Management of Triglycerides

Address possible secondary causes and appropriate lifestyle interventions before referral to lipid clinic**:**
Excessive alcohol intake (e.g. >40 units/week) , poorly controlled/new diabetes (e.g. HbA1c >53mmol/mol), TG – raising medication (e.g. steroids), hypothyroidism (e.g. TSH >15), Metabolic Dysfunction-Associated Steatotic Liver Disease (see guidance) - assess risk of advanced liver fibrosis: Fibrosis (FIB) 4 score (refer to hepatology), acute/chronic liver disease, renal disease (e.g. CKD 3), obesity, smoking

Fibrate therapy:
Such as fenofibrate 160mg daily SPC (if contra-indicated or not tolerated seek specialist advice)

- Discontinue: if Cr increase >50% (adjust dose as per SPC) and if ALT/AST >3xULN
- Check CK if muscular symptoms: The combination of fibrate with statin increases risk of myopathy

Icosapent ethyl therapy▾(Amber 2- specialist initiation and stabilisation before continuing in primary care) **(SPC) :**
Recommended by NICE for patients with CVD (secondary prevention) in combination with statin therapy where fasting TG >1.7mmol/L and LDL-C > 1.0mmol/L and ≤ 2.6mmol/L. Cautions (SPC): avoid in patients prescribed dual antiplatelets or an antiplatelet with an anticoagulant- refer to CRUSADE score for post-MI bleeding risk or ORBIT bleeding risk score for AF to assess individual risk: benefits. MHRA alert

- Adherence: In order for this medication to be effective it must be taken as prescribed and so adherence and tolerability should be monitored at each review. If patients cannot take 2 capsules twice a day, then STOP therapy. Pulse checks are also recommended at each review to identify potential AF, refer for ECG if indicated and manage associated stroke risk if AF is diagnosed.