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ASPC president's page: Getting back to basics one patient at a time

1. Introduction

Now that I am approaching the end of my tenure as president of the American Society for Preventive Cardiology, I realize there is so much more to do, so much focus to recalibrate and redirect, and so many issues to critically appraise and act upon in order to advance the field and improve patient care.

One of the more pressing issues that truly puzzles me is the dichotomy between the depth of our understanding of cardiovascular pathophysiology and how poorly, in general, this knowledge is applied in everyday clinical practice. Through basic scientific investigation, prospective longitudinal cohorts, hundreds of randomized controlled clinical trials, and a wealth of evidence-based practice guidelines, our ability to therapeutically intervene and beneficially impact or even halt the progression of disease, has never been greater. Yet, we are falling short. The rate of cardiovascular mortality has been on the rise for the last decade. The rates of myocardial infarction, stroke, and the need for revascularization remain unacceptably high. The majority of patients remain under-treated, not optimally treated, and there are great disparities in the quality of care by sex, race/ethnicity, socioeconomic status, and other social determinants of health [1–3].

What can we do to reverse these trends? I believe we need to get back to basics and capitalize more deeply in the trust that patients place in us as preventive cardiology specialists. They are relying on us to keep them from developing initial and having recurrent cardiovascular events. This is a solemn responsibility and requires that patients and their clinicians integrate their efforts and achieve mutual understanding of therapeutic goals and long-term health objectives in order to maximize the likelihood of good outcomes. How can we better foster this?

2. It is imperative that we practice guideline-based medicine

Risk calculators are profoundly under-utilized in the setting of primary prevention [4], despite the fact that they are becoming more accurate and are a crucial first step in risk assessment and part of the clinician-patient risk discussion. When clinicians "eyeball" risk, they typically underestimate it and under treat it. Over the last two decades goal attainment rates for the management of dyslipidemia have not budged, despite the development of guidelines that have become more user friendly over the years. Despite the widespread use and acceptance of a simple phrase, such as "when it comes to LDL-C, lower is better," statins continue to be used at low doses and titration often does not occur, particularly in the patients who most need it [5,6]. The use of adjuvant lipid-lowering therapies remains low, even with the generic availability of ezetimibe; moreover, the revolutionary proprotein convertase subtilisin: kexin type 9 monoclonal antibodies are only used in approximately 1% of high-risk patients [7]. Do we wait until someone has a myocardial infarction (MI) or stroke before we treat their hypertension? No. Then why is it we typically wait until someone has their first cardiovascular event before we treat their hyperlipidemia? Completely nonsensical, yet this is a frequently observed trend throughout the world and runs counter to every guideline addressing dyslipidemia. Are we surprised when some patients require 2 or more drugs to control blood pressure or diabetes? No. Then why are we so reluctant to use adjuvant therapies to control LDL-C?

3. Getting back to basics

Effective cardiovascular disease prevention is elegantly and simply encapsulated by the first five letters of the alphabet: ABCDE [8]. Assessment of risk, Antiplatelet therapy, Blood pressure control, Cholesterol control, Cigarette smoking cessation, Diet and weight management, Diabetes prevention and treatment, and Exercise. We are still having difficulty wrapping our heads around the issue of when and in whom we should prescribe prophylactic aspirin to in the primary prevention setting [9,10]. Blood pressure and cholesterol control remain suboptimal. Despite strong affirmation of statin use in primary prevention by the Cochrane group and other meta-analyses [11,12], some continue to challenge the value of statin therapy in primary prevention [13]. Far too many people continue to smoke, even when they have established cardiovascular disease. The incidence of obesity, metabolic syndrome, and diabetes continue to rise throughout the world [14]. Despite the availability of antiglycemic medications that impact risk for atherosclerotic cardiovascular disease related events, heart failure admission to hospital, and cardiovascular mortality, these medications have very limited penetration in clinical practice and their benefits are largely unknown or unappreciated by most clinicians. More must be done to expand their use and to improve glycemic indices in patients with diabetes mellitus.

4. Educating our patients

I believe every patient visit should be viewed as an opportunity to further a patient's education in their health and well-being. Yes, a patient should have a clear understanding of negative potential side-effects to any drug. However, they should be just as rigorously educated about the ***benefits*** of any given drug they are prescribed. Half of all patients prescribed a statin stop after 6 months [15]. Certainly, there can be many reasons for this. However, when a patient understands that a statin is a ***life-saving drug*** (and not just a cholesterol reducing drug) that

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decreases risk for MI, stroke, and need for revascularization, there is greater impetus to continue therapy. Patients should be educated about all of their drugs, their side effects, benefits, and how they beneficially impact the course of the disease they are being used to treat. Discussing mortality benefits and reducing the likelihood of stenting and bypass surgery can be influential in helping to maintain long-term adherence to medication. I encourage patients to bring in their spouse or another family member of their choice to help reinforce the importance of drug literacy and long-term adherence. Every drug has its purpose in their plan of care.

5. The core role of the preventive cardiology specialist

Each of us has to assume that for the patient in the examination room, we are the repository of guideline-directed care, that we will apply the ABCDE of risk factor burden, and that we will provide comprehensive treatment and education for the patient so as to maximize the likelihood of long-term adherence and disease-free life. If there is established disease, then these same tenets of care will help to forestall secondary events and reduce risk of disability and mortality. We need to lead at our respective institutions by example and help to inculcate this commitment to quality of care in our peers. An ASPC Center of Excellence will have to be able to demonstrate a variety of benchmarks, including control of blood pressure, lipids, and diabetes, smoking cessation, long-term adherence to medication, collaborative care, as well as documented efforts directed at patient education.

I look forward to seeing many of you in Louisville, Kentucky, in July for the ASPC Scientific Sessions. The scientific program is outstanding and there will be time for networking, catching up with friends, and even some good Bourbon. It has been my privilege to serve the ASPC as president for the past two years. I am also grateful to the ASPC Board of Directors, an extraordinary, highly collaborative group who gave nothing but their best, and of course our greater membership without whom there would be no society. All of your support was superlative. I will continue to work on all projects I initiated until they are completed to the satisfaction of ASPC. Finally, please believe that we can bring about great change and improvement in cardiovascular care one patient at a time. Thank you.

ASPC Bookshelf: I wish to bring attention to some new additions to the ***Contemporary Cardiology*** series of books by Springer which would be of interest to ASPC members. The following new volumes have been edited by ASPC members:

- Cardiovascular Disease in Racial and Ethnic Minority Populations (Contemporary Cardiology) 2nd Edition, by Keith C. Ferdinand, Herman A. Taylor, Jr., Carlos J. Rodriguez. (2021)
- Prevention and Treatment of Cardiovascular Disease: Nutritional and Dietary Approaches (Contemporary Cardiology) by Michael J. Wilkinson, Michael S. Garshick, Pam R. Taub.
- Cardiovascular Risk Assessment in Primary Prevention. (Contemporary Cardiology) by Michael Shapiro.

Another book by an ASPC member that will delight you is entitled, "Picture This," by Steve Raskin, MD, a cardiologist in California. Picture This is a cartoon anthology that provides a unique experience to better understand atherosclerotic cardiovascular disease.

Declaration of Competing Interest

Peter P. Toth is a member of the speaker's bureau for Amarin, Amgen, Esperion, and Novo-Nordisk and a consultant to Amarin, Kowa, Merck, and Resverlogix.

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