THERAPEUTIC GUIDELINES

What's new in Cardiovascular 2023

The Cardiovascular guidelines have been extensively revised. This update focuses on individualised assessment and management to optimise the prevention and treatment of common cardiovascular conditions.

Atherosclerotic cardiovascular disease (ASCVD) is the leading global cause of death and ill health. **ASCVD risk stratification** is crucial to identify patients at risk and guide management. New advice is included for assessing ASCVD risk for Aboriginal and Torres Strait Islander peoples, and outlines the role of coronary artery calcium scoring.

Targets for **lipid modification** are now based on ASCVD risk stratification, not indication (primary or secondary prevention); these are summarised in a new table. For patients who have been taking long-term lipid-modifying therapy, reconsider their target lipid concentrations. New information explains the role of proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors.

The relationship between blood pressure (BP) and risk of cardiovascular events is continuous, so effective **BP reduction** is important in managing ASCVD risk. Advice on when to start BP-lowering therapy (including for patients with a BP of 130/85 to 139/89 mmHg) has been updated. Guidance on how to start and adjust therapy has been clarified. Advice on the **urgent control of elevated BP**, including drug choice, has also been updated.

Accurate diagnosis of the cause of **acute chest pain of possible cardiac origin** is time sensitive and critical for appropriate management. A new table outlines the predictive value of clinical features of acute myocardial infarction or acute coronary syndromes.

New text clarifies the classification of **acute coronary syndromes** and helps identify when a troponin rise is related to myocardial infarction rather than myocardial injury from another cause. Two new flowcharts outline the management of **ST elevation myocardial infarction (STEMI)** and **non–ST elevation myocardial infarction (NSTEMI)**. A new table summarises drugs used and duration of therapy for the **long-term management of acute coronary syndromes**.

Guidance has been added on the use of low-intensity rivaroxaban plus low-dose aspirin therapy for the **secondary prevention of atherosclerotic cardiovascular events** and management of **peripheral artery disease**.

For patients with **heart failure with reduced ejection fraction (HFrEF)**, evidence supports combining an angiotensin receptor neprilysin inhibitor (ARNI) or angiotensin-converting enzyme (ACE) inhibitor with a beta blocker, mineralocorticoid receptor antagonist and sodium-glucose co-transporter 2 (SGLT2) inhibitor, as soon as possible after diagnosis. The approach to starting and titrating drug therapy is summarised in a new flowchart, and guidance on monitoring drug therapy has been expanded.

For patients with recent-onset **atrial fibrillation** (less than 12 months from diagnosis) and a concomitant cardiovascular condition, referral for early rhythm control (electrical or pharmacological cardioversion, or catheter ablation) is associated with a lower risk of cardiovascular death. Guidance on the approach to management includes updated advice on rhythm control.

Thorough assessment is needed to investigate the cause of **orthostatic hypotension**. Information has been added to aid diagnosis and guide nondrug management and drug therapy.

Guidance on treatment and prophylaxis of **venous thromboembolism (VTE)** has been extensively revised in line with the latest evidence, and restructured to improve usability. Management of **superficial vein thrombosis** depends on the risk of extension to proximal deep vein thrombosis (DVT) or pulmonary embolism (PE); recommendations for risk-based choice and duration of therapy have been added.

The **periprocedural management of anticoagulants in patients with cardiovascular disease** requires clinical judgement and consensus between treating clinicians. A new flowchart outlines the approach to periprocedural use of warfarin. A new figure guides the timing of preprocedural interruption of direct-acting oral anticoagulant (DOAC) therapy.

Evidence is limited to guide the choice and dosage of **anticoagulant therapy in patients with obesity**. General considerations have been added to help address this evidence gap.
