

Assess The Effectiveness Of Rosuvastatin In Reducing Low-density Lipoprotein Cholesterol (Ldl-c) Levels In Patients With ASCVD.

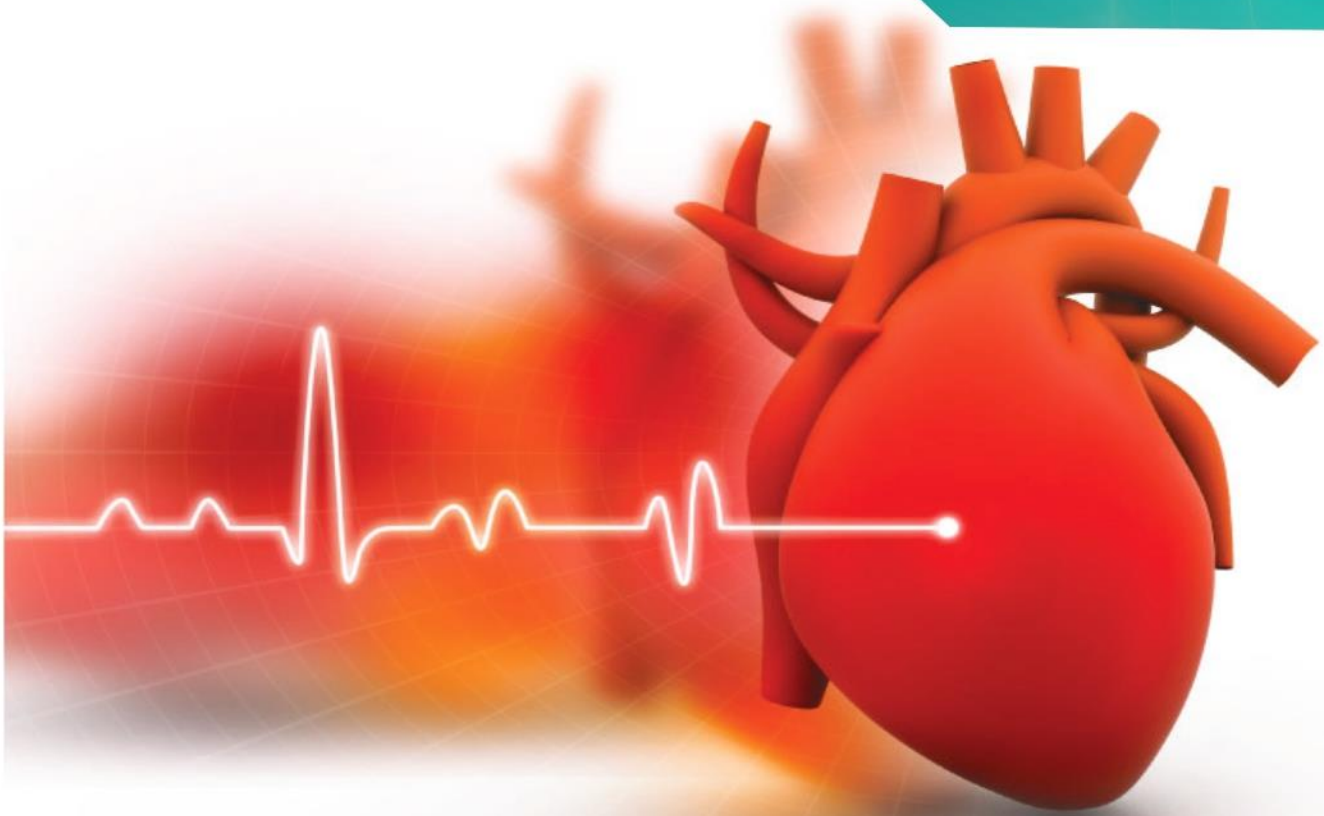


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INTRODUCTION

Cardiovascular diseases (CVDs) remain a leading cause of morbidity and mortality worldwide, significantly impacting public health systems and economies (1). The underlying pathology of CVDs is primarily attributed to atherosclerosis, which leads to severe complications such as acute coronary syndrome and cerebrovascular accidents (strokes) (2). Among the various risk factors associated with atherosclerosis, low-density lipoprotein cholesterol (LDL-C) stands out as a crucial modifiable risk factor (3). Reducing LDL-C levels is considered a primary therapeutic objective in the prevention and management of CVDs (4).

Statins, a class of lipid-lowering medications, play a vital role in this regard, with Rosuvastatin being one of the most potent agents in this group (5). As an HMG-CoA reductase inhibitor, Rosuvastatin effectively reduces LDL-C levels, making it a preferred choice among healthcare providers treating dyslipidemia (6). Clinical studies have consistently shown that Rosuvastatin not only lowers LDL-C but also exerts beneficial pleiotropic effects, such as enhancing endothelial function and stabilizing atherosclerotic plaques, which further contribute to its cardiovascular protective properties (7). The drug's efficacy is particularly pronounced in high-risk populations, including those with familial hypercholesterolemia, where its ability to significantly lower cholesterol levels is critical (8).

Despite the documented advantages of Rosuvastatin, there remains notable variability in its clinical use. This variability encompasses aspects such as dosing regimens, monitoring protocols, and the practice of combining Rosuvastatin with other lipid-lowering therapies (9). Differences in clinical practice may arise from varying clinician experiences, patient populations, and interpretations of clinical guidelines, which can ultimately affect patient outcomes and adherence to

treatment (10). Moreover, the nuances of Rosuvastatin's effectiveness, safety, and tolerability require thorough understanding to optimize lipid management strategies and improve cardiovascular health (11).

The growing body of evidence surrounding the safety profile and potential adverse effects associated with statin use, particularly myopathy and diabetes, has also contributed to clinician apprehension regarding statin therapy (12). Addressing these concerns through systematic evaluation of clinician perspectives on Rosuvastatin's efficacy is essential for guiding best practices in lipid management.

In light of these considerations, the present survey aims to assess the effectiveness of Rosuvastatin in reducing LDL-C levels and preventing atherosclerotic cardiovascular disease (ASCVD). By gathering insights from healthcare professionals regarding their experiences with Rosuvastatin, the study seeks to illuminate trends in prescribing practices, expectations for treatment outcomes, and the perceived benefits and challenges of using this medication in various patient populations (13). The findings of this survey will contribute to a better understanding of how Rosuvastatin is utilized in clinical practice and highlight areas where further education or guideline updates may be beneficial (14).

RATIONALE OF THE STUDY

The increasing prevalence of dyslipidemia and its significant contribution to cardiovascular diseases underscore the need for effective therapeutic interventions. Elevated LDL-C levels are a primary risk factor for atherosclerotic cardiovascular disease (ASCVD), necessitating robust strategies to manage cholesterol levels (1). Statins have been established as first-line agents in lipid-lowering therapy due to their proven efficacy in reducing LDL-C and improving cardiovascular outcomes (2).

Rosuvastatin, in particular, has garnered attention for its potency and favorable lipid profile. Despite its widespread use, there is considerable variability in clinical practice regarding its prescription, dosing, and monitoring (3). Additionally, patient adherence to therapy can be influenced by perceived efficacy and safety (4). Understanding the current practices and perceptions of healthcare providers regarding Rosuvastatin is crucial for optimizing treatment protocols and improving patient outcomes.

STUDY OBJECTIVE

The primary objective of this survey is to assess the effectiveness of Rosuvastatin in reducing Low-Density Lipoprotein Cholesterol (LDL-C) and its implications for Atherosclerotic Cardiovascular Disease (ASCVD) among healthcare providers. The specific aims include:

1. **Evaluate Clinical Practices:** To gather data on the frequency and conditions under which Rosuvastatin is prescribed, including dosing strategies and monitoring protocols.
2. **Assess Perceptions of Efficacy:** To understand clinicians' expectations regarding LDL-C reduction and the overall effectiveness of Rosuvastatin compared to other lipid-lowering agents.
3. **Identify Barriers to Optimal Use:** To identify potential barriers or concerns that may affect the utilization of Rosuvastatin in clinical practice, including side effects and contraindications.
4. **Explore Combination Therapies:** To evaluate the common practices regarding the combination of Rosuvastatin with other lipid-lowering agents and the rationale behind these combinations.

METHODS

This survey will employ a cross-sectional study design, targeting healthcare professionals involved in the management of dyslipidemia and cardiovascular disease. The methodology will include:

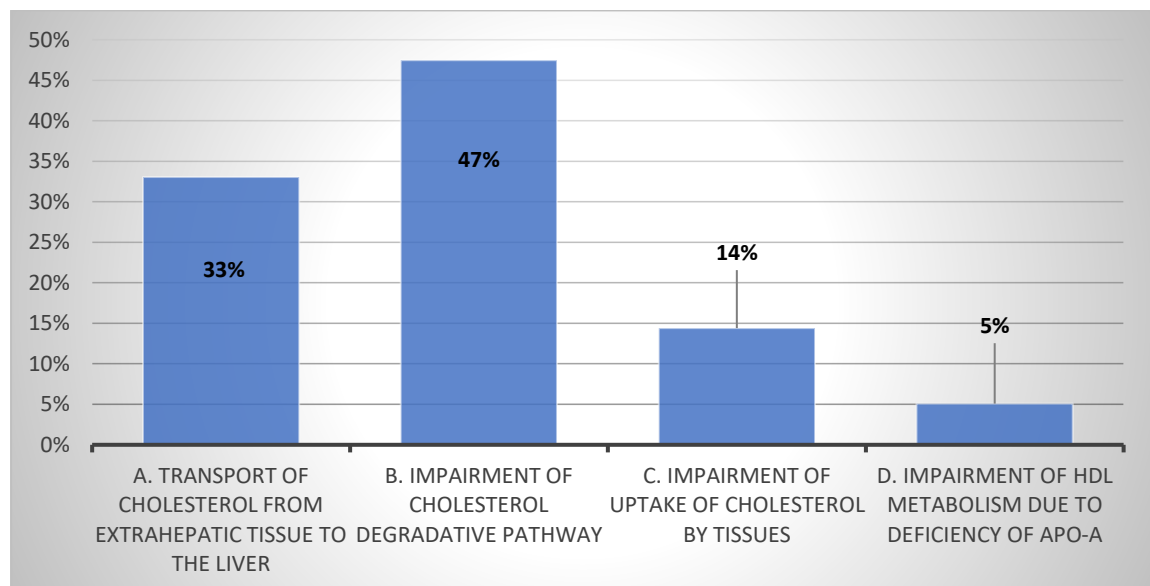
1. **Participant Recruitment:** Clinicians will be recruited through professional networks, hospitals, and clinics. An Booklet survey will facilitate data collection.
2. **Survey Instrument:** A structured questionnaire will be developed, consisting of multiple-choice questions and Likert scale items to assess perceptions and practices regarding Rosuvastatin. The questionnaire will cover various aspects, including:
 - Prescription habits
 - Expected outcomes
 - Monitoring practices
 - Concerns about adverse effects
3. **Data Collection:** The survey will be distributed electronically, ensuring anonymity and encouraging participation. Responses will be collected over a predetermined period.
4. **Data Analysis:** Descriptive statistics will be used to summarize the data. Frequencies and percentages will be calculated for each survey item. The analysis will also explore correlations between clinician demographics and their responses regarding Rosuvastatin.
5. **Ethical Considerations:** The study was conducted in accordance with ethical guidelines for research involving Informed consent was obtained from all participants clinicians for the study.

RESULTS

A total of 121 HCPs participated in the survey. Below is the summary of the responses.

1. Familial hypercholesterolemia is a genetic disorder of cholesterol metabolism. The defect lies in the _____

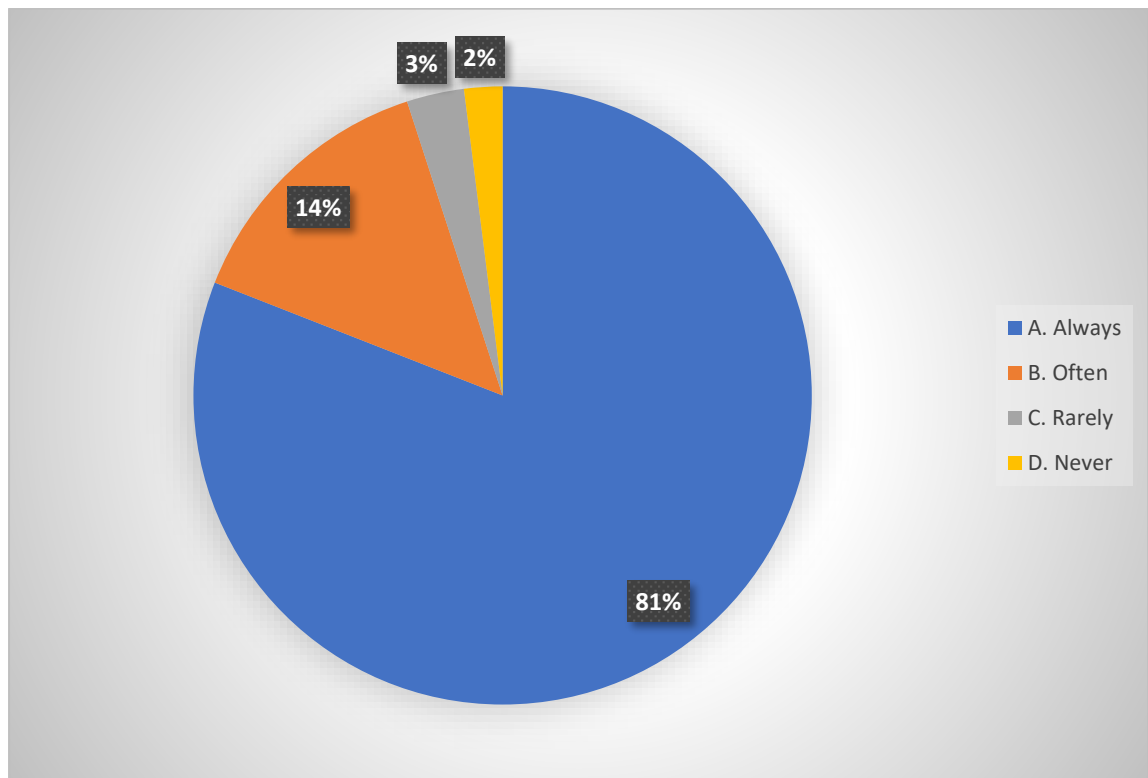
- A. Transport of cholesterol from extrahepatic tissue to the liver
- B. Impairment of cholesterol degradative pathway
- C. Impairment of uptake of cholesterol by tissues
- D. Impairment of HDL metabolism due to deficiency of Apo-A



- **Impairment of cholesterol degradative pathway (47%):** This is the most commonly recognized cause of familial hypercholesterolemia, highlighting the key role of cholesterol metabolism defects in the disorder.
- **Transport of cholesterol from extrahepatic tissue to the liver (33%):** Many clinicians also consider this factor important in the pathology.
- **Impairment of uptake of cholesterol by tissues (14%) and Impairment of HDL metabolism due to deficiency of Apo-A (5%):** These factors were less commonly cited.

2. How frequently do you prescribe Rosuvastatin in your clinical practice?

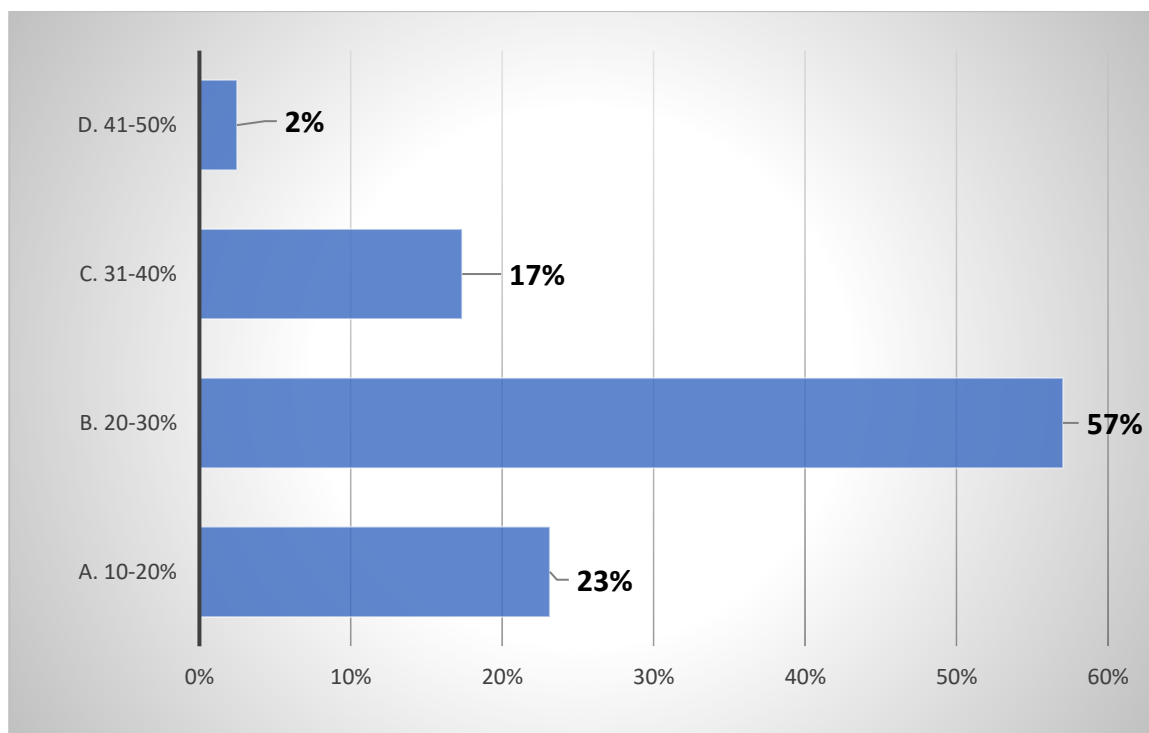
- A. Always
- B. Often
- C. Rarely
- D. Never



- **Always (81%):** The majority of clinicians frequently prescribe Rosuvastatin, indicating its widespread acceptance in clinical practice.
- **Often (14%):** A smaller portion prescribes it frequently but not universally.
- **Rarely (3%) and Never (2%):** Few clinicians prescribe Rosuvastatin infrequently or not at all.

3. How much LDL reduction do you expect after using medium intensity statin?

- A. 10-20%
- B. 20-30%
- C. 31-40%
- D. 41-50%

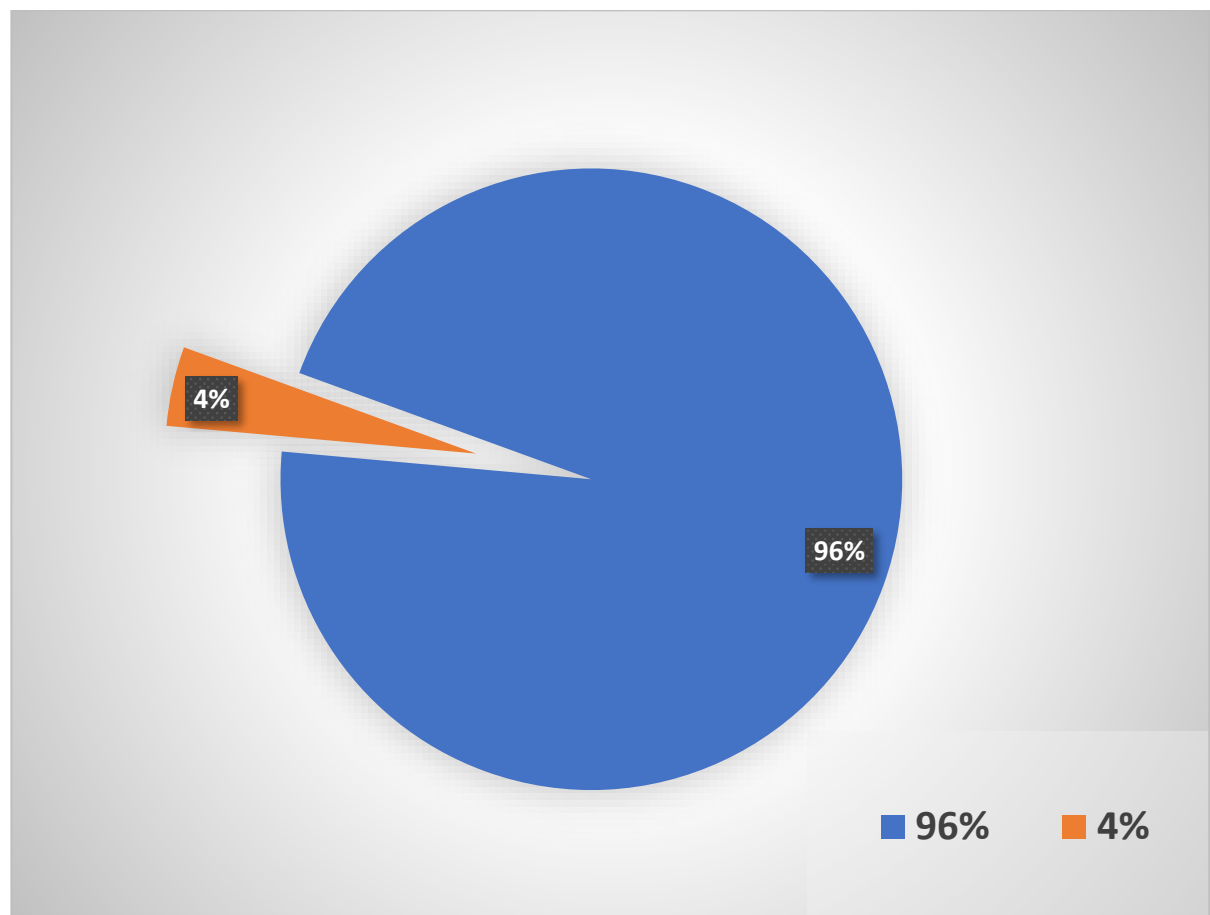


- **20-30% (57%):** Most clinicians expect this level of LDL reduction, demonstrating realistic expectations with medium-intensity statins.
- **10-20% (23%):** Some expect lower reductions.
- **31-40% (17%):** Higher LDL reductions are expected by a minority.
- **41-50% (2%):** Very few expect reductions above 40%.

4. In your clinical practice, do you often combine Rosuvastatin with other lipid-lowering medications or therapies?

A. Yes

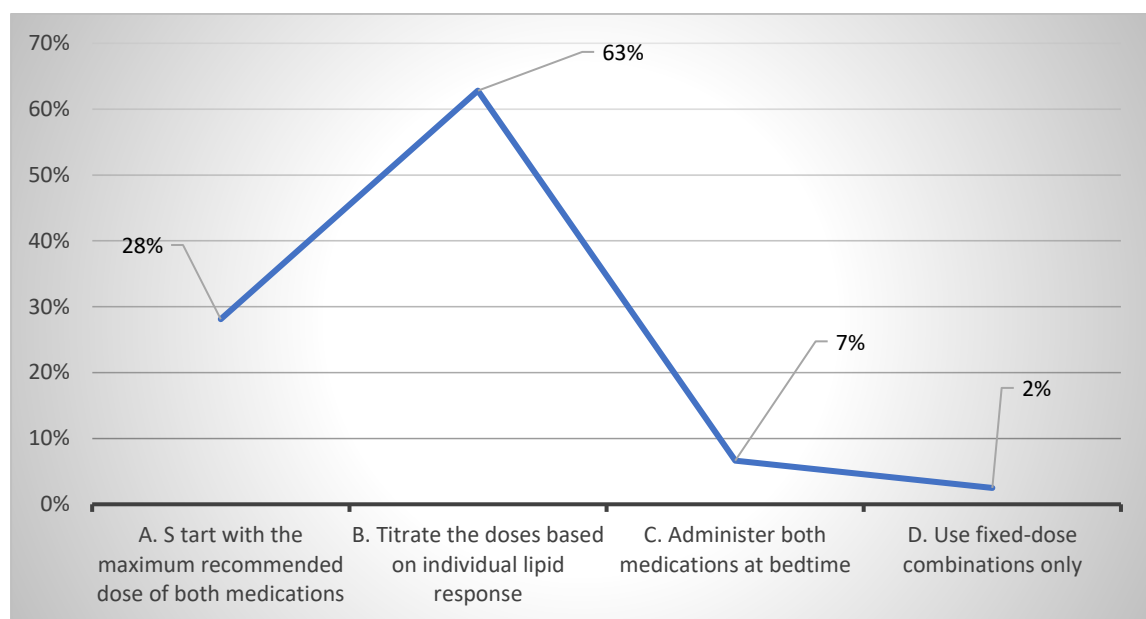
B. No



- **Yes (96%):** A vast majority of clinicians combine Rosuvastatin with other lipid-lowering medications, indicating a multi-therapy approach.
- **No (4%):** A small number do not combine it with other therapies.

5. According to you, what should be considered in terms of dosing adjustments while prescribing Rosuvastatin along with other lipid lowering therapies?

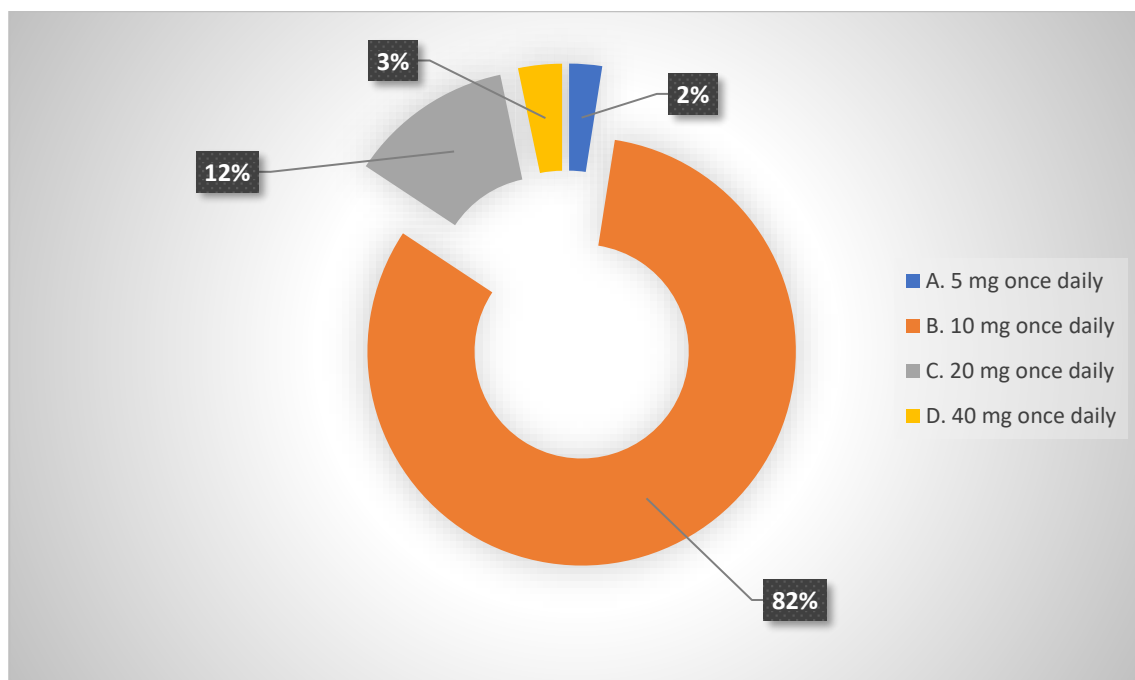
- A. Start with the maximum recommended dose of both medications
- B. Titrate the doses based on individual lipid response
- C. Administer both medications at bedtime
- D. Use fixed-dose combinations only



- **Titrate the doses based on individual lipid response (63%):** Most clinicians prefer to titrate doses, reflecting an individualized approach to lipid management.
- **Start with the maximum recommended dose of both medications (28%):** Some opt for a more aggressive initial dosing strategy.
- **Administer both medications at bedtime (7%) and use fixed-dose combinations only (2%):** Less common approaches.

6. According to you, what could be starting dose of Rosuvastatin for the treatment of hypercholesterolemia?

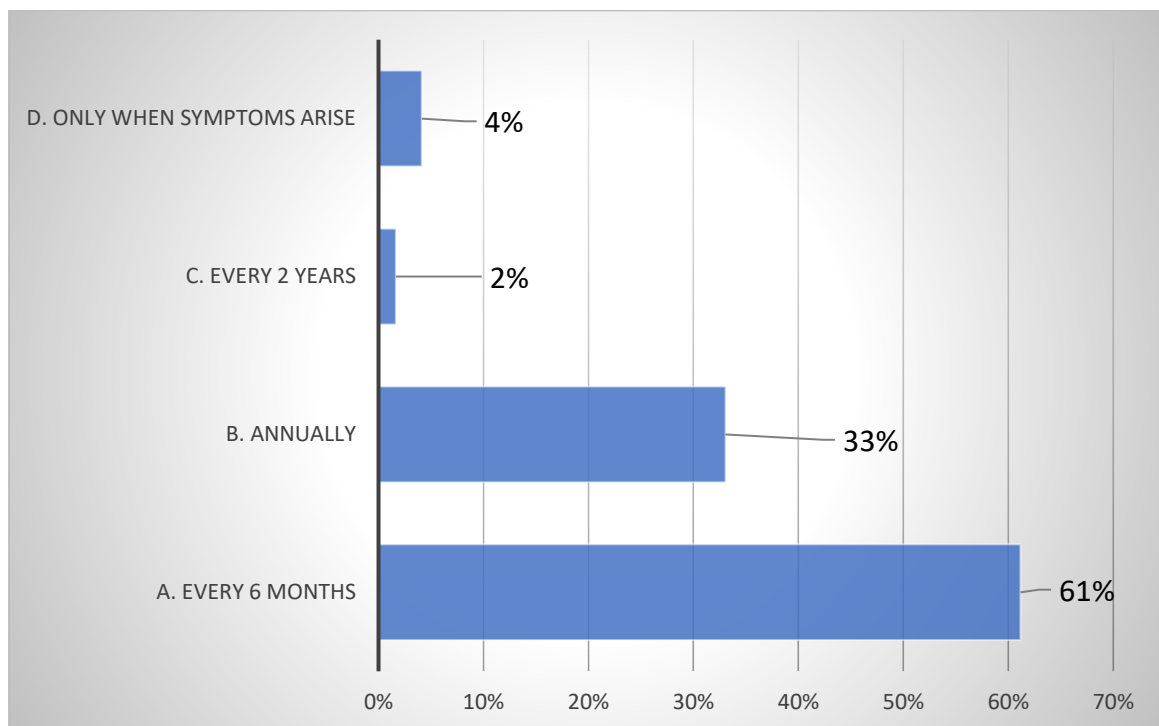
- A. 5 mg once daily
- B. 10 mg once daily
- C. 20 mg once daily
- D. 40 mg once daily



- **10 mg once daily (82%):** The majority of clinicians prefer starting at this dosage.
- **20 mg once daily (12%) and 5 mg once daily (2%):** Some choose a higher or lower starting dose.
- **40 mg once daily (3%):** Only a small group starts patients at the highest dose.

7. According to you, how often should lipid profiles be monitored in patients on rosuvastatin therapy?

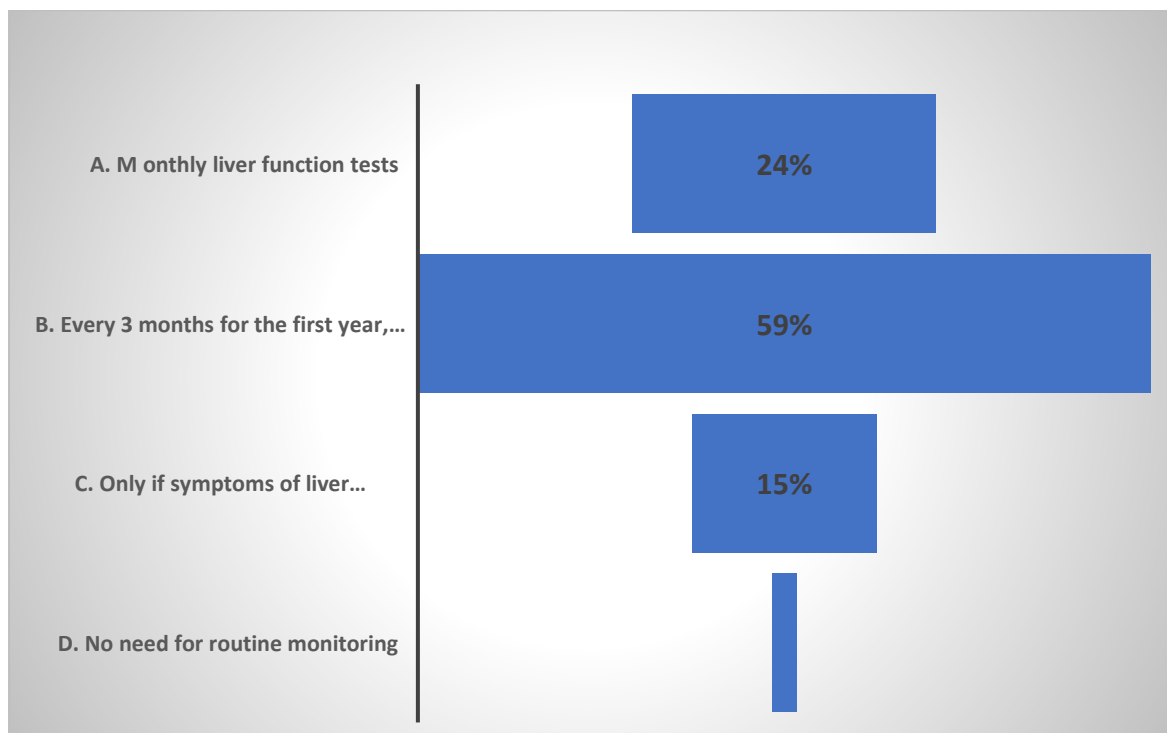
- A. Every 6 months
- B. Annually
- C. Every 2 years
- D. Only when symptoms arise



- **Every 6 months (61%):** Most clinicians recommend this frequency for lipid monitoring.
- **Annually (33%):** A significant portion prefers less frequent checks.
- **Every 2 years (2%) and only when symptoms arise (4%):** Very few opt for longer intervals or symptom-based monitoring.

8. According to you, how should liver function be monitored in patients taking rosuvastatin?

- A. Monthly liver function tests
- B. Every 3 months for the first year, then annually
- C. Only if symptoms of liver dysfunction occur
- D. No need for routine monitoring

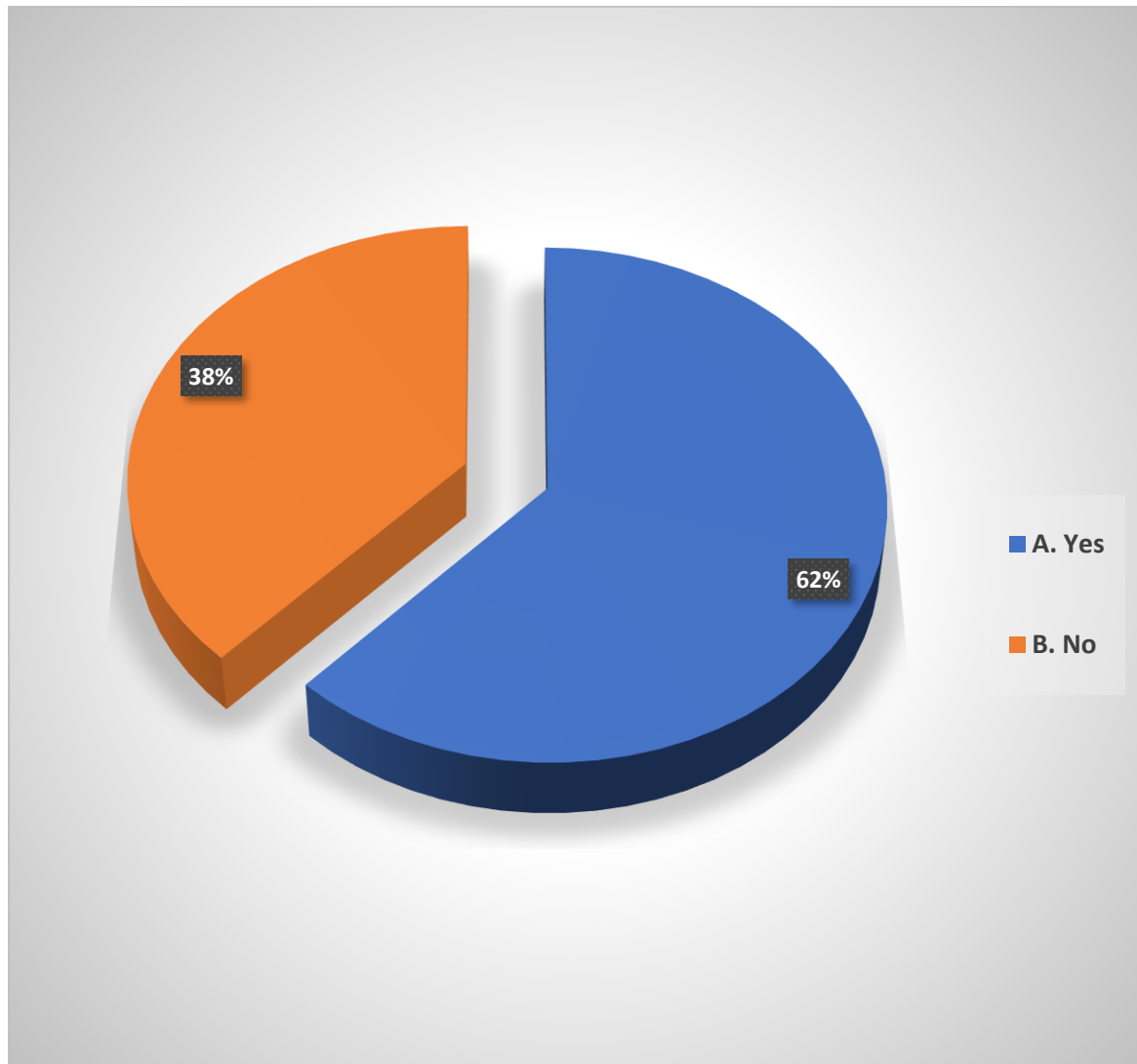


- **Every 3 months for the first year, then annually (59%):** This approach is common to ensure liver safety during long-term therapy.
- **Monthly liver function tests (24%):** A significant minority opts for more frequent monitoring.
- **Only if symptoms of liver dysfunction occur (15%):** Some prefer monitoring based on symptoms.
- **No need for routine monitoring (2%):** Very few clinicians do not monitor liver function regularly.

9. Have you encountered any instances of intolerance or adverse reactions to Rosuvastatin in your practice?

A. Yes

B. No

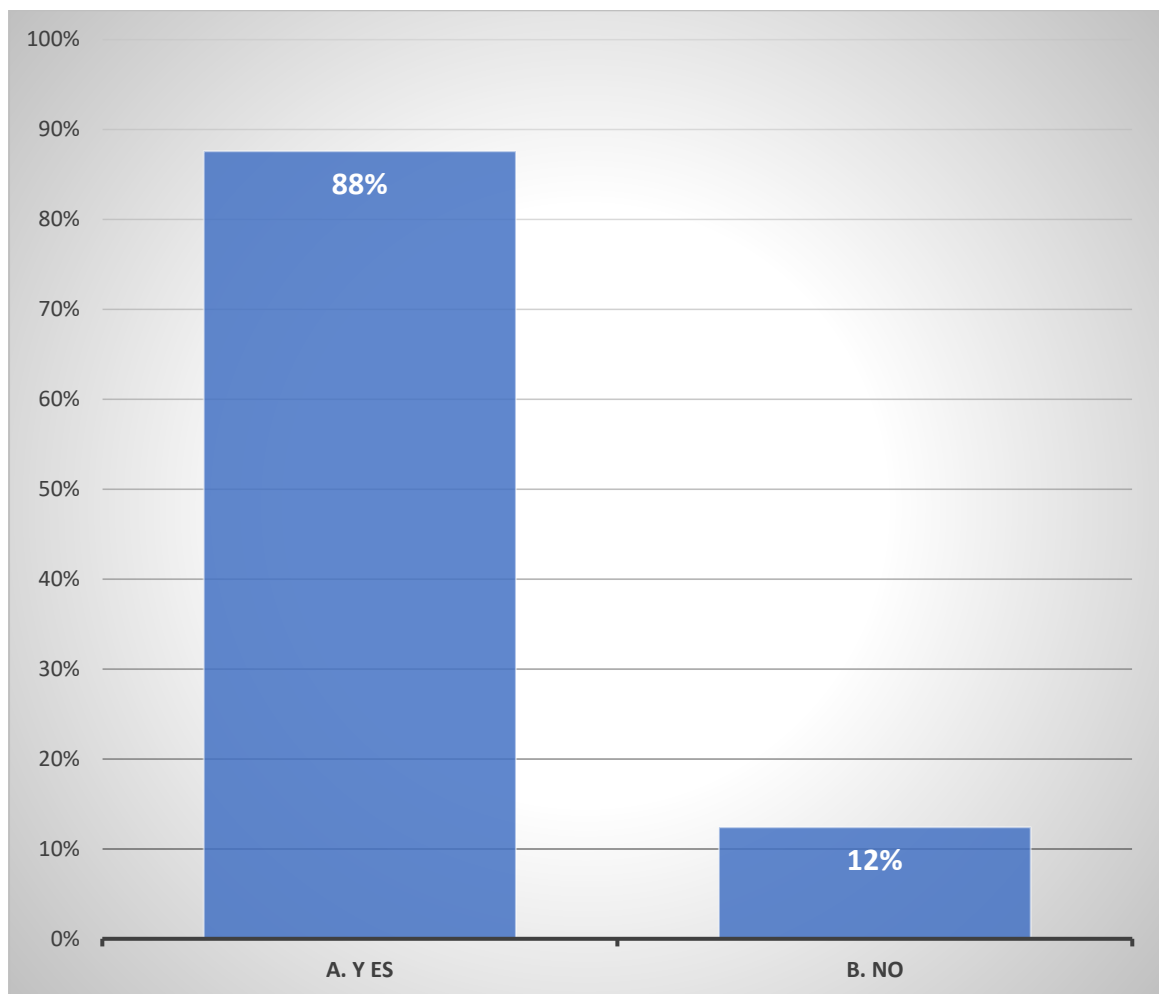


- **Yes (62%):** A majority have encountered instances of intolerance or adverse reactions.
- **No (38%):** A significant portion has not encountered such issues.

10. Are you concerned about statin induced myopathy/diabetes while prescribing them?

A. Yes

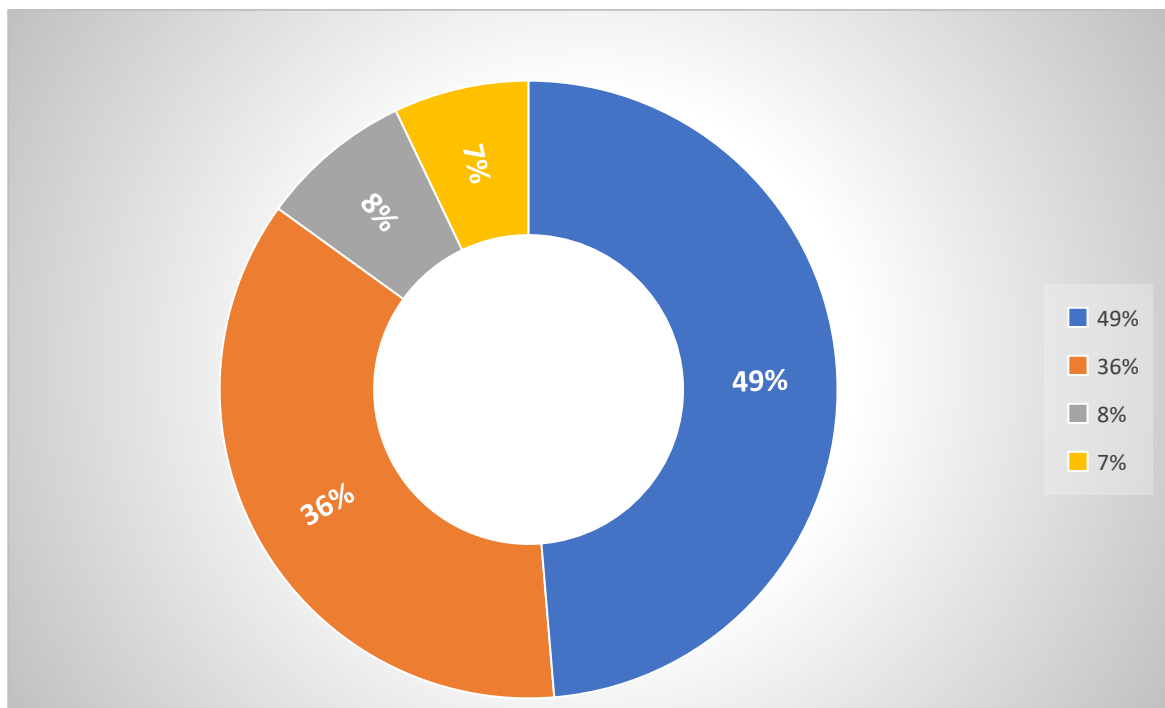
B. No



- **Yes (88%):** Most clinicians are concerned about the potential side effects of statins.
- **No (12%):** A small group does not share this concern.

11. As per your experience, which of the following is a contraindication to the use of Rosuvastatin?

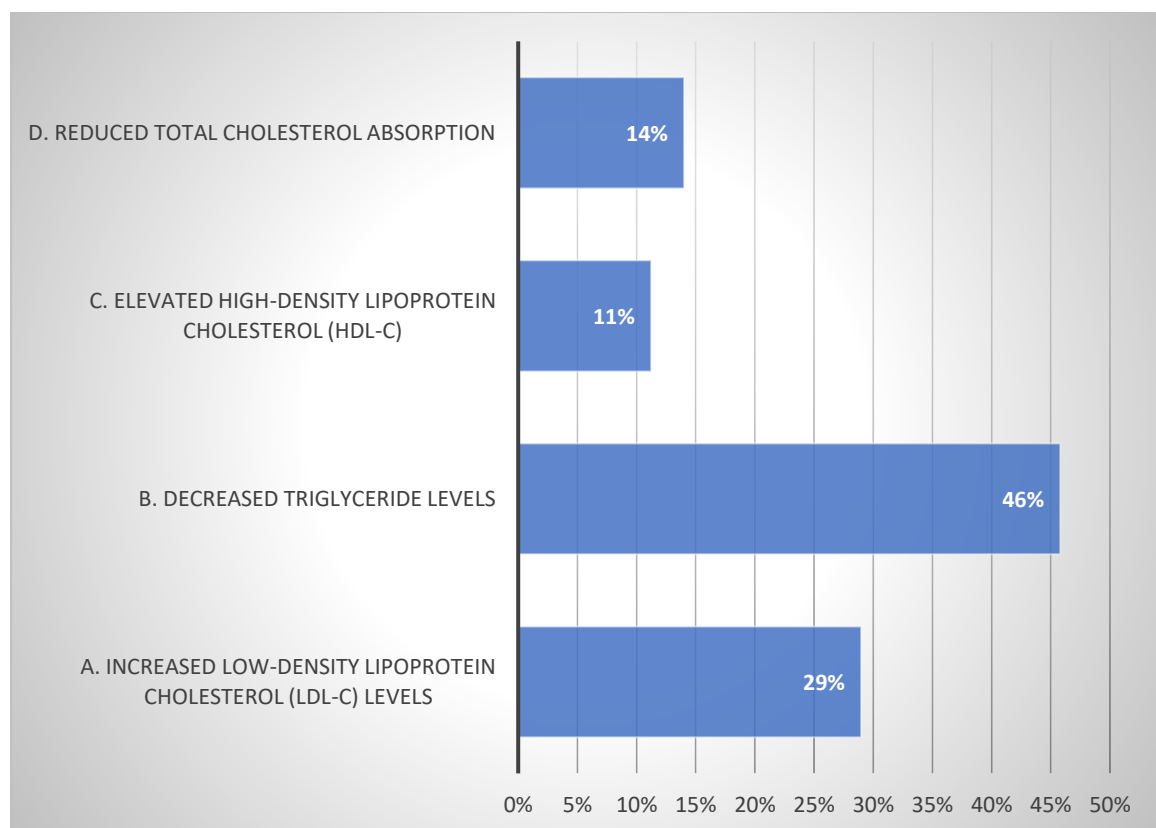
- A. Mild liver dysfunction
- B. Pregnancy
- C. Hypothyroidism
- D. Chronic obstructive pulmonary disease (COPD)



- **Mild liver dysfunction (49%):** This is the most commonly cited contraindication.
- **Pregnancy (36%):** A significant concern for many clinicians.
- **Hypothyroidism (8%) and Chronic obstructive pulmonary disease (7%):** Less commonly cited contraindications.

12. According to you, when combining Fenofibrate and Rosuvastatin, the synergistic effect is expected to result in:

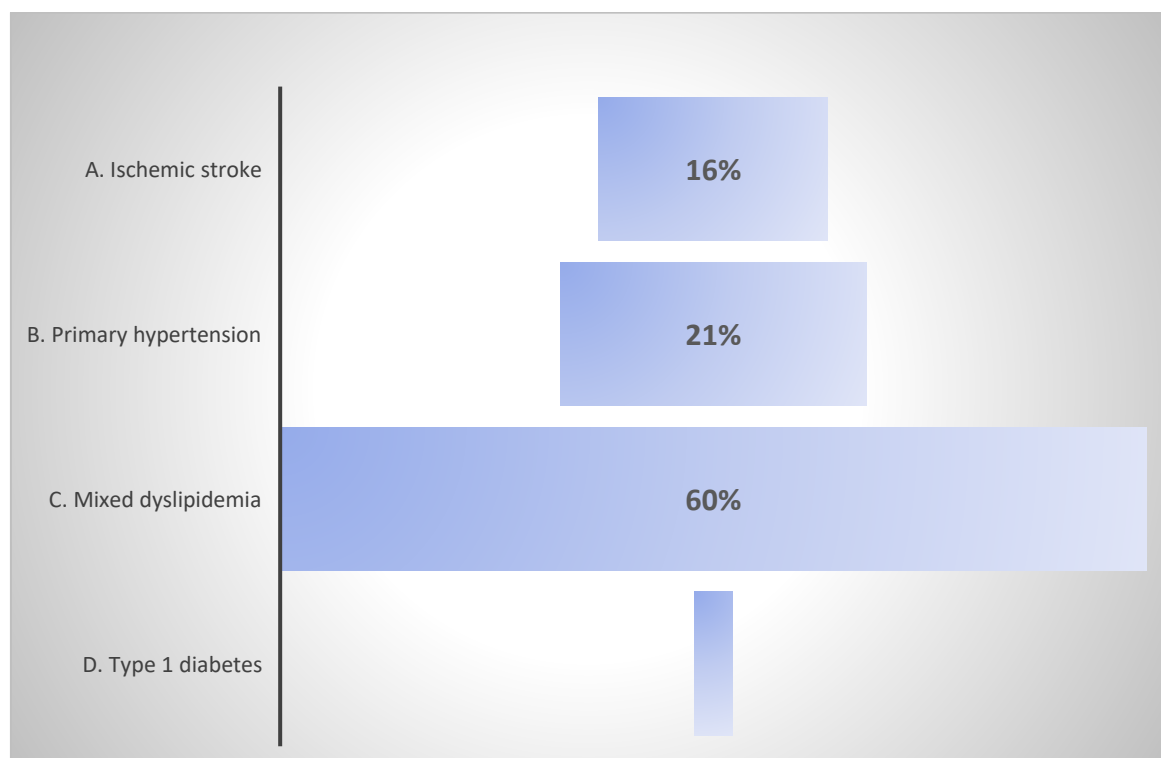
- A. Increased low-density lipoprotein cholesterol (LDL-C) levels
- B. Decreased triglyceride levels
- C. Elevated high-density lipoprotein cholesterol (HDL-C)
- D. Reduced total cholesterol absorption



- **Decreased triglyceride levels (46%):** Most clinicians expect this result.
- **Increased low-density lipoprotein cholesterol (29%) and Reduced total cholesterol absorption (14%):** Some expect different lipid profile effects.
- **Elevated high-density lipoprotein cholesterol (11%):** Few expect this benefit.

13. According to you, the combination of Fenofibrate and Rosuvastatin is commonly prescribed for patients with:

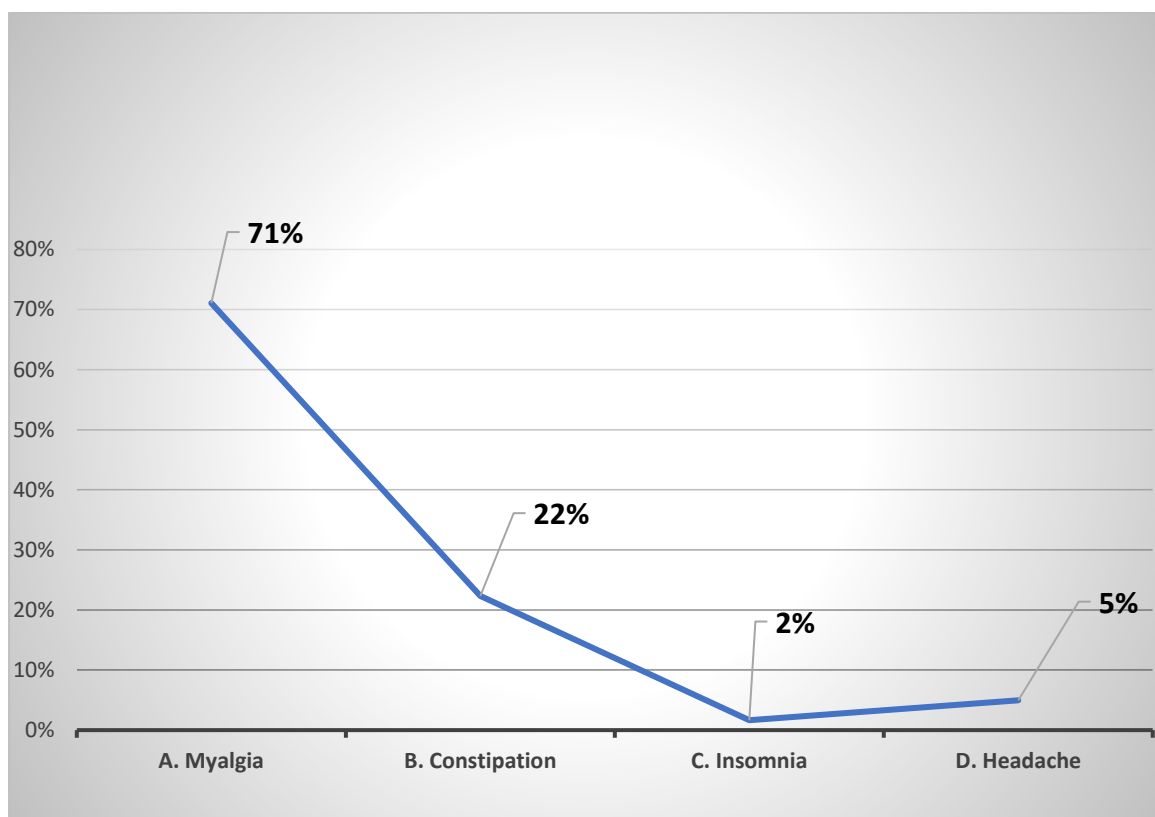
- A. Ischemic stroke
- B. Primary hypertension
- C. Mixed dyslipidemia
- D. Type 1 diabetes



- **Mixed dyslipidemia (60%):** The most common condition treated with this combination.
- **Primary hypertension (21%) and Ischemic stroke (16%):** These are less common reasons for using the combination.
- **Type 1 diabetes (3%):** Rarely prescribed for this condition.

14. As per your clinical practice, the combination of Fenofibrate and Rosuvastatin may be considered in patients with statin intolerance, especially those experiencing:

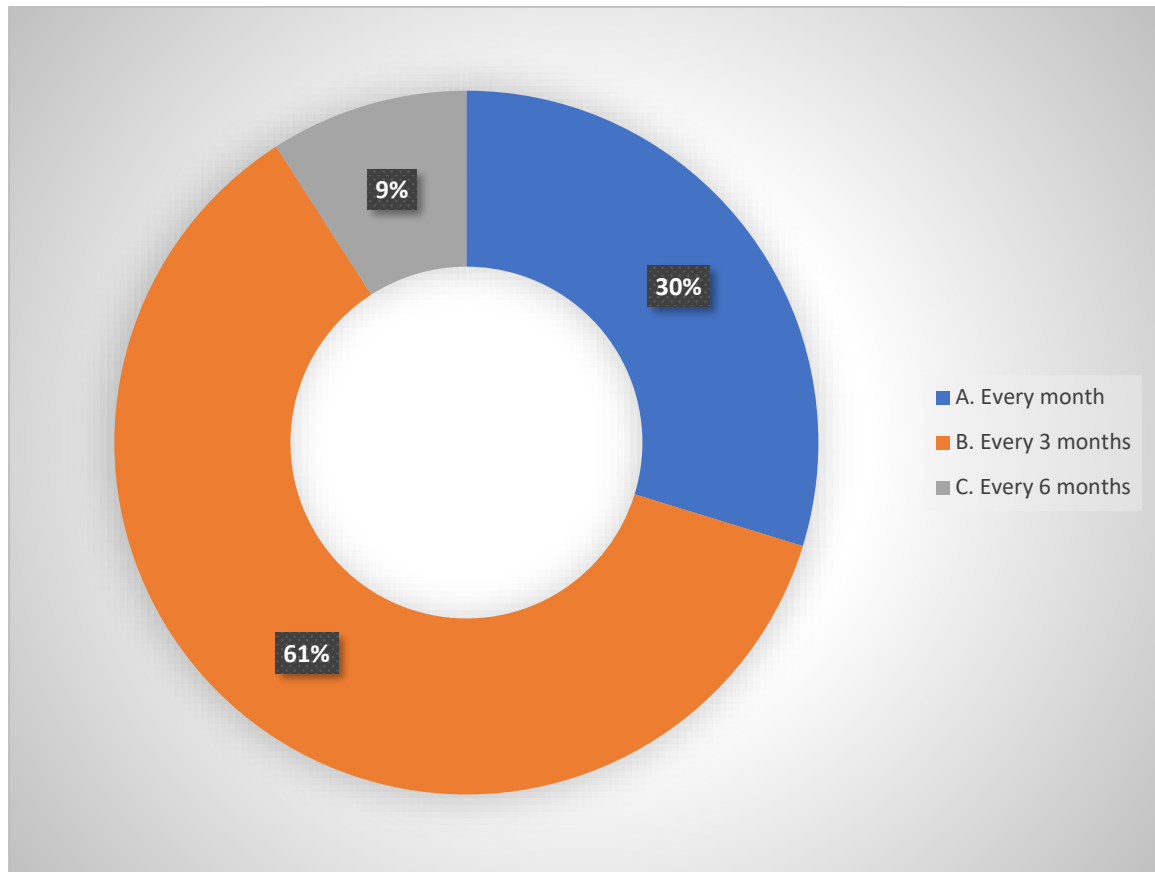
- A. Myalgia
- B. Constipation
- C. Insomnia
- D. Headache



- **Myalgia (71%):** Most clinicians prescribe Fenofibrate for patients intolerant to statins due to myalgia.
- **Constipation (22%) and Insomnia (2%):** Less commonly cited reasons.
- **Headache (5%):** Rarely cited as a reason.

15. How frequently do you schedule follow-up appointments to assess the lipid-lowering effects and overall health of patients on Rosuvastatin therapy?

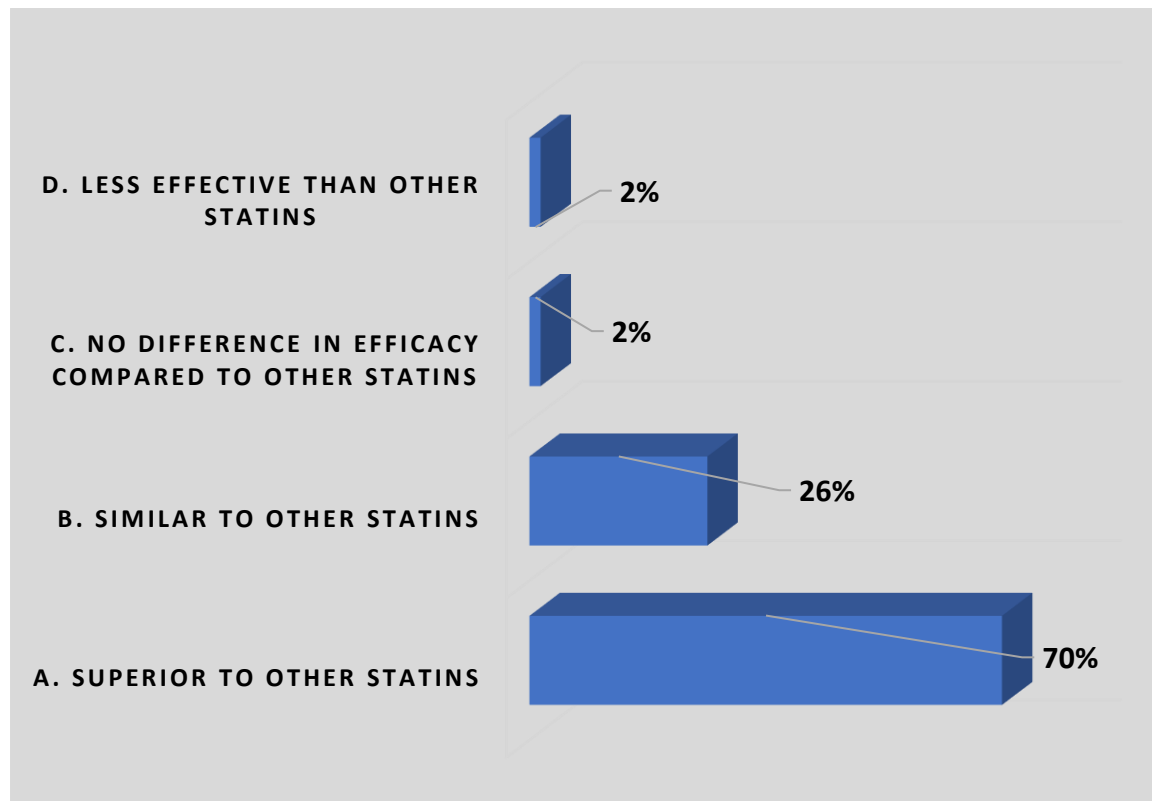
- A. Every month
- B. Every 3 months
- C. Every 6 months



- **Every 3 months (61%):** Most clinicians prefer this follow-up frequency to monitor therapy effects.
- **Every month (30%):** A significant portion opts for more frequent check-ups.
- **Every 6 months (9%):** A small group prefers less frequent follow-ups.

16. How do you perceive the overall efficacy of Rosuvastatin compared to other statins in your clinical practice?

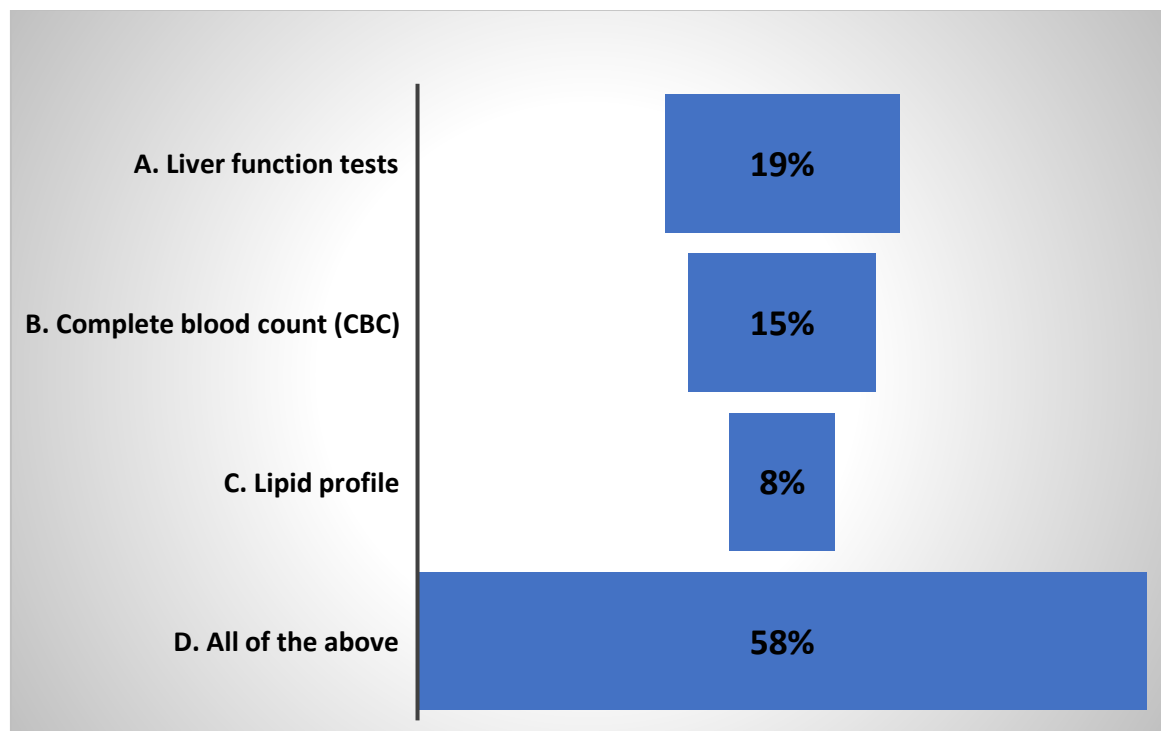
- A. Superior to other statins
- B. Similar to other statins
- C. No difference in efficacy compared to other statins
- D. Less effective than other statins



- **Superior to other statins (70%):** The majority of clinicians find Rosuvastatin more effective.
- **Similar to other statins (26%):** A notable minority views it as equally effective.
- **No difference in efficacy (2%) and Less effective (2%):** Very few clinicians find it less effective.

17. As per your clinical practice, which parameter(s) should be regularly monitored for those patients who are on long term treatment with Rosuvastatin + DAPT combination?

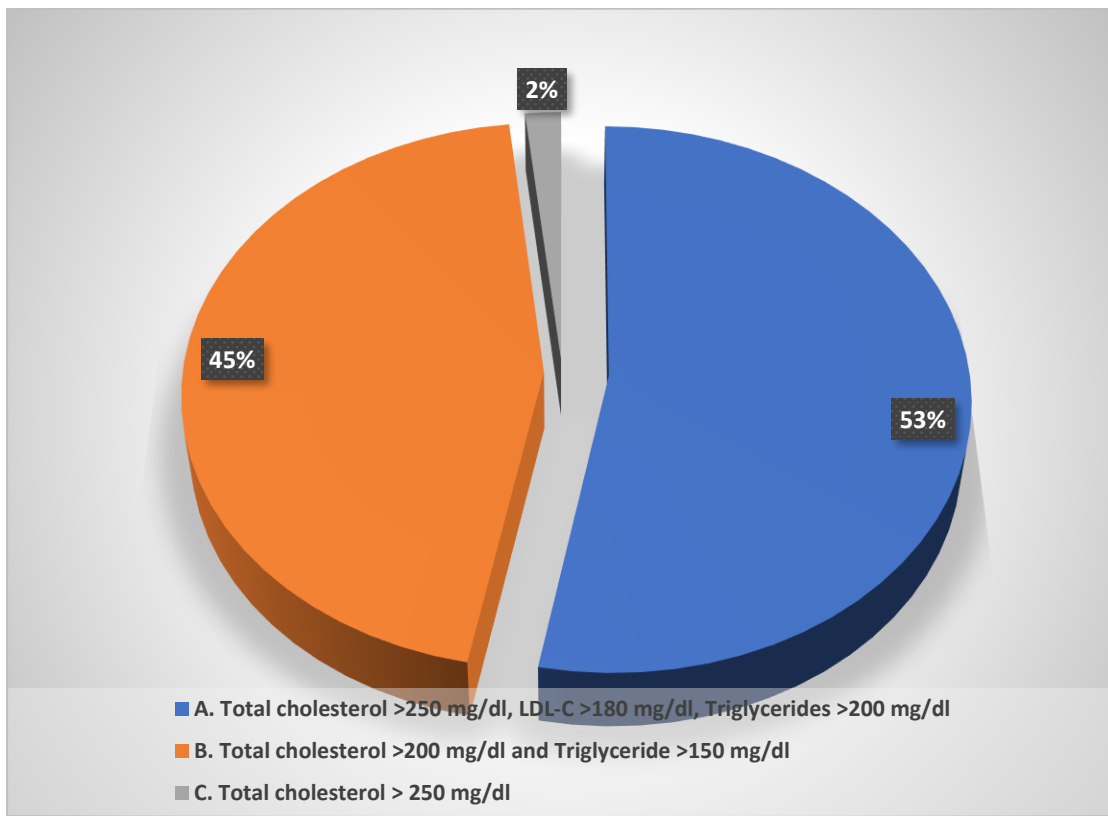
- A. Liver function tests
- B. Complete blood count (CBC)
- C. Lipid profile
- D. All of the above



- **All of the above (58%):** Most clinicians monitor liver function, CBC, and lipid profiles.
- **Liver function tests (19%):** Some focus specifically on liver function.
- **Complete blood count (15%) and Lipid profile (8%):** These are less commonly monitored individually.

18. When do you prefer to use Rosuvastatin + Fenofibrate combination?

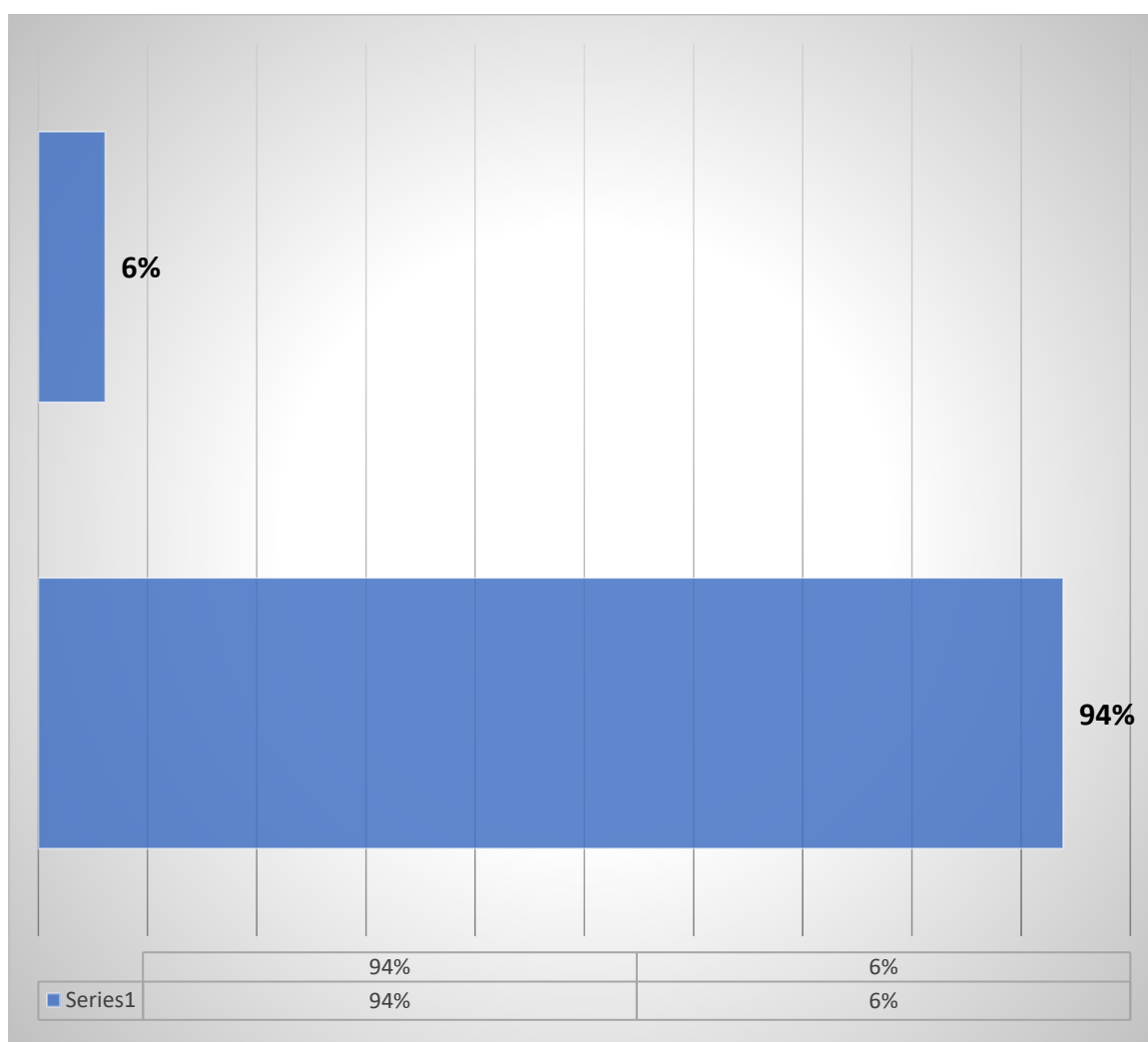
- A. Total cholesterol >250 mg/dl, LDL-C >180 mg/dl, Triglycerides >200 mg/dl
- B. Total cholesterol >200 mg/dl and Triglyceride >150 mg/dl
- C. Total cholesterol > 250 mg/dl



- **Total cholesterol >250 mg/dl, LDL-C >180 mg/dl, Triglycerides >200 mg/dl (53%):** The most common lipid profile triggering combination therapy.
- **Total cholesterol >200 mg/dl and Triglyceride >150 mg/dl (45%):** A significant portion of clinicians use this threshold.
- **Total cholesterol >250 mg/dl (2%):** Rarely used as the sole criterion.

19. What dose of Rosuvastatin do you prefer while prescribing FDC containing aspirin and Clopidogrel?

- A. 10 mg
- B. 20 mg
- C. Unsure

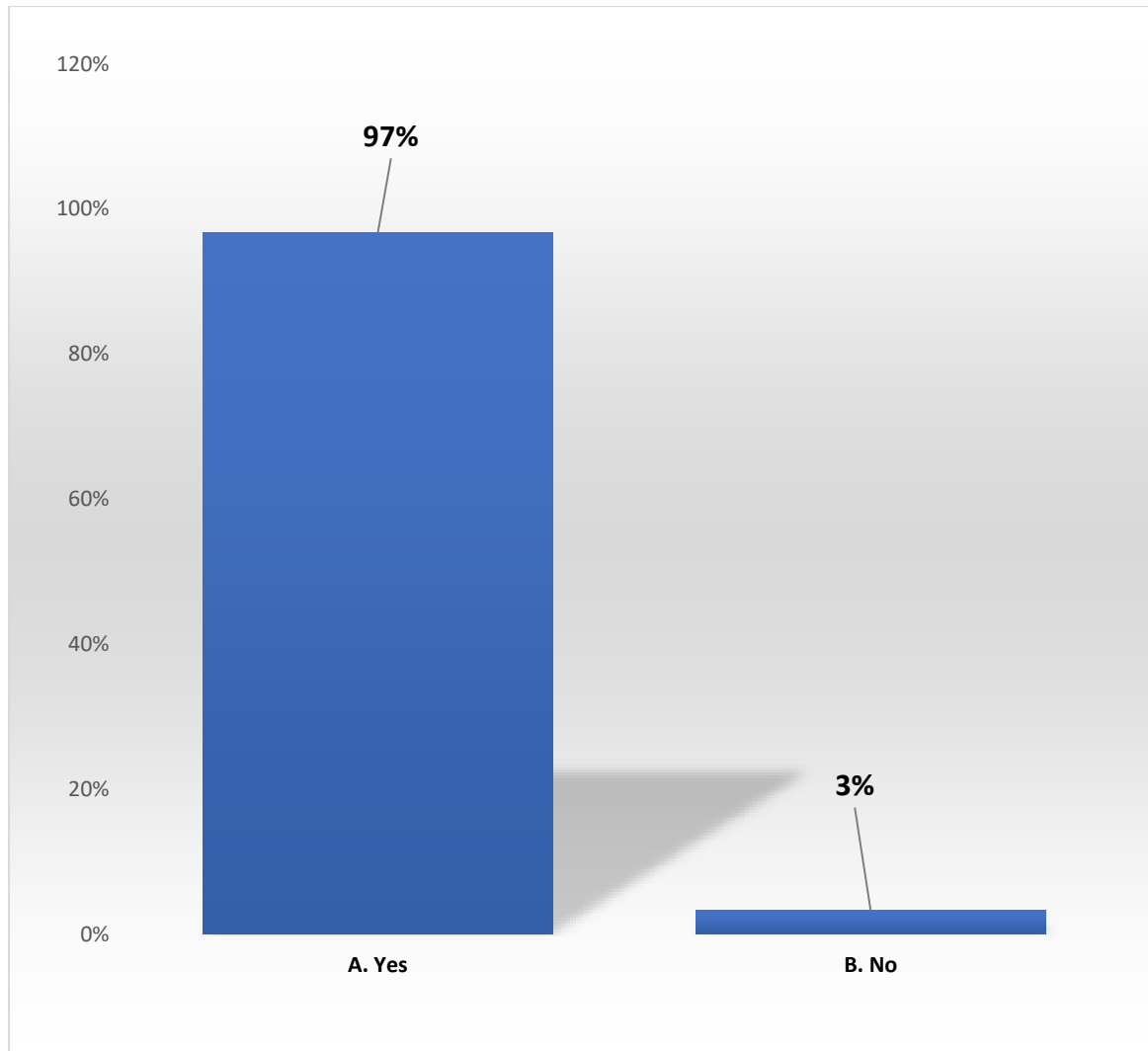


- **10 mg (94%):** The vast majority prefer this dose.
- **20 mg (6%):** A small group opts for a higher dose.

20. Do you think the cholesterol synthesis inhibitors are better tolerated than most other lipid-lowering agents?

A. Yes

B. No



- **Yes (97%):** Most clinicians believe cholesterol synthesis inhibitors are better tolerated than other lipid-lowering agents.
- **No (3%):** A small minority disagrees.

SUMMARY

This study provides valuable insights into the clinical practice of prescribing experiences and opinions on Rosuvastatin in Reducing Low-Density Lipoprotein Cholesterol (Ldl-C) ASCVD.

- ❖ **Familial Hypercholesterolemia Causes:** The predominant cause identified by clinicians is impairment of the cholesterol degradative pathway (47%), emphasizing the importance of cholesterol metabolism in this condition.
- ❖ **Cholesterol Transport:** Transport issues from extrahepatic tissues to the liver are noted by 33% of respondents as significant in familial hypercholesterolemia.
- ❖ **Cholesterol Uptake Impairment:** Only 14% cite impaired uptake of cholesterol by tissues as a cause, while 5% refer to deficiencies in HDL metabolism.
- ❖ **Prescription Frequency:** A remarkable 81% of clinicians consistently prescribe Rosuvastatin, demonstrating its strong acceptance in clinical practice.
- ❖ **Expected LDL Reduction:** The majority (57%) expect a 20-30% reduction in LDL levels with medium-intensity statins, reflecting realistic treatment expectations.
- ❖ **Combination Therapy Usage:** An overwhelming 96% of clinicians combine Rosuvastatin with other lipid-lowering therapies, indicating a preference for multi-drug strategies.
- ❖ **Dosing Adjustments:** Most clinicians (63%) prefer to titrate Rosuvastatin doses based on individual lipid responses to optimize efficacy.

- ❖ **Starting Dose Preference:** A significant 82% of clinicians typically initiate treatment with a 10 mg daily dose of Rosuvastatin.
- ❖ **Monitoring Lipid Profiles:** Regular monitoring is emphasized, with 61% of clinicians recommending lipid profile checks every 6 months.
- ❖ **Liver Function Monitoring:** The majority (59%) conduct liver function tests every 3 months during the first year of treatment, then annually.
- ❖ **Adverse Reactions Encountered:** A significant 62% of clinicians report experiencing intolerance or adverse reactions related to Rosuvastatin.
- ❖ **Concerns about Side Effects:** Most clinicians (88%) express concern regarding the potential for statin-induced myopathy or diabetes.
- ❖ **Key Contraindications:** Mild liver dysfunction is the most commonly cited contraindication for Rosuvastatin, mentioned by 49% of respondents.
- ❖ **Effects of Fenofibrate Combination:** 46% expect decreased triglyceride levels when combining Fenofibrate with Rosuvastatin.
- ❖ **Primary Conditions Treated:** The combination of Rosuvastatin and Fenofibrate is most frequently used for mixed dyslipidemia (60%).
- ❖ **Statin Intolerance Treatment:** Clinicians (71%) often prescribe Fenofibrate for patients experiencing myalgia due to statin intolerance.
- ❖ **Follow-Up Frequency:** Most clinicians (61%) prefer follow-up appointments every 3 months to monitor treatment effects.
- ❖ **Efficacy Compared to Other Statins:** 70% of respondents believe Rosuvastatin is more effective than other statins available.
- ❖ **Comprehensive Monitoring:** The majority (58%) advocate for monitoring liver function, CBC, and lipid profiles collectively during long-term treatment.

- ❖ **Indications for Combination Therapy:** The most common indication for combining Rosuvastatin with Fenofibrate is when total cholesterol exceeds 250 mg/dl, as indicated by 53% of clinicians.

In summary, the survey highlights a strong confidence in Rosuvastatin's effectiveness among clinicians, with a significant majority regularly prescribing it in combination with other therapies. There is a clear emphasis on individualized treatment strategies, with clinicians favoring titration based on lipid response and regular monitoring of both lipid profiles and liver function. Concerns regarding adverse reactions and statin-induced side effects remain prevalent, guiding prescribing practices and patient management. The findings underscore the importance of combining Rosuvastatin with other lipid-lowering agents to achieve optimal lipid control and manage complex dyslipidemia effectively.

DISCUSSION

Based on the survey data, The survey results indicate a strong reliance on Rosuvastatin among clinicians for managing low-density lipoprotein cholesterol (LDL-C) levels and reducing atherosclerotic cardiovascular disease (ASCVD) risk. The overwhelming majority (81%) of respondents prescribe Rosuvastatin regularly, highlighting its established role in clinical practice. However, concerns about side effects, particularly statin-induced myopathy and the risk of diabetes, remain prevalent among clinicians, with 88% expressing apprehension regarding these potential adverse reactions. This points to the necessity for ongoing education and communication about managing these risks while emphasizing the benefits of statin therapy.

The combination of Rosuvastatin with other lipid-lowering agents, particularly fenofibrate, is common, with 96% of clinicians incorporating multi-therapy strategies into their practice. This suggests a recognition of the complexity of

dyslipidemia management and a desire to tailor therapy to individual patient needs. The combination therapy approach, especially for mixed dyslipidemia, reinforces the importance of comprehensive treatment strategies in achieving optimal lipid control.

CLINICAL RECOMMENDATIONS

- **Patient Selection:** Clinicians should prioritize Rosuvastatin for patients with familial hypercholesterolemia and those with elevated ASCVD risk.
- **Dosing Strategy:** Initiating therapy with 10 mg of Rosuvastatin is recommended, with titration based on individual lipid response.
- **Monitoring Protocols:** Regular lipid profile assessments should occur every six months, alongside liver function tests every three months during the first year of treatment.
- **Addressing Side Effects:** Clinicians must actively monitor for adverse effects and educate patients about potential symptoms of statin intolerance.
- **Combination Therapy:** Employ Rosuvastatin in conjunction with other lipid-lowering agents, such as fenofibrate, especially in patients with mixed dyslipidemia.
- **Patient Education:** Inform patients about the importance of adherence to therapy and lifestyle modifications to enhance treatment efficacy.

CONSULTANT OPINION

Expert Consultants emphasize the need for a personalized approach to statin therapy. They advocate for thorough discussions with patients regarding the benefits and potential risks of Rosuvastatin. Furthermore, the integration of lifestyle changes alongside pharmacotherapy is essential for achieving desired outcomes in cholesterol management. Regular follow-up appointments and open communication channels between healthcare providers and patients are crucial for successful management.

MARKET OPPORTUNITIES

The landscape for lipid-lowering therapies in India is evolving, particularly with the rising incidence of cardiovascular diseases (CVD) linked to high levels of Low-Density Lipoprotein Cholesterol (LDL-C). As healthcare providers increasingly focus on effective management strategies for preventing Atherosclerotic Cardiovascular Disease (ASCVD), the demand for Rosuvastatin—a leading statin—continues to grow. The following market opportunities present significant avenues for promoting Rosuvastatin.

- **Growing Awareness of Cardiovascular Health:** With the increasing awareness of heart health, healthcare providers are prioritizing LDL-C management to reduce ASCVD risk. This trend highlights the need for effective statin therapies like Rosuvastatin.
- **Rising Incidence of Dyslipidemia:** The prevalence of dyslipidemia in India is escalating, driven by lifestyle changes, dietary habits, and increasing sedentary behavior. This surge necessitates effective lipid-lowering therapies.

- **Focus on Preventive Healthcare:** There is a growing emphasis on preventive healthcare, with a focus on early intervention strategies for at-risk populations. Rosuvastatin's proven efficacy in reducing LDL-C and ASCVD risk positions it favorably.
- **Expansion of Insurance Coverage:** The expansion of health insurance coverage in India is increasing access to lipid-lowering medications. This trend supports a broader market for Rosuvastatin, particularly among patients with insurance.
- **Pharmaceutical Collaborations:** Collaborations between pharmaceutical companies and healthcare institutions can facilitate awareness campaigns that educate healthcare providers and patients about the benefits of Rosuvastatin in managing cholesterol levels effectively.

MARKET POSITIONING

Effective market positioning of Rosuvastatin is essential to differentiate it from other statins and enhance its acceptance among healthcare providers and patients. The positioning strategy should emphasize its efficacy, safety, and specific advantages in managing cholesterol levels.

- **Highlight Efficacy in LDL-C Reduction:** Marketing efforts should focus on Rosuvastatin's superior ability to lower LDL-C levels compared to other statins, making it a preferred choice for clinicians seeking effective treatment options.
- **Demonstrate Cardiovascular Benefits:** The proven cardiovascular benefits associated with Rosuvastatin, including its role in reducing the risk

of ASCVD, should be emphasized in promotional materials to appeal to both healthcare providers and patients.

- **Target High-Risk Patient Segments:** Positioning Rosuvastatin as the go-to therapy for patients with established cardiovascular disease or those at high risk for ASCVD can enhance its market appeal. This includes individuals with comorbidities such as diabetes and hypertension.
- **Educate on Safety Profile:** Emphasizing the safety profile of Rosuvastatin, including its lower risk of muscle-related side effects compared to other statins, can help address concerns among patients and healthcare providers.
- **Leverage Digital Marketing Platforms:** Utilizing digital platforms to disseminate information and patient success stories can effectively raise awareness and acceptance of Rosuvastatin. Engaging healthcare providers through webinars and online educational resources can also enhance its positioning.
- **Encourage Long-Term Adherence:** Strategies to promote long-term adherence to Rosuvastatin therapy should be developed, including reminders and educational content about the importance of consistent cholesterol management in preventing ASCVD.

REFERENCES

1. World Health Organization. Global status report on noncommunicable diseases. Geneva: WHO; 2014.
2. Libby P. Inflammation in atherosclerosis. *Arterioscler Thromb Vasc Biol.* 2012;32(9):2045-2051.
3. Jellinger PS, et al. American Association of Clinical Endocrinologists' guidelines for management of dyslipidemia and prevention of atherosclerotic cardiovascular disease. *Endocr Pract.* 2017;23(Suppl 2):1-87.
4. Cholesterol Treatment Trialists' (CTT) Collaboration. Efficacy and safety of statin therapy in patients with cardiovascular disease. *Lancet.* 2010;376(9741):1670-1681.
5. Thokala E, et al. Cost-effectiveness of statins for primary prevention of cardiovascular disease. *Heart.* 2016;102(6):466-471.
6. Robinson JG, et al. Efficacy and safety of Rosuvastatin in patients with dyslipidemia: A systematic review. *Curr Atheroscler Rep.* 2016;18(6):54.
7. Wierzbicki AS, et al. Clinical implications of LDL-C reduction by statins: Evidence from clinical trials. *Expert Rev Cardiovasc Ther.* 2017;15(10):787-797.
8. Ruscica M, et al. The role of statins in familial hypercholesterolemia: Current management strategies. *Atherosclerosis.* 2018;275:206-216.
9. Ray KK, et al. Perspectives on the variability of statin prescribing practices. *Circulation.* 2019;139(10):1187-1198.
10. Stone NJ, et al. 2014 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. *Circulation.* 2014;129(25 Suppl 2)

11. Hlatky MA, et al. Importance of individualized therapy for managing cholesterol levels in high-risk patients. *J Am Coll Cardiol.* 2016;67(23):2767-2775.
12. Zhang H, et al. Statin-related myopathy: A critical review of the literature. *Expert Rev Cardiovasc Ther.* 2018;16(11):843-855.
13. Goldstein LB, et al. Clinical practices and preferences for statin use in patients at risk for CVD. *Stroke.* 2017;48(5):1365-1370.
14. Kearney PM, et al. Impact of statin therapy on clinical outcomes in patients with coronary artery disease. A systematic review and meta-analysis. *Eur Heart J.* 2019;40(29):2476-2484.
15. Mach F, et al. 2019 ESC/EAS Guidelines for the management of dyslipidaemias. *Eur Heart J.* 2020;41(1):111-188.

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