BHIVA and HIVPA rapid guidance on statins for primary prevention of CVD: suggested text for GP communication

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We have drafted the following text with the intention that this can be used to create local templates for communicating BHIVA statin recommendations with primary care colleagues.

We recommend the initiation of a statin for primary prevention of cardiovascular disease (CVD) in line with British HIV Association (BHIVA) guidance based on:

- Underestimation of CVD risk in people with HIV by risk calculators
- A higher prevalence of CVD in people with HIV
- A large, randomised trial showing significant benefit of pitavastatin over placebo in a population of people with HIV and an average baseline estimated CVD risk of 4.5%.

Delete as appropriate:

Scotland:
This is consistent with Scottish Intercollegiate Guidelines Network (SIGN) guidelines on risk estimation and the prevention of CVD which recommend statin initiation in people assessed as being at high CVD risk.

England/other nations following National Institute for Health and Care Excellence (NICE) guidance:
This is consistent with NICE guidelines on statins for primary prevention of CVD which advise that statins can be recommended to people with an estimated risk of less than 10% where the risk may be underestimated or a person has an informed preference for taking a statin.

As pitavastatin is not currently available, we recommend initiating atorvastatin. We have discussed the small risk of incident diabetes and muscle aches and emphasised the net benefit of statins.

Delete as appropriate:

- Specific drug interactions are outlined in the BHIVA guidance: https://www.bhiva.org/file/655cdf1d7dcb1/BHIVA-rapid-guidance-on-the-use-of-statins.pdf.

- There are no anticipated drug–drug interactions with antiretrovirals so we recommend atorvastatin 20 mg once daily.

- Co-administration of ritonavir- or cobicistat-boosted darunavir results in increased concentrations of atorvastatin; we advise starting at the lowest possible dose of atorvastatin, not exceeding 40 mg per day and careful safety monitoring.

- Co-administration of cobicistat-boosted elvitegravir results in increased concentrations of atorvastatin; we advise starting at the lowest possible dose of atorvastatin, not exceeding 40 mg per day and careful safety monitoring.

- Co-administration of ritonavir- or cobicistat-boosted atazanavir with atorvastatin is predicted or proven, respectively, to yield a significant increase in atorvastatin exposure. We advise starting at the lowest possible dose of atorvastatin and not exceeding 10 mg per day.

- Co-administration of lopinavir/ritonavir yields significantly higher atorvastatin concentrations; we advise using the lowest possible starting dose of atorvastatin, not exceeding 20 mg per day and careful safety monitoring.

- Co-administration of efavirenz with atorvastatin leads to variable reductions in plasma concentration of atorvastatin and an increase in atorvastatin dose may be required. We advise monitoring lipid values and adjusting the dose of atorvastatin based on clinical response.

We would be grateful if you could check lipids 3 months after initiation of atorvastatin and increase the dose if LDL-cholesterol is greater than 1.8 mmol/L.

We recommend that all nations follow the NHS England pathway for statin intolerance if required, using ezetimibe +/- bempedoic acid, checking for any relevant interactions with HIV medication.