamental role. The target will be to increase the proportion of patients treated and identify high-risk subjects, especially those with familial hypercholesterolemia (FH) and the indication of high-intensity statin therapy, as appropriate. We must overcome therapeutic inertia, that is, the failure to initiate or intensify treatment when indicated.

We must work with the health system to improve patients' accessibility to drugs, especially for the least favored populations or those living in rural areas that lack doctors, where we must also train health workers in the management of cholesterol.

The affordability of essential drugs should be ensured with programs providing free essential drugs for the most vulnerable populations, and availability should be checked both in pharmacies and health institutions, with monitoring of stock shortages. We will recommend non-fasting blood samples for the assessment of plasma lipid profiles to predict CVD risk, as supported by the studies. Practical management aspects should be considered, such as implementing prescriptions that last 3 or 6 months for all chronic non-communicable diseases so as not to bother patients with monthly medical visits to " get a prescription" and so as not to saturate the health system with unnecessary visits. Although the different clinical practice guidelines recommend drug combinations for certain diseases (as hypertension), it is unacceptable that some health care providers do not approve them. The new technologies have opened opportunities to improve detection and diagnosis, to better follow up patients and monitor adherence. Promoting their use will help to increase knowledge and awareness of this problem.

In summary, we must work on primordial prevention, preventing risk factors through population-based interventions, social and environmental interventions, health policies, laws, taxes, subsidies,

campaigns, etc., or pharmacological interventions. In primary prevention, treating risk factors with individual behavioral interventions taking advantage of digital tools that help patients to comply with smoking cessation, healthy eating and physical activity, or pharmacological interventions with lipid-lowering, antihypertensive and glucose-lowering drugs. Secondary prevention will focus on early diagnosis and prevention of complications.

We will need to establish future plans that consider follow-up meetings on solutions to WHF Roadmap obstacles and prevention of CVD. These meetings should be held periodically involving multiple sectors and including governmental and non-governmental organizations, in order to better inform the public and other agents of the health system. The great challenge will be implementation, with the coordination of all the actors involved.

The keys: ADHERENCE, ACCESSIBILITY, ADAPTABILITY, AFFORDABILITY, AVAILABILITY and QUALITY.

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