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Optimizing Primary Cardiovascular Prevention for Psychiatric Patients

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Abstract

Persons with psychiatric diagnoses are at a disproportionately high risk for cardiovascular disease mediated by the cardiovascular-kidney-metabolic syndrome. While lifestyle interventions are foundational for promoting heart health, behavioral initiatives alone often fall short in achieving attainable goals. GLP-1 receptor agonists are now FDA approved for treating obesity and diabetes mellitus. Statins are available for treating dyslipidemia to targets in the PREVENT risk calculator in the 2026 guidelines of the American Heart Association (AHA). Low-dose aspirin use is currently recommended for persons at intermediate risk by the American College of Cardiology (ACC). Such use by persons with subclinical coronary atherosclerosis identified by coronary artery calcium scoring (CACS) likely provides enhanced prevention. Incorporating these approaches into the primary care of psychiatric patients may thereby mitigate excess morbidity and mortality due to atherosclerotic cardiovascular disease (ASCVD) associated with psychiatric disorders.

Keywords: Primary cardiovascular prevention, Psychiatric disorders

Lifestyle Interventions (and GLP-1 Receptor Agonists) to Promote Heart Health

Both psychiatric illnesses and the side effects of some of the medications used for treatment make it difficult for patients to successfully incorporate the American Heart Association's six pillars of a heart-healthy lifestyle into their daily lives: participation in physical activity, plant-based diet, restorative sleep, social connectedness, and avoidance of addictive substances including tobacco and alcohol. The high prevalence of the cardiovascular-kidney-metabolic syndrome among persons with mental health disorders accounts for the excess in cardiovascular risk [1]. It is appropriate to emphasize that most major psychiatric disorders interfere with compliance to many of these lifestyle recommendations due to dynamics inherent in these disorders.

While incremental improvement in the lifestyle domain remains the foundation of primary cardiovascular prevention, pharmacotherapies are currently available to support persons with mental health conditions in reducing their risk for the cardiovascular-kidney-metabolic syndrome [1,2]. GLP-1 receptor agonists are FDA-approved to treat obesity and diabetes mellitus. Covered by Medicare, these agents are recently available for oral administration. One such agent (tirzepatide) has recently been FDA approved to reduce the risk for major acute cardiac events in patients with type 2 diabetes mellitus [2]. Patients with schizophrenia may especially benefit from GLP-1 receptor agonists for treatment and perhaps prevention of obesity and diabetes, which are adverse effects of some second-generation antipsychotic medications [3,4].

Treatment of Dyslipidemia

The 2026 American Heart Association/American College of Cardiology (AHA/ACC) dyslipidemia guidelines include the PREVENT (Predicting Risk of cardiovascular disease EVENTs) risk calculator, which lowered LDL treatment goals, reflecting evidence that "lower is better" for those at higher risk [5]. Under the updated guidelines, the recommended LDL level in the blood varies according to a patient's baseline cardiovascular risk. The higher a person's overall risk, the lower the LDL should be. It is incumbent therefore that primary care clinicians calculate the patient's status according to the PREVENT equation to prescribe treatment with statins to achieve the individualized target goal. The 2026-dyslipidemia

guidelines substantially expand the proportion of the US population eligible for primary prevention with statin therapy [6].

New recommendations are to initiate statin treatment for an LDL >160 mg/dl or higher for primary prevention in persons at low baseline risk, in contrast to a target below 55 mg/dl for secondary prevention in persons with established heart disease. These guidelines indicate the importance of knowing a patient's baseline LDL number in order to determine a target goal by the PREVENT equation [6].

Treatment of Inflammation

Beyond dyslipidemia, systemic inflammation is a co-promotor of progressive atherosclerotic cardiovascular disease, causing major acute cardiac events including sudden cardiac death. Aspirin use guided by coronary artery calcium scanning for enhanced risk stratification has been used to identify those with significant subclinical coronary heart disease to reduce the proximate risk for major acute cardiac events [7,8]. Current guidelines of the AHA/ACC recommend the addition of the CACS to the results of the PREVENT equation, which improves its predictive utility [9,10]. Persons with coronary artery calcium scores greater than 100 Agatston units likely benefit from low-dose aspirin use in the absence of contraindications in addition to statins for enhanced risk reduction.

The above approach is especially relevant for patients with major psychiatric disorders such as schizophrenia, which confers up to a 10-year decrease in life expectancy due primarily to atherosclerotic coronary vascular disease (ASCVD) [11]. There is additionally a 5-fold increase in risk in such patients for sudden cardiac death, which is the presenting symptom in 40% of fatalities due to ASCVD at large [12]. Treatment with aspirin for patients at intermediate risk by CACS may thereby attenuate their heightened risk for sudden cardiac death. Beyond patients with schizophrenia, persons with anxiety disorders and depression are also disproportionately vulnerable to excess risk for cardiovascular events [13,14].

Low-dose aspirin for its anti-inflammatory benefits may be recommended with statins, which the 2026 guidelines also consider for treating elevations in lipoprotein(a). Inflammatory biomarkers such as high-sensitivity C-reactive protein (hs-CRP), which independently predict residual cardiovascular risk beyond dyslipidemia, may likewise be an indication for low-dose aspirin use. Recent reports also indicate that glucagon-like peptide-1 receptor agonists (GLP-1s) may be associated with reductions in inflammation as assessed by sequential changes in this biomarker.

Psychiatrists are encouraged to refer appropriate patients to primary care providers to optimize primary cardiovascular prevention using the three-pronged approach considered herein [15]. Such collaborative care may serve to close the gap in the availability of primary cardiovascular preventative services for patients with mental health disorders, mitigating systematic bias embedded in the healthcare system. Improving cardiovascular outcomes in patients with serious psychiatric illness is presently a realistic and achievable goal.

Takeaways

- Oral GLP-1 receptor agonists are FDA-approved to treat obesity and diabetes mellitus.
- Statins are indicated to treat dyslipidemia to targets in the PREVENT equation in the 2026 AHA/ACC guidelines.
- Low-dose aspirin use is advised herein for persons with sub-clinical coronary atherosclerosis by results of CACS.

Conflicts of Interest

None.

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