MODERN APPROACHES TO DIAGNOSICS AND TREATMENT OF HYPERLIPOPROTEINEMIA

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Introduction. Lipid-lowering therapy is being considered as one of the primary goals of health care. It is a part of primary prevention of coronary heart disease (CHD) (when disease has not evolved yet) or secondary prevention (in patients with CHD). Many studies proved that diet and drug cholesterol-lowering therapy reduces the incidence of CHD and mortality from it.

Aim. To research the new approaches to diagnosis and correction principles hyperlipoproteinemias (HLP).

Results and discussion. Modern treatment of HLP is determined by the coronary risk degree depends on the cholesterol level and the presence of other CHD risk factors. It is recommended to determine the total cholesterol and HDL cholesterol (fasting is not required) as a screening test by all persons under the age of 20 years. If the total cholesterol level is acceptable (<5.2 mmol/L) and HDL cholesterol is not less than 35 mg/dL (0.9 mmol/L), no special action is required and the next tests is rational to perform every 5 years because the cholesterol tends to increase gradually with age. If the total cholesterol is greater than 5.2 mmol/L or HDL cholesterol is low (<0.9 mmol/L) fasting blood sampling is required to determine the content of total cholesterol, triglycerides and HDL cholesterol and to calculate LDL cholesterol.

Further tactic depends on the estimated LDL cholesterol and the number of CHD risk factors. If LDL does not exceed 130 mg/dL (3.4 mmol/L) general recommendations is sufficient and active intervention is not done. A similar tactic is carried out for persons with LDL cholesterol in the range of 130 to 160 mg/dL with no more than one additional risk factor. For patients with the same cholesterol level and the presence of two or more additional risk factors dietary therapy should be prescribed to reduce LDL cholesterol to normal (130 mg/dL or less). In cases of high LDL cholesterol (>160 mg/dL) dietary therapy (limiting intake of cholesterol, saturated fat and calories) should be prescribed to majority of patients. Deciding whether to start lipid-lowering therapy clinical status of the patient should be considered. Cholesterol-lowering therapy is not prescribed to elderly patients with poor prognosis of main disease or severe comorbidities.

Conclusions. Achieving the ideal cholesterol values within population is absolutely impossible task even in the most developed countries. Therefore, measures of CHD primary prevention is reasonable only to patients with very high cholesterol levels and the presence of several other CHD risk factors. The question about the purpose of drug lipid-lowering therapy is considered only if the diet therapy is ineffective.