RISICOBEOORDELING	ZEER HOOG RISICO	HOOG RISICO	MATIG RISICO	LAAG RISICO
Cardio-vasculaire voorgeschiedenis	ASCVZ (klinisch/beeldvorming)	-	-	-
Diabetes	• Doelorgaanschade (microalbuminurie, retinopathie or neuropathie) • ≥ 3 belangrijke risicofactoren of • T1DM van > 20 jaar	• Geen doelorgaanschade • met ≥ 1 belangrijke risicofactor of • met duur van ≥ 10 jaar (T1DM of T2DM)	Jonge patiënten • T1DM < 35 jaar oud • T2DM < 50 jaar oud met DM duur < 10 jaar zonder andere risicofactoren	-
Nierfunctie	eGFR < 30 mL/min/1,73m²	eGFR 30 – 59 mL/min/1,73m²	-	-
Erfelijke factor	FH & ASCVZ of andere belangrijke risicofactor	FH zonder andere belangrijke risicofactoren	-	-
Geïsoleerde risicofactoren	-	• BD > 180/110 mmHg of • TC > 310 mg/dL of • LDL-C > 190 mg/dL	-	-
SCORE *10-jaars risico op fatale ASCVZ*	≥ 10%	≥ 5% en < 10%	≥ 1% en < 5%	<1%

1ste TARGET	LDL-C	< 40 mg/dL** Klasse IIb	< 55 mg/dL **EN** ≥ 50% reductie* Klasse I	< 70 mg/dL **EN** ≥ 50% reductie* Klasse I	< 100 mg/dL Klasse IIa	< 116 mg/dL Klasse IIb
2de TARGET	Non-HDL-C OF ApoB	< 85 mg/dL < 65 mg/dL		< 100 mg/dL < 80 mg/dL	< 130 mg/dL < 100 mg/dL	
	Interventie	1. Levensstijl aanpassen EN Statine met hoge intensiteit 2. EZETIMIBE 3. PCSK9 inhibitor Lipidenniveaus moeten 4-6 weken na ACS opnieuw worden geëvalueerd		1. Levensstijl aanpassen 2. Statine met hoge intensiteit 3. EZETIMIBE	1. Levensstijl aanpassen 2. Statine	Levens-stijl advies

ASCVZ: Atherosclerotische Cardiovasculaire ziekte/ *Vanaf onbehandelde waarde/ FH: familiale hypercholesterolemie/DM: liabetes mellitus/BD: bloeddruk/TC:totaal cholesterol; **:zie tekst

Descamps OS et aL; Louvain Medical 2020; 139 : 3-11.

Vrouw

Vermenigvuldig SCORE met

HDL-C (mg/dl)	
< 23	2,4
≥ 23	2,2
≥ 26	2
≥ 28	1,9
≥ 30	1,8
≥ 33	1,7
≥ 37	1,5
≥ 40	1,4
≥ 43	1,3
≥ 46	1,2
≥ 49	1,1
≥ 53	1
≥ 56	0,9
≥ 60	0,8
≥ 65	0,7
≥ 69	0,6
≥ 74	0,5
≥ 80	0,4

Familiale antecedenten van premature ASCVZ	
positief	X 1,7

Systolische bloeddruk (mm Hg)

	Niet Roker				Leeftijd	Roker			
≥ 170	8	10	13	16	≥ 68	16	20	24	30
≥ 150	6	7	9	11		12	14	18	22
≥ 130	4	5	6	8		8	10	13	15
< 130	3	3	4	5		6	7	9	11
≥ 170	5	6	8	9	≥ 63	10	12	15	18
≥ 150	3	4	5	7		7	8	10	13
≥ 130	2	3	4	5		5	6	7	9
< 130	2	2	3	3		3	4	5	6
≥ 170	3	4	4	6	≥ 58	6	7	9	11
≥ 150	2	2	3	4		4	5	6	8
≥ 130	1	2	2	3		3	3	4	5
< 130	1	1	1	2		2	2	3	4
≥ 170	2	2	3	3	≥ 53	3	4	5	7
≥ 150	1	1	2	2		2	3	4	5
≥ 130	1	1	1	2		2	2	3	3
< 130	1	1	1	1		1	1	2	2
≥ 170	1	1	2	2	≥ 48	2	2	3	4
≥ 150	1	1	1	1		1	2	2	3
≥ 130	0	1	1	1		1	1	2	2
< 130	0	0	1	1		1	1	1	1
≥ 170	0	0	1	1	< 48	1	1	1	1
≥ 150	0	0	0	0		1	1	1	1
≥ 130	0	0	0	0		0	0	1	1
< 130	0	0	0	0		0	0	0	0
	< 175	≥ 175	≥ 225	≥ 275		< 175	≥ 175	≥ 225	≥ 275

Totaal cholesterol (mg/dL)

Man

Vermenigvuldig SCORE met

HDL-C (mg/dl)	
< 23	1,6
≥ 23	1,4
≥ 27	1,3
≥ 31	1,2
≥ 36	1,1
≥ 41	1
≥ 47	0,9
≥ 55	0,8
≥ 63	0,7
≥ 72	0,6
≥ 83	0,5

Familiale antecedenten van premature ASCVZ	
positief	X 2

Systolische bloeddruk (mm Hg)

	Niet roker				Leeftiid	Roker			
≥ 170	15	18	22	27	≥ 68	28	34	41	48
≥ 150	10	13	16	20		20	25	30	36
≥ 130	7	9	11	14		15	18	22	27
< 130	5	6	8	10		10	13	16	19
≥ 170	10	12	15	18	≥ 63	19	23	28	34
≥ 150	7	8	11	13		13	17	20	25
≥ 130	5	6	7	9		9	12	15	18
< 130	3	4	5	6		7	8	10	13
≥ 170	6	8	10	12	≥ 58	12	15	19	23
≥ 150	4	5	7	8		9	11	13	17
≥ 130	3	4	5	6		6	8	9	12
< 130	2	3	3	4		4	5	7	8
≥ 170	4	5	6	8	≥ 53	8	10	12	15
≥ 150	3	3	4	5		6	7	9	11
≥ 130	2	2	3	4		4	5	6	8
< 130	1	2	2	3		3	3	3	5
≥ 170	2	3	4	5	≥ 48	5	6	8	10
≥ 150	2	2	3	3		3	4	5	7
≥ 130	1	1	2	2		2	3	4	5
< 130	1	1	1	2		2	2	2	3
≥ 170	1	1	1	2	< 48	2	2	3	4
≥ 150	1	1	1	1		1	2	2	2
≥ 130	0	1	1	1		1	1	1	2
< 130	0	0	0	1		1	1	1	1
	< 175	≥ 175	≥ 225	≥ 275		< 175	≥ 175	≥ 225	≥ 275

Totaal cholesterol (mg/dL)

nieuwe richtlijnen rond VKF 2020 ABC

A anticoagulatie

B betere symptoom controle

C Cardiale risicofactoren en behandeling van cardiale ziekten

Table 8 CHA_2DS_2-VASc score[334]

CHA_2DS_2-VASc score Risk factors and definitions		Points awarded	Comment
C	**Congestive heart failure** Clinical HF, or objective evidence of moderate to severe LV dysfunction, or HCM	1	Recent decompensated HF irrespective of LVEF (thus incorporating HFrEF or HFpEF), or the presence (even if asymptomatic) of moderate-severe LV systolic impairment on cardiac imaging[335]; HCM confers a high stroke risk[336] and OAC is beneficial for stroke reduction.[337]
H	**Hypertension** or on antihypertensive therapy	1	History of hypertension may result in vascular changes that predispose to stroke, and a well-controlled BP today may not be well-controlled over time.[324] Uncontrolled BP - the optimal BP target associated with the lowest risk of ischaemic stroke, death, and other cardiovascular outcomes is 120 - 129/<80 mmHg.[338]
A	**Age 75 years or older**	2	Age is a powerful driver of stroke risk, and most population cohorts show that the risk rises from age 65 years upwards.[339] Age-related risk is a continuum, but for reasons of simplicity and practicality, 1 point is given for age 65 - 74 years and 2 points for age ≥75 years.
D	**Diabetes mellitus** Treatment with oral hypoglycaemic drugs and/or insulin or fasting blood glucose >125 mg/dL (7 mmol/L)	1	Diabetes mellitus is a well-established risk factor for stroke, and more recently stroke risk has been related to duration of diabetes mellitus (the longer the duration of diabetes mellitus, the higher the risk of thromboembolism[340]) and presence of diabetic target organ damage, e.g. retinopathy.[341] Both type 1 and type 2 diabetes mellitus confer broadly similar thromboembolic risk in AF, although the risk may be slightly higher in patients aged <65 years with type 2 diabetes mellitus compared to patients with type 1 diabetes mellitus.[342]
S	**Stroke**Previous stroke, TIA, or thromboembolism	2	Previous stroke, systemic embolism, or TIA confers a particularly high risk of ischaemic stroke, hence weighted 2 points. Although excluded from RCTs, AF patients with ICH (including haemorrhagic stroke) are at very high risk of subsequent ischaemic stroke, and recent observational studies suggest that such patients would benefit from oral anticoagulation.[343–345]
V	**Vascular disease** Angiographically significant CAD, previous myocardial infarction, PAD, or aortic plaque	1	Vascular disease (PAD or myocardial infarction) confers a 17 - 22% excess risk, particularly in Asian patients.[346–348] Angiographically significant CAD is also an independent risk factor for ischaemic stroke among AF patients (adjusted incidence rate ratio 1.29, 95% CI 1.08 - 1.53).[349] Complex aortic plaque on the descending aorta, as an indicator of significant vascular disease, is also a strong predictor of ischaemic stroke.[350]
A	**Age 65 – 74 years**	1	See above. Recent data from Asia suggest that the risk of stroke may rise from age 50 - 55 years upwards and that a modified CHA_2DS_2-VASc score may be used in Asian patients.[351,352]
Sc	**Sex category (female)**	1	A stroke risk modifier rather than a risk factor.[353]
Maximum score		**9**	