Clinical practice guidelines serve as an educational reference, and do not supersede the clinical judgment of the treating physician with respect to appropriate and necessary care for an individual patient. In the event that HMSA policies differ from the clinical practice guidelines, for benefit purposes, HMSA policies shall supersede the clinical practice guidelines.

Guideline summary

This guideline serves as:

An aid to healthcare professionals in treating patients without established CAD or other atherosclerotic diseases

An entry point to more detailed recommendations (see Table 3 - Guide to Primary Prevention of Cardiovascular Disease and Stroke - Risk Intervention)

A reference for the assessment, management and follow-up of patients at risk for cardiovascular disease

This guideline is intended to:

Assist primary care providers in their assessment, management and follow-up of patients who may be at risk for, but who have not yet manifested, cardiovascular disease.

Emphasize that adoption of healthy life habits is the cornerstone of primary prevention, including the avoidance of tobacco (including secondhand smoke), healthy dietary patterns, weight control and regular, appropriate exercise.

Stress the important role of healthcare providers in supporting and reinforcing these public health recommendation for all patients.

Introduction

The initial guidelines for Primary Prevention of Cardiovascular Diseases were published in 1997 as an aid to healthcare professionals for treating patients without established
coronary artery disease or other atherosclerotic diseases. They were intended to provide a comprehensive approach to treatment for patients across a wide spectrum of risk. The imperative to prevent the first episode of coronary disease or stroke or the development of aortic aneurysm and peripheral arterial disease remains as strong as ever because of the still high rate of first events that are fatal or disabling or require expensive intensive medical care. There is growing evidence that most cardiovascular disease is preventable.

This 2002 update of the guideline acknowledges a number of advances in the field of primary prevention. It also integrates other guidelines and consensus statements developed since the initial guideline’s approval.

This guideline might be viewed as the entry point to the more specific and detailed recommendations and the rationale behind them. The recommendations, as presented in the accompanying tables, are therefore consistent with the recommendations listed in:

**Table 1 - Guideline Recommendation Sources**

**Table 2 - Guide to Primary Prevention of Cardiovascular Disease and Stroke - Risk Assessment**

The aspirin guidelines recommended here agree with the Task Force Report in the use of aspirin in persons at high coronary and stroke risk but use a > 10 percent risk per 10 years rather than >6 percent risk over 10 years. This improves the likelihood of a positive balance of coronary risk reduction over bleeding and hemorrhagic stroke caused by aspirin.

**Diagnosis**

**Table 3 - Clinical Trial and Guideline Basis for Compelling Indications for Individual Drug Classes** identifies risk assessments and recommendations for the primary prevention of cardiovascular disease and stroke. The assessment of absolute cardiac risk increasingly is advocated by international organizations and by individual risk factor guidelines in the United States. The Framingham database has been widely used, though HMSA acknowledges that the multiple risk score may not apply equally to all sexes, races and ethnic groups. The use of more sophisticated technologies than a risk factor inventory and global risk score has been addressed, and we conclude that most screening tests for occult atherosclerosis remain in the research arena, with the exception of the ankle-brachial blood pressure index.

**Risk reduction**
Interventions to reduce risks must be based on a decision made by the patient with the support of the physician. Many or most asymptomatic patients will not benefit from the treatment, but the population at risk must be treated for some to realize benefits. Patients need to be informed of both the risks and potential benefits of treatment to make an informed decision.

**Multiple therapies**

Physicians must work with the patient to develop an acceptable care plan that maximizes the potential benefits. Multiple risk factor interventions should be tailored to the individual.

The recommended interventions involving "nutriceutical" and pharmaceutical interventions in [Table 3 - Guide to Primary Prevention of Cardiovascular Disease and Stroke - Risk Intervention](#) have support from randomized clinical trials establishing their efficacy and safety. Dietary supplements, and potentially cardioprotective drugs other than aspirin require additional investigation in well-designed clinical trials in people without established cardiovascular disease. See [Cardiovascular Disease and Stroke - Primary Prevention Algorithm (1 of 2)](#) and [Cardiovascular Disease and Stroke - Primary Prevention Algorithm (2 of 2)](#)

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**Sources**


Guideline review date: July 13, 2010

<table>
<thead>
<tr>
<th>Rev#</th>
<th>Date</th>
<th>Nature of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>07/26/2005</td>
<td>Corrected typo in Table 3 under 'Blood lipid management' to read: Primary goal: LDL-C [less than or equal to] 160 mg/dL if 1 risk factor is present. Previously read &lt;160. Updated the guideline date from November 9, 2004 to reflect date that revision was approved.</td>
</tr>
<tr>
<td>1.1</td>
<td>01/04/2006</td>
<td>Corrected change made in Table 3 Revision 1.0. Under Blood Lipid Management LDL-C changed back to &lt;160.</td>
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<tr>
<td>1.2</td>
<td>09/03/2010</td>
<td>Replaced both PDFs to the algorithm links with updated versions.</td>
</tr>
<tr>
<td>1.3</td>
<td>11/02/2010</td>
<td>Updated Information.</td>
</tr>
</tbody>
</table>

Latest Revision: 11/02/2010

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