Statins are the standard of care for the treatment of dyslipidemia, based on their ability to reduce LDL-C levels by up to 60% and thus lower the risk of atherosclerosis and CV events.

However, a significant proportion of patients are unable to tolerate statin therapies, either a specific product or statins in general, or can only tolerate low dose statins, potentially preventing patients from reaching their LDL-C target.

PCSK9 inhibitors, used alone or in combination with maximum-tolerated dose statins, offer an alternative for these patients. Adelphi’s Dyslipidemia DSP, conducted in the USA and nine other countries, identifies lack of efficacy as the most frequently recorded reason for regimen change, further highlighting the need for more effective treatment options to achieve the desired LDL-C goal.

Evidence of the need for increased potency in LDL-C reduction is also provided by patients’ most recent LDL-C tests with 58% having a result >100 mg/dL and four out of five patients having one or more lipid abnormalities (low HDL 41%, high TG 21%). These results are further impacted by the fact that 3 out of 10 patients are not fully compliant with their medication.

Among the 6% of patients recorded as intolerant to statins, 42% are intolerant to all statins, 40% to certain statins, and 18% only able to tolerate low dose statins. Most frequently these are atorvastatin and simvastatin, the first line therapies of choice in most major markets.

DSP data suggest that significant levels of unmet medical need remain, with physicians highlighting unmet need in all three major lipid parameters, as well as total cholesterol, more frequently than for any other attributes.

Use of the PCSK9s is more evident in higher risk patients, with 23% having a diagnosis label of Familial Hypercholesterolemia, 36% being statin intolerant and 34% having had an ACS event.

The most frequent reason for choice of PCSK9 therapy is beneficial effect on LDL-C, further demonstrating the need for increased LDL-C reduction in high risk patients, those unable to reach target on statin alone and those who are statin intolerant.
SGLT2 inhibitor use in heart failure

Drivers for adoption by cardiologists:

- Guideline recommendations: 77%
- Evidence from clinical practice: 69%
- Evidence of cost effectiveness: 38%
- Use by my peers: 23%
- Formulary recommendations: 15%

Data from 2019 Heart Failure DSP Physician Survey - % of cardiologists

Following the EMPA-REG OUTCOME study of the oral SGLT2* inhibitor empagliflozin, interest has been growing in the potential cardiovascular benefits of this therapy class. Currently indicated for Type 2 Diabetes, various SGLT2 inhibitors are being trialled in patients with heart failure (with or without T2D).

Wave 2 data from Adelphi Real World’s Heart Failure Disease Specific Programme (DSP) suggested that positive results from these trials would encourage the majority of cardiologists to prescribe an SGLT2 inhibitor in order to provide CV benefits to patients with heart failure/T2D.

Cardiologists reported that almost half of their patients with heart failure and T2D could be candidates for an SGLT2 inhibitor, with the treatment likely being used as an add-on to existing regimens.

Cardiologists indicated that, alongside themselves, diabetologists and endocrinologists would be primarily responsible for initiating SGLT2 inhibitors in these patients, with general practitioners less likely to do so.

Additional trials are in progress to determine whether there are similar CV benefits for heart failure patients who do not have a T2D diagnosis; however, it seems that fewer cardiologists would be keen to prescribe an SGLT2 inhibitor in this patient population (six out of ten compared with 94% who would prescribe for patients with T2D).

In order to encourage the remaining four out of ten cardiologists to start prescribing an SGLT2 inhibitor to patients without diabetes, guideline and formulary recommendations, observed use in clinical practice, evidence of cost effectiveness and evidence from early usage by their peers will all be needed.

Sarah Cotton

* sodium-glucose cotransporter 2

*cardiovascular Renal Metabolic (CVRM) Real-World Studies

NASH: Non-alcoholic steatohepatitis
T2DM: Type 2 Diabetes Mellitus
T1DM: Type 1 Diabetes Mellitus

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Full Spectrum CV-Metabolic DSP™ Franchise

ADELPHI CARDIOVASCULAR RENAL METABOLIC (CVRM) REAL-WORLD STUDIES

- Dyslipidemia
- Obesity
- NASH
- T2DM
- Chronic Kidney Disease
- Heart Failure
- Atrial Fibrillation
- Acute Coronary Syndrome

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