

# JBS 2: Promoting a consistent approach to CVD

The aim of the recently published Joint British Societies' guidelines on prevention of cardiovascular disease in clinical practice (JBS 2; British Cardiac Society et al, 2005; see *Table 4* on page 16) is to promote a consistent multidisciplinary approach to the management of individuals with established cardiovascular disease (CVD) and those at high risk of developing it. The latter group includes, in particular, people with diabetes.

In the modern management of diabetes, cardiovascular risk reduction is seen to be as important as glycaemic control, although the latter remains essential to prevent microvascular complications. The landmark Steno-2 study demonstrated that an aggressive multifactorial target-driven strategy reduced CVD events in high-risk individuals by no less than half (Gaede et al, 2003). This is precisely what the JBS 2 guidelines advocate.

What is required is a strategy which integrates all dimensions of diabetes care into a single multidisciplinary user-centred approach. The JBS 2 guidelines endorse the Alphabet Strategy developed at the George Eliot Hospital. This is a mnemonic-based template designed to ensure that all elements of management are delivered in a systematic, coherent and timely fashion (Morrissey et al, 2005; see *Table 1*). This approach has been shown in practice to deliver results comparable to those of Steno 2 (Jaiveer et al, 2003).

The JBS 2 guidelines address the main modifiable risk factors responsible for premature accelerated CVD in individuals with diabetes: hypertension, dyslipidaemia and hyperglycaemia. The extensive existing evidence base is reviewed and clear recommendations are made. The most effective single intervention to reduce CVD risk in diabetes is lipid lowering with a statin (Lee et al, 2004). The guidelines' authors therefore recommend statin treatment in all individuals with diabetes, whether type 1 or type 2, aged 40 years or older, and in younger individuals at additional risk. In practice this adds up to over 90% of people with diabetes.

The blood pressure target advocated is 130/80 mmHg, although the guidelines'

authors recognise that this is difficult to achieve. However, in diabetes there appears to be no blood pressure threshold below which risk no longer declines (Hansson et al, 1998). The issue of which antihypertensive agents should be used remains debatable, but most people will require combination therapy including an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker. With respect to glycaemia, the special role of metformin in the obese individual with diabetes is emphasised in the guidelines. However, whether glitazones have benefits additional to their glucose-lowering effect remains uncertain. Insulin therapy should be introduced early when control with oral agents deteriorates.

## Quality and Outcomes Framework

The recommendations are straightforward and should be easy to implement in primary care. Most primary care practitioners will continue to be guided in the first instance by the Quality and Outcomes Framework (QOF; new indicators will take effect from 1 April 2006 [see page 22]). However, the evidence reviewed by the JBS 2 guidelines suggests that some of the QOF targets should be tightened. A target total cholesterol may be obsolete since individuals with diabetes appear to benefit from lipid-lowering therapy almost irrespective of their lipid profile. And with respect to glycaemia and blood pressure lowering, we should perhaps be treating our patients more aggressively than the QOF suggests. ■

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**Table 1. The Alphabet Strategy.**

<b>A</b> dvice (diet, weight loss, smoking cessation, exercise)
<b>B</b> lood pressure lowering
<b>C</b> holesterol lowering
<b>D</b> iabetes control
<b>E</b> ye examination
<b>F</b> eet examination
<b>G</b> uardian drugs (such as aspirin, angiotensin-converting enzyme inhibitors and statins)

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