Update In Preventive Cardiology

R. Todd Hurst, MD, FACC, FASE

Resident Conference
August 17, 2021
Disclosure

Relevant Financial Relationship(s)
• None

Off Label Usage
• None
CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

CHRONIC DISEASES IN AMERICA

6 IN 10
Adults in the US have a chronic disease

4 IN 10
Adults in the US have two or more

THE LEADING CAUSES OF DEATH AND DISABILITY and Leading Drivers of the Nation’s $3.3 Trillion in Annual Health Care Costs
Cardiometabolic Disease
The 21st Century Epidemic

High blood pressure
121 million

High cholesterol
100 million

Diabetes/Pre-diabetes
77 million

Unhealthy Weight
160 million

- Heart Disease
- Stroke
- Cancer
- Kidney Disease
- COVID
We Already Know What Works

- Decrease MI 80%
- Decrease CKD 62%
- Decrease Stroke 50%
- Decrease Dementia 37%
- Decrease Cancer 33%
Life’s Simple 7

- Normal Weight
- Normal Blood Sugar
- Healthy Diet
- Don’t Smoke
- Physically Active
- Normal Cholesterol
- Normal Blood Pressure

Good Health
We Already Know What Works

- Decrease CAD 80%
- Decrease CKD 62%
- Decrease Stroke 50%
- Decrease Dementia 37%
- Decrease Cancer 33%
Don’t Smoke
- Decreased 20.9 to 15.5% from 2005 to 2016
- 38 million smoke in US

Normal Weight
- 71% overweight or obese
- Average BMI 29.1 kg/m²

Glucose Control
- 750% increase in DM
- 5-6% of eligible pts on SGLT2 inhibitor/GLP-1 agonist

Healthy Diet
- 57.9% ultra-processed foods
- 9.4% processed foods

Stay Active
- 22.9% meet exercise guidelines

BP Control
- 43.7% controlled

Lipid Control
- 55.5% of statin eligible patients taking a statin
- 60% not taking statin said doctor did not recommend
Total heart disease deaths on the rise

Majority of these deaths are preventable, study authors say

US Deaths From Cardiometabolic Disease on the Rise

Total U.S. deaths from heart disease, stroke, diabetes, and high blood pressure — collectively known as cardiometabolic disease — have been increasing since 2011, thanks in large part to surging obesity rates.

HEALTH

'Deaths of Despair': U.S. Life Expectancy Has Been Falling Since 2014, With Biggest Impacts in Rust Belt and Ohio Valley

BY KASHMIRA GANDER ON 11/26/19 AT 11:26 AM EST
Cardiometabolic Disease
The 21st Century Epidemic

- Diabetes/Pre-diabetes: 77 million
- High cholesterol: 100 million
- High blood pressure: 121 million
- Unhealthy Weight: 160 million

• Heart Disease
• Stroke
• Cancer
• Kidney Disease

2,000 Preventable deaths/day
Life’s Simple 7

- Don’t Smoke
- Normal Weight
- Normal Blood Sugar
- Healthy Diet
- Physically Active
- Normal Cholesterol
- Normal Blood Pressure

Good Health
Important Numbers

46%  American adults have hypertension

44%  With hypertension are controlled

1,100  Deaths per day in the US
Call to Action to Control Hypertension

Surgeon General

- Highly prevalent
- Poorly managed
- Inequitably experienced
- Highly controllable

A National Commitment to Improve the Care of Patients With Hypertension in the US

Hypertension is common, costly, and controllable. Almost 1 in 3 U.S. adults have hypertension, and among those, the estimated rate of controlled blood pressure was only 43.7% in 2017-2018. In 2015-2016, uncontrolled blood pressure can lead to largely preventable events such as myocardial infarction, stroke, and mortality, as well as debilitating and expensive conditions such as kidney disease, heart failure, and cognitive decline. Hypertensive disorders of pregnancy, which have increased in the US, contribute to adverse maternal and child health outcomes and can increase a woman's lifetime risk of cardiovascular disease. Disparities in blood pressure control and, consequently, in these health outcomes, persist by race and ethnicity, age, and geography. Yet broad and equitable hypertension control is possible, and some health care systems have achieved rates of 80% or higher across a wide spectrum of sites and populations

These facts about hypertension are highly prevalent, poorly managed, inequitably experienced, and more than sufficient to warrant the Surgeon General's Call to Action to Control Hypertension. Some may question the release of this report, especially when coupled with widespread implementation of best practices in clinical settings and empowering individuals to actively manage their blood pressure. Acknowledging and addressing a community's social conditions may generate sustained improvements in control of both hypertension and COVID-19.

Now is the time to do our part to ensure that communities support hypertension control and that communities are prepared for hypertension control. The goals and strategies presented in this report are the result of years of research and evidence. The goals are (1) to identify and target hypertension as a priority for action and (2) to implement and maintain effective hypertension control programs. The first goal is to identify hypertension control as a national priority, and the second is to implement and maintain effective hypertension control programs. The goals and strategies are grounded in evidence, informed by experiences of high-performing systems and communities, and adaptable to match the resources available and the populations served.

The first major goal is to declare hypertension control a national priority, as is supported by the costs to lives, health, and dollars lost to a largely controllable condition. Generating widespread awareness of the effect of uncontrolled blood pressure on health and the economy is the first step in gaining action from the diverse set of sectors outlined in the document. Among the partners essential to achieving a national shift in hypertension control are payers and employers, who, by prioritizing blood pressure control in value-based contracting and incentive programs, could establish plans to invest in the teams and processes proven to achieve high performance over time. Payers and employers could help individuals manage their hypertension by eliminating cost-sharing for blood pressure monitoring and medications. Systolic blood pressure control at a population level is likely to improve the patient's quality of life, reduce the risk of chronic diseases associated with hypertension, and reduce the burden of hypertension on healthcare systems.
Optimize Patient Care

Home Blood Pressure

What we can do
- Quit relying on office blood pressure
  - Associated with lower BP and improved control
  - Cost effective

Circulation. 2020;142:e42–e63.
Optimize Patient Care

Use the Right Meds

- What we can do
  - Use first line generic meds
    - Chlorthalidone or indapamide > HCTZ
    - ACEi OR ARB
    - Amlodipine
  - Screen for sleep apnea

A National Commitment to Improve the Care of Patients With Hypertension in the US

Hypertension is common, costly, and controllable. Among 2 to 3 US adults, 1 adult has hypertension, and among those, the estimated rate of controlled blood pressure was only 43.7% in 2018, a decline from 53.9% in 2015-2016. Uncontrolled blood pressure can lead to largely preventable events such as myocardial infarction, stroke, and maternal mortality, as well as debilitating and expensive conditions such as kidney disease, heart failure, and cognitive decline. Hypertension is not a disease or disorder of pregnancy, which have increased, the US, contributing to maternal and child health outcomes and can increase a woman’s lifetime risk of cardiovascular disease. Disparities in blood pressure control and, consequently, in these health outcomes, persist by race and ethnicity, age, and geography. Yet broad and equitable hypertension control is possible, and some health care systems report high rates of 80% or higher across a wide spectrum of sites and populations served.

These facts about hypertension—its highly prevalent, poorly managed, inequity experienced, and highly controllable—make more than sufficient to substantiate the Surgeon General’s Call to Action. The goals and strategies presented in the Surgeon General’s Call to Action provide a national roadmap to drive change (in care in the Supplement). The goals are 1) make hypertension control a national priority, and 2) ensure that communities support hypertension control and 3) optimize patient care for hypertension control. The goals and strategies are grounded in the evidence, informed by experiences of high-performing systems and communities, and adaptable to match the resources available and the populationserved.

JAMA. 2020;324(18):1825-1826.
Primary Aldostoronism
Underrecognized?

What we can do

• Consider primary aldostoronism?

- Up to 20% of resistant hypertensives (1 in 1000 are screened)
- Strongly consider with hypokalemia, OSA or adrenal mass
- Secret weapon in resistant HTN
  - Aldactone or eplerenone

Hygia Chronotherapy

Nighttime meds

Bedtime hypertension treatment improves cardiovascular risk reduction: the Hygia Chronotherapy Trial

Ramón C. Hermida 1, Juan J. Crespo 1,2, Manuel Domínguez-Sardina 2, Alfonso Otero 3, Ana Moya 4, María T. Rios 1,2, Elvira Sineiro 1,4, Maria C. Castineira 1,5, Pedro A. Callejas 1,2, Lorenzo Pousa 1,2, José L. Salgado 1,2, Carmen Durán 3, Juan J. Sánchez 1,4, José R. Fernández 1, Artemio Mojon 1, and Diana E. Ayala 1;

for the Hygia Project Investigators 7

1 Bioengineering & Chronobiology Laboratories, Atlantic Research Center for Information and Communication Technologies (AtlantIC), University of Vigo, E-36310, Spain; 2 Estrutura de Xerencia Integrada de Vigo, Servicio Gallego de Saúde (SERGAS), Vigo 36214, Spain; 3 Servicio de Neumología, Consorcio Hospitalario Universitario, Estrutura de Xerencia Integrada de Ourense, Vigo e O Barco de Valdeorras, Servicio Gallego de Saúde (SERGAS), Ourense: 32005, Spain; 4 Estrutura de Xerencia Integrada Pontevedra e O Salés, Servicio Gallego de Saúde (SERGAS), Pontevedra 36416, Spain; 5 Estrutura de Xerencia Integrada de Lugo, Catoira e Monterroso de Lemos, Servicio Gallego de Saúde (SERGAS), Lugo 27000, Spain; and 6 Estrutura de Xerencia Integrada de Santiago de Compostela, Servicio Gallego de Saúde (SERGAS), Santiago de Compostela 15701, Spain.

Received 14 June 2019; revised 26 July 2019; editorial decision 1 October 2019; accepted 1 October 2019; online published-ahead-of-print 22 October 2019.

See page 4577 for the editorial comment on this article (doi: 10.1093/eurheartj/ehz836)

Aims

The Hygia Chronotherapy Trial, conducted within the clinical primary care setting, was designed to test whether bedtime in comparison to usual upon awakening hypertension therapy events better cardiovascular disease (CVD) risk reduction.

Methods and results

In this multicentre, controlled, prospective endpoint trial, 19,084 hypertensive patients (10,614 men/8770 women, 60.5 ± 13.7 years of age) were assigned (1:1) to ingest the entire daily dose of ≥1 hypertension medications at bedtime (n = 9552) or all of them upon awakening (n = 9532). At inclusion and at every scheduled clinic visit (at least annually) throughout follow-up, ambulatory blood pressure (ABP) monitoring was performed for 48h. During the 6.3-year median patient follow-up, 17,527 participants experienced the primary CVD outcome (CVD death, myocardial infarction, coronary revascularization, heart failure, or stroke). Patients of the bedtime, compared with the upon-waking, treatment-time regimen showed significantly lower hazard ratio—adjusted for significant influential characteristics of age, sex, type 1 diabetes, chronic kidney disease, smoking, HDL cholesterol, as well systolic blood pressure (BP) mean, sleep-time relative systolic BP decline, and previous CVD event—of the primary CVD outcome [0.55 (95% CI 0.50-0.61), P < 0.001] and each of its single components (P < 0.001 in all cases), i.e. CVD death [0.44 (0.34-0.56)], myocardial infarction [0.66 (0.52-0.84)], coronary revascularization [0.60 (0.47-0.73)], heart failure [0.58 (0.49-0.70)], and stroke [0.51 (0.41-0.63)].

Conclusion

Routine ingestion by hypertensive patients of ≥1 prescribed BP-lowering medications at bedtime, as opposed to upon waking, results in improved ABP control (significantly enhanced decrease in asleep BP and increased sleep-time relative BP decline, i.e. BP dipping) and, most importantly, markedly diminished occurrence of major CVD events.

Trial registration

ClinicalTrials.gov, number NCT00741585.

• n = 19,084, randomized to taking meds at bedtime or on awakening

• 6.3 year follow-up

• Improved BP control

• Lower combined primary endpoint, HR 0.55
  • CVD death 0.44
  • MI 0.66
  • CHF 0.58
  • Stroke 0.51

• Exceptions - diuretics or pts at risk of hypotension

Don’t Smoke
Normal Weight
Glucose Control
Healthy Diet
Stay Active
Lipid Control
BP Control

Good Health
Statin Therapy

- Age 40-75 “routinely” assess lipids and ASCVD risk
- Age 20-39 q 4-6 years

Clinical CVD
- High intensity statin
  - Add ezetimibe and/or PCSK9 if LDL > 70

Diabetes
- Age 40-75, LDL 70-189
  - Moderate Intensity Statin in all
  - High Intensity Statin with Multiple Risk Factors

No Diabetes
- Age 40-75, LDL 70-189
  - Calculate 10-year risk

LDL ≥190
- High intensity statin

Risk < 5%
- Emphasize lifestyle

Risk 5-7.5%
- If risk enhancers, consider Moderate Intensity Statin

Risk 7.5 - < 20%
- Moderate Intensity Statin

Risk ≥20%
- High Intensity Statin
ASCVD Risk Score

Risk Factors for ASCVD

- Gender: Male
- Female
- Age: 47 years
- Systolic BP: 110 mmHg
- Receiving treatment for high blood pressure (if SBP > 120 mmHg): No
- Yes
- Race: White or other
- Diabetes: No
- Yes
- Total Cholesterol: 202 mg/dL
- HDL Cholesterol: 65 mg/dL
- Smoker: No
- Yes
So Many Risk Scores

That aren’t used

- **Framingham**
  - MI and CVD death

- **Reynold’s Risk Score**
  - Includes CRP and Family history
  - MI, CVA, CVD death, revascularization

- **ASCVD/pooled cohort equation**
  - MI, CVD death, and CVA
  - Includes race
57-year-old Physician
Concerned About Heart Risk

- No history or symptoms of CVD
- Personal history of high cholesterol (greater than 300 mg/dL during residency)
- Family history of CVD
  - Father had MI at 76 years
57-year-old Physician
Concerned About Heart Risk

- Smoked 2 packs for 8 years, quit 30 years ago
- No diabetes
- BP 116/58 mm Hg
- BMI 27 Kg/m2
- Exercises regularly
- Primarily plant-based diet
57-year-old Physician

- Outside stress test 2 years ago negative by report
- Currently
  - T Chol 224 mg/dl
  - TG 47 mg/dl
  - HDL 67 mg/dl
  - LDL 128 mg/dl
  - Glucose 106 mg/dl

ASCVD Risk Score 5%
What Would You Do For This Patient?

A) Reassure and congratulate him
B) Start a statin
C) Carotid ultrasound
D) Stress test
E) Coronary artery calcium score
CT Coronary Calcium Score

- Total calcium score
  4,444 AU
- 99\textsuperscript{th} percentile compared to gender and age matched controls
What Would You Do For This Patient?

A) Reassure and congratulate him
B) Start a statin
When do we need additional information to assess CV risk?
When it changes management
When to do Additional Testing?

Statin or No Statin?

• Family history of CVD
• Striking risk factor in a young person
• “Grey zone” ASCVD risk score (5-7.5%)
When NOT to do Additional Testing?

CV Risk Stratification

- Established CVD
- Already on a statin
- Patient and provider agree
- To assess effectiveness of treatment
Statins Are Side Effects Real?

TO THE EDITOR: Statins are often discontinued because of side effects,¹ ² even though some blinded trials have not shown an excess of symptoms with statins as compared with placebo.³ ⁴ Patients who had previously discontinued statins because of side effects that occurred within 2 weeks after the initiation of treatment were enrolled in a double-blind, three-group, n-of-1 trial to test whether symptoms would be induced by a statin or placebo. Details of the trial methods are provided in Section S2 of the Supplementary Appendix (available with the full text of this letter at NEJM.org), the trial protocol and statistical analysis plan are also available at NEJM.org.

The patients received four bottles containing atorvastatin at a dose of 20 mg, four bottles containing placebo, and four empty bottles; each bottle was to be used for a 3-month period according to a random sequence. The patients used a smartphone application to report symptom intensity daily. Symptom scores ranged from 0 (no symptoms) to 100 (worst imaginable symptoms). If the patients determined that their symptoms were unacceptably severe, they could discontinue the tablets for that month.

The primary end point was symptom intensity as assessed with the use of the nocebo ratio (i.e., the ratio of symptom intensity induced by taking placebo to the symptom intensity induced by taking a statin). This ratio was calculated as the symptom intensity with placebo minus the symptom intensity with neither statin nor placebo, divided by the symptom intensity with a statin minus the symptom intensity with neither statin nor placebo.

From June 2016 through March 2019, a total of 60 patients underwent randomization. The screening data, the baseline characteristics of the patients, and a diagram showing randomization, intervention, and follow-up are provided in Sections S1 through S3 in the Supplementary Appendix. A total of 49 patients completed all 12 months of the trial.

The original primary end-point analysis showed a nocebo ratio of 2.2 (95% confidence interval, 1.3 to 3.6). This value was high and had a wide confidence interval because in some of the patients the value of the symptom intensity with statins minus the symptom intensity with neither statin nor placebo was unexpectedly small or negative. An independent statistician therefore recommended a different analysis (see Section S2 in the Supplementary Appendix) in which individual patient data were pooled before calculation of the ratio. This analysis showed a nocebo ratio of 0.90. Among all 60 patients, the mean symptom intensity was 8.0 during no-tablet months (95% CI, 4.7 to 11.3).

Statins Are Side Effects Real?

• 90% of symptoms while taking atorva also reported in placebo

• No pill bottles ~ half the symptoms

• All subjects shown results at end of trial – 50% restarted statins

Statins in Elderly

Meta-analysis

- n = 244,090, 21,492 over 75 years of age

- HR 0.74 MACE in those > 75 years for every 1 mmol/L decrease in LDL

- HR 0.85 for death

- HR 0.80 for MI

- HR 0.73 for stroke

- HR 0.80 for revasc

Lancet 2020;396:1637-43.
REDUCE-IT
Icosapent ethyl (Vascepa®)

- n = 8179 with CVD or DM and other risk factors on a statin
- TG 135-499 mg/dL, LDL 40-100 mg/dL on a statin
- CV death reduced 20%
- Primary endpoint reduced 25%

VITAL
Vitamin D and Fish Oil

- n = 25,871, primary prevention of CVD and cancer in men >50 and women > 55
- Randomized to 2,000 IU Vit D and 1 gm fish oil, FU 5.3 years
- NO difference in outcomes

From the Department of Medicine, Brigham and Women’s Hospital and Harvard Medical School (E.M., N.R.C., I.M.L., W.C., S.B.B., S.M., H.G., C.M.A., D.G., T.C., D.D., G.F., C.R., V.B., E.L.G., W.C.W., J.E.B.), and the Departments of Epidemiology (E.M., N.R.C., I.M.L., W.C., J.E.B.) and Nutrition (E.L.G., W.C.W.), Harvard T.H. Chan School of Public Health — all in Boston. Address reprint requests to Dr. Manson at the Department of Medicine, Brigham and Women’s Hospital and Harvard Medical School. 500 Commonwealth Ave., 4th Flr., Boston, MA 02215, or at jmanson@bwh.harvard.edu.

A complete list of the members of the VITAL Research Group is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on November 29, 2018, at NEJM.org.
DOI: 10.1056/NEJMoa1812499
Copyright © 2019 Massachusetts Medical Society.
REDUCE-IT
*Other Things of Interest*

- Amazing outcome! (Too amazing?)
- Outlier result or is it the pure EPA that is important?
- Questionable effect of mineral oil placebo
- ADA, ALA and ESC have all given strong recommendation to add icosapent ethyl to statin therapy in high-risk pts with TG > 135 mg/dL
Omega 3 FA
What do we recommend now?

• As best as I can tell:
  • Fish oil (EPA/DHA) at any dose does not change CVD or cancer outcomes and MAY increase Afib and bleeding
  • If TG are high, fish oil is reasonable, icosapent ethyl preferred if insurance will cover
Don't Smoke
Normal Weight
Glucose Control
Healthy Diet
Stay Active
Lipid Control
BP Control
Good Health
SGLT2 Inhibitors

**Benefits**

- Death rate: -30%
- CHF: -25-35%
- MI: -10-15%
- ESRD: -40-50%
- Albuminuria: -25-35%
- Weight loss: -2 Kg
- BP: -4/2 mmHg
- HgbA1c: -0.7-1.0%
SGLT2 Inhibitors

Adverse effects

- Ketoacidosis
  0.3% to 0.6%
- Diarrhea
  6% to 8.5%
- Genital mycotic infection
  0.9% to 2.4%
He’s one of the busiest men in town. While his door may say Office Hours 2 to 4, he’s actually on call 24 hours a day.

The doctor is a scientist, a diplomat, and a friendly sympathetic human being all in one, no matter how long and hard his schedule.

According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS THAN ANY OTHER CIGARETTE
Most Smokers Want to Quit
But it’s not easy

76% of smokers want to quit

59% have tried to quit in the last year

6% were successful
Early and Late Benefits

Lots of reasons to quit

• 1 month - lung function improves
• 1 year – heart attack risk cut in half
• 10 years – risk of heart disease is same as never smoking
• 20 years – risk of lung disease, cancer, heart disease same as never smoking
How much does pharmacootherapy and counseling increase smoking cessation rates?

A) 2 times
B) 5 times
C) 10 times
D) It doesn’t
Counseling AND medications are more effective than either alone.

1-800-QUIT-NOW
It’s free. It’s personalized.
It’s up to you.
For stable CAD, revascularization with PCI has been shown to:

A) Improve mortality
B) Decrease myocardial infarction
C) Decrease heart failure
D) Decrease angina
E) None of the above
ISCHEMIA
Stable CAD – Invasive or Not?

• n= 5179 subjects
• Moderate or severe ischemia
• Initial invasive + OMT vs. initial OMT
• Initial invasive approach did not change outcomes or death rates.
Our Patients Are **NOT** getting the best care.
Good Health

- Normal Weight
- Glucose Control
- Healthy Diet
- Don’t Smoke
- Stay Active
- Lipid Control
- BP Control

Healthy Diet
Stay Active
BP Control
Lipid Control
Don’t Smoke
Glucose Control
Normal Weight
MOST EFFECTIVE TREATMENT FOR CARDIOMETABOLIC DISEASE

Expert Medical Care + Treat the Root Causes
What percentage improvement in being free of Afib at 4 years does weight loss and lifestyle change provide for Afib above ablation and medication?

A) 25%
B) 50%
C) 100%
D) 500%
Impact of CARDIOrespiratory FITness on Arrhythmia Recurrence in Obese Individuals With Atrial Fibrillation
The CARDIO-FIT Study

ABSTRACT

BACKGROUND: Obesity begets atrial fibrillation (AF). Although cardiorespiratory fitness is protective against AF in obese individuals, its effect on AF recurrence or the benefit of cardiorespiratory fitness remains unknown.

OBJECTIVES: This study sought to evaluate the role of cardiorespiratory fitness and the incremental benefit of cardiorespiratory fitness improvement on rhythm control in obese individuals with AF.

METHODS: Of 1,415 consecutive patients with AF, 825 had a body mass index of ≥27 kg/m² and were offered risk factor management and participation in a tailored exercise program. After exclusions, 308 patients were included in the analysis. Patients underwent exercise stress testing to determine peak metabolic equivalents (METs). To determine a dose response, cardiorespiratory fitness was categorized as low (<55%), adequate (55% to 100%), and high (>100%). Impact of cardiorespiratory fitness gain was ascertained by the objective gain in fitness at final follow-up (≥2 METs vs. <2 METs). AF rhythm control was determined using 7-day Holter monitoring and AF severity scale questionnaire.

RESULTS: There were no differences in baseline characterics or follow-up duration between the groups defined by cardiorespiratory fitness. Arrhythmia-free survival with and without rhythm control strategies was greatest in patients with high cardiorespiratory fitness compared to adequate or low cardiorespiratory fitness (p < 0.001 for both). AF burden and symptom severity decreased significantly in the group with cardiorespiratory fitness gain ≥2 METs as compared to <2 METs group (p = 0.001 for all). Arrhythmia-free survival with and without rhythm control strategies was greatest in those with METs gain ≥2 compared to those with METs gain <2 in cardiorespiratory fitness (p < 0.001 for both).


Meds and ablation alone

66% had more Afib

Treat the root causes

6% had more Afib
Problems

- Damage or destroy our house
- Sink overflowing
- Root cause: Too much water coming in

Possible Solutions

- Replace the floor/baseboards/dry wall
- Move
- Mops
- More drains
- Bigger sink
- Turn the water off (or at least down)
Problems

CVD/CVA/Cancer/Dementia
Death

HTN/DM/Lipids/Obesity

Root cause
Diet/Activity/Toxins

Possible Solutions

PCI/surgery/transplant
meds

Meds/Procedures
Is Lifestyle/Weight Loss Healthcare’s Responsibility?

1. We’re not paid for this.
2. Have enough to worry about.
3. Don’t have time.
CARDIOMETABOLIC DISEASE
THE 21ST CENTURY EPIDEMIC

- Heart Disease
- Stroke
- Cancer
- Kidney Disease

>2,000++ Preventable deaths/day

- Diabetes/Pre-diabetes
  77 million
- High cholesterol
  100 million
- High blood pressure
  121 million
- Unhealthy Weight
  160 million
Update In Preventive Cardiology

R. Todd Hurst, MD FACC
FASE

Email: todd@toddhurstmd.com

LinkedIn