Lifestyle interventions

Healthy eating recommendations (E3-4)

Encourage patients to base their eating patterns on the following guidelines:

- Use spreads instead of butter or dairy blends.
- Use a variety of oils for cooking, such as canola, sunflower, soybean and olive oils.
- Use salad dressings and mayonnaise made from oils such as canola, sunflower, soybean and olive oils.
- Choose low or reduced fat milk and yoghurt or calcium-fortified soy beverages. Restrict cheese and ice cream intake to twice a week.
- Have fish (fresh or canned) at least twice a week.
- Select lean meat (trimmed of fat, chicken without skin) and limit fatty meats, including sausages and delicatessen meats such as salami.
- Snack on plain, unsalted nuts and fruit.
- Incorporate legumes into two meals a week.
- Base meals around vegetables, and grain-based foods such as bread, pasta, noodles and rice.
- Limit take-away foods such as pastries, pies, pizza, hamburgers and creamy pasta dishes to once a week.
- Limit snack foods such as potato and corn crisps to once a week.
- Limit cakes, pastries and chocolate or creamy biscuits to once a week.
- Limit cholesterol-rich foods such as egg yolks and offal.

Consider referral to an Accredited Practising Dietitian.

Fish oil and fish: Fish oils may have an important place when used in combination with statins to lower the triglyceride level in combined hyperlipidaemia. However, at this time, it is uncertain whether the use of fish oil capsules adds anything over and above the inclusion of a moderate consumption of fish. Therefore, patients should be encouraged to consume fish at least twice per week. (E4)

Plant sterol esters: Plant sterols may provide a useful and acceptable way of enhancing cholesterol lowering in people taking statins. (E2)

Smoking cessation

Counselling to strongly encourage patients and their families to stop smoking is vital. Passive smokers should be provided with appropriate facts on smoking.

Consider referral to the Quitline (phone 131 848) or a smoking cessation program. If the patient is smoking more than 20 cigarettes/day and the first cigarette is within 30 minutes of waking, consider nicotine replacement therapy to assist with smoking cessation.

Physical activity (E3-4)

- At least 30 minutes of moderate-intensity physical activity should be undertaken on most, preferably all, days of the week.

Weight reduction (E3-4)

- Aim for a body mass index (BMI) of < 25 (set intermediate achievable goals).
- Waist circumference for men should be < 90cm and, for women, < 80cm (these are based mainly on evidence of increased risk of death in European populations and may not be appropriate for all age and ethnic groups).
- Encourage patients to enjoy regular moderate-intensity physical activity and change their eating habits to modify energy intake. Consider referral to an Accredited Practising Dietitian for individual counselling and advice.

Alcohol

- Advise patients with elevated plasma triglyceride levels to limit their alcohol intake. (E4)

Salt

- Reduction of salt intake is important for people with hypertension, as it has been shown to reduce blood pressure in this group and lower cardiovascular disease risk. (E1)

Further information

For further information about lifestyle interventions contact the Heart Foundation's Heartline on 1300 36 27 87 for the cost of a local call.

Lipid-modifying therapy (E4)

- HMG-CoA reductase inhibitors are the agents of choice for LDL-C lowering.
- Liver function should be tested at least once about six weeks after starting therapy with an HMG-CoA reductase inhibitor and care is needed in patients with pre-existing liver disease. The dose of HMG-CoA reductase inhibitor must be reduced in patients taking cyclosporin.
- Fibrates are effective triglyceride-lowering/HDL-C-raising agents.
- The combination of an HMG-CoA reductase inhibitor and fibrate may be considered in high-risk people whose lipid profile remains unacceptable after a trial on monotherapy. In general, combination therapy should be initiated by a specialist. Levels of creatine kinase (CK) and liver enzymes should be monitored within the first six weeks and then at six-monthly intervals in patients taking such combination therapy.
- Resins can be used to increase the lowering of LDL-C substantially when given in combination with HMG-CoA reductase inhibitors. This additional benefit can be achieved with relatively low (and usually well tolerated) doses of the resins.
- The addition of low dose nicotinic acid to an HMG-CoA reductase inhibitor is well tolerated by most people, and substantially enhances triglyceride lowering and HDL-C raising and, to some extent, also LDL-C lowering.

Adherence

- When relevant, commence lipid-modifying therapy in patients with CHD while patients are still in hospital. (E2)
- When possible, consider ancillary measures (eg, special clinics, telephone support, coaching) to help patients achieve and maintain target lipid levels. (E2)
- Assess patients' adherence to medications at each visit. (E4)