Riesgo cardiovascular pdf 2019

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Both the mediation and arbitration will be conducted by JAMS applying the laws of the District of Columbia without regard to its conflicts of laws principles and in the District of Columbia as venue. Certification I hereby certify that I understand and agree to the terms stated in this Agreement and that this Agreement applies to my initial use of the Product and all other subsequent uses of the Product. BY USING THIS PRODUCT, I HEREBY AFFIRM THAT I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE ABOVE STATEMENTS. Esta nueva guía de Prevención Primaria de la Enfermedad Cardiovascular 2019 del Colegio Americano de Cardiología/Asociación Americana de Cardiología (ACC/AHA) reúne en un documento único todas las recomendaciones (1). Es un análisis exhaustivo surgido de las evidencias, consensos y recomendaciones de expertos más recientes, que cubren la mayor parte de los ítems que de alguna manera están vinculados al tema de la prevención primaria de la enfermedad aterosclerótica cardiovascular (EASCV). En su gran mayoría ya son conocidas, salvo en el caso de la aspirina, donde podría considerarse que se ha tomado una posición mejor definida. Se abre la ventana a la aplicación del criterio médico en la evaluación del riesgo para el análisis de factores incrementadores de riesgo y que las eventuales recomendaciones a tomar puedan surgir de un equipo multidisciplinario en situaciones más complejas. Impone un respeto a las condiciones particulares de cada persona en cuanto los determinantes sociales, culturales, educacionales y financieros que puedan afectar la salud individual. Recomienda que la toma final de decisiones surja de un intercambio de ideas entre el médico que propone las indicaciones y el paciente que expondrá sus preferencias. Recuerdan que las estrategias de prevención para retardar el desarrollo de la EASCV deben realizarse a nivel poblacional y también a nivel individual. Se resalta que la forma más importante de prevenir la EASCV es estimular un estilo de vida saludable durante toda la vida. La Guía tiene un formato en módulos tanto para facilitar su lectura, como sus eventuales actualizaciones. A modo de resumen y para fijar los principales conceptos se destacan los siguientes diez puntos: Establecer del riesgo de EASCV Fijar el riesgo de EASCV es la piedra fundamental de la prevención primaria. Para personas entre 20 y 39 años es razonable registrar los factores de riesgo tradicionales (tabaco, lípidos, historia familiar de EASCV prematura, hipertensión, diabetes mellitus tipo 2 [T2DM], enfermedades inflamatorias crónicas). Para adultos entre 40 y 75 años de edad se recomienda registrar los factores de riesgo tradicionales y calcular el riesgo a 10 años de EASCV utilizando la Ecuación derivada de la Fusión de Cohortes (PCE: Pooled Cohort Equation) (La ASCVD Risk Estimator Plus puede bajarse a cualquier Smartphone sin cargo para realizar la determinación del nivel del riesgo). No se descarta el empleo de otras tablas de riesgo. Hacen consideraciones que las ecuaciones de riesgo cardiovascular no representan bien a quienes se encuentren en desventaja socioeconómica. Otra limitación es que la edad es tomada como factor de riesgo y con el avance de la misma tiende a dominar la calificación; de manera que se puede sobreestimar o subestimar el riesgo en el caso individual. De todos modos, aceptan que siguen siendo la herramienta más robusta para calcular el riesgo de personas entre 40 a 75 años de edad en los EEUU. En aquellos adultos cuyo nivel de riesgo es “borderline” (5% a 50 mg/dL o >125 nmol/L, apoB ≥130 mg/dL, índice tobillo-brazo (ABI) 6.5%. Este trastorno metabólico caracterizado por resistencia a la insulina que conduce a la hiperglucemia aumenta el riesgo de padecer EASCV. Para los adultos con T2DM, los cambios de estilo de vida como practicar una dieta saludable y lograr las recomendaciones de ejercicio son cruciales. Si se requiere medicación, la metformina es el tratamiento de primera línea, seguido por un inhibidor de la SGLT2 (glifosinas) o bien un agonista del GLP-1. El panel sigue identificando el uso del tabaco como la causa primordial de enfermedad prevenible, incapacidad y muerte en los EEUU. El fumar o mascar tabaco aumenta el riesgo de mortalidad de cualquier causa y por EASCV. También el fumador pasivo tiene mayor riesgo de EASCV y de stroke, y alrededor de un tercio de las muertes por enfermedad coronaria son atribuibles a fumar o estar expuesto a humo de cigarrillo de terceros. Aún muy bajos niveles de tabaquismo están asociados a incrementos de riesgo significativo. Los llamados cigarrillos electrónicos (e-cigarettes) que emiten un aerosol de partículas finas y ultrafinas con o sin contenido de nicotina y otros gases tóxicos pueden aumentar el riesgo de enfermedades cardiovasculares y pulmonares. También se han reportado arritmias e hipertensión. Se recomienda interrogar sobre la utilización de tabaco en cada visita de todo paciente. En aquellos que consumen tabaco se les debe aconsejar que lo suspendan y deben recibir asistencia. Puede ser de ayuda la derivación a especialistas para modificar conductas y para recibir distintas medicaciones (variedades de reemplazo de nicotina, o vareniclina, o bupriopión). La aspirina en bajas dosis puede ser considerada en prevención primaria de EASCV en grupos seleccionados de adultos entre 40 y 70 años de edad que estén en mayor riesgo de EASCV y que no tengan riesgo incrementado de sangrado. En aquellas personas mayores de 70 años no está indicada su utilización. En aquellas personas de cualquier edad que tengan mayor riesgo de sangrado no debe emplearse. La prevención primaria de la EASCV requiere determinar los factores de riesgo lipídicos comenzando en la infancia. Los menores de 19 años con hipercolesterolemia familiar tienen indicación de recibir una estatina. En aquellos jóvenes entre 20 a 39 años debe priorizarse estimar su riesgo a largo plazo y promover un estilo de vida saludable. Se aceptan las guías ACC/AHA 2018 de empleo de estatinas (2); cuyos puntos principales establecen: Los adultos entre las edades de 20 a 75 años que presentan C-LDL ≥190 mg/dL no requieren una estimación de riesgo y se debe prescribir directamente estatinas de alta intensidad. Quienes presentan T2DM y edad entre 40 a 75 años deben recibir estatinas en dosis moderadas y se les debe realizar una estimación de riesgo para considerar utilizar estatinas en alta intensidad. En el diabético se consideran incrementadores de riesgo la presencia de: >10 años de T2DM o >20 años de T1DM, ≥30 mcg de albuminuria por mg de creatinina, tasa de fracción glomerular estimada