Cases in Lipids

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Disclosure

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

Consultant: Scene Health

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Ramzi Dudum, MD

Advisory Board: Novartis

Research Grant: DalCor

Stockholder: Centene; Walmart

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Case Study #1

Michael Blaha, MD

55-year-old Male Asymptomatic Patient

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Case 1: Asymptomatic Patient

- **55-year-old non-smoking man with no diabetes with good diet and exercise habits**
  - Family history of premature CAD (father)
  - BP 139/85, HDL 60, LDL 145
- **Pooled Cohort Equations**
  - 6.4% 10-year risk of ASCVD
- **PREVENT**
  - 3.8% 10-year ASCVD risk

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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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Case 1: Asymptomatic Patient

- **55-year-old non-smoking man with no diabetes with good diet and exercise habits**
  - Family history of premature CAD (father)
  - BP 139/85, HDL 60, LDL 145
  - BMI 26, UACR 29
- **Other risk enhancing factors**
  - hsCRP 1.9 mg/L
  - Lipoprotein (a) 43 nmol/L

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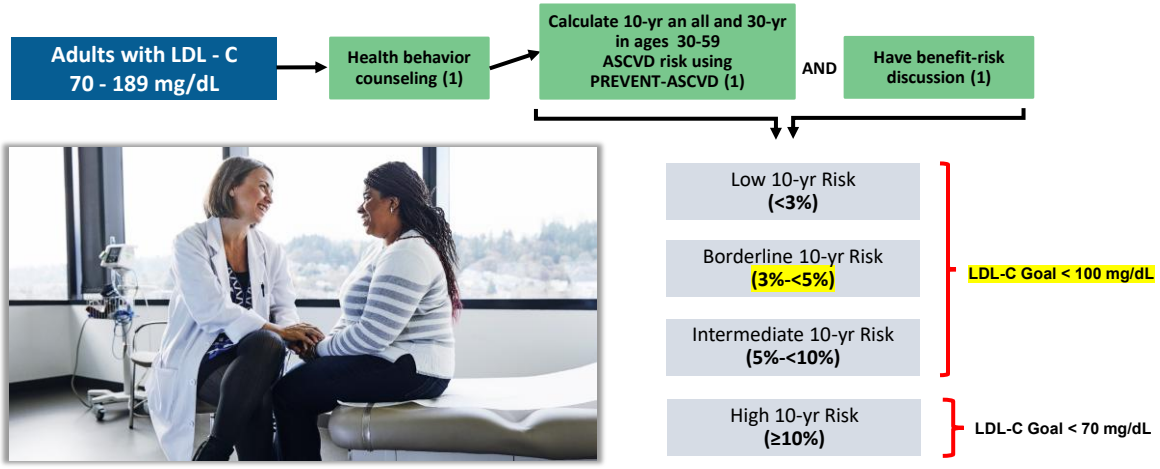
Case 1, Question 1

How Would You Treat This Patient?

A. Lifestyle therapy only
B. Moderate intensity statin
C. High intensity statin + aspirin
D. Intensive lifestyle, High intensity statin, aspirin, consider anti-hypertensive, and non-statin add-on to achieve LDL/apoB<70 & non-HDL<100 (Optional LDL/ApoB<55)

Primary Prevention 30–79 Years Without ASCVD



Blumenthal, R.S., Morris P.B. et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia
Circulation. https://www.ahajournals.org/doi/10.1161/CIR.0000000000001423
J Am Coll Cardiol. https://doi.org/10.1016/j.jacc.2025.11.016

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.
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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Case 1: Asymptomatic Patient

- **55-year-old non-smoking man with no diabetes with good diet and exercise habits**
  - Family history of premature CAD (father)
  - BP 139/85, HDL 60, LDL 145
  - BMI 26, UACR 29
- **Other risk enhancing factors**
  - hsCRP 1.9 mg/L
  - Lipoprotein (a) 43 nmol/L
- **Coronary artery calcium score**
  - CAC=325, 95th percentile

Case 2, Question 2

How Would You Treat This Patient?

A. Lifestyle therapy only
B. Moderate intensity statin
C. High intensity statin + aspirin
D. Intensive lifestyle, High intensity statin, aspirin, consider anti-hypertensive, and non-statin add-on to achieve LDL/apoB<70 & non-HDL<100 (Optional LDL/ApoB<55)

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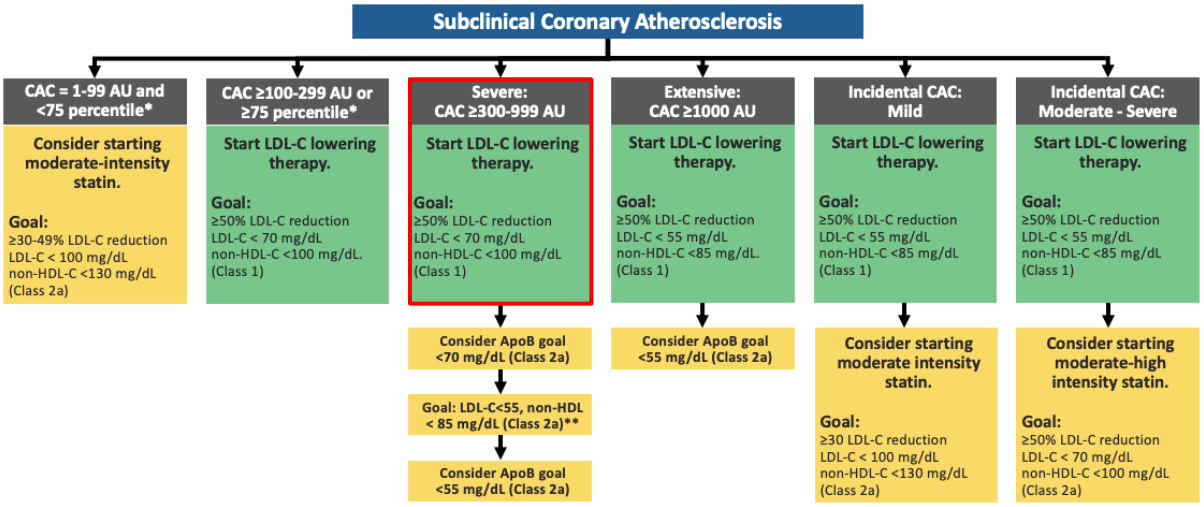
Lipid Goals in Patients with Coronary Artery Calcium



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

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Future CAC-Based Treatment Recommendations?

CAC Score	Lifestyle	Statin and Statin Intensity	Non-Statin Add-on	Aspirin	Blood Pressure Goals	Secondary Prevention Meds#
0	✓					
1-99 < 75th % ≥ 75th %	 ✓ ✓	 *Consider Mod* Moderate	 Consider*	 	 Routine Routine	
100-299	✓	Moderate to High	Consider*	✓	Routine	
≥ 90th %	✓✓	High	Always**	✓	Aggressive	Consider
> 300	✓	High	Always**	✓	Aggressive	Consider
>1000	*HIGH RISK SECONDARY PREVENTION!!***					

** To achieve an optional LDL-C target of <70 mg/dL or <55 mg/dL (blue).*
*** To achieve an optional LDL-C target of <70 mg/dL or <55 mg/dL (blue).*
 # P2Y12, low dose colchicine, icosapent ethyl, Lp(a) lowering therapy?

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Case Study #2

Ramzi Dudum, MD

Referred for Carotid Atherosclerosis Seen on Thyroid Scan

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Referred for Carotid Atherosclerosis Seen on Thyroid Scan

- A young woman in her 40s with no pertinent medical history
- Family history of MI in her father at age 36, paternal uncle with CVA at 60, high cholesterol in multiple paternal relatives
- No medications, surgeries, or allergies
- Not planning on getting pregnant and uses contraception
- Goals: interested in doing what she can to mitigate risk, but hesitant for medications

Representative, not actual case.
Microsoft Powerpoint stock image "Young woman"

Referred for Carotid Atherosclerosis Seen on Thyroid Scan

- Lipid panel:
  - TC: 244mg/dL
  - TGL: 179mg/dL
  - HDL: 42mg/dL
  - LDL: 166mg/dL
- Hgb A1C: 5.6%

2013 PCE 10-Year Risk: 0.7%
2023 PREVENT 10-Year ASCVD: 0.7%
2023 PREVENT 30-Year ASCVD: 4.9%

Representative, not actual case.
Microsoft Powerpoint stock image "Young woman"

Time to Enhance Our Engagement in ASCVD Risk Assessment

Table 13. Risk Enhancers

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) (**Section 4.2.3.5, "Polygenic Risk Scores"**)
• 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; **Section 4.2.3.4, "Reproductive Risk Marker"**)

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

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Case 2 Question 1

What Testing Would You Order?

A. Lp(a)
B. ApoB
C. A & B
D. None of the above

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Referred for Carotid Atherosclerosis Seen on Thyroid Scan

- Lipid panel:
  - TC: 244mg/dL
  - TGL: 179mg/dL
  - HDL: 42mg/dL
  - LDL: 166mg/dL
- Hgb A1C: 5.6%

We order Lp(a) and apoB:
-Lp(a) is 234nmol/L
-ApoB is 160mg/dL

Representative, not actual case.
Microsoft Powerpoint stock image "Young woman"

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Time to Enhance Our Engagement in ASCVD Risk Assessment

Table 13. Risk Enhancers

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) (**Section 4.2.3.5, "Polygenic Risk Scores"**)
• Chronic inflammatory diseases (eg, systemic lupus, rheumatoid arthritis, advanced psoriasis, inflammatory arthritis
• Lp(a) ≥125 nmol/L or ≥50 mg/dL
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• 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; **Section 4.2.3.4, "Reproductive Risk Marker"**)

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

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6. Lipoprotein(a) [Lp(a)] Should Be Measured at Least Once to Identify Individuals at Higher Risk of ASCVD

risk-enhancing factor:

≥125 nmol/L (50 mg/dL)- 1.4-fold increased ASCVD risk

≥250 nmol/L (100 mg/dL) ≥2-fold higher risk

An elevated Lp(a) is an indication for more intensified LDL-C lowering and management of other risk factors.

J Am Coll Cardiol.2026;XX:XXX-XXX; *Circulation*. 2026;153:e00–e00

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

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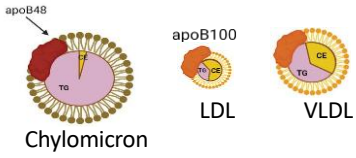
Use ApoB to Assess Residual Lipid-Related Risk

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 <u>on lipid-lowering therapy</u>, particularly those with ASCVD, type 2 DM, and/or elevated TG, measurement of apoB <u>is reasonable</u> to guide decisions regarding further therapeutic intensification once LDL-C and/or non-HDL-C goals are achieved (2a)

In adults <u>not on lipid lowering therapy</u>, measurement of apoB <u>may be reasonable</u> to enhance ASCVD risk assessment, guide initiation of lipid lowering therapy, and characterize inherited lipid disorders (2b)

Particularly for secondary prevention, metabolic syndrome, diabetes, elevated triglyceride > 200 mg/dL

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

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Case 2 Question 2

What Would You Do Next?

A. Recommend diet/lifestyle changes
B. Recommend rosuvastatin 40mg daily
C. Recommend ezetimibe 10mg daily
D. A & B
E. All of the above

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.
2a	**Goal:** LDL-C<100 mg/dL and non-HDL-C <130 mg/dL

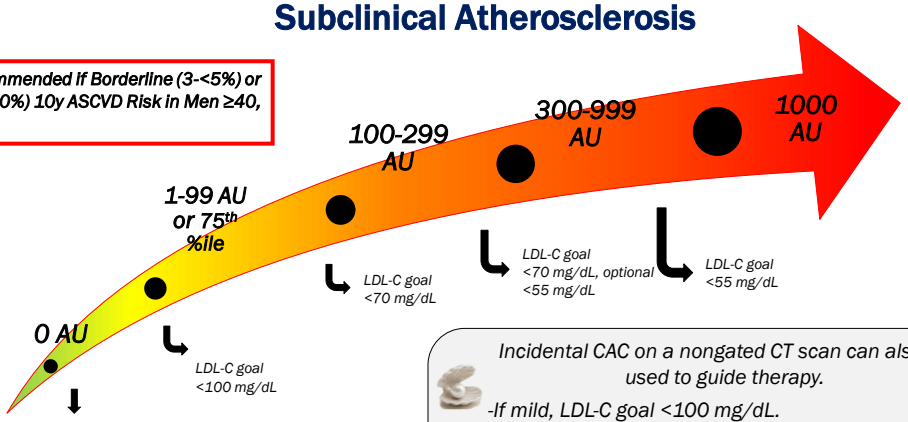
American Heart Association.

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*.

CAC Score Guided Rx of Subclinical Atherosclerosis

CAC Scoring Recommended if Borderline (3-<5%) or intermediate (5-<10%) 10y ASCVD Risk in Men ≥40, Women ≥45 y.o



May defer LLT if not high risk: no DM, FH, tobacco use, family history of premature ASCVD, or LDL-C ≥190 mg/dL.
Repeat CAC in 3-7 yr.

Incidental CAC on a nongated CT scan can also be used to guide therapy.

-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 Rx given the low negative predictive value of nongated scans.

J Am Coll Cardiol.2026;XX:XXX-XXX; *Circulation*. 2026;153:e00–e00

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Referred for Carotid Atherosclerosis Seen on Thyroid Scan

- Lipid panel:
  - TC: 244mg/dL
  - TGL: 179mg/dL
  - HDL: 42mg/dL
  - LDL: 166mg/dL
- Hgb A1C: 5.6%

Plan: Start with diet and lifestyle

Representative, not actual case.
Microsoft Powerpoint stock image "Young woman"

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Referred for Carotid Atherosclerosis Seen on Thyroid Scan

- Lipid panel:
  - TC: 217mg/dL
  - TGL: 88mg/dL
  - HDL: 59mg/dL
  - LDL: 140mg/dL
- Hgb A1C: 5.1%

Representative, not actual case.
Microsoft Powerpoint stock image "Young woman"

Case 2 Question 3

What Would You Do Next?

A. Recommend rosuvastatin 10mg daily
B. Recommend ezetimibe 10mg daily
C. Evolocumab 140mg every other week
D. No further recommendations

Referred for Carotid Atherosclerosis Seen on Thyroid Scan

- Lipid panel:
  - TC: 217mg/dL
  - TGL: 55mg/dL
  - HDL: 72mg/dL
  - LDL: 135mg/dL
- Hgb A1C: 5.1%

Plan: Add on moderate-intensity statin (rosuvastatin 10mg)

Representative, not actual case.
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Referred for Carotid Atherosclerosis Seen on Thyroid Scan

- Goals: interested in doing what she can to mitigate risk
- Lipid panel:
  - TC: 159mg/dL
  - TGL: 54mg/dL
  - HDL: 71mg/dL
  - LDL: 77mg/dL
- Hgb A1C: 5.1%

Depending on severity of quantified plaque, goal would either be <100mg/dL or <70mg/dL

Representative, not actual case.
Microsoft Powerpoint stock image "Young woman"

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Case Study #3

Michael Blaha, MD

64-year-old Male, Retired Teacher

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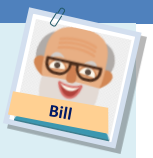
Case #3



Patient characteristics

- **Age:** 64 years old
- **Sex:** Man
- **Profession:** Retired Teacher

Past medical history

- Hypertension dx 7 years ago
- Prediabetes
- Anterior MI 4 years ago, two additional PCIs
- Very strong family history,premature

Clinical parameters

BMI: 26 kg/m^2
BP: 128/78 mmHg
LVEF: 50%

Laboratory parameters

HbA$_{1c}$: 5.7%
LDL-C: 67 mg/dL
HDL-C: 42 mg/dL
TGs: 133 mg/dL
Lp(a): 234 nmol/L *(elevated)*
eGFR: 59 mL/min *(Stage 3A CKD)*
ACR: 29.0 mg/g *(borderline microalbuminuria)*
hsCRP: 0.7 mg/L

Lifestyle

Former smoker (1 pack/day for 10 years)
Drinks 1–2 glasses of wine 4 days a week
~6000 steps/day, no dedicated exercise

Current medications

Aspirin 81 mg
High-intensity statin
Beta blocker
ARB

How Would You Approach Bill's Medical Care?

- ACR, albumin-to-creatinine ratio; BMI, body mass index; BP ,blood pressure; eGFR, estimated glomerular filtration rate; HbA$_{1c}$, glycated hemoglobin; hsCRP, high-sensitivity C-reactive protein; HTN, hypertension; LDL-C, low-density lipoprotein-cholesterol; Lp(a), lipoprotein (a); T2D, type 2 diabetes; TGs, triglycerides.

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Case 3, Question 1

What Would You Choose Next for This Patient?

A. SGLT2i
B. Addition of a P2Y12
C. Non-statin add on such as PCSK9i
D. GLP1-RA
E. More intensive BP control

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

American Heart Association.

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*.

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.

American Heart Association.

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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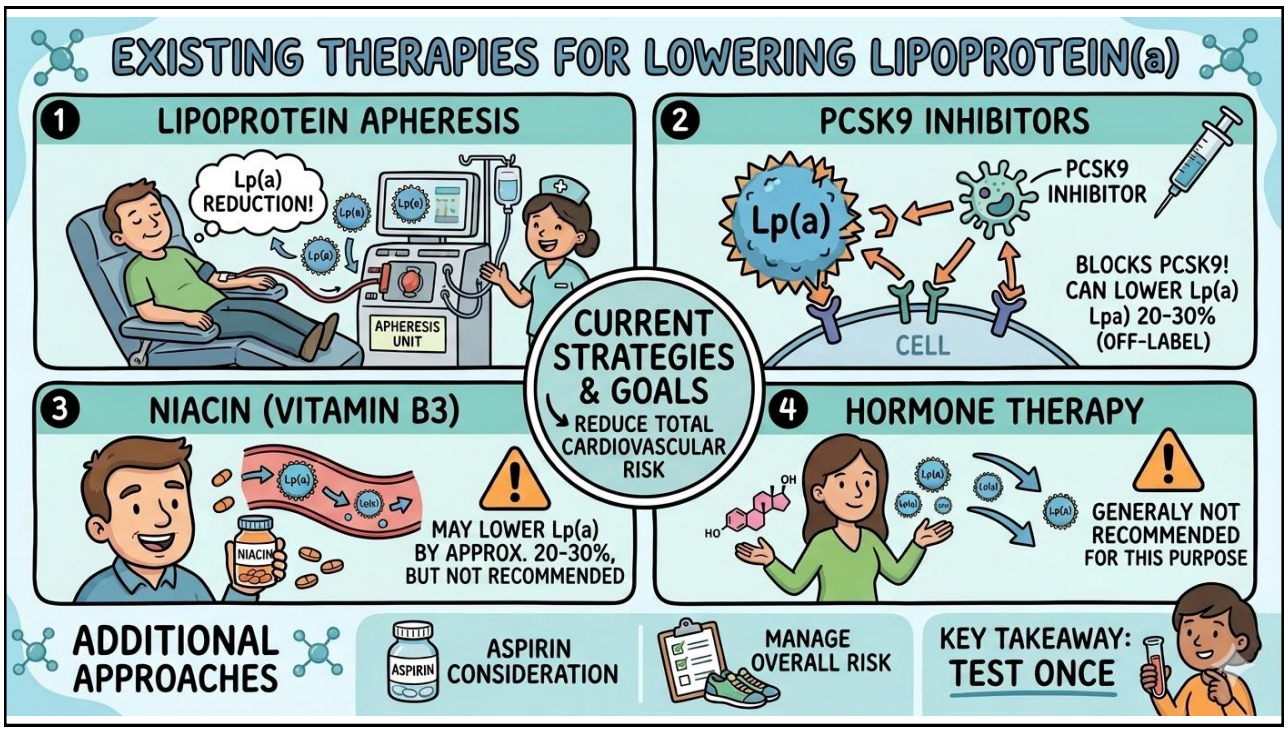

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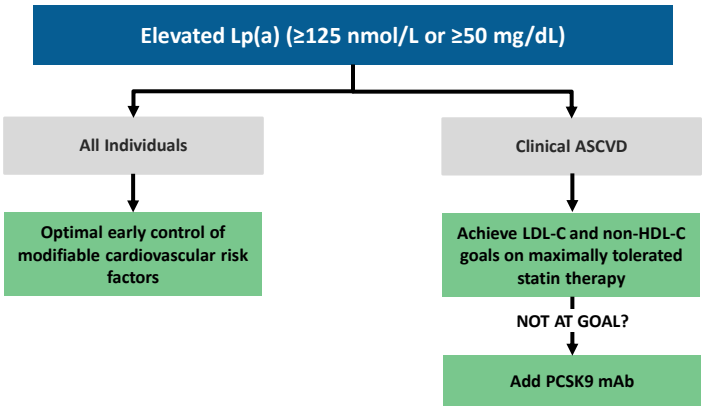
Approach to Patients with Elevated Lp(a)



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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Case Study #4

Ramzi Dudum, MD

Referred for Management of Elevated Triglycerides

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Referred for Management of Elevated Triglycerides

- Goals: Understand the cause and avoid medications
- Referral lipid panel (3m prior):
  - TC: 271mg/dL
  - TGL: 488mg/dL
  - HDL: 38mg/dL
  - LDL: unable to measure
- Hgb A1C: 5.9%

Representative, not actual case.
Microsoft Powerpoint stock image "Man"

Referred for Management of Elevated Triglycerides

- Has a sedentary job—worked as a truck driver but work has been harder to come by
- Weight has steadily increased
  - BMI now 26.8kg/m^2
- Diet
  - Previously, ate while on the road
  - Now, take out and packaged foods

Representative, not actual case.
Microsoft Powerpoint stock image "Man"

Case 4, Question 1

What Testing Would You Order?

A. Fasting lipid panel
B. Lp(a)
C. apoB
D. A & B
E. All of the above

Referred for Management of Elevated Triglycerides

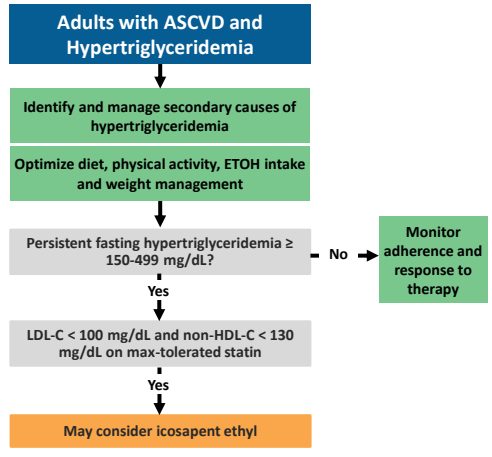
- Lipid panel:
  - TC: 261mg/dL
  - TGL: 476mg/dL
  - HDL: 37mg/dL
  - LDL: unable to measure
- Additional lipids
  - -Lp(a) is <6nmol/L
  - -ApoB is 107mg/dL

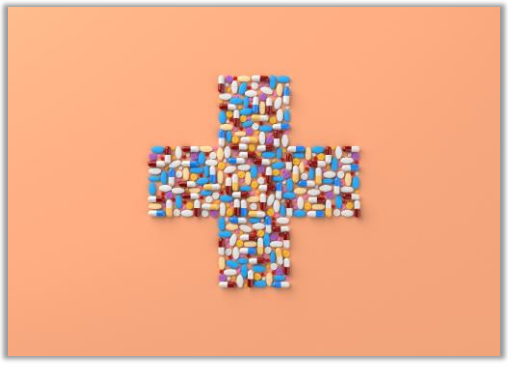
Representative, not actual case.
Microsoft Powerpoint stock image "Man"

Case 4, Question 2
What Secondary Causes Should Be Evaluated For?

A. Detailed diet history
B. Detailed lifestyle practices
C. Medication reconciliation
D. Screen for thyroid, kidney and liver disease
E. All of the above

Management of Hypertriglyceridemia





American Heart Association.

Abbreviations: ASCVD indicates atherosclerotic cardiovascular disease; ETOH, ethyl alcohol; HDL-C, high-density lipoprotein cholesterol; 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*.

Referred for Management of Elevated Triglycerides

- CMP without abnormalities
- Normal TSH, UA without protein
- Consumes 3 beers per night
- No culprit medications
- Increased central adiposity on exam

Representative, not actual case.
Microsoft Powerpoint stock image "Man"

Referred for Management of Elevated Triglycerides

- We decide on the following:
  - Abstain from alcohol for one week
  - Review local takeout places for choices we're both OK with
  - Hit 5,000 steps per day
- Repeat Fasting labs after 1 week

Representative, not actual case.
Microsoft Powerpoint stock image "Man"

Referred for Management of Elevated Triglycerides

- Repeat Fasting lipid panel:
  - TC: 226mg/dL
  - TGL: 290mg/dL
  - HDL: 41mg/dL
  - LDL: 127mg/dL
  - ApoB 100mg/dL

Representative, not actual case.
Microsoft Powerpoint stock image "Man"

Case 4, Question 3

You Recommend All of the Following, *Except*:

A. Continue alcohol abstinence
B. Track calories with total fat and added sugar goals
C. Reduce daily alcohol intake
D. Calorie deficit to achieve a healthful BMI

Dietary Interventions for Hypertriglyceridemia

Lifestyle is 1st Line for All With Elevated TGs:

≥5% weight loss, ≥150 min/week moderate intensity activity

Implemented shared decision-making intervention	TG ≥150 to 499 mg/dL* (1.7 to <5.7 mmol/L)	TG ≥500 to 999 mg/dL* (5.7 to <11.3 mmol/L)	TG ≥1000 mg/dL† (≥11.3 mmol/L)
Added sugars (percent calories)	<6%	<5%	Eliminate
Total fat (percent calories)	30%–35%	20%–25%‡	10%–15%§¶
Alcohol	Avoid	Abstain completely	Abstain completely
Physical activity	At least 150 minutes/week of accumulated moderate-intensity or 75 minutes/week of vigorous intensity aerobic activity (or equivalent combination of both) and 2 days/week of upper and lower body resistance exercise‖		
Weight loss (percent body weight)	Recommended weight loss goal of 5%–10% for patients who are overweight or obese with elevated TG		

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

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Referred for Management of Elevated Triglycerides

- In clinic 3 months later
- Eating out less and found a one-pot recipe book that is easy
- Averaging 7,000 steps per day
- Has lost 10 pounds

Repeat lipid panel:

- TC: 191mg/dL
- TGL: 182mg/dL
- HDL: 45mg/dL
- LDL: 110mg/dL
- ApoB 92mg/dL

Representative, not actual case.
Microsoft Powerpoint stock image "Man"

CONTINUING EDUCATION COMPANY

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