Member Spotlight: A personal and professional journey

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Note: We have been hearing good things about Dr. Rolando deGoma's NJ Preventive Cardiology and Cholesterol Clinic, and he was kind enough to give an interview with the *Lipid Spin*. This is the story of how his practice has adopted many of the hallmarks of a successful lipid clinic. Those seeking to incorporate more lipid-focused treatment and counseling concepts into their work will undoubtedly find much to consider here. –ed

In the beginning

In private practice for over 25 years, Dr. deGoma was focused primarily on the diagnosis and treatment of heart disease, and many of his patients were in secondary prevention. As a result, he was treating patients' lipids, high blood pressure, and lifestyle risk factors such as smoking.

When the results of the Lipid Treatment Assessment Program (L-TAP) were published in February 2000, Dr. deGoma took careful note on the findings which compiled surveys of primary care doctors, noting how many are complying with NCEP guidelines. These were high statin prescribers, so it was surprising to see how few were getting their patients to goal (only 18% of patients with coronary heart disease were being treated to the target of less than 100 mg/dL, and 72% were either not treated or treated inadequately). At about the same time, Dr. deGoma's cardiology group participated in similar retrospective compliance study expecting to see better performance. Much to his surprise, cardiologists did not significantly do a better job. It was at this point that Dr. deGoma decided to pursue a greater knowledge of lipidology. "I started to look around, wondering how I could do a better job. If there is a drug that reduces event rates by nearly half, that is safe and nearly 95% of patients can take, that is covered by insurance and even has guidelines telling me which patients to treat, and I thought I was treating them but wasn't, there is something wrong here. But in 2001 there was little support for prevention," he recalls.

> "I could do more, but not less"

Fortunately, Dr. deGoma was able to obtain informal preceptorships at several lipid clinics, spending a few days at both Dr. Daniel Rader's and Dr. Paul Ziajka's clinics. These were profound influences on Dr. deGoma and these well known experts had a major influence on him. In addition, Dr. Ziajka introduced Dr. deGoma to the Southeast Lipid Association (this was in the pre-NLA days). At this point, Dr. deGoma began to seek ways to incorporate lipidology as a form of preventive cardiology in his practice.

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Building up a practice based on risk reduction

In his studies, it became apparent to Dr. deGoma that *compliance* was a key issue for both primary care physicians and cardiologists, who weren't getting many patients to goal, and for patients, who often do not adhere to their recommended treatment plan. "I began to audit my own practice," he says, "taking just 5 minutes at the end of every day to review my cases and check my own progress." Later, at a

SELA meeting, a member of the NCEP ATP III expert panel pointed out that the ATP III guidelines were only 'mere suggestions,' which surprised Dr. deGoma. "I decided to elevate the ATP III to my minimum standard of care. I can do more, but not less."

Determined to go beyond the guidelines and press for powerful levels of risk reduction, Dr. deGoma began to analyze his patient base and his opportunities for intervention. He witnessed how coronary heart disease (CHD) impacted patients' lives and families, how many patients in a cardiology practice seem to be in a revolving door of tests, procedures and surgeries. Deciding to reformat the guidelines in a way that he could implement them sensibly into his practice, Dr. deGoma broke them down into steps that could be implemented on first, second, third and subsequent visits. "A lipid management plan should be part of every routine cardiology visit, but it also needs to be implemented in a cost-effective manner. Every patient encounter is an opportunity for prevention," he says. If a patient presents for any cardiac evaluation, a formal cardiac risk assessment is incorporated into the visit and a treatment plan enacted, with modification if necessary on follow-up visits.

Dr. deGoma counsels a patient regarding risk.

"We know that lipid medication is very safe," Dr. deGoma says, "so I decided to start with fairly high doses of statins when medication was indicated. The mean effects of each dose of statin on each lipid parameter are known. One of the problems seen in the L-TAP study was that many patients were not at goal because they were still on their initial starting statin dose 2 years later. The initial dose of a selected statin should get the majority of patients to their LDL-C goal. An LDL-C goal below 100 mg/dL does not mean that the goal is 99. Ninety-nine is acceptable but 69 is better." As a result, his patients began to reach and exceed their lipid level goals at impressive rates. This wound up to have disadvantages. "I was the biggest supporter of intervention in my group before. Our group's interventional cardiologist eventually left our practice after 3 years because we were referring fewer and fewer patients to him." Dr. deGoma published and presented clinical data from his practice at the 29th Society of General Internal Medicine (SGIM) Annual Meeting. Unlike the results of L-TAP, in deGoma's practice some 85% of high-risk patients were treated successfully to LDL cholesterol below 100 mg/dL. Not only were just 15% not at goal, but he had more patients with LDL-C below 50 mg/dL than over 130 mg/dL.

Bringing patients into the treatment team

During follow up visits, all of Dr. deGoma's patients end up in his consultation room after the exam room for discussion and patient mentoring. "I say to every patient after my examination, 'Get dressed and we will talk in my office.' Patient mentoring is incorporated in my website to provide a visual tool that makes it easier for my patients to grasp what I am explaining," he says, "Physicians are not just healers, but also mentors and motivators." He uses his consultation time based on the needs of the patient, explaining treatment strategies, answering questions, and working with the patient to set goals. "For secondary prevention patient, I might show a 4S trial slide, and for primary prevention, a AFCAPS/TexCAP or JUPITER trial slide" he says, "showing the magnitude of risk reduction—42% reduction in fatal heart attack, 37% reduction in need of future heart bypass, 30% reduction in stroke in the 4S or showing the early onset of benefits in the ASCOT trial, or early termination of the JUPITER trial after only 19 months due to benefits." There's more: "Patients might ask me what is LDL, they might have a misconception. I can show them cholesterol in the arterial wall or my YouTube video. I can show them what plaque looks like on intravascular imaging, and walk them through concepts like oxidation, progression and plaque rupture." This may sound too time-consuming for a busy practitioner, but this approach is a key part of Dr. deGoma's impressive results. By showing patients how primary prevention is better than secondary, and how optimal lipid therapy breaks the recurring cycle of events in secondary prevention and showing the risk reduction achieved by various measures, he gets them to understand their role in reducing their CHD risk.

"You have to be effective with your time,"

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Dr. deGoma cautions. "You may have been speaking with a patient for 5 or 15 minutes on an issue. I use customized forms to shorten the time needed for writing and documentation." He also has developed an impressive website at www.deGomaMD.com, where you can view many of his patient counseling materials.

He asks his patients directly, "You tell me how much prevention you want—40%? You are at high risk, almost the same as if you were in secondary prevention. Do you know someone who died suddenly of heart attack? We have to lose some weight, change your profile, get exercise, stop smoking." Dr. deGoma adds, "I can show how they can reduce their risk by 70%—and nobody ever says, 'I only want 0% reduction. Given the choice, most high risk patients will choose the maximum possible evidence-based prevention." The ultimate goal of treatment, after all, is to reduce events.

"Heal thyself"

What happens to a practice with many high-risk patients after 9 years of aggressive lipid therapy? "It's incredible!" Dr. deGoma says. In 2004, Dr. Michael Wolk, then president of the ACC, published an editorial titled, *The Promise of Prevention—So,why aren't all cardiologists preventive?* This was an encouragement to Dr. deGoma, as it underscored his being on the right track, evolving his practice as cardiology itself continues to evolve.

Another important way he motivates his patients is by sharing with them his own cardiology experiences. Taking advantage of an opportunity to take a free EBT test for coronary artery calcification, he found that he had a significant calcium score, and so Dr. deGoma became his own patient. "I have experienced muscle aches and muscle weakness with 2 of the 3 potent statin drugs available. I discontinued niacin 3 times due to almost unbearable itching and flushing but persevered on the fourth attempt (after the EBT) and overcame the side effects after 6 months. I used aggressive combination therapy to halt disease progression and hopefully, even cause some regression by reducing my LDL-P below 1,000, my LDL-C below 70 and raising my HDL-C to over 50," he says. This helps him both empathize with the challenges his patients face, and gives him credibility with them. He tells a patient that, "I can do for you what I do for myself," he becomes both a reliable source of information to the patient and also a behavioral motivator.

The future of CVD prevention

Clinical trials of statin medications often show a 40% reduction in risk. "The 4S trial ended after 5 years, the JUPITER trial ended after less than 2 years, but in practice you don't stop," Dr. deGoma says. "So in clinical practice, you see the clinical events dropping steadily." He founded NJ Preventive Cardiology and Cholesterol Clinic in 2004, with the thought of incorporating lipid treatment in a regular cardiology practice. "The traditional lipid clinic model cannot treat the over 40 million Americans eligible for lipid drug treatment, even more if you add in those at intermediate risk with significant coronary calcification, high hs-CRP or increased CIMT. We should empower all medical practices to become basic lipid clinics. The solution is more education and a widely available, cost-effective preventive care delivery system that minimizes regional variations in quality." Speaking of which, Dr deGoma became a board member of the Northeast Lipid Association, and he has worked to help the NLA be a strong voice for CVD prevention. A Diplomate of the American Board of Clinical Cardiology, he is also a Fellow of the NLA.

Dr. deGoma knows he is ahead of many in his profession, but notes that according to the Institute of Medicine, it takes an average of 16 years for a new mode of treatment to become widely implemented in clinical practice. "We need changes in reimbursement, to create more incentives for physicians, patients and insurance companies," he says, "Some of my colleagues thought I was crazy when I started. Cholesterol wasn't part of my training. I was too busy in my practice to acquire new skills. The young generation of physicians have a chance to get on board this concept."

In cardiology, the goal of treatment is relief of symptoms, such as shortness of breath in congestive heart failure. Dr. deGoma observes that, "Prevention is a different approach. It requires reaching specific numeric targets, not symptom relief, and we're not used to that. After 5 years, I've developed a numerically goal-oriented clinical information management system." The future of cardiology, he feels, will not lie in more aggressive intervention, but in more aggressive prevention. He summarizes his experience by saying, "My personal and professional journey to prevention took longer than my 3-year cardiology fellowship more than 25 years ago, but it changed the way I practice cardiology. Prevention is the missing component of cardiac care." ■

For clinical tips and downloads, please visit **www.deGomaMD.com/PracticalTips.htm**. Dr. deGoma discusses the following topics:

1. How to use the Cyber Dietitian.
2. How to make yourself known in your community as a certified lipidologist—putting all the pieces together.
3. EZ Daily LDL Chart Audit
4. EZ Cardiovascular Risk Assessment