

10559 and 10560 Dyslipidemia in Primary Prevention Post Test – March 1, 2010

Examining the Benefits of Cardiovascular Risk Reduction in Primary Prevention: Focus on Dyslipidemia

This knowledge-based activity is located at www.ashpadvantage.com/cemornings

There are 10 questions associated with this self-assessment test.

1. Which of the following is the primary therapeutic target in patients with dyslipidemia?
 - a. HDL cholesterol.
 - b. LDL cholesterol.
 - c. Non-HDL cholesterol.
 - d. Triglycerides.

2. In which of the following patient populations might use of the Reynolds risk score be preferred over the Framingham risk score because of greater accuracy in estimating cardiovascular risk?
 - a. Adolescents.
 - b. Men.
 - c. Women.
 - d. Elderly.

3. Which of the following is the basis for new and emerging drug therapies for dyslipidemia?
 - a. Use of the active metabolite of fenofibrate in combination with a statin.
 - b. Use of the active metabolite of niacin in combination with a statin.
 - c. Use of bile acid sequestrants in combination with a statin.
 - d. Use of ezetimibe in combination with a statin.

4. As a measure of the benefit of treating dyslipidemia or any other disease state or condition, the number of patients needed to treat (NNT) to prevent one event is calculated by:
 - a. Dividing 1 by the absolute risk reduction (ARR).
 - b. Dividing 1 by the relative risk reduction (RRR).
 - c. Subtracting the RRR from the ARR.
 - d. Subtracting the ARR from the RRR.

5. Which of the following statements about the comparative benefit of statin therapy for primary prevention and secondary prevention of cardiovascular events in patients with dyslipidemia is correct?
 - a. It is of benefit for only secondary prevention because the NNT for primary prevention is higher than the NNT for secondary prevention.
 - b. It is of benefit for only primary prevention because the NNT for primary prevention is lower than the NNT for secondary prevention.
 - c. It is of benefit for both primary and secondary prevention, although the NNT for primary prevention is higher than the NNT for secondary prevention.
 - d. It is of benefit for both primary and secondary prevention, although the NNT for primary prevention is lower than the NNT for secondary prevention.

6. Which of the following was demonstrated in the Collaborative Atorvastatin Diabetes Study of the effectiveness of atorvastatin 10 mg/day for primary prevention of major cardiovascular events in patients with type 2 diabetes without high baseline concentrations of LDL cholesterol?
 - a. Significant reduction in LDL cholesterol but not in major cardiovascular events.
 - b. Significant reduction in major cardiovascular events but not in LDL cholesterol.
 - c. Significant reductions in LDL cholesterol and major cardiovascular events.
 - d. No significant reduction in LDL cholesterol or major cardiovascular events.



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7. Which of the following results of the JUPITER primary prevention study were reported for women?
 - a. Statin therapy significantly reduced LDL-C, but not cardiovascular risk.
 - b. Statin therapy significantly reduced both LDL-C and cardiovascular risk.
 - c. Statin therapy had no significant effect on LDL-C or cardiovascular risk.
 - d. Insufficient numbers of women were enrolled in the study to draw conclusions about efficacy.

8. Which of the following statements about the relationship among LDL-C reduction, cardiovascular risk reduction, and age was found in the retrospective primary prevention study by Rahilly-Tierney et al of 20,123 men, some of whom were more than 75 years old?
 - a. The magnitude of LDL-C reduction was proportional to the magnitude of cardiovascular risk reduction until around age 65, but it was not proportional at older ages.
 - b. The magnitude of LDL-C reduction was proportional to the magnitude of cardiovascular risk reduction only after around age 50.
 - c. The magnitude of LDL-C reduction was proportional to the magnitude of cardiovascular risk reduction only after around age 65.
 - d. The magnitude of LDL-C reduction was proportional to the magnitude of cardiovascular risk reduction at all ages.

Please use the following patient case for questions 9 and 10:

A 79-year-old man with a history of poorly-controlled hypertension has an LDL-C of 90 mg/dL while taking rosuvastatin 20 mg/day for primary prevention of cardiovascular events. His other lipid values are within normal limits, and his Framingham risk score is 25%. He does not have atherosclerotic vascular disease or diabetes mellitus.

9. Which of the following is the most appropriate primary goal of therapy for dyslipidemia at this time?
 - a. LDL-C < 160 mg/dL.
 - b. LDL-C < 130 mg/dL.
 - c. LDL-C < 100 mg/dL.
 - d. LDL-C < 70 mg/dL.

10. Which of the following is an appropriate clinical concern in treating this patient's dyslipidemia?
 - a. He is too old to benefit from statin therapy.
 - b. He is at higher risk for drug-related side effects than younger adults.
 - c. He is just as likely to benefit from rosuvastatin 5 mg/day as 20 mg/day.
 - d. The rosuvastatin dosage is too low to provide benefit.



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