NZMA
New Zealand Medical Association

27 February 2015

CVD Guideline Update Team
Ministry of Health
PO Box 5013
Wellington 6145

By email: cvddiabetes@moh.govt.nz

CVD guideline update

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback to the Ministry of Health on key issues to consider as part of the revision of cardiovascular disease (CVD) guidelines.

The NZMA is the country's largest voluntary pan-professional medical organisation with approximately 5,000 members. Our members come from all disciplines within the medical profession and include general practitioners, doctors-in-training, specialists, and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values, and the health of New Zealanders. Our submission on this issue has been informed by feedback from our Advisory Councils as well as the Board.

We understand that feedback arising from this consultation will be used to determine the breadth and depth of the CVD guideline update. It is the NZMA's view that the existing CVD guidelines in the New Zealand Primary Care Handbook 2012 (Updated 2013) are out of date and out of step with CVD guidelines in other jurisdictions, eg, the UK, US and Australia. As such, we welcome a comprehensive review of these guidelines that includes a review of treatment, in addition to simply recalculating risk.

We request that the Ministry ensure the following aspects/issues are addressed as part of the CVD guideline update.

i) There should be representation from the key relevant groups including general practitioners, the Cardiac Society, the New Zealand Society for the Study of Diabetes, epidemiologists and lay persons.
ii) Hard endpoints should be used (ie, death, MI and stroke) and not endpoints such as TIAs and new onset angina (which can be difficult to define).

iii) Life time risk should be presented as well as 5 year risk. Patients may be falsely reassured that their 5 year risk is less than 5% when they actually have a lifetime risk that is greater than 50%.

iv) CVD risk assessment should take into account the entirety of the patient's condition including all co-morbidities.

v) Screening for CVD risk in women should commence at the same age as breast screening, ie, at 45 years of age. The existing guidelines that begin to assess asymptomatic low risk women at 55 years of age are of concern, given the availability of effective treatments for women (non-pharmacologic and pharmacologic) that can prevent heart disease and, particularly, stroke, and when the loss of life potential in New Zealand women aged ≥45 years is appreciably higher than from breast cancer.[1] The age at which screening commences in particular population groups at higher risk of CVD (eg, Māori, Pacific, Indo-Asian men, and those with mental illness) should also be lowered commensurately, in line with recalculated risk estimates.

vi) Socioeconomic factors should be included in the revised guidelines, as in other risk models.

vii) A review of treatment implementation/uptake issues, including the inequity of access/uptake and the possible role of delivery systems like fixed dose combination treatments (eg, the CVS polypill) should be included.

viii) Explicit data should be given from the Cholesterol Treatment Trialists (CTT) overview showing the benefit of statins.

ix) Comments should be added about the role of new screening methods such as calcium scoring and CT angiography.

x) The comments on ezetimibe should be updated.

xi) The possible benefits of aspirin in reducing cancer should be discussed.

xii) As in the US (where there is a black box warning for simvastatin), the revised guidelines should make it clear that simvastatin 80mg should not be initiated because of the high risk of myalgia and myositis.

xiii) More information should be added about diet, including the strong evidence for adding poly unsaturated fats and decreasing sugar, and the controversy about saturated fats.

While we strongly support a comprehensive review of CVD guidelines, the NZMA believes that the ultimate decision to treat an individual should rest between the clinician and the patient, informed but not dictated by algorithms that are only partly predictive because other relevant factors are not included. This is particularly relevant for elderly patients, who as a population are very heterogeneous – some will benefit much less from CVD treatments because of non-CVD co-morbidities, but others may benefit greatly because they are otherwise fit and well. Finally, the NZMA would like to know more about the composition of the guideline review group and would welcome the opportunity to contribute a representative to this group.

We hope that our feedback on this consultation is helpful and we look forward to continued engagement with the guideline review group during the next stage of the review of these important guidelines.

Yours sincerely

Dr Mark Peterson
NZMA Chair

[1] Brief analysis available on request.