# What's New in the New ACC/AHA Dyslipidemia Guidelines?

**Michael J. Blaha, MD, MPH**
Professor of Cardiology and Epidemiology
Director of Clinical Research
Director of Cardiometabolic Clinic
Johns Hopkins Ciccarone Center for the Prevention of Cardiovascular Disease
Director of the Preventive Cardiology fellowship at Johns Hopkins
Baltimore, MD



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## Disclosure

Advisory Board: Bayer; Boehringer Ingelheim; Eli Lilly; Idorsia; Merck; New Amsterdam; Novartis; Novo Nordisk

Consultant: Scene Health

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Speaker's Bureau: Boehringer Ingelheim; Novo Nordisk



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# Learning Objectives

1. Describe the new features of the 2026 ACC/AHA Dyslipidemia Guidelines Learning
2. Understand the role of lipoprotein(a), coronary artery calcium scores, and LDL-C goals in clinical practice
3. Explain the implications of high risk vs. very high risk in secondary ASCVD prevention

CONTINUING EDUCATION COMPANY

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Table 1.
Applying Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care

| CLASS (STRENGTH) OF RECOMMENDATION | LEVEL (QUALITY) OF EVIDENCE‡ |
|---|---|
| **CLASS 1 (STRONG)**<br>**Benefit >>> Risk**<br>**Suggested phrases for writing recommendations:**<br>• Is recommended<br>• Is indicated/useful/effective/beneficial<br>• Should be performed/administered/other<br>• Comparative-Effectiveness Phrases†:<br>– Treatment/strategy A is recommended/indicated in preference to treatment B<br>– Treatment A should be chosen over treatment B | **LEVEL A**<br>• High-quality evidence‡ from more than 1 RCT<br>• Meta-analyses of high-quality RCTs<br>• One or more RCTs corroborated by high-quality registry studies |
| **CLASS 2a (MODERATE)**<br>**Benefit >> Risk**<br>**Suggested phrases for writing recommendations:**<br>• Is reasonable<br>• Can be useful/effective/beneficial<br>• Comparative-Effectiveness Phrases†:<br>– Treatment/strategy A is probably recommended/indicated in preference to treatment B<br>– It is reasonable to choose treatment A over treatment B | **LEVEL B-R (Randomized)**<br>• Moderate-quality evidence‡ from 1 or more RCTs<br>• Meta-analyses of moderate-quality RCTs |
| **CLASS 2b (Weak)**<br>**Benefit ≥ Risk**<br>**Suggested phrases for writing recommendations:**<br>• May/might be reasonable<br>• May/might be considered<br>• Usefulness/effectiveness is unknown/unclear/uncertain or not well-established | **LEVEL B-NR (Nonrandomized)**<br>• Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies<br>• Meta-analyses of such studies |
| **CLASS 3: No Benefit (MODERATE)**<br>**Benefit = Risk**<br>**Suggested phrases for writing recommendations:**<br>• Is not recommended<br>• Is not indicated/useful/effective/beneficial<br>• Should not be performed/administered/other | **LEVEL C-LD (Limited Data)**<br>• Randomized or nonrandomized observational or registry studies with limitations of design or execution<br>• Meta-analyses of such studies<br>• Physiological or mechanistic studies in human subjects |
| **CLASS 3: Harm (STRONG)**<br>**Risk > Benefit**<br>**Suggested phrases for writing recommendations:**<br>• Potentially harmful<br>• Causes harm<br>• Associated with excess morbidity/mortality<br>• Should not be performed/administered/other | **LEVEL C-EO (Expert Opinion)**<br>• Consensus of expert opinion based on clinical experience. |

COR and LOE are determined independently (any COR may be paired with any LOE).

COR indicates Class of Recommendation; EO, expert opinion; LD, limited data; LOE, Level of Evidence; NR, nonrandomized; R, randomized; and RCT, randomized controlled trial.

American Heart Association.

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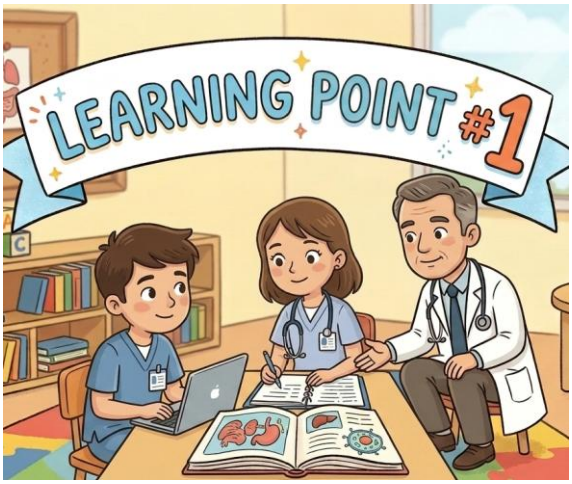
# Part 1




# Lipid Measurement Across the Lifespan

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## Screening in Adults and Children

| COR | RECOMMENDATIONS |
|---|---|
| 1 | In adults, screening with a lipid profile is recommended beginning at age 19 years and at least every 5 years thereafter to identify treatable ASCVD risk, with frequent screening recommended for individuals with additional ASCVD risk factors. |
| 1 | In children 9 to 11 years of age not previously tested, it is recommended to screen with a lipid profile to identify familial hypercholesterolemia (FH) and other significant lipid disorders. |
| 2a | In individuals with first- or second-degree relatives with premature ASCVD, severe hypercholesterolemia, or FH, it is reasonable to perform screening with a single lipid profile (eg, cascade screening) starting at ≥2 years of age to identify FH. |

American Heart Association.

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; and FH, familial hypercholesterolemia.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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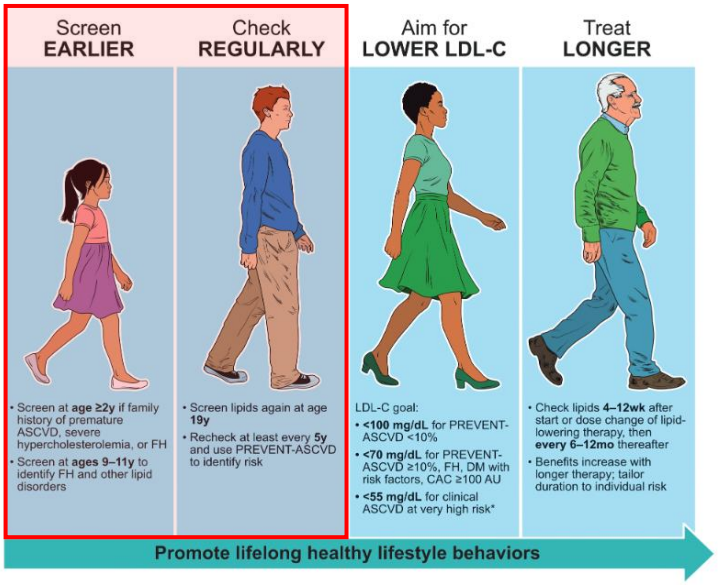
## When to Do It & How Often




American Heart Association.

LIVE FIERCE

Wiggins BS, et al. J Am Coll Cardiol. 2026;Epub ahead of print.

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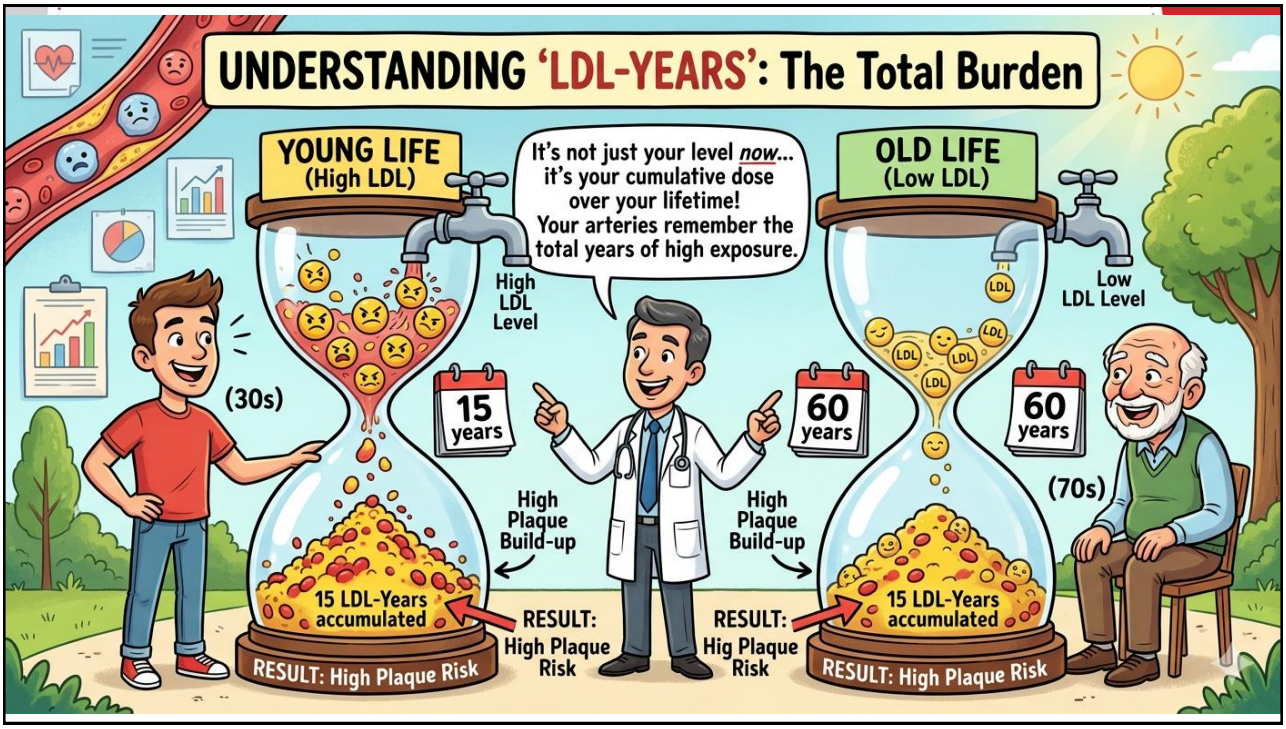


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# Primordial Prevention of Dyslipidemia: Childhood Through Adulthood


| COR | RECOMMENDATIONS |
|---|---|
| 1 | In children and healthy adults, healthy dietary patterns, regular physical activity, maintenance of a healthy weight, healthy sleep, stress management, and avoidance of tobacco products should be promoted and reinforced lifelong to reduce the risk for dyslipidemia and ASCVD. |

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# You Can't Treat What You Don't Measure

| COR | RECOMMENDATIONS |
|---|---|
| 1 | Standard nonfasting or fasting lipid profile is recommended to document baseline lipid levels, estimate ASCVD risk, & guide initiation of lipid-lowering therapy (LLT) |
| 1 | With a family history of dyslipidemia or premature ASCVD, a known or suspected disorder in TG metabolism, or whose nonfasting lipid profile reveals a TG level ≥400 mg/dL (≥4.5 mmol/L), a fasting lipid profile should be performed to more accurately estimate LDL-C level |
| 1 | In those who have undergone a standard lipid profile, use of either the Martin/Hopkins equation or the Sampson/NIH equation is preferred over calculation by the Friedewald equation to estimate LDL-C |
| 1 | In those who have undergone a standard lipid profile, use of either the Martin/Hopkins equation or Sampson/NIH equation is preferred over direct LDL-C measurement to estimate LDL-C |
| 1 | In those who have undergone a standard lipid profile, reporting of non–HDL-C is recommended for ASCVD risk assessment and to guide initiation and monitoring of lipid-lowering therapy |
| 3: No Benefit | Routine advanced lipoprotein testing to assess lipoprotein subclasses and parameters such as LDL particle size is NOT recommended to estimate ASCVD risk or guide initiation of LLT |

Blumenthal RS, Morris PB et al. *J Am Coll Cardiol & Circulation*. 2026;Epub ahead of print.

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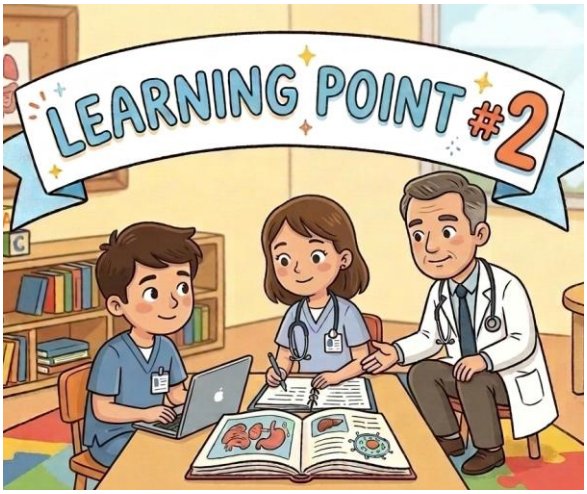
# Part 2




# ApoB and Lp(a) Measurement

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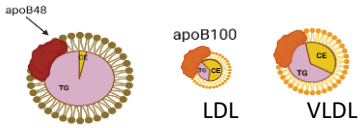
## Consider ApoB to Assess Residual Lipid-Related Risk

*ApoB measures all atherogenic particles and is more accurate compared to LDL-cholesterol*

**Screening with Apolipoprotein B**




Chylomicron LDL VLDL

*All atherogenic lipoproteins have a single apoB100 protein. ApoB is not affected by fasting*

**In adults on LLT, particularly those with ASCVD, type 2 DM, &/or elevated TG, measurement of apoB is reasonable to guide decisions regarding further therapeutic intensification once LDL-C &/or non-HDL-C goals are achieved (2a)**

**In adults not on LLT, measurement of apoB may be reasonable to enhance ASCVD risk assessment, guide initiation of LLT, & characterize inherited lipid disorders (2b)**

*Particularly for secondary prevention, metabolic syndrome, diabetes, elevated TG*

American Heart Association.

LIVE FIERCE

Blumenthal RS, Morris PB et al. *J Am Coll Cardiol & Circulation*. 2026;Epub ahead of print.

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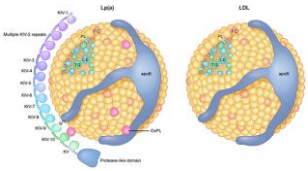
# Measure Lipoprotein(a) Once in All Adults



| Lp (a) in nmol/L | ASCVD relative risk |
|---|---|
| 450 | 4x |
| 375 | 3x |
| 250 | 2x |
| 125 | 1.4x |
| 75 | Reference |

**Screening with Lp(a)**

- **Measurement of Lp(a) in all adults is recommended at least once for ASCVD risk assessment (1)**
- **In those with FH, premature ASCVD, or high Lp(a), cascade testing of 1st- degree relatives is recommended (1)**

*Lp(a) particles consist of an LDL-cholesterol-like particle bound to an apo(a) protein*

*Lp(a) levels are largely genetically determined and stable over one's lifetime*

*Repeat testing is generally not needed*

**If Lp(a) is elevated, intensify LDL-C lowering and aggressively control other ASCVD risk factors**

Blumenthal RS, et al. J Am Coll Cardiol. 2026;Epub ahead of print.

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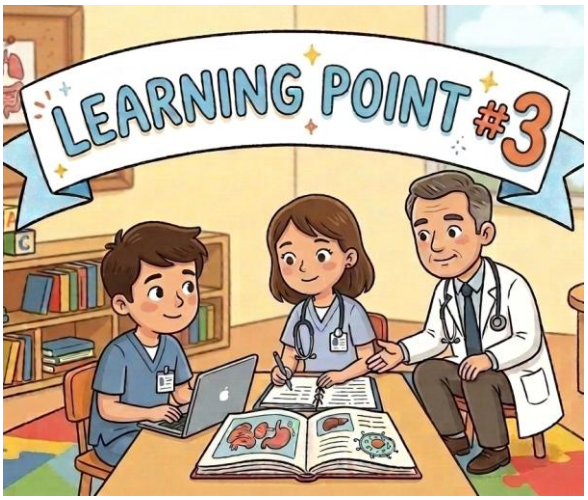
# Part 3




# Primary Prevention: Initial Risk Assessment

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# Role of Individualized Benefit-Risk Discussion

**Information**

Clinician provides the best available evidence for treatment options, including the risks & benefits of each option

**Patient-Centered Care**

Treatment & care options take into consideration individual values & preferences

**Shared Decision-Making**

A collaborative decision about treatment or care is documented and shared with relevant stakeholders

| COR | RECOMMENDATIONS |
|---|---|
| 1 | In individuals with dyslipidemia, clinicians and their patients should engage in a discussion of the patient's ASCVD risk, healthy lifestyle as the foundation of risk reduction, expected risk reduction benefits from LLT, possible harms and DDI, costs, and patient preferences to make individualized treatment decisions and/or consider additional options for evaluation to aid in decision-making. |

**Discussion should emphasize**

- Patient's ASCVD risk
- Consideration of additional options for evaluation
- Healthy lifestyle as the foundation of risk reduction
- Expected risk reduction benefits from lipid-lowering therapies
- Possible harms and drug-drug interactions
- Costs
- Administration frequency
- Patient preferences

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; DDI, drug-drug interaction; and LLT, lipid-lowering therapy.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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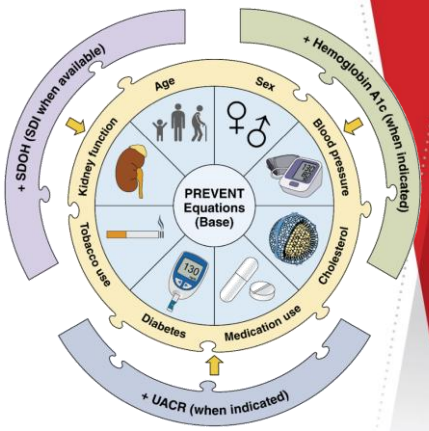
# PREVENT-ASCVD Risk Calculator

| COR | RECOMMENDATIONS |
|---|---|
| 1 | PREVENT-ASCVD equations should be used for risk assessment in adults aged 30-79 years without ASCVD or subclinical atherosclerosis, with LDL-C 70-189 mg/dL. |

**Approximate Equivalent Ranges of 10-yr ASCVD Risk Estimates**

| RISK | POOLED COHORT EQUATIONS | PREVENT-ASCVD |
|---|---|---|
| Low | <5% | <3% |
| Borderline | 5 - <7.5% | 3 to <5% |
| Intermediate | 7.5 - <20% | 5 to <10% |
| High | ≥20% | ≥10% |




**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; LDL-C, low-density lipoprotein cholesterol; PREVENT, Predicting Risk of cardiovascular disease EVENTS; SDI, social deprivation index; SDOH, social determinants of health; and UACR, urine albumin-to-creatinine ratio.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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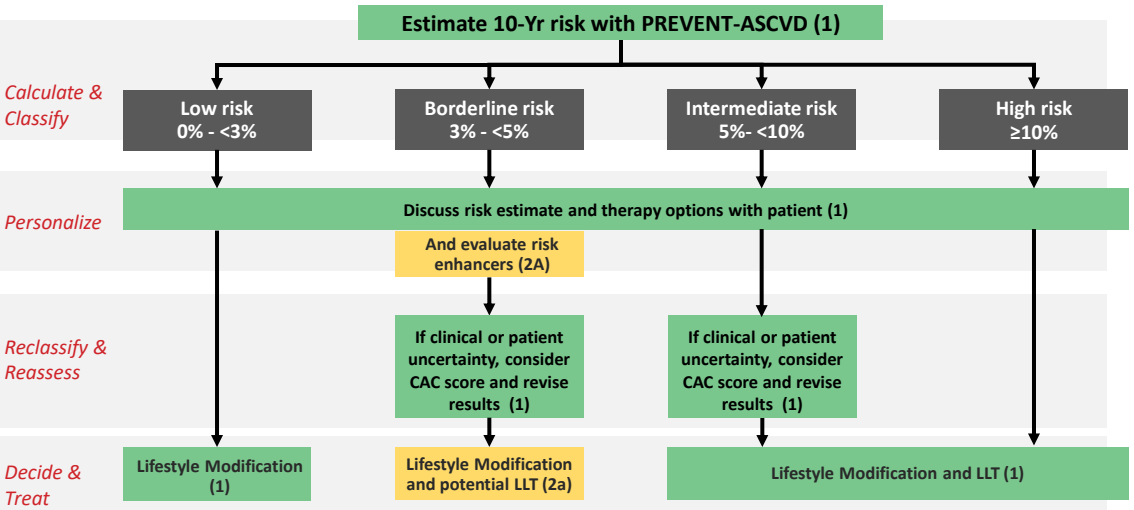
# Calculate, Personalize, Reclassify (CPR) Framework




**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; CAC, coronary artery calcium; LLT, lipid-lowering therapy; and PREVENT, Predicting Risk of cardiovascular disease EVENTS.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Risk Enhancers

- History of premature ASCVD in a parent or sibling (onset age <55 y for men, <65 y for women)
- Higher risk ancestry (eg, South Asian, Filipino)
- High polygenic risk (if measured)
- Chronic inflammatory diseases (eg, systemic lupus, rheumatoid arthritis, advanced psoriasis, inflammatory arthritis)
- Lp(a) ≥125 nmol/L or ≥50 mg/dL
- hsCRP ≥2 mg/L on >1 occasion (if measured)
- TG persistently ≥175 mg/dL (2 mmol/L) (if nonfasting) and ≥150 mg/dL (1.7 mmol/L) (if fasting)
- CKM syndrome
- LDL-C persistently ≥160-189 mg/dL (4.1-4.9 mmol/L), non–HDL-C≥190-219 mg/dL or apoB ≥120 mg/dL
- Reproductive risk markers (premature menopause, preeclampsia, gestational diabetes, gestational hypertension, preterm delivery)

| COR | RECOMMENDATIONS |
|---|---|
| 2a | In adults without ASCVD with a borderline 10-year ASCVD risk estimate (3% to <5%) by the PREVENT-ASCVD equations, consideration of risk-enhancers is reasonable to personalize risk assessment and the potential benefit of initiating LLT as an adjunct to lifestyle management to reduce ASCVD risk. |
| 2a | In adults without ASCVD with a borderline 10-year ASCVD risk estimate (3% to <5%) by the PREVENT-ASCVD equations, if high-sensitivity C-reactive protein (hsCRP) is measured and is ≥2 mg/L on 2 successive occasions with no identifiable underlying cause of hsCRP elevation, high-intensity statin therapy can be useful to reduce the risk of ASCVD events. |

**Abbreviations:** ApoB indicates apolipoprotein B; ASCVD, atherosclerotic cardiovascular disease; HDL-C, high-density-lipoprotein cholesterol; hsCRP, high-sensitivity C-reactive protein, LDL-C, low-density lipoprotein cholesterol; LLT, lipid-lowering therapy; and PREVENT, Predicting Risk of CVD Events.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Reproductive Risk Markers

**Adverse Pregnancy Outcomes with a Stronger Association with ASCVD Events**

- Hypertensive disorders of pregnancy (preeclampsia, gestational hypertension)
- Gestational diabetes
- Small for gestational age (birthweight <10th percentile)
- Preterm delivery (before 37 weeks of gestation)
- Recurrent spontaneous pregnancy loss

**Other Reproductive Risk Markers**

- Early menarche (<10 yr old)
- Early menopause (<45 yr), especially if premature (<40 yr)
- Polycystic ovarian syndrome and irregular menses

| COR | RECOMMENDATIONS |
|---|---|
| 2a | In adults without ASCVD, consideration of reproductive risk markers, such as early menopause (<45 years of age) and history of adverse pregnancy outcomes is reasonable to personalize ASCVD risk assessment when considering the potential benefit of initiating LLT as an adjunct to lifestyle management for primary ASCVD prevention. |

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; and LLT, lipid-lowering therapy.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Primary Prevention 30–79 Years Without ASCVD

**Adults with LDL - C 70 - 189 mg/dL** → **Health behavior counseling (1)** → **Calculate 10-yr and 30-yr in ages 30-59 ASCVD risk using PREVENT-ASCVD (1)** **AND** **Have benefit-risk discussion (1)**

- Low 10-yr Risk **(<3%)**
- Borderline 10-yr Risk **(3%-<5%)**
- Intermediate 10-yr Risk **(5%-<10%)**
- High 10-yr Risk **(≥10%)**

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; LDL-C, low-density lipoprotein cholesterol; and PREVENT-ASCVD, Predicting Risk of cardiovascular disease EVENTS–ASCVD equations.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Primary Prevention 30-79 Years Without ASCVD

| Low-Intermediate 10-y Risk (<3%-10%) | |
|---|---|
| **COR** | **RECOMMENDATIONS** |
| **1** | **Low risk** (<3%)+ LDL<160 mg/dL → Health behavior counseling. |
| **2a** | **Low risk** + LDL 160–189 mg/dL or high 30-yr risk → Start moderate statin. Goal: ≥30% LDL-C reduction; LDL-C<100 mg/dL and non-HDL-C <130 mg/dL |
| **2a** | **Borderline risk (3%-<5%)** → Moderate statin reasonable. Goal: ≥30% LDL-C reduction; LDL-C<100 mg/dL and non-HDL-C <130 mg/dL |
| **1** | **Intermediate risk (5%-<10%)** → Start moderate- to high-intensity statin. |
| **AND** | |
| **2a** | **Goal:** LDL-C<100 mg/dL and non-HDL-C <130 mg/dL |

American Heart Association.

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; and non-HDL-C, non–high-density lipoprotein cholesterol.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Primary Prevention 30-79 Years Without ASCVD (Continued)

| High 10-y Risk (≥10%) | |
|---|---|
| **COR** | **RECOMMENDATIONS** |
| **1** | Start high-intensity statin. |
| **2a** | **Goal:** ≥50% LDL-C reduction; LDL-C<70 mg/dL and non-HDL-C <100 mg/dL |
| **2a** | If LDL-C and non-HDL-C goals still not achieved, add ezetimibe. |
| **2b** | If LDL-C and non-HDL-C goals still not achieved, add PCSK9 mAb or bempedoic acid. |

American Heart Association.

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; non-HDL-C, non–high-density lipoprotein cholesterol; and PCSK9, proprotein convertase subtilisin/kexin type 9.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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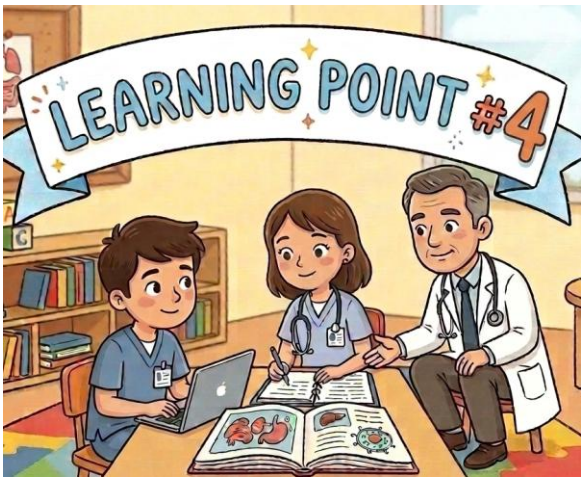
# Part 4




## Coronary Artery Calcium

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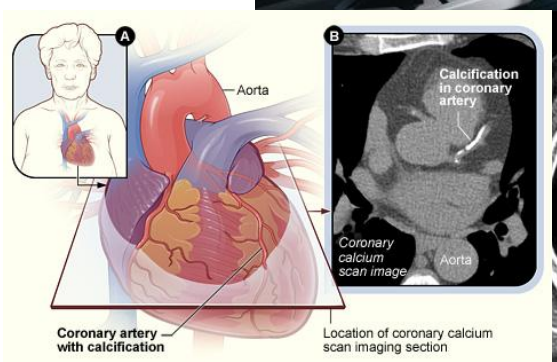
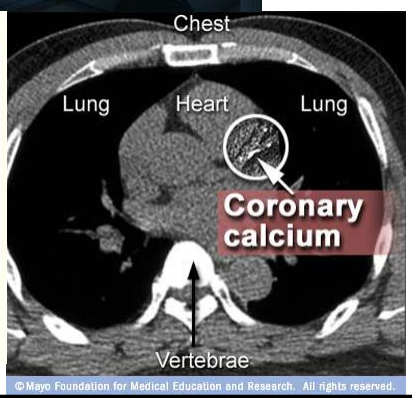
~1 mSv

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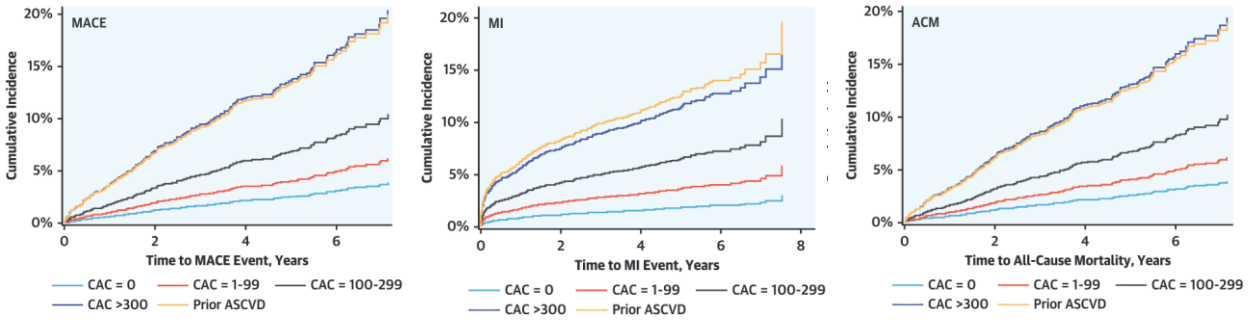
# Coronary Artery Calcium Scores and Cardiovascular Risk

Observational analysis of 4511 individuals with an elevated coronary artery calcium score compared to 438 individuals with established ASCVD (CONFIRM registry)




**Individuals with a CAC score ≥300 face cardiovascular risks similar to those with established ASCVD**

Budoff MJ, et al. *J Am Coll Cardiol Img*. 2023;16:1181-1189.

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# CAC Guidelines – 2018 → 2026

| COR | LOE | |
|---|---|---|
| IIa | B-NR | In intermediate-risk or selected borderline-risk adults, if the decision about statin use remains uncertain, it is reasonable to use a CAC score in the decision to withhold, postpone, or initiate statin therapy |
| I | B-R | In adults at intermediate risk and select adults at borderline risk with no prior ASCVD, if the decision regarding LLT remains uncertain, a CAC score should be used for further risk stratification and to guide the decision to withhold, postpone, or initiate therapy. |

- COR, class of recommendation; LOE, level of evidence.
- Arnett DK, et al. J Am Coll Cardiol. 2019;74:1376-1414. Blumenthal RS, et al. J Am Coll Cardiol. 2026.



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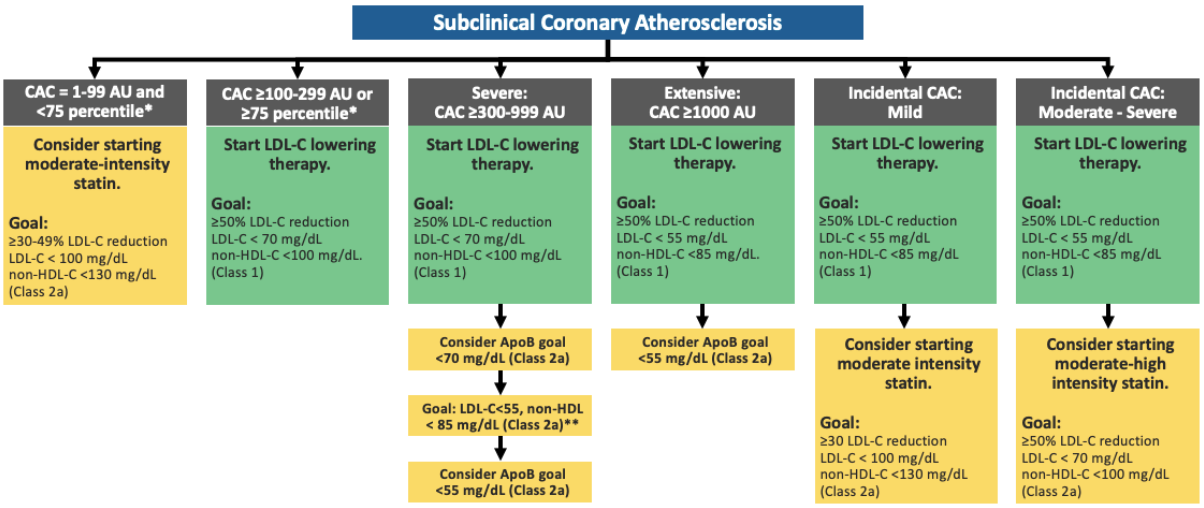
# Lipid Goals in Patients with Coronary Artery Calcium




*Percentiles for age, sex, and race
**Optional
Blumenthal RS, et al. J Am Coll Cardiol. 2026;Epub ahead of print.

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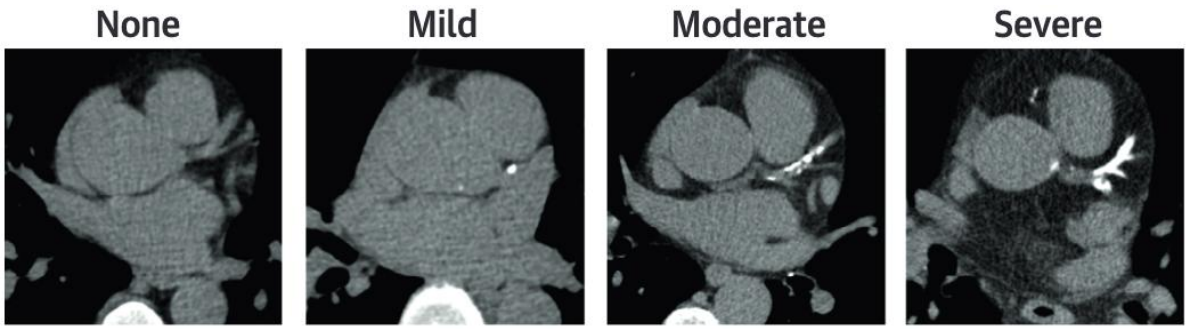
# Importance of Incidental Coronary Artery Calcium




*Incidental CAC on a non-gated CT scan can also be used to guide therapy → Class I Recommendation*

- *If mild, LDL-C goal <100 mg/dL*
- *If moderate or severe, LDL-C goal is <70 mg/dL*

*Absence of incidental CAC should not be used to defer therapy given the low negative predictive value of non-gated scans*

Parsa S, et al. *J Am Coll Cardiol*. 2024;83:1557-1567; Blumenthal RS, Morris PB et al. *J Am Coll Cardiol & Circulation*. 2026;Epub ahead of print.

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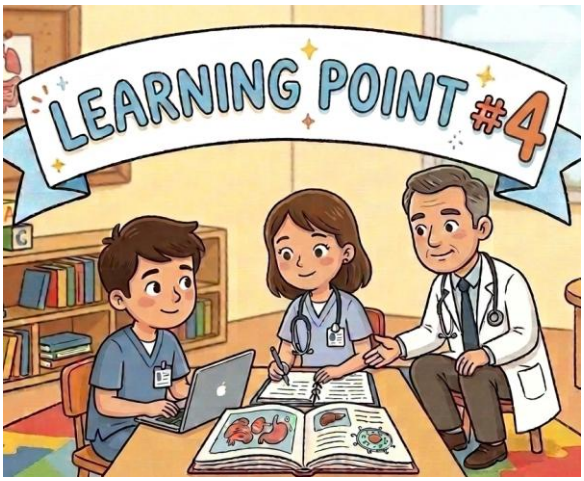
# Part 5




# Familial Hyperlipidemia

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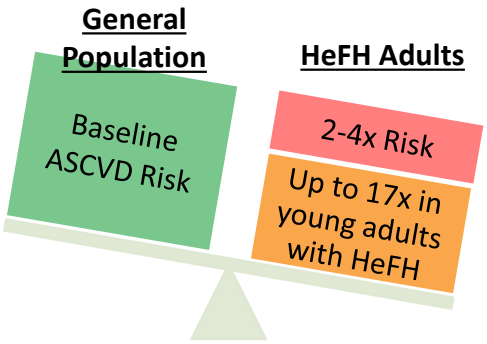
## Role of Risk Assessment in Heterozygous Familial Hypercholesterolemia




| COR | RECOMMENDATIONS |
|---|---|
| 2b | In adults with HeFH, FH-specific risk scores may be useful in predicting short-term ASCVD risk. |
| 3: Harm | In adults with HeFH, standard risk assessment tools developed for the general population should NOT be used to calculate 10-year or 30-year ASCVD risk. |

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; CAC, coronary artery calcium; FH, familial hypercholesterolemia; and HeFH, heterozygous familial hypercholesterolemia.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Genetic Testing for Familial Hypercholesterolemia

### Genetic Testing
- Identify individuals meeting clinical suspicion
- Prevalence 1:250 → underdiagnosed

### Variants
- LDLR
- PCSK9
- ApoB

### Risk Stratification & Treatment
- Higher ASCVD risk even with modest LDL
- Supports earlier LLT and cascade screening

| COR | RECOMMENDATIONS |
|---|---|
| 1 | In adults with possible, probable, or definite FH, panel-based genetic testing for pathogenic/likely pathogenic rare variants for FH is beneficial to identify individuals at highest risk of cardiovascular events and to facilitate cascade screening. |
| 2a | In adults with severe hypercholesterolemia with an LDL-C ≥190 mg/dL (4.9 mmol/L) without an identified secondary cause, panel-based genetic testing for pathogenic/likely pathogenic rare variants for FH can be useful to identify those with FH who are at higher risk of ASCVD events. |
| 2b | In adults with an elevated LDL-C of 160 to 189 mg/dL (4.1-4.9 mmol/L) without an identified secondary cause, panel-based genetic testing for pathogenic/likely pathogenic rare variants for FH may be considered to identify those with FH who are at higher risk of events. |

**Abbreviations:** ApoB indicates apolipoprotein B; ASCVD, atherosclerotic cardiovascular disease; FH, familial hypercholesterolemia; LDLR, low-density lipoprotein receptor; and PCSK9, proprotein convertase subtilisin/kexin type 9.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Lipid Goals in Patients with Severe Hypercholesterolemia

**Severe hypercholesterolemia**
- **LDL-C ≥190 mg/dL** (non-HDL-C ≥220 mg/dL, apoB ≥140 mg/dL)
- Very high *lifetime* ASCVD risk even without other risk factors
- Often due to **long-term LDL-C exposure** (cumulative burden)

**Always exclude secondary causes** including a *ketogenic or high saturated fat diet, hypothyroidism, chronic kidney disease, nephrotic syndrome, steroids, etc.*

| | Patient Examples | LDL-C mg/dL | Non-HDL-C mg/dL | ApoB mg/dL |
|---|---|---|---|---|
| **Severe hypercholesterolemia** | • **Without** FH, ASCVD risk factors, and subclinical atherosclerosis | <100 | <130 | <90 |
| **Severe hypercholesterolemia** | • **With** FH, ASCVD risk factors, and subclinical atherosclerosis | <70 | <100 | <70 |
| **Severe hypercholesterolemia** | • **With** FH and ASCVD | <55 | <85 | <55 |

Adapted from Blumenthal RS, et al. J Am Coll Cardiol. 2026;Epub ahead of print.

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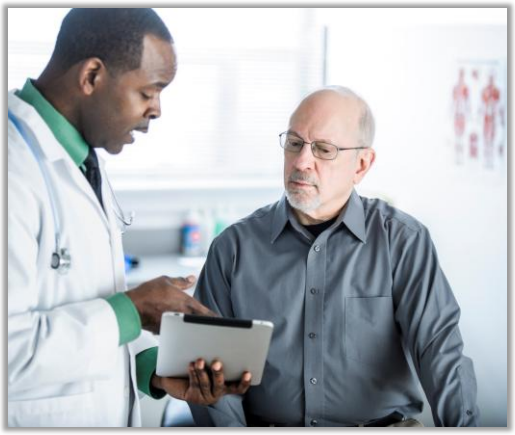
## Severe Hypercholesterolemia with Clinical or Genetic Confirmation of Homozygous Familial Hypercholesterolemia



| COR | RECOMMENDATIONS |
|---|---|
| 1 | Refer to lipid specialist. |
| 1 | Maximally tolerated statin recommended. |
| 2a | Add ezetimibe, PCSK9 mAb, or bempedoic. |
| 2b | Add evinacumab if LDL≥100 persists. |
| 2b | Consider lomitapide with monitoring. |

American Heart Association.

**Abbreviations:** LDL indicates low-density lipoprotein cholesterol; and PCSK9, proprotein convertase subtilisin/kexin type 9.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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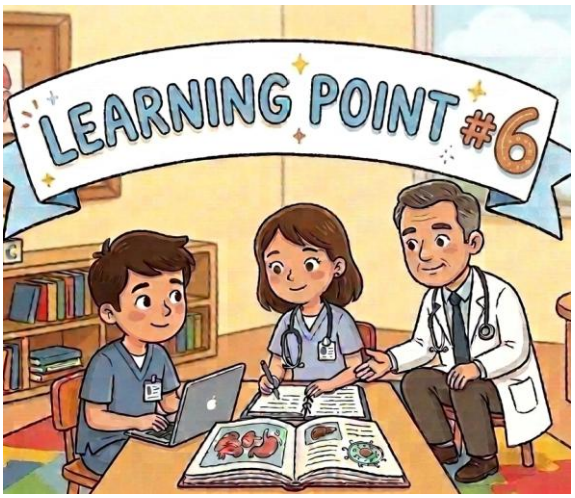
# Part 6




## Secondary Prevention

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# Criteria for Defining "At Very High Risk" in ASCVD Patients

**At Very High Risk**

**≥ 2 Major ASCVD Events**

OR

**1 Major ASCVD Event + ≥2 High Risk Conditions**

**Major ASCVD Events**

- Consider drug-drug interactions between lipid-lowering therapies and antiretroviral therapies.

**High Risk Conditions**

- Age ≥65
- Coronary bypass or percutaneous intervention
- Current smoker
- Diabetes
- Hx of congestive heart failure
- Hypertension
- LDL-C ≥ 100mg/dL despite maximally tolerated statin + ezetimibe

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; and LDL-C, low-density lipoprotein cholesterol.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Secondary Prevention of ASCVD in Adults at Very High Risk

| Clinical ASCVD in adults at very high risk: | |
|---|---|
| **COR** | **RECOMMENDATIONS** |
| 1 | High-intensity statin therapy should be initiated to achieve ≥50% lowering in LDL-C and a goal LDL-C <55 mg/dL and non-HDL-C <85 mg/dL and to reduce the risk of ASCVD events. |
| 1 | For those on maximally tolerated statin therapy, ezetimibe and/or a PCSK9 mAb should be added to achieve a goal of LDL-C <55 mg/dL and non-HDL-C <85 mg/dL to reduce risk of ASCVD events. |
| 2a | For those on maximally tolerated statin, it is reasonable to add bempedoic acid to a statin, with or without ezetimibe and/or PCSK9 mAb, to reach an LDL-C goal <55 mg/dL and non-HDL-C <85 mg/dL to reduce the risk of ASCVD events. |
| 2a | For those on maximally tolerated statin therapy with or without ezetimibe, it is reasonable to add inclisiran in those unable to tolerate or obtain evolocumab or alirocumab or have a strong preference for less frequent dosing to achieve an LDL-C goal <55 mg/dL and non-HDL-C <85 mg/dL. |

**Abbreviations:** ASCVD, atherosclerotic cardiovascular disease; LDL-C, low-density lipoprotein cholesterol; non-HDL-C, non–high-density lipoprotein cholesterol; and PCSK9, proprotein convertase subtilisin/kexin type 9.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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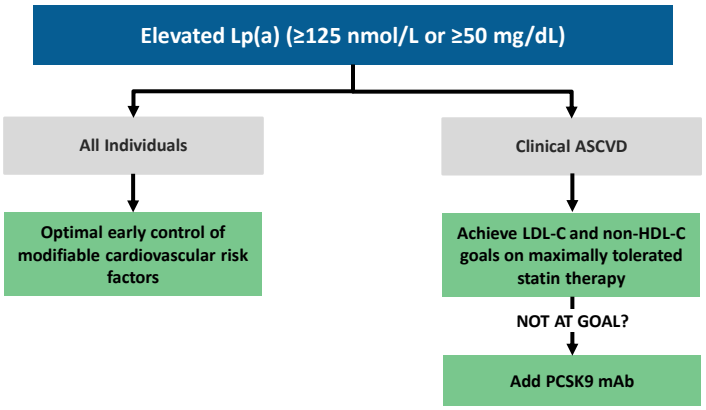
## Approach to Patients with Elevated Lp(a)




American Heart Association.

**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; HDL-C, high-density lipoprotein cholesterol; LDL-C, low-density lipoprotein-cholesterol; Lp(a), lipoprotein(a); mAb, monoclonal antibody; and PCSK9, Proprotein Convertase Subtilisin/Kexin type 9.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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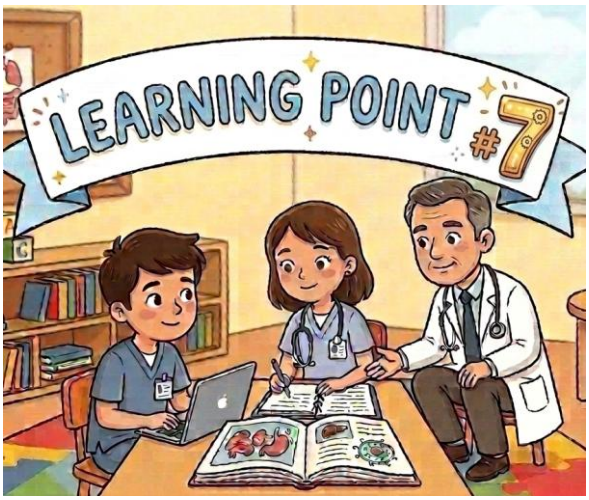
## Part 7




# LLT in Primary Prevention of Adults >75

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STATIN
MEDICINE
Take 1 Tablet
Daily
℞ E. Smith
Mon
Tue
Wed
Thu
Fri

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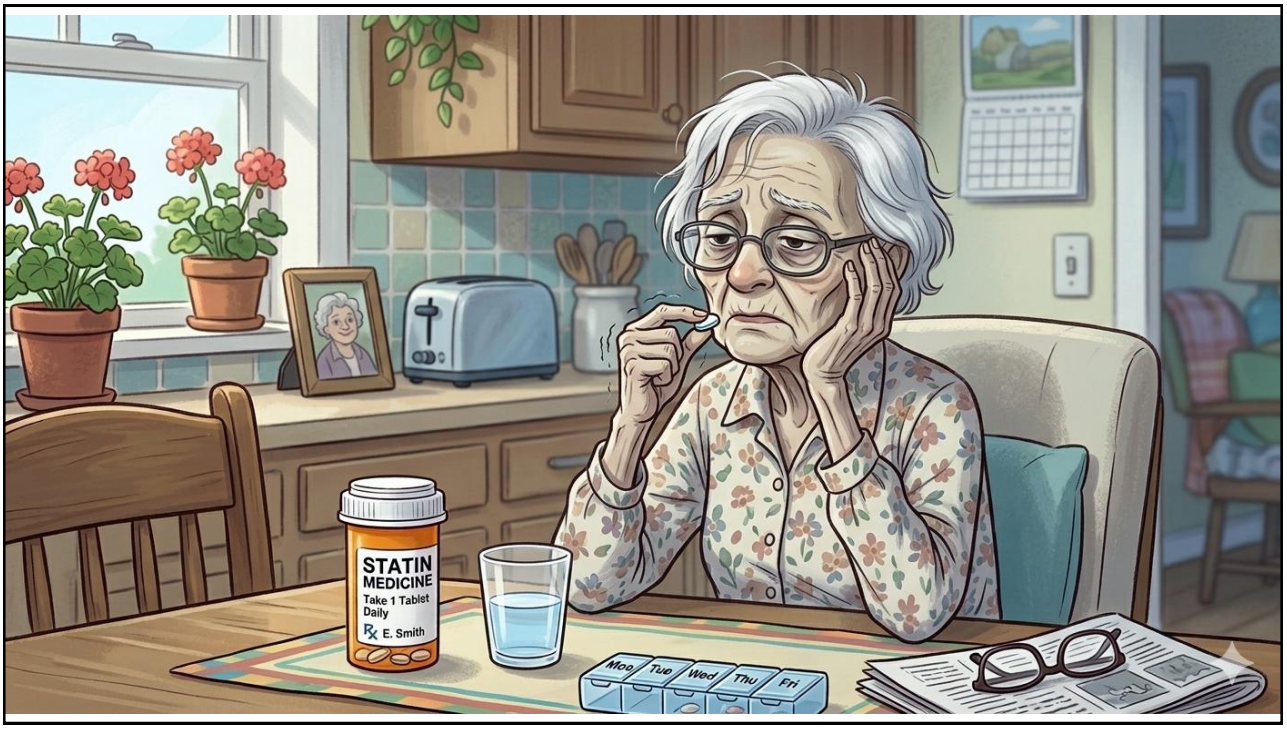
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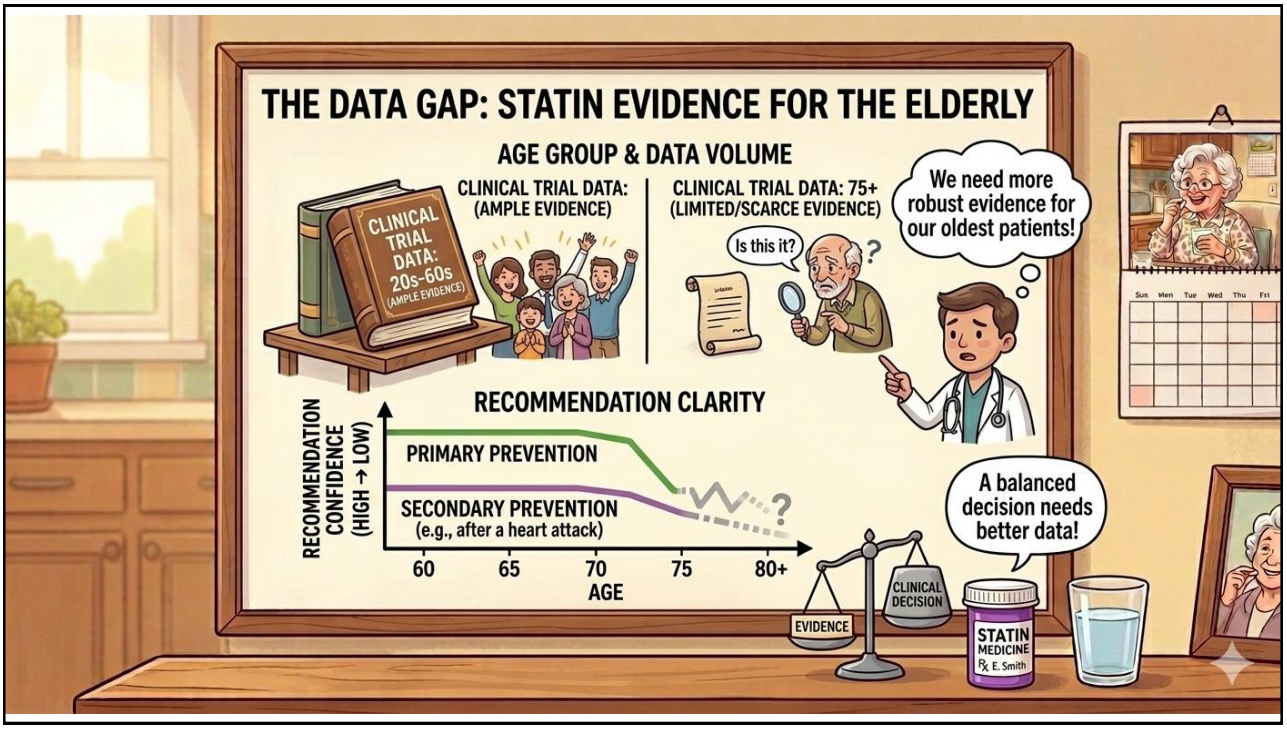


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## Benefits of Statin Therapy in Adults ≥75 Years of Age

Retrospective cohort study of 326,931 U.S. veterans ≥75 years without ASCVD using propensity scoring to compare all-cause and CV mortality rates among those on and not on statin therapy

| Outcome | Statin user (n=57,178) Weighted rate/1000 person-years | Statin nonuser (n=269,803) Weighted rate/1000 person-years | HR (95% CI) | P value |
|---|---|---|---|---|
| All-cause mortality | 78.7 | 98.2 | 0.75 (0.74-0.76) | <0.001 |
| All CV death | 22.6 | 25.7 | 0.80 (0.78-0.81) | <0.001 |
| ASCVD composite | 66.3 | 70.4 | 0.92 (0.91-0.94) | <0.001 |
| MI | 13.2 | 12.6 | 0.99 (0.97-1.03) | 0.94 |
| Ischemic stroke | 18.4 | 18.2 | 0.98 (0.96-1.01) | 0.20 |
| CABG surgery/ PCI | 35.2 | 39.2 | 0.89 (0.88-0.91) | <0.001 |

Orkaby AR, et al. JAMA. 2020;324:68-78.

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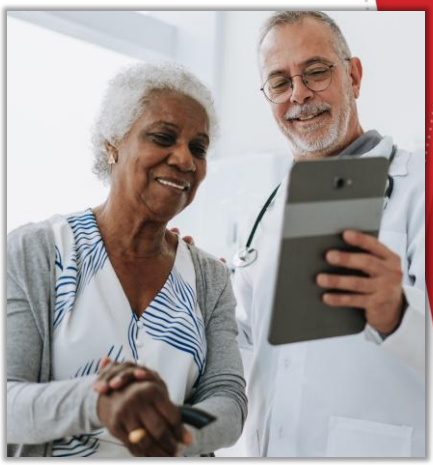
# Recommendations for Older Adults

| COR | RECOMMENDATIONS |
|---|---|
| 1 | In older adults, the benefit-risk discussion should include patient priorities, functional status, multimorbidity, frailty, polypharmacy, and life expectancy, and should not be based solely on chronological age when considering the decision to discontinue LLT. |
| 2a | In adults aged >75 years with an estimated life expectancy of at least 2.5 years, it may be reasonable to initiate moderate-intensity statin therapy after a clinician–patient discussion of potential benefits and risks to reduce ASCVD risk. |
| 2a | In patients with a life expectancy of <1 year, it may be reasonable to discontinue LDL-lowering therapy to avoid unnecessary medication use or adverse medication effects. |
| 2b | In adults aged >75 years with an estimated life expectancy of at least 2.5 years, and for whom the decision regarding LLT is uncertain, it may be reasonable to measure CAC to reclassify those with minimal (1-10) or no CAC to avoid LLT. |



**Abbreviations:** ASCVD indicates atherosclerotic cardiovascular disease; CAC, coronary artery calcification; LDL, low-density lipoprotein; and LLT, lipid-lowering therapy.

American Heart Association.

Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. *Circulation*.

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# Summary – LDL Goals

| Patient population | LDL-C <100 mg/dL (2.6 mmol/L)<br>Non-HDL-C <130 mg/dL (3.4 mmol/L) | LDL-C <70 mg/dL (1.8 mmol/L)<br>Non-HDL-C <100 mg/dL (2.6 mmol/L) | LDL-C <55 mg/dL (1.4 mmol/L)<br>Non-HDL-C <85 mg/dL (2.2 mmol/L) |
|---|---|---|---|
| **Primary prevention** | PREVENT-ASCVD < 10%<br>• If TG ≥ 150 mg/dL to 499 mg/dL, apoB goal: <90 mg/dL | PREVENT-ASCVD ≥ 10%<br>• If TG ≥ 150 mg/dL to 499 mg/dL, apoB goal: <70 mg/dL | N/A |
| **Severe hypercholesterolemia** | **Without** FH, ASCVD risk factors, and subclinical atherosclerosis | **With** FH, ASCVD risk factors, and subclinical atherosclerosis | Severe hypercholesterolemia or HeFH with clinical ASCVD |
| **Diabetes** | **Without** ASCVD risk factors or diabetes-specific risk modifiers<br>• apoB goal: <90 mg/dL | **Without** ASCVD risk factors or diabetes-specific risk modifiers<br>• apoB goal: <70 mg/dL | N/A |
| **Subclinical atherosclerosis** | CAC = 1-99 AU and <75$^{th}$ percentile for age, sex, and race | • CAC ≥ 100 to 299 AU or ≥75th percentile for age, sex, and race<br>• CAC ≥ 300 to 999 AU<br>– Optional goal: LDL-C <55 mg/dL, non-HDL-C <85 mg/dL, and consider apoB goal <55 mg/dL | CAC ≥ 1000 AU |
| **Hypertriglyceridemia** | <50 y old with no additional risk enhancers | • With clinical ASCVD not at very high risk<br>– apoB goal: <70 mg/dL<br>• Age 40-75 y with ≥1 ASCVD risk factor<br>– apoB goal: <70 mg/dL | • With clinical ASCVD at very high risk<br>– apoB goal: <55 mg/dL |
| **Clinical ASCVD** | N/A | Not at very high risk<br>• Optional goal: LDL-C <55 mg/dL, non-HDL-C <85 mg/dL, and consider apoB goal <55 mg/dL | • At very high risk<br>– apoB goal: <55 mg/dL<br>• With CKD |

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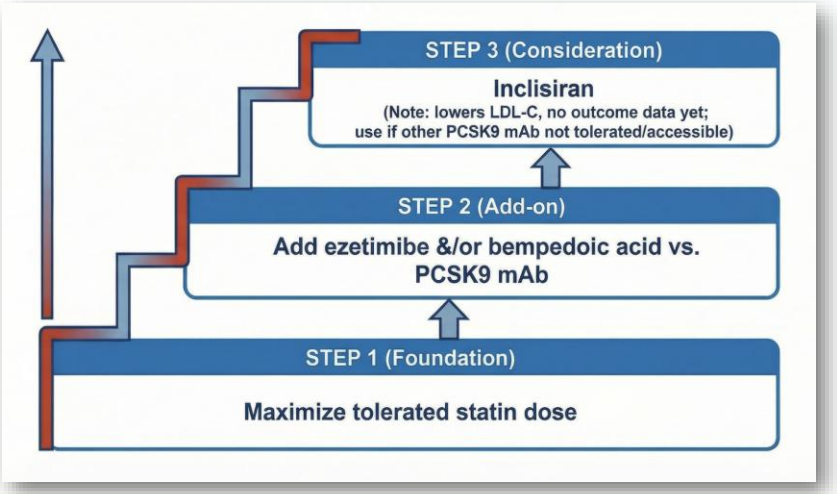
# Summary – General LLT Sequence




Blumenthal RS, Morris PB et al. *J Am Coll Cardiol & Circulation*. 2026;Epub ahead of print.

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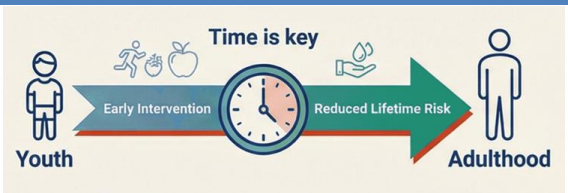
# Summary – Treat Earlier




Start statin therapy for:

- All adults with heterozygous familial hypercholesterolemia
- All adults ≥30 yrs with:
  - LDL-C ≥160 mg/dL
  - Strong family history of premature ASCVD
  - High 30-year risk of ASCVD
  - CAC >0

*Treat these groups early, even if their "estimated risk is low", to prevent long-term exposure to high LDL-cholesterol*

Blumenthal RS, Morris PB et al. *J Am Coll Cardiol & Circulation*. 2026;Epub ahead of print.

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# Presentation Summary

- Lipid testing is integral to LLT initiation & intensification
- LLT should be initiated earlier in higher risk patients
- LDL goals are back and are explicitly risk-based
- Pre-eminent role for coronary artery calcium (Class 1)
- Measure Lp(a) and consider ApoB as well
- Special considerations for FH and age >75
- Secondary prevention – identify very high-risk status