Management of Dyslipidemia: New 2026 AHA/ACC Guideline Update

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Disclosure

Consultant: Alnylam (Hypertension); AstraZeneca; Blue Earth Diagnostics; Boehringer Ingelheim; Corcept; Eli Lilly (SURPASS-CVOT); Idorsia (Hypertension); Mineralys; Novo Nordisk; ReCor; Up-to-Date (Hypertension)

Research Grant: Corcept; Eli Lilly – TRIUMPH; Sonivie – THRIVE Study

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Objectives

At the conclusion of this presentation the participant will Know:

1. Describe the New Top 10 Messages of the 2026 ACC/AHA Dyslipidemia Guidelines.
2. Understand the role of LDL-C Goals in Clinical Practice, Coronary artery Calcium Scores, and Lipoprotein(a) and Apo(B) in clinical practice.
3. Explain the implications of high risk vs. very high risk in secondary ASCVD prevention.

3

Recent Dyslipidemia Guideline

CLINICAL PRACTICE GUIDELINES

2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

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

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What Are These Guidelines?

- The Guidelines are 139 pages long-including 68 tables, 18 figures, and multiple algorithms.
- It is a joint effort from multiple societies.
- Evidence continues to be graded, as in past guidelines.
- There are 31 pages of references

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

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American Heart Association.

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

CLASS 1 (STRONG)
Benefit >>> Risk

Suggested phrases for writing recommendations:
- Is recommended
- Is indicated/useful/effective/beneficial
- Should be performed/administered/other
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is recommended/indicated in preference to treatment B
  - Treatment A should be chosen over treatment B

CLASS 2a (MODERATE)
Benefit >> Risk

Suggested phrases for writing recommendations:
- Is reasonable
- Can be useful/effective/beneficial
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is probably recommended/indicated in preference to treatment B
  - It is reasonable to choose treatment A over treatment B

CLASS 2b (Weak)
Benefit ≥ Risk

Suggested phrases for writing recommendations:
- May/might be reasonable
- May/might be considered
- Usefulness/effectiveness is unknown/unclear/uncertain or not well-established

CLASS 3: No Benefit (MODERATE)
Benefit = Risk

Suggested phrases for writing recommendations:
- Is not recommended
- Is not indicated/useful/effective/beneficial
- Should not be performed/administered/other

CLASS 3: Harm (STRONG)
Risk > Benefit

Suggested phrases for writing recommendations:
- Potentially harmful
- Causes harm
- Associated with excess morbidity/mortality
- Should not be performed/administered/other

LEVEL (QUALITY) OF EVIDENCE‡

LEVEL A
- High-quality evidence‡ from more than 1 RCT
- Meta-analyses of high-quality RCTs
- One or more RCTs corroborated by high-quality registry studies

LEVEL B-R (Randomized)
- Moderate-quality evidence‡ from 1 or more RCTs
- Meta-analyses of moderate-quality RCTs

LEVEL B-NR (Nonrandomized)
- Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies
- Meta-analyses of such studies

LEVEL C-LD (Limited Data)
- Randomized or nonrandomized observational or registry studies with limitations of design or execution
- Meta-analyses of such studies
- Physiological or mechanistic studies in human subjects

LEVEL C-EO (Expert Opinion)
- 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.

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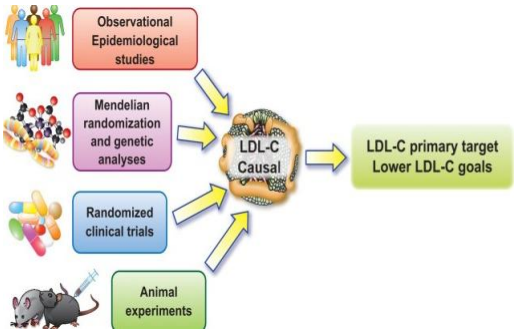
Support for LDL Causality in ASCVD

- **Observational Epi Data**
- **Genetic Studies**
- **Randomized Trials**
- **Animal Experimental**



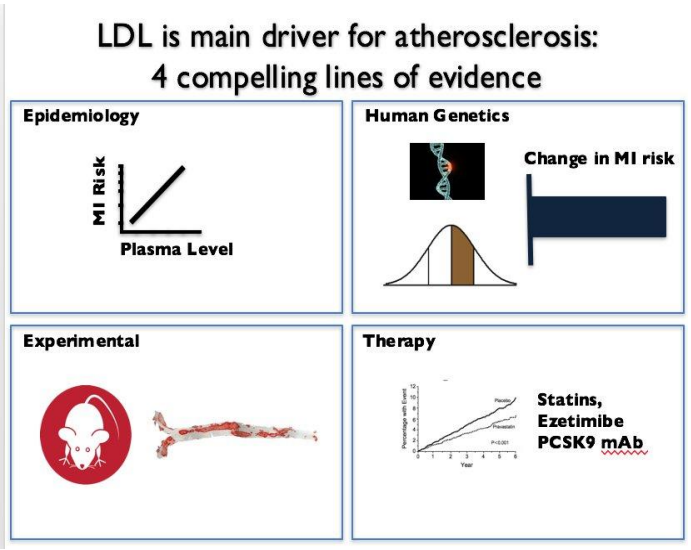


Figure 2. Tokgozoglu L., Libby P. Eur Heart Junl 2022;43(34):3198-3206.

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Objectives

At the conclusion of this presentation the participant will be able to:

1. Describe the New Top 10 Messages of the 2026 ACC/AHA Dyslipidemia Guidelines.

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Lipid Measurement Across the Lifespan

Treat Dyslipidemia Earlier to Reduce Lifelong Risk of Prolonged Exposure to Atherogenic Lipoproteins.

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

1.Screen and Rx Earlier in Life in Both Adults and Children and Treat Across the Lifespan

- Take action early in life because high cholesterol can begin to impact your heart disease risk even in childhood and adolescence.

Blumenthal R.S. et al. 2026 ACC/AHA Dyslipidemia Guideline. Circulation 2026;153:e00.DOI: 10.1161/CIR.0000000000001423.

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Screen Earlier in Life in Both 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.

ASCVD-atherosclerotic cardiovascular disease;
FH-Familial Hypercholesterolemia.

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

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You Can't Treat What You Don't Measure

COR	RECOMMENDATIONS
1	A standard non-fasting or fasting lipid profile is recommended to document baseline lipid levels, estimate ASCVD risk, and guide initiation of LLT.
1	With a family history of dyslipidemia or premature ASCVD, a personally known or suspected disorder in TG metabolism, or whose non-fasting lipid profile reveals a TG level ≥400 mg/dL (≥4.5 mmol/L), a fasting lipid profile should be performed to more accurately estimate the LDL-C level.
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 the initiation of lipid-lowering therapy

ASCVD-atherosclerotic cardiovascular disease;
HDL-C-High-Density Lipoprotein cholesterol;
LDL-C-Low-Density Lipoprotein-cholesterol;
non-HDL-C, non-High-Density Lipoprotein Cholesterol;
TG-Triglycerides.

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

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

1.Screen and Rx Earlier in Life in Both Adults and Children and Treat Across the Lifespan

- Enjoy a healthy eating pattern including
  -vegetables, fruits, whole grains, beans, nuts, seeds, unsaturated fats and lean proteins.
  -Limit ultra-processed foods that are high in saturated fats and added sugars and sodium.

Blumenthal R.S. et al. 2026 ACC/AHA Dyslipidemia Guideline. Circulation 2026;153:e00.DOI: 10.1161/CIR.0000000000001423.

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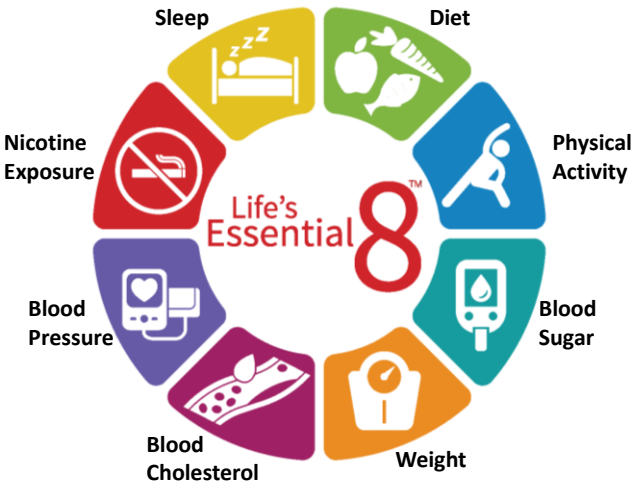
Primordial Prevention of Dyslipidemia: Childhood Through Adulthood



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.

Arnett D.K. et.al. *J Am Coll Cardiol. 2019;74:1376.*

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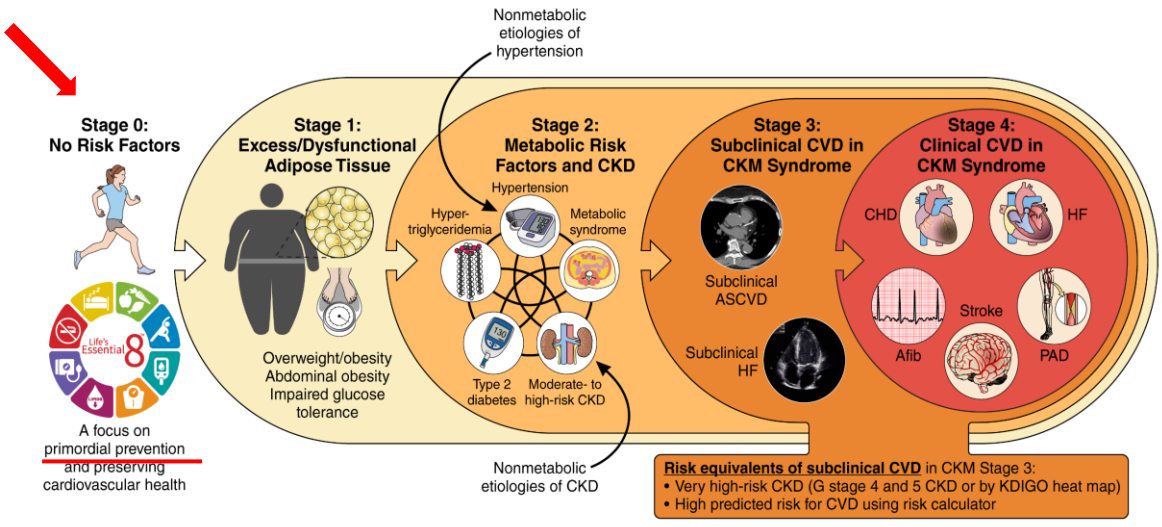
Stages of Cardio-Kidney-Metabolic Syndrome



Ndumele, C.E., et al. 2026 AHA/ACC/ADA/ASN Guideline for the Prevention, Detection, Evaluation, and Management of CKM Syndrome. *Circulation*.

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Treat Earlier

Start statin therapy for:

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

CAC=coronary artery calcium

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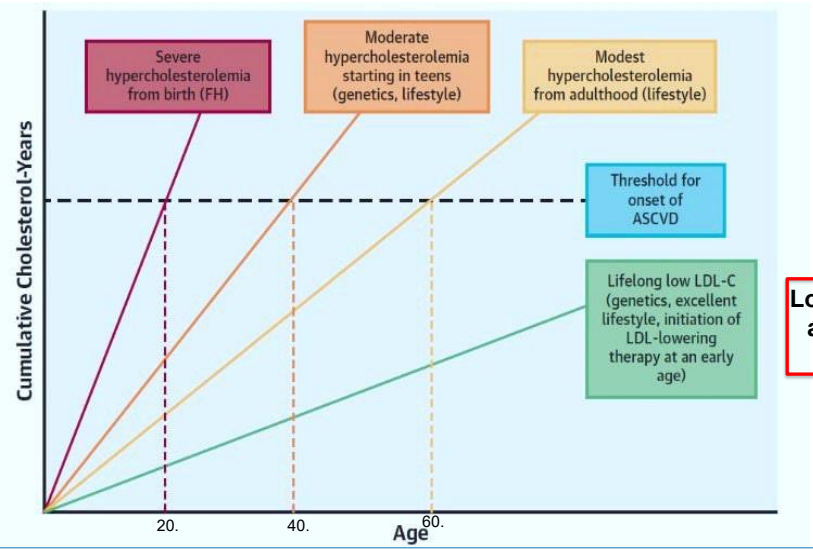
Assessing "Cholesterol (LDL)-Years" Like "Pack-Years" for ASCVD Risk Prediction



Lower LDL-C Earlier and for Longer is Better

Cumulative prior exposure to elevated LDL-C is a critical driver of ASCVD Risk

Shapiro MD, Bhatt DL. *J Am Coll Cardiol*. 2020;76(13):1517-1520.

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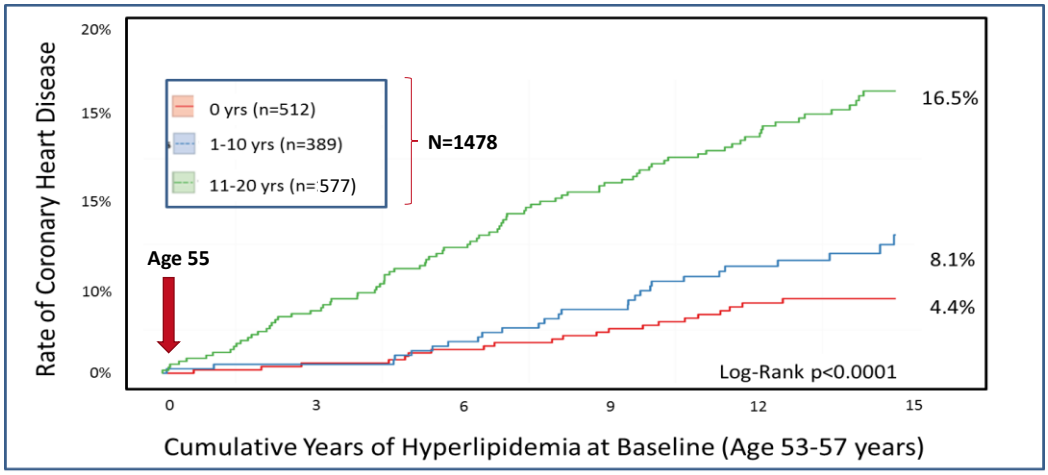
Cumulative Exposure to High Cholesterol Increases Heart Disease Risk in Those W/O CVD at Age 55 (non-HDL-C > 160 mg/dL)



Navar AM, Peterson ED et al. *Circulation*. Vol 131 Issue 5 Feb. 2015, pgs 451-458.

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

2. LDL-C and Non-HDL-C Goals are Back

- LDL-C and non-HDL-C treatment goals are back to guide Lipid-lowering Therapy.

  -Percentage reduction in LDL-C remains a priority goal as well, depending on level of ASCVD risk.

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2. Lipid Goals: LDL-C and Non-HDL-C Are Back

	Patient Examples	LDL-C mg/dL	Non-HDL-C mg/dL
Borderline (3-4.9%) To Intermediate Risk (5-9.9%)	3-<5% or 5-<10% 10-year ASCVD Risk • <3% 10-year ASCVD risk + (LDL-C ≥160 mg/dL or family history or 30-year risk ≥10%) • T2DM without ASCVD or risk factors • CAC score of 1-99 or mild incidental CAC	<100	<130
High Risk (≥ 10%) (For Primary and Secondary Prevention not at Very high risk)	≥10% 10-year ASCVD Risk • T2DM + risk factors • HeFH without ASCVD • CAC ≥100 – 999 AU • Moderate to severe incidental CAC	<70	<100
Very High Risk (Secondary P with recurrent events)	• CAC ≥1000 AU (optional if ≥300 AU)	<55	<85

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

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Primary Prevention:
Initial Risk Assessment

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

3a. Use the New AHA Predicting Risk of CV Disease EVENTS (PREVENT ®) Calculator

- Based on more recent 2023 populations, the **PREVENT®** calculator more accurately predicts the 10 and 30-year risk assessment to guide LLT in primary prevention.
- Used for Primary Prevention in those with LDL-C levels of 70-189 mg/dl who are 30-79 years of age.
- A lifetime risk can also be calculated in those 30-59 years of age.

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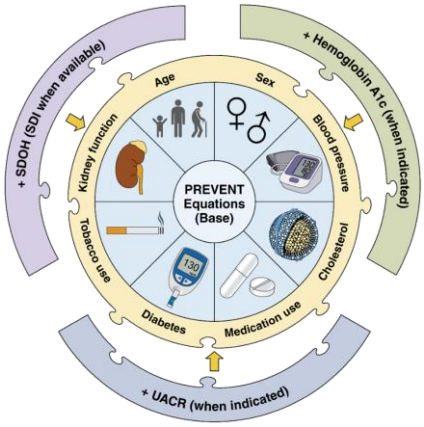
PREVENT-ASCVD Risk Calculator

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
UACR, urine albumin-to-creatinine ratio.

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

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~~Pooled Cohort Equation~~ ➡ PREVENT™

PCE (2013)

- 5 cohorts, 1960's-1990's (25,000 adults)
- Age 40-79, only 10-year risk
- ASCVD risk only
- Overestimates risk in our more modern populations with better background therapy

Khan SS, et al. *Circulation*. 2023;148(24):1982–2004.

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~~Pooled Cohort Equation~~ ➡ PREVENT™

PCE (2013)

- 5 co…, 1960's …0's (…ults)
- Age …ear risk
- ASCVD
- Ov… …e… …r more n… …pula… …better back… …nd thera…

PREVENT (2023)

- 25 contemporary datasets (1998-2019); validated in another 21 datasets (6.6 million adults)
- Age 30-79, 10 & 30-year risk
- Tells Risk of ASCVD, as well as CVD and heart failure risk
- Recalibrated to current event rates, better in women and older adults
- Not as well studied in minority(Asian) populations

Khan SS, et al. *Circulation.* 2023;148(24):1982–2004.

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Comparing PCE vs PREVENT

	PCE (2013)	PREVENT (2023)
Age	X	X
Sex	X	X
Race	X	—
Blood Pressure	X	X
Tobacco Use	X	X
Cholesterol	X	X
Diabetes	X	X
Hypertension Tx	X	X
Lipid Tx	—	X
BMI	—	X
eGFR	—	X
Optional		
UACR	—	X
Hgb A1C	—	X
Zip Code	—	X

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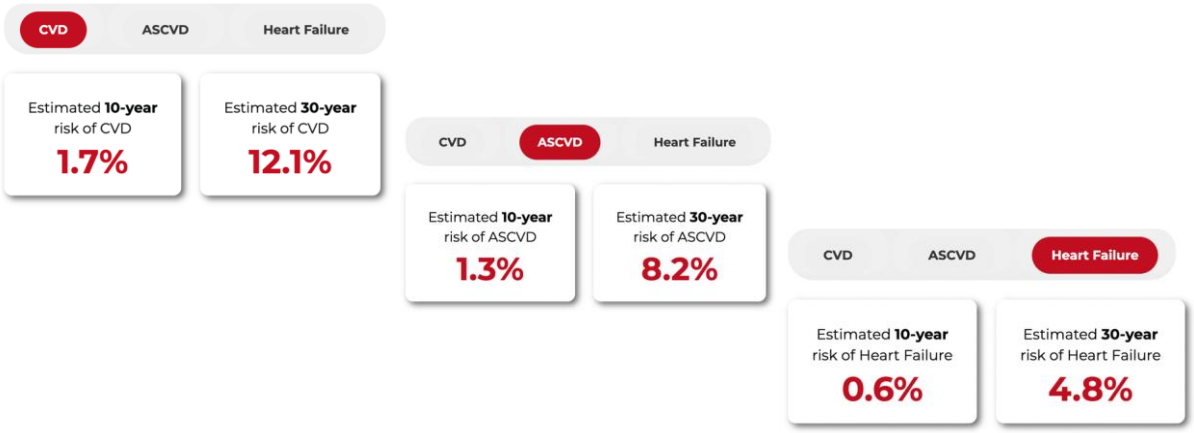
Predicting Risk of CVD EVENTs Calculator

PREVENT RISK CALCULATOR

The American Heart Association PREVENT™ Online Calculator



Khan SS et. al. *Circulation* 2023

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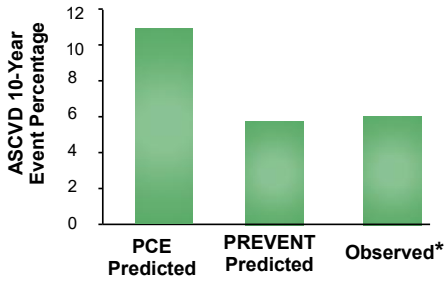
Pooled-Cohort Equation (PCE-2013) vs PREVENT (2023)

10-Year Predicted ASCVD Events in MESA*



***MESA-Multi-Ethnic Study of Atherosclerosis**

Murphy B et al. JACC Adv. 2025 Vol 4 No. 6 June 2025:101825 .

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

3b. Apply the **CPR(R)** Model

-**C**alculate –the 10 yr ASCVD risk
-**P**ersonalize –the risk by considering factors not included in PREVENT
-**R**eclassify –with selective use of coronary artery calcium (CAC)
-**R**eassess –your treatment recommendations

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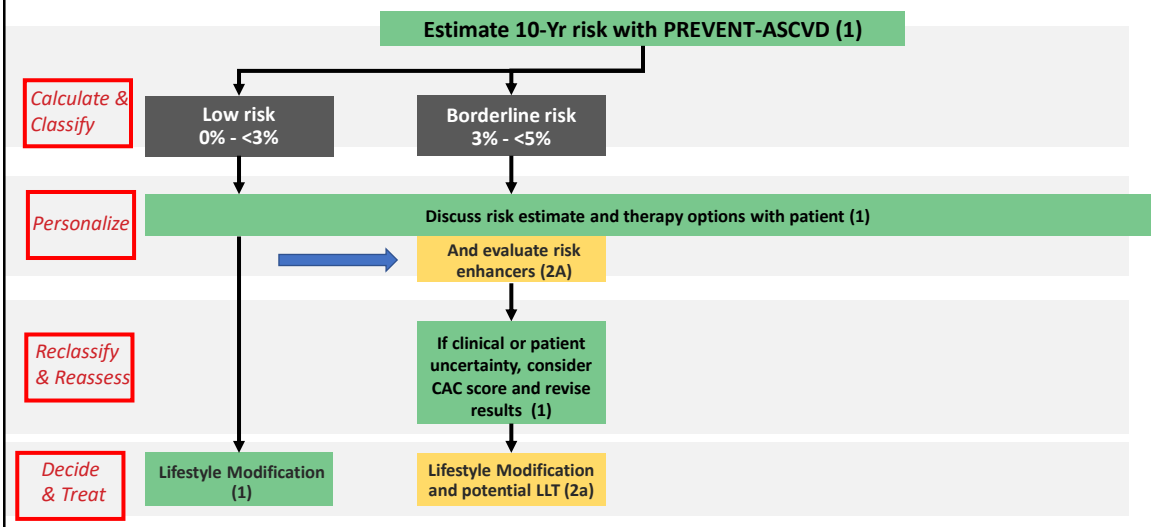
Calculate, Personalize, Reclassify (CPR) Framework



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

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

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Risk Enhancers to Personalize Risk

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

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Reproductive Risk Markers Considered in Primary Prevention

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.

*Now called PMOS-polyendocrine Metabolic Ovarian Syndrome

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

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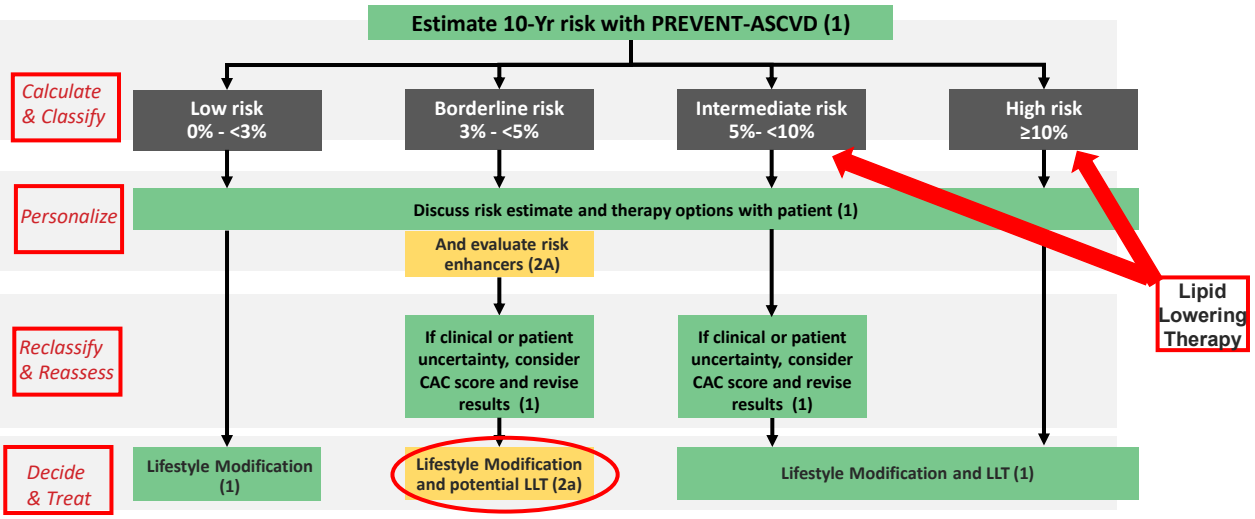
Calculate, Personalize, Reclassify (CPR) Framework



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

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

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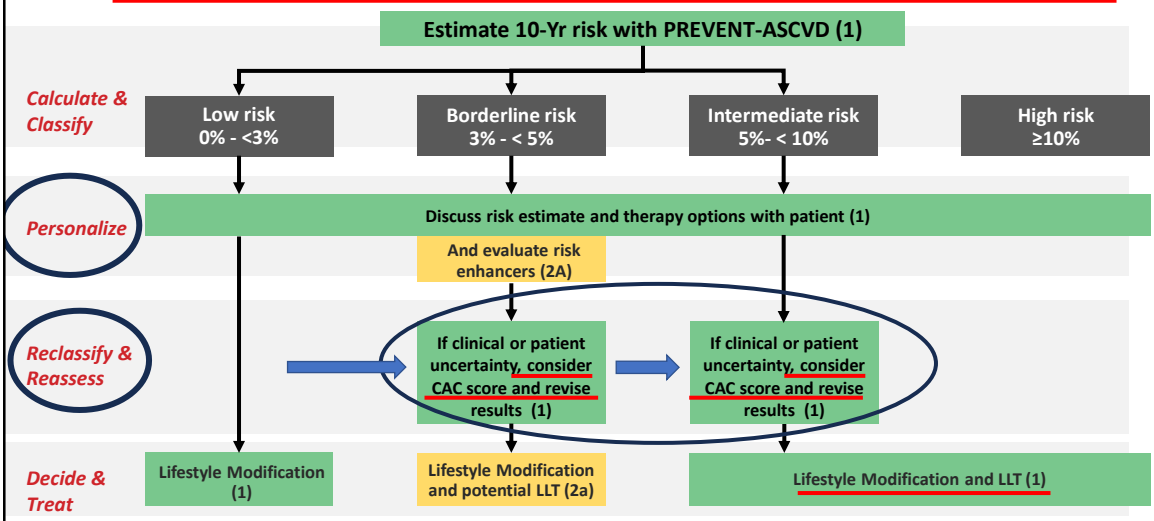
Calculate, Personalize, Reclassify (CPR) Framework Using PREVENT

For primary prevention in adults 30-79 with low-density lipoprotein cholesterol (LDL-C) levels of 70-189 mg/dL



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. https://www.ahajournals.org/doi/10.1161/CIR.0000000000001423
J Am Coll Cardiol. https://doi.org/10.1016/j.jacc.2025.11.016

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

4. The Role of Coronary Artery Calcium (CAC) Scoring

- Used in Men > 40 years of Age; Women > 45 years of Age
- Absolute CAC is Used to Reclassify Risk
- CAC scoring correlates with LDL-C Target
- Use in those not previously treated with statins

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

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CAC Scoring When There is Uncertainty with Borderline or Intermediate Risk – 2019 to 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 Arnett DK, et al. J Am Coll Cardiol. 2019;74:1376-1414.
I	B-R	In adults at intermediate risk (5 to <10%) and select adults at borderline risk (3 to <5%) 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. Blumenthal RS, et al. J Am Coll Cardiol. 2026.

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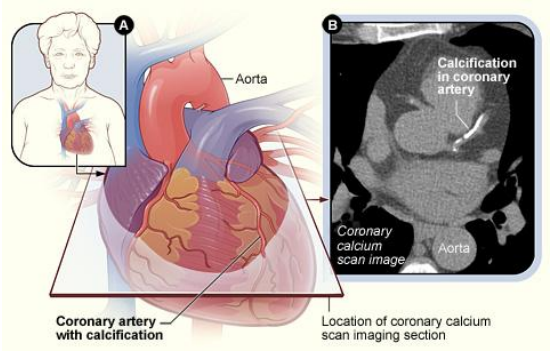
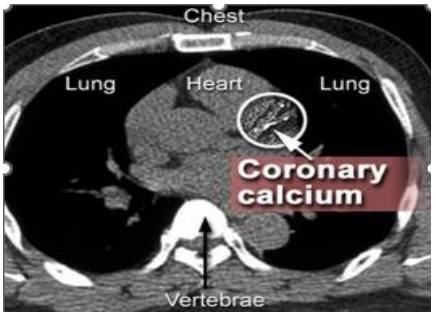
The Role of Coronary Artery Calcium (CAC) Scoring In Reclassifying Risk

~1 mSv





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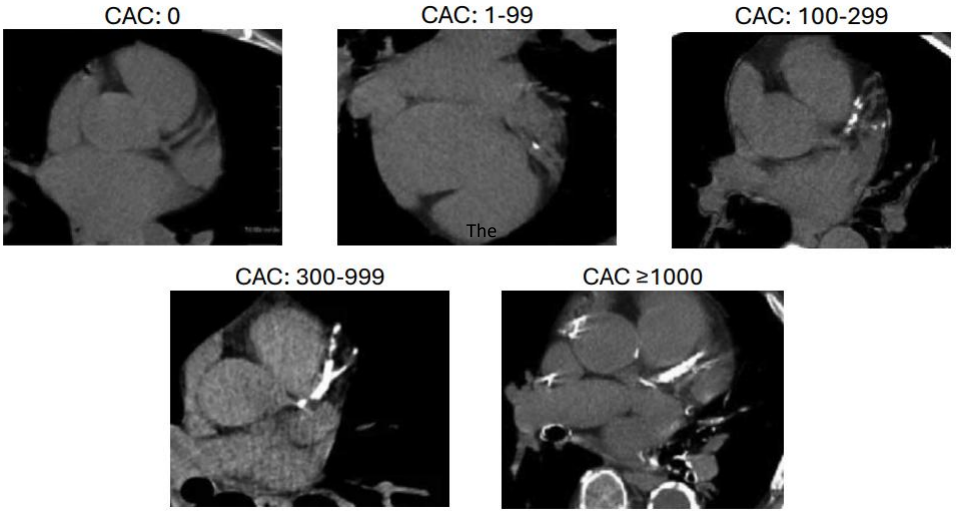
The Role of Coronary Artery Calcium (CAC) Scoring In Reclassifying Risk



Adapted from Maron DL. et al. *JACC Adv*. 2024;3:101287.

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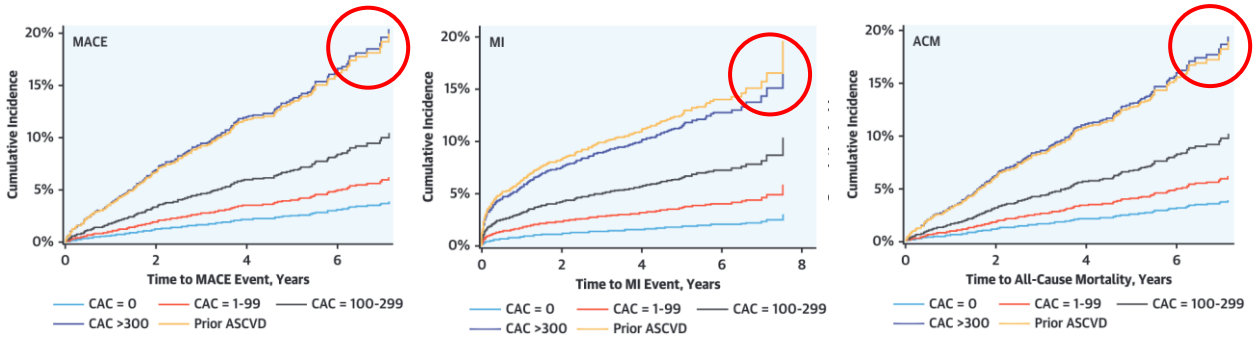
Coronary Artery Calcium Scores and Cardiovascular Risk

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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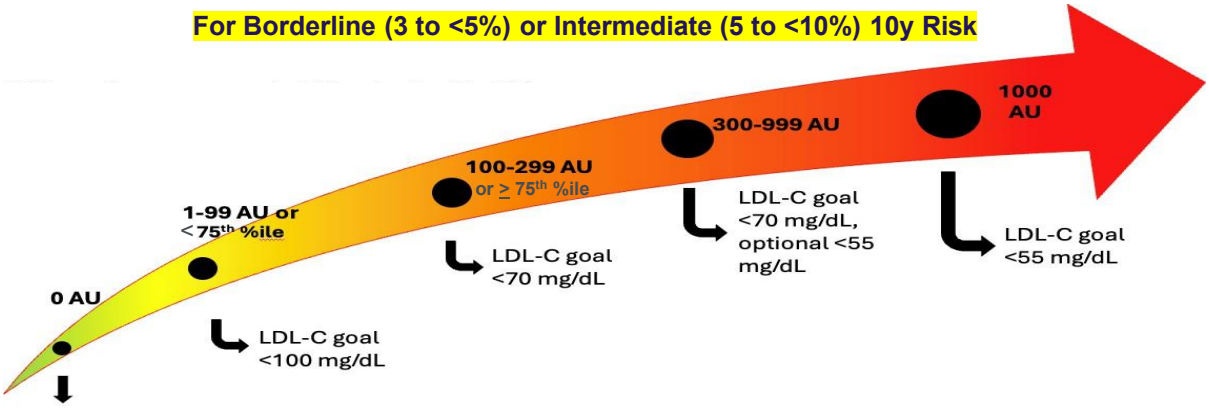
Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

American Heart Association.

AMERICAN COLLEGE of CARDIOLOGY

4. CAC Scoring in Men ≥ 40 Years of Age and Women ≥ 45 Can Improve Risk Stratification and Help Guide Treatment Goals in Those with Subclinical Atherosclerosis

For Borderline (3 to <5%) or Intermediate (5 to <10%) 10y Risk



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

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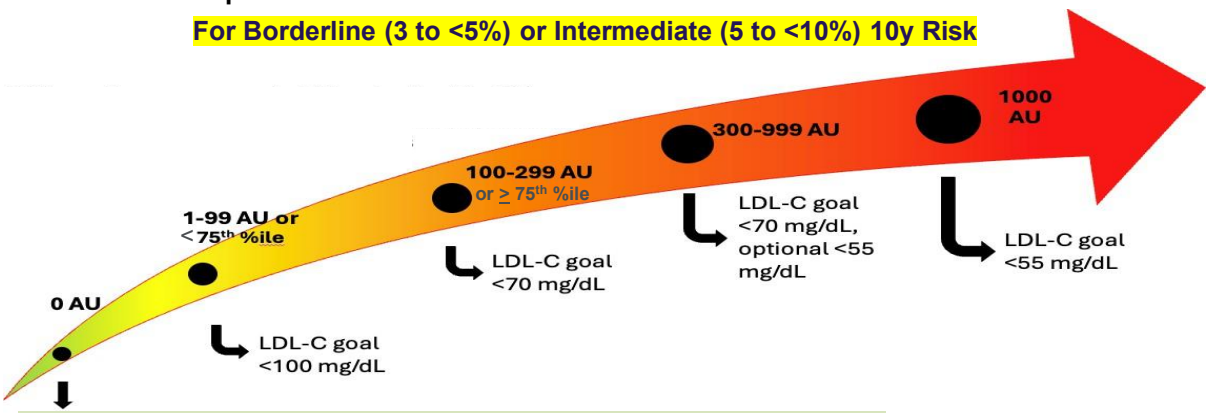
Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

4. CAC Scoring in Men ≥ 40 Years of Age and Women ≥ 45 Can Improve Risk Stratification and Help Guide Treatment Goals in Those with Subclinical Atherosclerosis

For Borderline (3 to <5%) or Intermediate (5 to <10%) 10y Risk



Do NOT withhold LDL-C pharmacotherapy with a CAC Score of 0 if any of the following:
1. diabetes mellitus,
2. familial hypercholesterolemia (LDL-C ≥190 mg/dL),
3. current tobacco use,
4. family history of premature ASCVD

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

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Time to Use ALL Available Imaging

1	B-NR	5. In adults with no prior ASCVD, if incidental CAC is identified on noncardiac computed tomography (CT) scans (eg, by visual estimation or a validated artificial-intelligence based algorithm), the presence of coronary atherosclerosis should be considered during decision-making about initiation or intensification of LLT to reduce ASCVD risk.

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

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Time to Use All Available Imaging: The Role of Incidental CAC on Non-CT Guided Scans

- If CAC is not feasible, remember to ask the patient about prior imaging.
- Calcification may be found incidentally on prior image testing such as breast imaging.

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

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Additional Information on Incidental CAC Found on a Non-Gated Scan

Incidental CAC found on a non-gated 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 therapy given the low negative predictive value of non-gated scans.

Blumenthal R. Morris P. et al. *J Am Coll Cardiol*. 2026 https://doi.org/10.1016/j.jacc.2025.11.016.

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Additional Lipid Testing: The Role of Apo(B) and Lp(a)

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

5. Apo B Measurement is Recommended in Specific Populations

- Apo B Measurement can improve residual risk assessment and guide therapy, especially when LDL-C and non-HDL-C goals are met-in patients with:

  -High Triglycerides ≥ 200 mg/dL

  -Diabetes

  -Cardio-Kidney-Metabolic Syndrome with low achieved LDL-C

- If Apo B is above goal, treatment should be intensified

About ApoB:

1)All atherogenic lipoproteins have a single apoB100 protein

2)ApoB reflects the total number of atherogenic lipoproteins

3)ApoB is not affected by fasting

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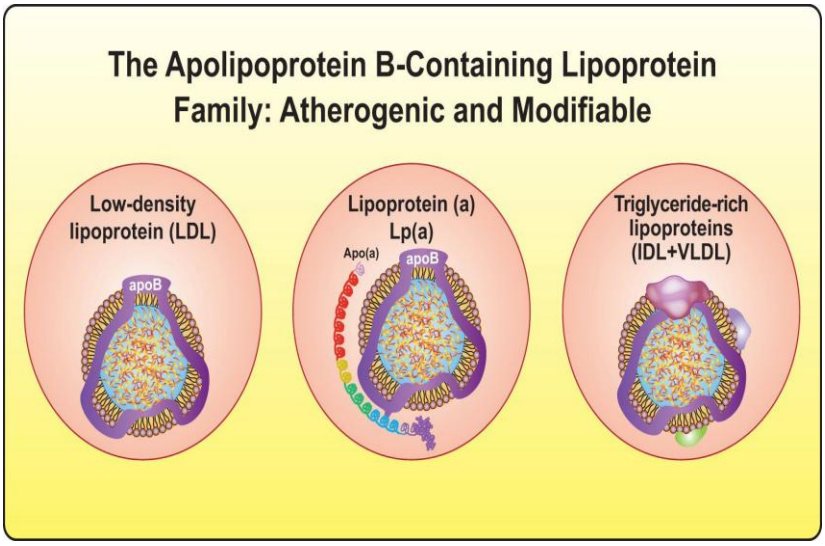
Additional Risk Markers in the 2026 Dyslipidemia Guideline



Tokgözoğlu L et al. *Eur Heart J*. 2022;43(34):3198-3208.

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Additional Risk Markers in the 2026 Dyslipidemia Guideline

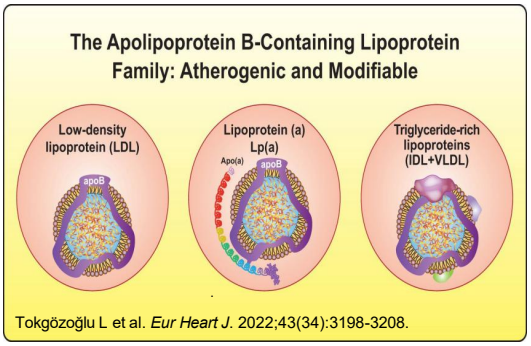
Measures all atherogenic particles

More accurate compared to LDL-C

Screening with Apo B

Particularly for secondary prevention, metabolic syndrome, diabetes, elevated triglyceride

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



Tokgözoğlu L et al. *Eur Heart J*. 2022;43(34):3198-3208.

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

ApoB-Apolipoprotein B
ASCVD-atherosclerotic cardiovascular disease
LLT-lipid-lowering treatment
HDL-C-high-density lipoprotein cholesterol
VLDL-very low-density lipoprotein

All atherogenic lipoproteins have a single apo B100 protein. ApoB is not affected by fasting

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

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5. Lipid Goals (LDL-C, Non-HDL-C, and ApoB) in Others

	Patient Examples	LDL-C mg/dL	Non-HDL-C mg/dL	ApoB mg/dL
Borderline to Intermediate Risk	• 3-<5% or 5-<10% 10-year ASCVD Risk • <3% 10-year ASCVD risk + (LDL-C ≥160 mg/dL or family history or 30-year risk ≥10%) • T2DM without ASCVD or risk factors • CAC score of 1-99 or mild incidental CAC	<100	<130	<90
High Risk	• >10% 10-year ASCVD Risk • T2DM + risk factors • HeFH without ASCVD • CAC ≥100 – 999 AU • Moderate to severe incidental CAC	<70	<100	<70
Very High Risk	• CAC ≥1000 AU (optional if ≥300 AU)	<55	<85	<55

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

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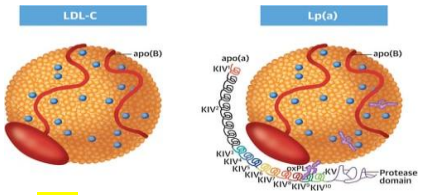
Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

6. Lp(a) Measurement

Lipoprotein A – Lp(a)

[LDL + apo(a) = Lipoprotein(a)]



- Lp(a) should be measured at least once in all Adults.
- Lp(a) levels are genetically determined and stable after age 9.
- Currently elevated levels should prompt intensified risk factor management until clinical outcome trials of Lp(a) reduction are completed.

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

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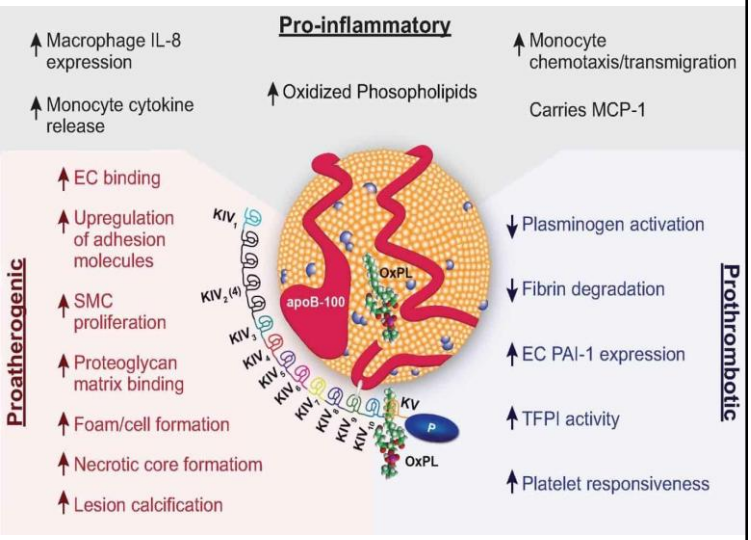
Why Is Lp(a) a Risk Factor for ASCVD?

- Pro-atherosclerotic
- Pro-thrombotic
- Pro-inflammatory



Wilson DP, et al. *J Clin Lipidol* 2019;13(3):374-392,

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Journal of Clinical Lipidology
Available online 27 April 2026
In Press, Corrected Proof What's this?

It's Time to Test All Adults for Lipoprotein(a)

- Lipoprotein(a) should be tested at least once in all adults.
- Despite the high 20-25% estimated prevalence of elevated Lp(a) in our population, testing rates for Lp(a) remain very low.
- Clinical trials, cohort studies, real-world data, and implementation studies are needed as Lp(a) testing expands.

Wilkinson M.J. and Koschinsky M.L. *Jnl Clin Lipidology* Published online March 23, 2026. doi.org/10.1016/jacl.2026.04.022

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Risk Markers in the 2026 Dyslipidemia Guideline

Screening with Lp(a)

Lp(a)

Measurement of Lp(a) in all adults is recommended at least once for ASCVD risk assessment. (1)

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

In those with FH, premature ASCVD, or high Lp(a), cascade testing of 1st - degree relatives is recommended. (1)

ASCVD, atherosclerotic cardiovascular disease
Lp(a), lipoprotein(a).

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

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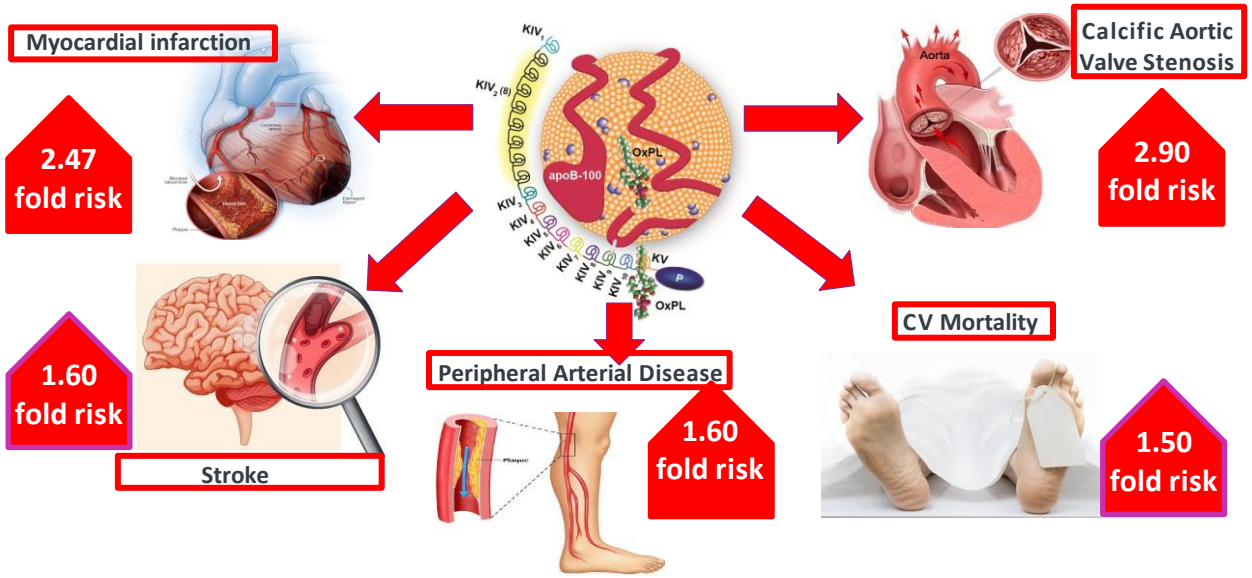
Lp(a) and Cardiovascular Disease (CVD) Risk



Reyes-Soffer G et al. *Am J Prev Cardiol*. 2024;18:100651.

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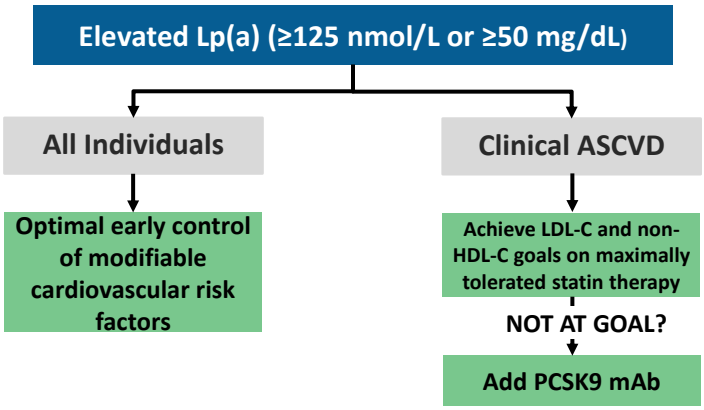
Approach to Patients with Elevated Lp(a)



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

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Treatment Recommendations for Elevated Lp(a)

- Manage LDL-C risk with statins.
- Consider PCSK9i or apheresis in select high risk patients.
- Currently refer patients to a lipid specialist and/or a clinical trial.
- Secondary prevention patients: awaiting results of HORIZON, OCEAN(a), ACCLAIM.
- High risk primary prevention: ACCLAIM, PRE-EVENT, MOVE-Lp(a).

Adapted from Grundy SM et al. *J Am Coll Cardiol* 2019;73(24):3234-3237

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Drug to reduce Lp(a)	Company	Mechanism	Drug administration	Trial	CV Outcomes Completed
Pelacarsen	Novartis	ASO 80% reduction	Subcutaneous injection Q4weeks (monthly)	HORIZON: Phase 3-secondary	2026-2027 (should be first part of 2026)
Olpasiran	Amgen	siRNA 95-98% reduction	Subcutaneous injection Q12 weeks	OCEAN (a): Phase 3-secondary PRE-EVENT: Phase 3-primary	2026 ? (probably 2027) ?
Lepodisiran	Eli Lilly	siRNA	Subcutaneous injection Q6 months?	ALPACA: Phase 2 ACCLAIM-Lp(a): Phase 3-secondary	 2025-2029
Zerlasiran (SLN360)	Silence Therapeutics	siRNA	Subcutaneous injection	APOLLO/ ALPACAR: Ph2	Phase 3 Not started
Muvalaplin	Eli Lilly	Oral small molecule	Oral medication once daily	KRAKEN: Phase 2 MOVE-Lp(a): Phase3-primary	? ?

Adapted from Dr Ashley Waring-Personal Communication

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Primary Prevention in Special Populations:

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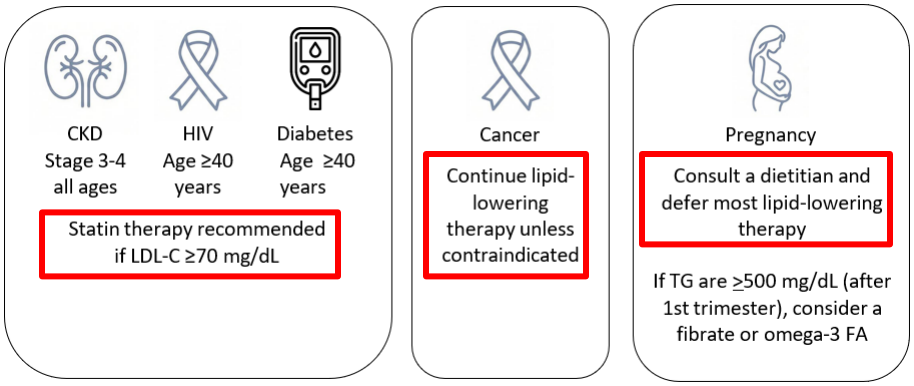
Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

7. In Primary Prevention, LDL-C Lowering Rx Is Recommended Regardless of LDL-C in Adults Ages 40-75 with Diabetes, CKD, or HIV.

Special Populations to Consider for Lipid-Lowering Therapy



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

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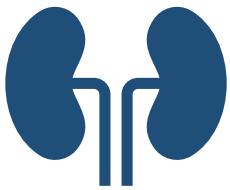
Adults with Chronic Kidney Disease



Adults with CKD	
COR	**RECOMMENDATIONS**
1	In adults 40 to 75 years of age with CKD Stage 3 or higher and an LDL-C of 70-189 mg/dL (1.8-4.9 mmol/L), moderate-intensity statin therapy (± ezetimibe) is recommended to reduce ASCVD risk.
1	In adults with CKD Stage 3 or higher and clinical ASCVD, LLT with high-intensity statin therapy (± ezetimibe) and/or a PCSK9 mAb, is recommended to achieve ≥50% reduction in LDL-C levels and a goal of LDL-C <55 mg/dL (1.4 mmol/L) and non-HDL-C <85 mg/dL (2.2 mmol/L) to reduce ASCVD risk.
2b	In adults with CKD who require maintenance hemodialysis, it may be reasonable to continue statin therapy to reduce the risk of ASCVD events. Treatment decisions should be individualized, considering expected survival, other comorbidities, and severity of ASCVD.

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

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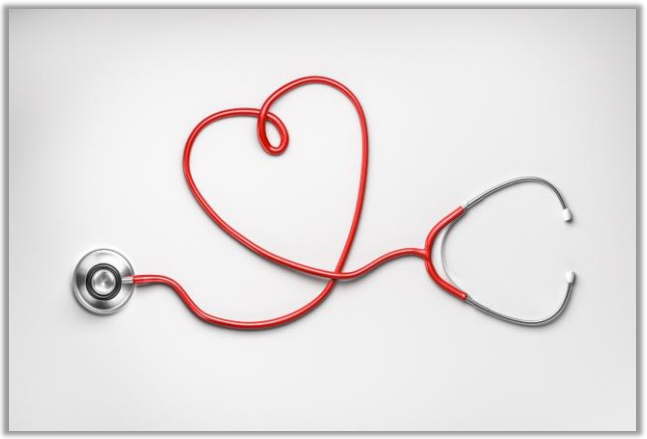
Adults with HIV

Persons Living With Human Immunodeficiency Virus (HIV)	
COR	**RECOMMENDATIONS**
1	In people living with HIV aged 40-75 on stable combination antiretroviral therapy, statin therapy is recommended to reduce risk of a first ASCVD event and reduce the rate of coronary atherosclerosis progression.

- The REPRIEVE trial demonstrated that in people living with HIV, pitavastatin 4 mg daily led to a 35% reduction in risk of the first MACE.
- Consider drug-drug interactions between lipid-lowering therapies and antiretroviral therapies.



Abbreviations: REPRIEVE, Randomized Trial to Prevent Vascular Events in HIV.

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

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Adults with Cancer or a History of Cancer

Adults with Cancer or a History of Cancer	
COR	**RECOMMENDATIONS**
1	Adult cancer survivors with life expectancy of at least 2 years who otherwise qualify for LLT should be treated similarly to people without history of cancer to reduce the risk of ASCVD events.
1	In adults with active cancer currently on statin therapy, treatment should be continued to reduce ASCVD risk unless there is concern for a specific drug interaction or life expectancy is <1 year.
2b	In adults with active cancer, initiation of statin therapy may be considered to prevent anthracycline-induced cardiotoxicity.

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

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Primary Prevention: Targets and Drugs

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

8. Goals (Targets) and Drugs in Primary Prevention

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

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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 an all 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%)

→ LDL-C Goal < 100 mg/dL

- High 10-yr Risk (≥10%)

→ LDL-C Goal < 70 mg/dL

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

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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

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

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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.

Abbreviations:
LDL-C, low-density lipoprotein cholesterol
non-HDL-C, non–high-density lipoprotein cholesterol
PCSK9, proprotein convertase subtilisin/kexin type 9.

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

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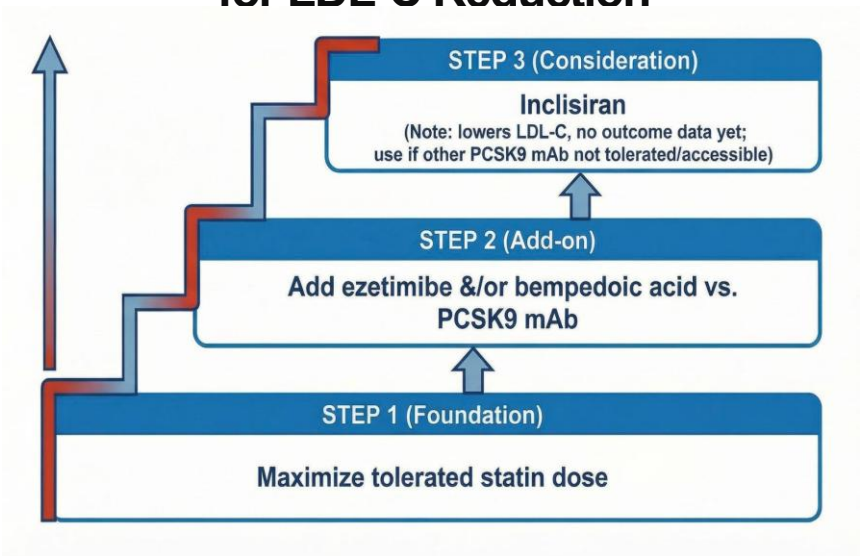
Hierarchy of Lipid-lowering Therapy for LDL-C Reduction



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

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LDL Lowering Pharmacotherapy Summary of Clinical Trial Data

	LDL-C Reduction	HDL-C	TG	LP(a)	CV RR Reduction 1° / 2° Prevention
Statins	18-63%	↑ 5-15%	↓ 7-30%	neutral	25-39% / 19-34%
Ezetimibe	18%	↑ 1%	↓ 7%	neutral	minimal data / 6.4%
PCSK9 inhibitors	40-60%	neutral	↓	↓ ~20-30%	19-25%* / 17%*
Bile acid sequestrants	15-30%	↑ 3-5%	0 or ↑	neutral	19% / minimal data
Inclisiran	~50-60%	↑ ~5%	↓ ~7-12%	↓ ~18-26%	no data / 26%*
Bempedoic acid	18%	↓ 6%	↑ 3%	neutral	30% / +/- 13%

*RCT evidence of ASCVD risk reduction when added to statin therapy

Expert Panel. *JAMA*. 2001;285:2486; Ray. et al. *N Engl J Med*. 2020; 382:1507-151; Data compiled from various package inserts; Zhang Y, et al. *Frontiers in Pharmacology* (2023).; Ray KK, Raal FJ, Kallend DG, et al; ORION Phase III Investigators. Eur Heart J. 2023;44(2):129-138.; Sabatine MS, et al. N Engl J Med. 2017 May 4;376(18):1713-1722.; Turgeon, Ricky D. et al. Canadian Journal of Cardiology, Volume 34, Issue 12, 1600 – 1605.; (4S). Lancet. 1994 Nov 19;344(8934):1383-9.; Heart Protection Study Collaborative Group. Lancet. 2002 Jul 6;360(9326):7-22.; Lloyd SM, et al. PLoS One. 2013 Sep 2;8(9):e72642.; Bosch J, et al. Eur Heart J. 2021 Aug 17;42(31):2995-3007.; Ridker PM, et al. Lancet. 2012 Aug 11;380(9841):565-71.; Cannon CP, et al. N Engl J Med. 2015;372(25):2387–2397.; JAMA. 1984 Jan 20;251(3):351-64. Nissen SE, Menon V, Nicholls SJ, et al. JAMA. 2023;330(2):131–140.; Bohula EA et al. Am Heart J. 2024;269:179-190; Gaine SP, Quispe R, et al. Curr Cardiovasc Risk Rep. 2022 Sep;16(9):69-78.

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Secondary Prevention: Targets

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

9.Considerations in Secondary Prevention of ASCVD

- Treatment Goals of LDL-C < 55 mg/dL and non-HDL-C < 85 mg/dL are recommended in patients at very high risk of ASCVD events.

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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 CHF
- Hypertension
- LDL-C ≥ 100mg/dL despite maximally tolerated statin + ezetimibe

The majority of patients with established ASCVD are Very High Risk

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

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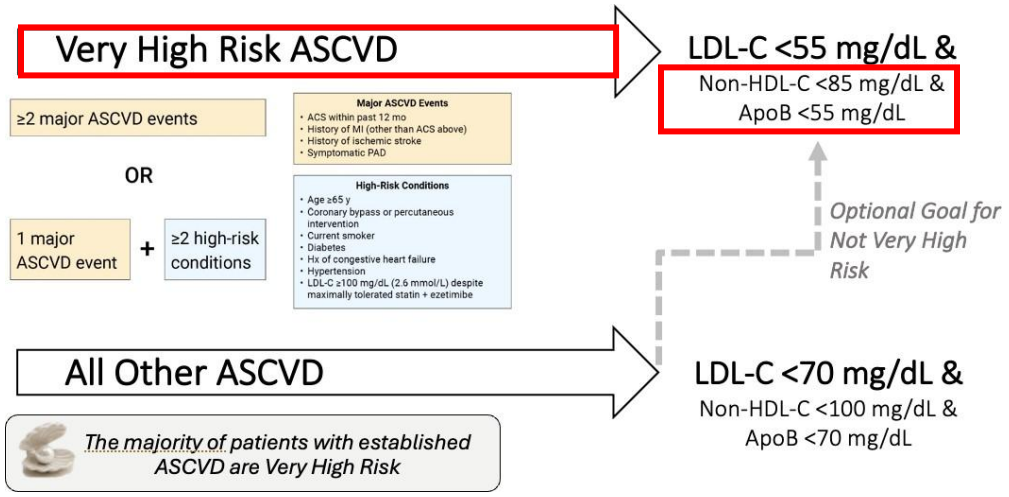
Lipid Goals (LDL-C, Non-HDL-C, and Apo B) with ASCVD



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

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

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Lipoprotein Goals for ASCVD Risk Reduction

Patient population	LDL-C <100 mg/dL (2.6 mmol/L) Non-HDL-C <130 mg/dL (3.4 mmol/L)	LDL-C <70 mg/dL (1.8 mmol/L) Non-HDL-C <100 mg/dL (2.6 mmol/L)	LDL-C <55 mg/dL (1.4 mmol/L) Non-HDL-C <85 mg/dL (2.2 mmol/L)
Primary prevention	PREVENT-ASCVD < 10% • If TG ≥ 150 mg/dL to 499 mg/dL, apoB goal: <90 mg/dL	PREVENT-ASCVD ≥ 10% • 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 • apoB goal: <90 mg/dL	**Without** ASCVD risk factors or diabetes-specific risk modifiers • apoB goal: <70 mg/dL	N/A
Subclinical atherosclerosis	CAC = 1-99 AU and <75th percentile for age, sex, and race AU, Agatston units	• CAC ≥ 100 to 299 AU or ≥75th percentile for age, sex, and race • CAC ≥ 300 to 999 AU – Optional goal: LDL-C <55 mg/dL, non-HDL-C <85 mg/dL, and consider apoB goal <55 mg/dL	CAC ≥ 1000 AU
Clinical ASCVD	N/A	Not at very high risk • Optional goal: LDL-C <55 mg/dL, non-HDL-C <85 mg/dL, and consider apoB goal <55 mg/dL	• At very high risk – apoB goal: <55 mg/dL • With CKD

Abbreviations: ApoB indicates apolipoprotein B; ASCVD, atherosclerotic cardiovascular disease; AU, Agatston units; CAC, coronary artery calcium; CKD, chronic kidney disease; FH, familial hypercholesterolemia; HDL-C, high-density lipoprotein-cholesterol; LDL-C, low-density lipoprotein-cholesterol; and TG, triglycerides.

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

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Top 10 Things to Know About the 2026 ACC/AHA Cholesterol Guideline

10. Elevated Triglyceride

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

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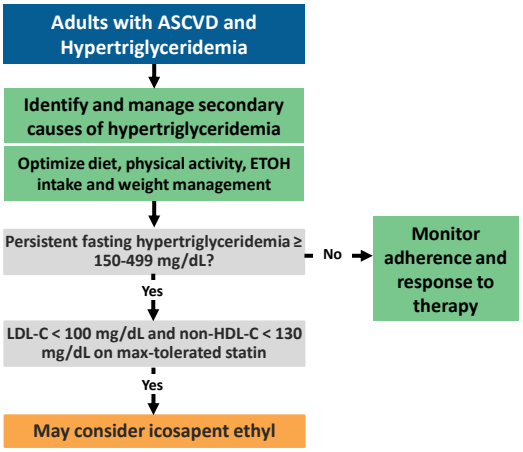
Management of Hypertriglyceridemia



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

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

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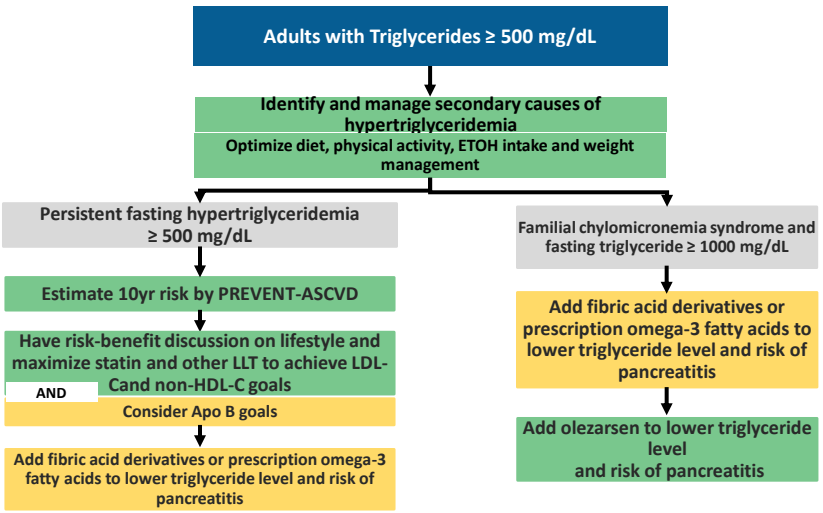
Management of Hypertriglyceridemia (Cont.)



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

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

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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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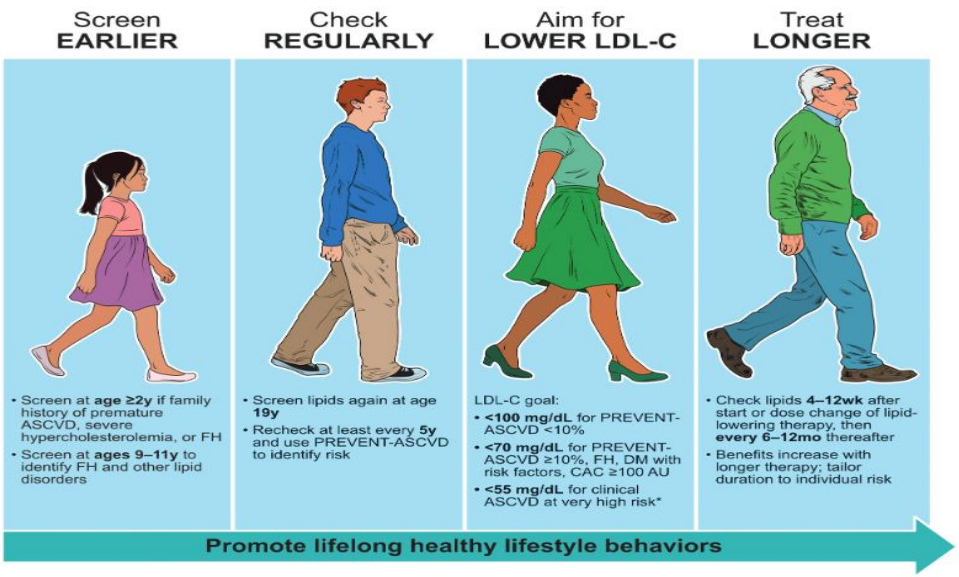
When to Do It & How Often



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

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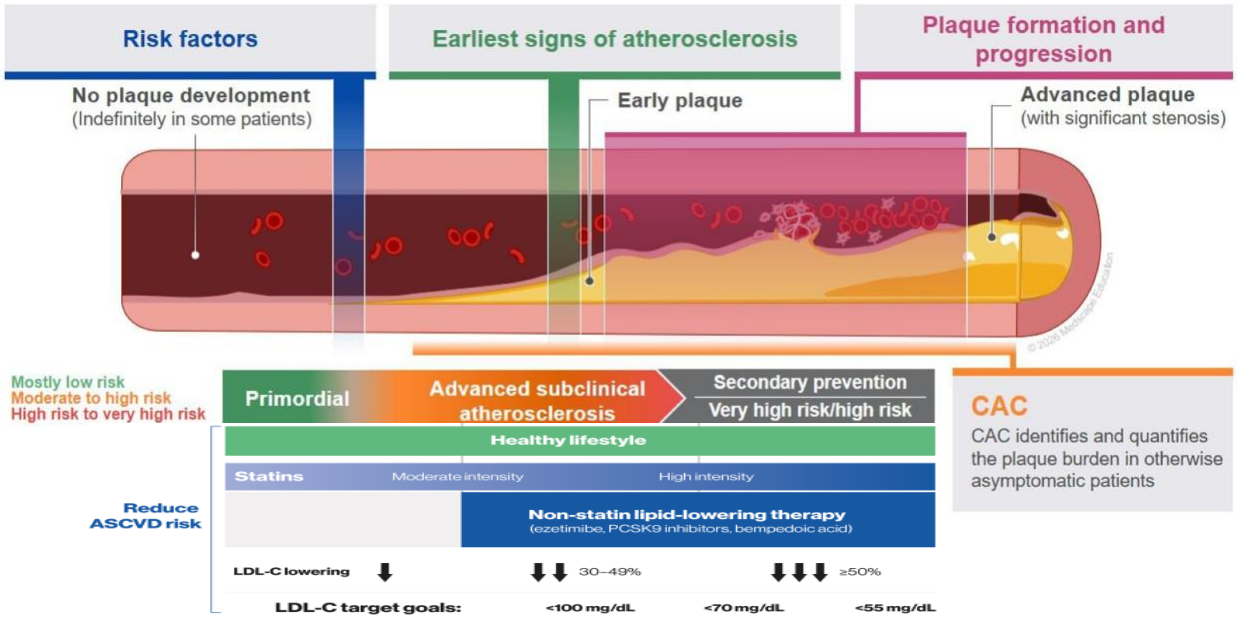
The CV Risk Continuum



Adapted from Fig 4. Wilkinson MJ, et al. J Am Heart Assoc. 2023;12:e028892.

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Take Home Points

- **Lipid Testing is integral to Initiate and Intensify Lipid-Lowering Rx.**
- **For LDL-C, Lower for longer is best for CV Outcomes.**
- **LDL-C Goals (Targets) are back and should be risk-based.**
- **Coronary Artery Calcium is Emphasized Looking for Sub-clinical and Clinical Atherosclerosis in those not on statins.**
- **Measure Lp(a) Once in all patients and Apo B when occasionally required.**
- **Very High Risk ASCVD patients require aggressive LDL-C lowering to < 55 mg/dL and often require multiple classes of lipid-lowering Rx.**
- **The data supports the incremental benefit of LDL-C lowering with ezetimibe, bempedoic acid, and PCSK9 inhibition in high and very high-risk patients, including those with statin intolerance.**
- **The new 2026 Lipid Guidelines will take a while to absorb but the principles are similar to our most recent guideline update in 2022.**

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Case 1

- 45-year-old male presents for routine evaluation and is without complaints.
- He has seen health care providers for the past 20 years.
- Has a long hx of hyperlipidemia but no other underlying diseases.
- He was adopted so he is unaware of his family hx for ASCVD.
- A CAC score done 2 years ago before atorvastatin was started was 400.
- Currently he is on atorvastatin 80 mg and ezetimibe 10 mg and tolerating it well.
- Last weeks' lipids were TC 194, HDL-C 46, TG-145, LDL-C 119.

ARS Question #1

What Would You Recommend to Control His LDL-C and Reduce His ASCVD Risk?

A. Nothing as he is primary prevention and his LDL-C is fine.
B. Add bempedoic acid 180 mg.
C. Add icosapent ethyl 2 grams bid with food.
D. Add evolucumab 420 mg sq monthly.
E. Change Atorvastatin 80 to rosuvastatin 40 and continue the 10 mg ezetimibe.

Total Chol 192, HDL 46, TG 145, Calculated LDL-119, non-HDL-C 146.

On atorvastatin 80 mg and Ezetimibe 10 mg

Case 2

- A 50-year-old male is very concerned of his own personal risk as his father died of a heart attack at age 47 and his father's brother, his uncle, had a stroke at age 40.
- He exercises 5 days a week and gets in 7500 steps a day, maintains a vegan diet, and has no htn, diabetes, or tobacco use.
- He has a BMI of 26, a BP of 126/72, an A1C of 4.8, normal renal function and a normal u/a with alb/creat of 17 mg/gram creat.
- Recent labs: Total Chol 186, HDL 45, TG 130, Calculated LDL 115, non-HDL-C 141.
- He is on no medications and would rather not be on one and has no hx of easy bruising or bleeding.

ARS Question #2

What Would You Recommend?

A. Reassurance and no further testing
B. Order Genetic testing for Familial Hypercholesterolemia
C. Order hs-CRP
D. Order a Coronary Calcium Score
E. Check Lp(a)
F. (D) and (E)
G. (C), (D), and (E)