Management of hyperlipidaemia

To the Editor: As physicians with expertise in the management of lipid disorders, we express our concern that the guideline for hyperlipidaemia published in the Council for Medical Schemes PMB-X 2023 booklet[1] is out of date. Following this guide would hinder rather than encourage timeous and effective prevention of atherosclerosis and pancreatitis. More appropriate management is indicated in the South African (SA) guidelines.[2,3]

Given space limitations, we can only highlight a few criticisms of the guideline here. In our opinion, the guideline fails to emphasise the importance of severe hypertriglyceridaemia (triglycerides >10 mmol/L or samples reported as turbid or lipaemic), which poses a high risk of pancreatitis and is usually very responsive to interception of secondary causes (dietary fat, alcohol, diabetes mellitus) and fibrates. Risk calculation is not required for severe hypertriglyceridaemia or in primary low-density lipoprotein (LDL) hypercholesterolaemia of >5 mmol/L, as is often seen in familial hypercholesterolaemia (FH), which is an indication for lipid-lowering therapy. In patients with overt cardiovascular disease, lipid-lowering therapy should not be 'considered' but is mandatory unless contraindicated. The latest recommended LDL cholesterol (LDL-C) targets are also much lower than 3.0 mmol/L, e.g. <1.4 mmol/L for those with established cardiovascular disease together with at least a 50% reduction from baseline LDL-C. This cannot be achieved with the recommended treatment in the PMB-X 2023 guidelines. Many patients require the addition of ezetimibe to statins to achieve targets. The importance of lipid-lowering therapy in patients with type 2 diabetes mellitus who are at high risk of atherosclerotic cardiovascular disease is also not adequately emphasised. The *International Classification of Diseases* 10th revision (ICD-10) code of E78.1 is accompanied by the wrong wording.

Increased insight into metabolic disorders and improvement in treatment justify the creation of the subspecialty of lipidology as well as a network of clinics and a dedicated laboratory for the estimated >500 000 persons with severe disorders of lipid and lipoprotein metabolism in SA. Support for lipid clinics has waned since the 1980s. Unfortunately, postgraduate training only rarely exposes doctors to the severe lipid disorders they may later encounter. Referral to a lipid clinic should be considered according to the following criteria: (*i*) serum total cholesterol >7.5 mmol/L or LDL-C >5 mmol/L; (*ii*) high-density lipoprotein cholesterol >2.5 mmol/L; (*iii*) triglycerides >10 mmol/L; (*iv*) cutaneous xanthomas apart from xanthelasma or tendinous xanthomas; (*v*) very premature cardiovascular disease; (*vi*) incomplete control of severe dyslipidaemia; and (*vii*) adverse effects attributed to lipid-modifying medication. Unfortunately, there is no commitment in either the private or the public sector to support lipid expertise in SA.

Given the increasing burden of non-communicable diseases, and in particular atherosclerotic cardiovascular disease, in SA, the guideline from the Council for Medical Schemes should promote appropriate assessment and treatment. The PMB-X 2023 guideline makes it especially difficult for individuals with FH, a particularly common condition in SA,[4] to receive treatment, and does not promote well-established and proven LDL-C targets for other individuals.

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