Scottish Government
Riaghaltas na h-Alba

Questionnaire

We have a total of 11 questions with some being multi-part, please answer as many as you feel able to.

1. Approach to review

We recommend for all patients, medications are reviewed using a person-centred approach using the standardised Polypharmacy 7-Steps guidance.

Question 1a

Do you agree with this recommendation?

☒ Agree

☐ Neither agree nor disagree

☐ Disagree

☐ Not sure

Question 1b

Please tell us more about your views on our approach to review.

We generally support medications being reviewed using a person centred approach. As well as seeking to remove unnecessary medications, we understand that there may be opportunities for identifying the undertreatment of cardiovascular risk factors. Given that more studies are now showing an increased benefit of CV risk management well into people's 70s, we would welcome more clarity in relation to assurances and guidance that stopping medication in the elderly simply based on age is no longer appropriate.

2. Use of ASSIGN v2.0

- ASSIGN v2.0 (ASsessing cardiovascular risk using SIGN guidelines to assign preventive treatment) should be used to estimate the 10-year percentage risk of developing cardiovascular disease (coronary heart disease, stroke, and transient ischaemic attack) of individuals in Scotland who do not currently have a diagnosis of cardiovascular disease (CVD)
- In some ethnic minorities, risk tools under- and overestimate CVD risk, because they have not been validated in these populations. For example, in people originating from the south Asian subcontinent it is safest to assume that the CVD risk is modestly higher than predicted from most scoring tools
- The following individuals should be assumed to be at high risk and do not require risk assessment with ASSIGN (v2.0) or other cardiovascular risk scoring systems:

- Chronic Kidney Disease Estimated Glomerular Filtration Rate (CKD eGFR) <60 or Albumin-to-Creatinine Ratio (ACR) >3mg/mmol (approx. equal to 30 mg/g)
- Familial hypercholesterolaemia (FH)
- Type 1 diabetes who are over 40 years old, or disease duration >10 years, or nephropathy or other CVD risk factors

Question 2a
Do you agree or disagree with these recommendations on the use of ASSIGN v2.0?

☒ Agree

☐ Neither agree nor disagree

☐ Disagree

☐ Not sure

Question 2b

Please provide any further comments about our recommendations.

We support the recalibrated ASSIGN v.20 and the recognition of ingrained health inequalities. Some Fellows wished to highlight risks of underestimating prevalence in young adults and sought more detail on how clinicians could assess additional risk factors that are not incorporated within ASSIGN v 2.0. We also support further future evaluation of ASSIGN v.20 to ensure all data around age groups, ethnic populations and deprivation categories is reviewed as appropriate as more data becomes available.

3. Healthier Lifestyle

Diet

- Increased fruit and vegetable consumption is recommended for the entire population to reduce cardiovascular risk
- People with hypertension should be advised to reduce their salt intake as much as possible to lower blood pressure
- Eating a portion of oily fish (such as salmon and trout) each week can also help to lower the risk of developing heart disease
- Individuals are encouraged to follow the advice in NHS inform Eat Well Guide which helps support individuals to make healthier food choices

Alcohol

- Patients with or without evidence of cardiovascular disease should be advised to reduce alcohol consumption and that even light to moderate alcohol consumption may increase cardiovascular risk

Physical Activity

- Physical activity of at least moderate intensity is recommended for the whole population (unless contraindicated by an individual's condition)
- Those who are moderately active and are able to increase their activity should be encouraged to do so. Activity can be increased through a combination of changes to intensity, duration or frequency
  Those who are already moderately active without contraindication can safely be encouraged to undertake vigorous-intensity exercise to achieve additional benefits

Question 3a
Do you agree or disagree with these recommendations on healthier lifestyle?

☒ Agree

☐ Neither agree nor disagree

☐ Disagree

☐ Not sure

Question 3b
Please provide any further comments about our recommendations.

We support these recommendations for a healthier lifestyle and encourage the Scottish Government to support the promotion of these, working with relevant organisations including the Scottish Obesity Alliance, SHAAP and others. The College would like to see reference to the impact of air pollution as an increased risk factor for developing cardiovascular disease with specific advice for those living in areas of higher air pollution.

4. Hypertension in adults

- Hypertension in adults should be diagnosed and treated as per National Institute for Health and Care Excellence (NICE) 136 guidance
- Individuals should be identified who need referred for same-day specialist review as per NICE 136 guidance
- People with hypertension should be advised to reduce their salt intake as much as possible to lower blood pressure
- When choosing an antihypertensive medication, the individual should be part of the decision-making. Discuss individual cardiovascular disease risk and the individual's preferences for treatment, including no treatment, and explain the risks and benefits before starting antihypertensive drug treatment
- A suitable algorithm such as NICE or the British and Irish Hypertension Society (BIHS) adult hypertension referral pathway for therapeutic

management should be utilised when choosing an antihypertensive medication considering the individual's age, family origins and co-morbidities
- Clinical judgement and shared decision-making should be used when prescribing in individuals with frailty or multimorbidity

Question 4a
Do you agree or disagree with the recommendations for hypertension in adults?

☐ Agree

☒ Neither agree nor disagree

☐ Disagree

☐ Not sure

Question 4b
Please provide any further comments about our recommendations.

Some Fellows felt the rationale behind the reliance on NICE's targets for identification should be better set out, noting NICE's relatively conservative criteria when compared to other international targets and guidance.

5. Hyperlipidaemia

- Non-fasting sampling of lipid parameters is recommended for general risk screening
- Measure both total blood cholesterol and high-density lipoprotein (HDL) cholesterol to achieve the best estimate of CVD risk
- Primary prevention using a statin is recommended in individuals with:
    - ASSIGN v2.0 score ≥10%
    - CKD eGFR <60 or ACR >3mg/mmol (approx. equal to 30mg/g)
    - Familial hypercholesterolaemia (FH)
    - Type 1 diabetes who are over 40 years old, or disease duration >10 years, or nephropathy or other CVD risk factors
- Atorvastatin 20mg daily is the statin of choice in primary prevention
- Consider ezetimibe
    - where initial statin therapy is contraindicated or individuals cannot tolerate statin therapy
    - co-administered with initial statin therapy when Serum total or Low-density Lipoprotein (LDL) cholesterol concentration is not appropriately controlled or a change from initial statin therapy to an alternative statin is being considered
- If treatment is initiated, its effect must be evaluated, and subsequent treatment intensification to reach ultimate risk factor goals must be considered

in all patients, taking into account additional benefit, comorbidities, and frailty, all of which converge with patient preferences in a shared decision-making process

- The absolute benefit of lowering Low-Density Lipoprotein Cholesterol (LDL-C) depends on the absolute risk of Atherosclerotic Cardiovascular Disease (ASCVD) and the absolute reduction in LDL-C, so even a small absolute reduction in LDL-C may be beneficial in a high- or very-high-risk patient

Question 5a
Do you agree or disagree with the recommendations for hyperlipidaemia?

☐ Agree

☒ Neither agree nor disagree

☐ Disagree

☐ Not sure

Question 5b
Please provide any further comments about our recommendations.

Again, some Fellows were interested to understand the rationale behind using these recommendations when some other targets, such as the 2025 ESC/EAS EVIDENCE BASED guidelines, appear to be more ambitious. Fellows also felt that the section relating to statin use in older adults should acknowledge the risk of under treating older adults.

6. Pharmacotherapies for obesity

We recommend that clinicians:

- Ask for permission each time before discussing overweight, obesity or central adiposity and before taking measurements
- In adults with Body Mass Index (BMI) below 35 kg/m2, measure and use their waist-to-height ratio, as well as their BMI, as a practical estimate of central adiposity and use these measurements to help to assess and predict health risks (for example, type 2 diabetes, hypertension or cardiovascular disease)
- Incretin-based therapies should be considered for those who meet Scottish Medicines Consortium (SMC)/consensus statement criteria

Question 6a
Do you agree or disagree with the recommendations for pharmacotherapies for obesity?

☒ Agree

☐ Neither agree nor disagree

☐ Disagree

☐ Not sure

Question 6b
Please provide any further comments about our recommendations.

7. Diabetes

- Primary care healthcare professionals should implement a two-stage strategy to identify people at high risk of type 2 diabetes (and those with undiagnosed type 2 diabetes)
    - Firstly, a risk assessment should be offered
    - Secondly, for those with high-risk scores, a blood test should be offered to investigate if they have type 2 diabetes or prediabetes
- Reassess people with a high-risk score, but with a Glycated Haemoglobin (HbA1c) less than 42mmol/mol (6.0%) or a fasting plasma glucose less than 6.1mmol/L or, every three years
- Reassess people with a low or intermediate risk score every five years using a validated risk-assessment tool
- Use clinical judgement to determine when someone might need to be reassessed more frequently, based on their combination of risk factors
- Metformin should be considered as the first-line oral treatment option for people with type 2 diabetes
- NICE 28 flowchart should be utilised when choosing medication considering the individual's cardiovascular status, risk of developing cardiovascular disease in the future, renal status and if considered clinically significantly frail

Question 7a
Do you agree or disagree with the recommendations for diabetes?

☐ Agree

☒ Neither agree nor disagree

☐ Disagree

☐ Not sure

Question 7b
Please provide any further comments about our recommendations.

While we understand that these recommendations are broadly consistent with existing guidance, we would welcome greater clarity in terms of the statement that metformin should be considered first-line oral treatment. It should not be interpreted as requiring metformin monotherapy before introducing an SGLT2 inhibitor where cardiovascular or renal benefits justify early combination treatment.

The effectiveness of the recommendations depends on patients actually receiving appropriate treatment. NICE's 2026 review identified under-prescribing of SGLT2 inhibitors across the UK as an issue.

8. Smoking

- All people who smoke should be advised to stop and offered support to help facilitate this in order to minimise cardiovascular and general health risks
- At every opportunity, ask people if they smoke or have recently stopped smoking
- Varenicline or combination nicotine replacement therapy should be offered alone or as part of a smoking cessation programme to augment professional advice and increase long-term abstinence rates

Question 8a
Do you agree or disagree with the recommendations for smoking?

☒ Agree

☐ Neither agree nor disagree

☐ Disagree

☐ Not sure

Question 8b
Please provide any further comments about our recommendations.

We generally support the recommendations here but would like to see some reference to vaping given vapes are not risk-free. Information on usage of vapes should also be recorded on a similar basis to smoking.

9. Effectiveness of these recommendations

Question 9
How effective do you think these recommendations will be in reducing CVD?

☐ Very effective

☒ Effective

☐ Neutral

☐ Not effective

☐ Not at all effective

10. Implementation of this guidance

We have a few questions, which will help us implement the recommendations from this prescribing guide.

Question 10a

Do you feel there are any barriers to implementing the recommendations from this guidance?

☒ Yes

☐ No

☐ Not sure

Question 10b

If you answered yes to Question 10a, how do you feel these barriers could be addressed?

Pressure on services and the time available to clinicians remain a key concern and must be considered by policy makers and government.

Question 10c

What are the key factors that will enable successful implementation of these recommendations?

Success in the key area of prevention is vital to stop the demands becoming unmanageable.

11. Finally

Question 11

Do you have any further comments on this prescribing guide?