New ACC/AHA Prevention Guidelines: Building a Bridge to Even Stronger Guideline Collaborations

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This past month, the American College of Cardiology (ACC) and the American Heart Association (AHA), in collaboration with the National Heart, Lung, and Blood Institute (NHLBI) and other specialty societies, released 4 long-awaited guidelines focused on the assessment of cardiovascular risk, lifestyle modifications to reduce cardiovascular risk, and management of elevated blood cholesterol and body weight in adults. A fifth guideline, which addresses hypertension, will be initiated by the AHA and ACC in the near future.

These guidelines are based on rigorous, comprehensive, systematic evidence reviews sponsored by the NHLBI. The ACC and AHA collaborated with professional organizations to finalize these ACC/AHA cardiovascular prevention guidelines and stakeholder organizations were invited to review and endorse the final documents. Each guideline provides important updated guidance for primary care providers, nurses, pharmacists, and specialty medicine providers on how best to manage the care of patients at risk for cardiovascular-related diseases on the basis of the latest scientific evidence.

For example, the Guideline for the Management of Overweight and Obese Adults addresses the appropriateness of the current body mass index and waist circumference cut points used to determine risk in overweight and obese adults across diverse populations; the impact of weight loss on risk factors for cardiovascular disease and type 2 diabetes; optimal behavioral and dietary intervention strategies; lifestyle treatment approaches, such as community-based programs, for weight loss and weight-loss maintenance; and the benefits and risks of various bariatric surgical procedures.

According to the expert panel, the “information will help providers decide who should be recommended for weight loss, and what health improvements can be expected.” However, the panel suggests that further research into the benefits of weight loss and the risks associated with overweight and obesity is needed. In addition, the role of new weight-loss drugs, as well as the type of patient most likely to benefit from surgical interventions, is also needed, the panel notes.

Similarly, the Guideline for Lifestyle Management to Reduce Cardiovascular Risk provides updates to dietary and physical activity recommendations for adult patients with high low-density lipoprotein cholesterol and/or hypertension, while the Guideline for the Assessment of Cardiovascular Risk offers a new approach to risk assessment. According to the expert panel responsible for the risk assessment guideline, these recommendations represent a step forward in the prevention of atherosclerotic cardiovascular disease (ASCVD): “The ability to estimate risk for a more broadly based ASCVD outcome that is more relevant to contemporary populations, especially women and African Americans, and the ability to provide risk estimates specific to African Americans, are the major advances of this approach,” the panel notes. “Promoting lifetime risk estimation may represent an additional step forward in supporting lifestyle behavior change counseling efforts.”

The Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults also generates important discussion around the use of statins for primary and secondary prevention of ASCVD in higher risk patients. The expert panel recommends statin therapy for patients at increased ASCVD risk who are most likely to experience a net benefit in terms of the potential to reduce ASCVD events and the potential for adverse effects. The panel also suggests the use of statins to prevent both nonfatal and fatal ASCVD events, an approach, the panel argues, that can not only reduce the large burden of disability from nonfatal stroke and nonfatal coronary heart disease events but also reduce increasing health care costs.

The overarching goal of both the ACC and the AHA is to prevent cardiovascular diseases and improve the care of people living with, or at risk for, these diseases. Professional education, research, and the development of evidence-based guidelines, standards, and policies are at the heart of both organizations’ efforts to achieve this goal. Given the ACC and AHA’s long-time partnership and leadership in developing
cardiovascular-related guidelines, the collaboration with the NHLBI to complete these guidelines seemed a logical transition. Moreover, the collaborative effort adheres to the model recommended in a 2011 NHLBI Advisory Council report: let the NHLBI focus on comprehensive, timely evidence reviews and subsequently partner with organizations to develop guideline recommendations.

As with any major change, however, transition stages are often needed to bridge the past and the future. These currently published guidelines are intended to be that transitional bridge. Where there were inherent differences in grading systems and/or imperfect alignment between the NHLBI and ACC/AHA methodological explanations, these variations were duly noted. In addition, all recommendations are included in both the current NHLBI grading format and the AHA/ACC Class of Recommendation/Level of Evidence construct, with which our members are most familiar.

In the interest of transparency, the ACC and AHA also requested that panel authors resubmit disclosures of relationships with industry as of July 8, 2013. Any new relationships since the respective panels did their final voting on their recommendations and the ACC and AHA’s involvement in the process are disclosed in an appendix to each document. Finally, the expert panels were largely unable to consider evidence beyond 2011, with a few exceptions that are noted in the documents. The ACC and AHA recognize that new scientific research in some of these areas has occurred since then. In fact, planning is already under way, working with the NHLBI and partner societies, to begin any needed updates to these guidelines starting in early 2014.

The joint ACC/AHA Task Force on Practice Guidelines and the Subcommittee on Prevention Guidelines should be commended for taking on the Herculean task of shepherding this transition, communicating the rationale and expectations to the expert panels and partnering organizations, and finalizing the guideline documents expeditiously. Because of these efforts, we have laid the groundwork for even stronger guidelines on these issues moving into the future. Even more important, we have created important recommendations that will serve only to benefit patients, providers, and the broader public health as we continue to take on the nation’s number one killer: cardiovascular disease.

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