What Have We Learned – Day 3

30th Annual Conference on Hypertension Diabetes, and Dyslipidemia

Hyatt Regency Hotel
Savannah, Georgia
June 3-5, 2026

CONTINUING EDUCATION COMPANY

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Day 3-Focus on Dyslipidemia
Dr. Blaha spoke on "What's new in the ACC/AHA Dyslipidemia Guidelines"

- The 2026 ACC/AHA dyslipidemia guidelines emphasize earlier lipid testing, earlier treatment, and explicit LDL-C goals based on individualized ASCVD risk.
- Measure lipoprotein(a) at least once in all adults and consider apo B measurement in patients with diabetes, metabolic syndrome, elevated triglycerides, or residual risk.
- Coronary artery calcium (CAC) scoring now has a central role in risk reclassification and treatment decision-making, especially in borderline- and intermediate-risk patients.
- LDL-C targets are now risk-based: <100 mg/dL for lower-risk patients, <70 mg/dL for higher-risk primary prevention and significant CAC, and <55 mg/dL for very high-risk ASCVD.
- Incidental CAC identified on non-gated CT scans should be used clinically to intensify preventive therapy rather than ignored.

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30th Annual Hypertension, Diabetes & Dyslipidemia Conference
Day 3 Review – Jan Basile, MD

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Day 3-Focus on Dyslipidemia
Dr. Dudum spoke on " Applying the New ACC/AHA Cholesterol Guidelines in Practice"

- Risk discussions should focus on cumulative exposure to cholesterol over time rather than only short-term 10-year risk estimates.
- Subclinical atherosclerosis, especially coronary artery calcium (CAC), can dramatically simplify clinical decision-making and personalize treatment recommendations.
- Any CAC generally favors initiation of lipid-lowering therapy in addition to lifestyle modification, with higher CAC scores warranting lower LDL-C targets.
- Clinicians should actively look for incidental CAC or vascular calcification already present on prior non-gated CT imaging before ordering additional tests.
- Risk-enhancing conditions such as adverse pregnancy outcomes, chronic inflammatory disease, HIV, elevated triglycerides, and family history meaningfully shift ASCVD risk upward.

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Day 3-Focus on Dyslipidemia
Dr. Dudum spoke on " Applying the New ACC/AHA Cholesterol Guidelines in Practice"

- Apo B measurement is particularly useful when triglycerides are elevated or when LDL-C and total atherogenic burden appear discordant.
- Management of statin intolerance requires careful history-taking, re-challenge strategies, and consideration of hydrophilic statins at lower starting doses.
- Lifestyle interventions remain foundational and should include dietary improvement, physical activity, weight management, and reduction in alcohol and added sugars.
- Combination lipid-lowering therapy is often necessary to achieve modern LDL-C goals, especially in high-risk and secondary prevention populations.
- Primary care clinicians should think practically: identify starting LDL-C, determine goal LDL-C, and select therapies capable of realistically achieving that reduction.

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Day 3-Focus on Dyslipidemia
Dr. Blaha on "What's on the HORIZON with Lp(a): Comparing the Nearly Completed Lp(a) Trials"

- Lipoprotein(a) [Lp(a)] is highly heritable, mechanistically linked to ASCVD and aortic stenosis, and is substantially undermeasured in clinical practice.
- The 2026 ACC/AHA guidelines recommend measuring Lp(a) at least once in all adults for cardiovascular risk assessment.
- Elevated Lp(a) significantly increases ASCVD risk even when LDL-C is well controlled and should prompt more aggressive overall risk reduction.
- Patients with elevated Lp(a) should receive intensive LDL-C lowering, lifestyle optimization, and management of all modifiable cardiovascular risk factors.
- PCSK9 inhibitors may be especially useful in high-risk patients with elevated Lp(a), particularly when residual risk persists despite LDL-C control.

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Day 3-Focus on Dyslipidemia
Dr Blaha on "What's on the HORIZON with Lp(a): Comparing the Nearly Completed Lp(a) Trials"

- **Emerging therapies—including pelacarsen, olpasiran, lepodisiran, and muvalaplin—can dramatically reduce Lp(a) levels and may transform preventive cardiology.**
- **The HORIZON, OCEAN(a), ACCLAIM-Lp(a), and MOVE-Lp(a) trials are expected to determine whether major Lp(a) lowering reduces cardiovascular events.**
- **The first major outcome data from dedicated Lp(a)-lowering trials are expected beginning in late 2026 from the HORIZON trial.**
- **Primary care clinicians should begin identifying patients with elevated Lp(a) now because targeted therapies may soon become clinically available.**
- **Current best practice is aggressive management of traditional ASCVD risk factors while awaiting definitive Lp(a)-specific outcome therapies.**

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Day 3-Focus on Dyslipidemia
Dr. Blaha on "Lipoprotein (a): What We Know, What We Do Not Know, and What We Will Know Soon"

Drugs in Development Targeting Lp(a)

Drug	Company	Mechanism	Drug administration	Trial	CV Outcomes Completed
Pelacarsen	Novartis	ASO	SQ injection Q4weeks	HORIZON: Phase 3	Late 2026 Lowers 80-85%
Olpasiran	Amgen	siRNA	SQ injection Q12 weeks	OCEAN (a): Phase 3	December 2026 90-95%
Lepodisiran	Eli Lilly	siRNA	SQ injection Q6 months?	ALPACA: Phase 2 ACCLAIM-Lp(a): primary prevention Phase 3	March 2029
Zerlasiran (SLN360)	Silence Therapeutics	siRNA	SQ injection	APOLLO: Phase 2	Unsure
Muvalaplin	Eli Lilly	Oral small molecule	Oral medication once daily	KRAKEN: Phase 2	Unsure

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Day 3-Focus on Dyslipidemia
Dr. Dudam on "Making Sense of Non-Statin Lipid-Lowering Therapies: The When and Why to Use Them"

- Non-statin therapies should be selected based on the degree of LDL-C reduction needed, patient tolerance, cardiovascular risk, cost, and adherence considerations.
- Ezetimibe is inexpensive, generally well tolerated, and useful when modest additional LDL-C lowering (~20%) is needed or when statin intolerance is present. It can often be added to a lower dose of a high-potency statin.
- PCSK9 inhibitors provide profound LDL-C reduction (> 50%) and cardiovascular event reduction in very high-risk primary and especially in secondary prevention patients.
- Inclisiran offers twice-yearly maintenance dosing and may improve long-term adherence in patients unable or unwilling to self-inject frequent PCSK9 monoclonal antibodies.
- Bempedoic acid is particularly useful in statin-intolerant patients but requires monitoring for hyperuricemia, gout, and tendon complications.

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Day 3-Focus on Dyslipidemia
Dr. Dudam on "Making Sense of Non-Statin Lipid-Lowering Therapies: The When and Why to Use Them"

- Combination therapy is frequently required to achieve contemporary LDL-C goals, especially in patients with ASCVD, severe hypercholesterolemia, or high CAC burden.
- Triglyceride management begins with lifestyle intervention, weight loss, glycemic control, alcohol reduction, and treatment of metabolic syndrome.
- Icosapent ethyl reduces cardiovascular events in high-risk patients with persistent hypertriglyceridemia despite statin therapy.
- GLP-1 receptor agonists improve weight, glycemia, triglycerides, and cardiovascular risk and should be considered when obesity or metabolic disease predominates.
- Pregnancy and reproductive planning are essential parts of lipid management; bile acid sequestrants remain the safest LDL-lowering agents during pregnancy.

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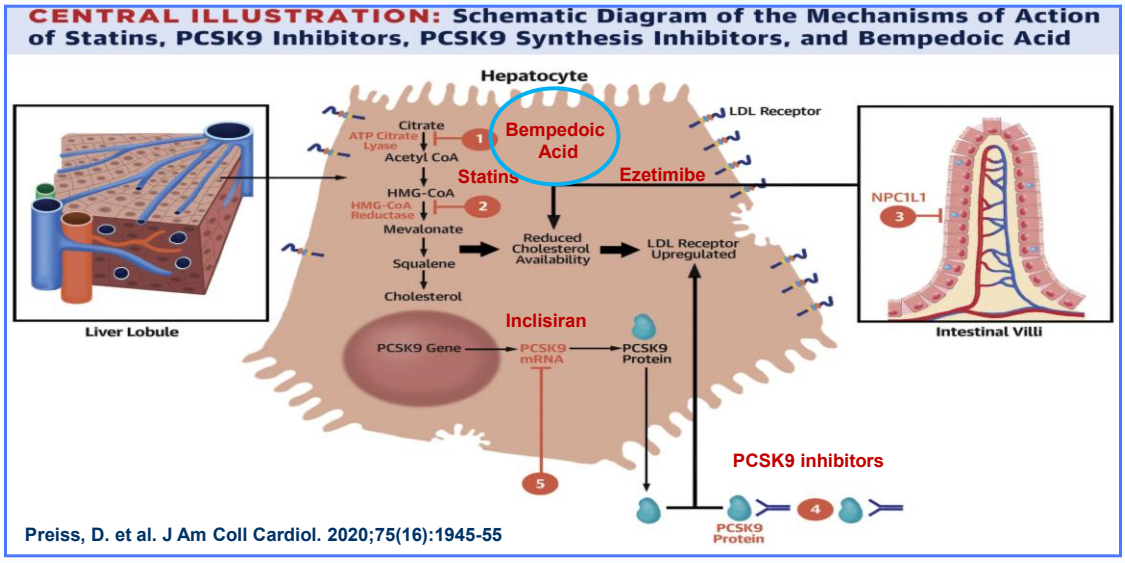
Review of Mechanism of Action of Non-Statin Agents



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Approved LDL-C-lowering Therapies

Drug	Benefits	Limitations
Statins	• Lowers LDL-C and other atherogenic lipoproteins • Reduces CV risk; extensive evidence	• Side effects, primarily myalgia • Drug interactions
Ezetimibe	• Added to statin, reduces LDL-C • Reduces CV risk; 1 outcomes trial	• Side effects rare, but may include fever, headache, muscle pain, runny nose, sore throat
PCSK9 inhibitors	• Substantial LDL-C lowering • Reduces CV risk; 2 outcomes trials	• Administered by subcutaneous injections • High cost
Bile acid sequestrants	• Added to statin, reduces LDL-C • May reduce glucose in hyperglycemia • Reduces CV risk; 1 outcomes trial as monotherapy	• Gastrointestinal adverse effects • May increase triglycerides • Drug interactions
Bempedoic acid	• Added to statin, reduces LDL-C • CLEAR outcome CV outcome trial positive for both primary and secondary prevention	• Hyperuricemia • Tendon rupture or injury (0.5% vs. 0% with placebo) • Drug interactions (simvastatin, pravastatin)

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