Audits in clinical practice are in the air nowadays and the questions arising about the prescription of hypolipidemic agents are legion and all the more legitimate as the medical expenses involved are considerable.

Even with its limits, correctly self-criticized in the discussion, CEPHEUS provides complementary data that confirm previous work that are less non-existent than the authors claim[1—3].

The regression of fibrates has pursued inexorably its course since the disappointing results of the FIELD trial [4]. The level of proof of statins has restricted their indications to severe and exclusive hypertriglyceridemia with vascular repercussions. Although the place of rosuvastatin is certainly overestimated in this sample of general practitioners, not necessarily representative, simvastatin has curiously remained in the background in France. It has not been projected in the foreground as in Germany when it was converted as generic.

The critical point converging with previous data remains the rate of attainment of the objective which remains still low and the more so as the patients are high-risk patients. This paradox is explainable only in part by a threshold to be reached that is even further off. It is to be regretted that CEPHEUS study could not explore more deeply what concerns the respective non-observance of the physician and the patient.

On the other hand, the merit of CEPHEUS is to have carefully examined the plasma LDLc distribution. Indeed, to find oneself at 50 mg/l from the consensus threshold is not necessarily catastrophic since the relation LDLc-CV risk is certainly not as linear in the low values as some would like to believe. It is distressing to note that nearly 30% of the high-risk patients retain a plasma LDLc concentration above 1.3 g/l and it is deplorable that 1% retains an LDLc above 2 g/l while potent treatments are available.
Such observations open up avenues for industry to promote drug association and to develop new molecules. Nevertheless, a rational use of existing resources consisting in a systematic detection of high-risk patients and in titrating the most potent statins should allow one to compensate this disparity in practice which is all the more reprehensible as access to care is facilitated in France. Is wide statin dispersion acceptable when the patients on the right side of the Gauss Curve of the cardiovascular risk distribution are not or inadequately treated?... Recruitment in the outpatients clinics of lipidology has shifted in the last 10 years since we find now only those who are intolerant to hypolipidemic agents and those with major dyslipidemia resistant to conventional management. There is nowadays in each region at least one tertiary care center for lipidology assessment and it is deeply disappointing that this 1% of high-risk subjects inefficiently treated remains not referred.

On the eve of the publication of JUPITER, a trial evaluating rosuvatatin versus placebo in situation of increase in ultra-sensitive CRP, thus in situation of metabolic syndrome, it would have been useful to better define the modalities of management of patients with a metabolic syndrome since their CV risk level is close to that of type 2 diabetics and thus make up a privileged target. Finally, CEPHEUS study provides confirmation that a large proportion of patients under treatment remains hypoalphalipoproteinemic. In spite of the recent failure of torcetrapib [5], the development of therapies able to simultaneously increase both HDLc level and cardiovascular benefit remains henceforth a major challenge for the coming 5 years.

References