Outpatient Lipid Management

2026 ACC/AHA Multisociety Dyslipidemia Guideline · PREVENT replaces the pooled cohort equations

Earlier & lower *for longer*

STEP 1 · THE CPR FRAMEWORK *the guideline's own model for primary prevention*

C — CALCULATE

PREVENT-ASCVD, ages 30-79, LDL 70-189. Bands: **low < 3% · borderline 3-<5% · intermediate 5-<10% · high ≥ 10%.** Race dropped as an input; CKD, HbA1c and BMI added; reports **10- and 30-year** risk.

P — PERSONALIZE

Apply **risk enhancers** PREVENT misses: family history of premature ASCVD, LDL ≥ 160, metabolic syndrome, CKD, elevated Lp(a), South Asian ancestry, **inflammatory disease** (RA, lupus, psoriasis, HIV) and **reproductive history** (preeclampsia, early menopause, gestational diabetes).

R — RECLASSIFY & REASSESS

When the decision is still uncertain, **CAC scoring** reclassifies. Then reassess the treatment plan. **Age 30-59, low risk, LDL < 160 and 30-year risk < 10%: lifestyle counseling alone** is the Class 1 answer.

STEP 2 · GOALS ARE BACK *LDL and non-HDL-C, plus a percent reduction*

Risk category	LDL-C goal	non-HDL-C goal	Also
Very-high-risk ASCVD Class 1	**< 55**	**< 85**	High-intensity statin, **≥ 50% LDL reduction**. apoB < 55. **Most patients with ASCVD land here.**
ASCVD, not very high risk	**< 70**	**< 100**	A minority of ASCVD patients.
Primary prevention, high (≥ 10%)	**< 70**	**< 100**	**High-intensity:** atorvastatin 40-80, rosuvastatin 20-40 (≥ 50% reduction).
Borderline 3-<5% or intermediate 5-<10%	**< 100**	**< 130**	**Moderate:** atorvastatin 10-20, rosuvastatin 5-10 (30-49%). Intermediate: **should** be considered; borderline: **may** be, after discussion. Use CAC if undecided.

Very high risk = multiple major ASCVD events, *or* one major event plus multiple high-risk conditions (age > 65, prior revascularization, smoking, diabetes, heart failure, hypertension, LDL > 100 on maximal statin + ezetimibe).

STEP 3 · WHO GETS THERAPY *and at what intensity*

Indication	Intensity and notes
Clinical ASCVD	**High-intensity.** Add ezetimibe, then a PCSK9i, to reach goal. Combination is the expectation, not the exception.
LDL ≥ 190	**High-intensity.** Treat as familial hypercholesterolemia until proven otherwise; **no risk calculation needed**.
Diabetes, CKD stage 3-4, or HIV age 40-75	**Recommended regardless of LDL level.** After 75, therapy *can be considered* alongside lifestyle.
Early intervention NEW	**HeFH at diagnosis** (including children 8-10), **young adults with LDL ≥ 160**, or strong family history of premature ASCVD. Exists because 10-year risk is always low in the young and systematically under-treats them.

CAC · NOW A CLASS 1 TOOL *upgraded from 2a in 2018*

WHO TO SCAN

Men ≥ 40, women ≥ 45, at **intermediate** risk or **selected borderline** risk, when the treatment decision remains uncertain. Both the **absolute score and the age/sex/race percentile** carry prognostic weight.

HOW IT CHANGES THE PLAN

CAC 0 supports withholding or postponing therapy in a low- or intermediate-risk patient with no other comorbidity. **Any calcium argues for treating**, and a higher score argues for treating harder. **Incidental calcium on a non-gated CT now counts**, so do not ignore "coronary calcifications" on a chest CT report.

ORDER ONCE, AND ONCE ONLY *Lp(a), plus apoB when LDL misleads*

Test	When, and what the number means
Lp(a) Class 1, all adults	**Measure at least once in every adult.** Genetically fixed, so one result settles it. **≥ 125 nmol/L (50 mg/dL)** is a risk enhancer, roughly **1.4×** risk; **≥ 250 nmol/L (100 mg/dL)** is **≥ 2×**. It has no drug of its own yet: it intensifies LDL lowering and risk-factor control. **Cascade test first-degree relatives.** In ASCVD with high Lp(a) not at goal on maximal statin, **add a PCSK9 mAb (Class 1)**.
apoB	Useful **once LDL and non-HDL goals are met**, and especially when **TG ≥ 150**, in **diabetes**, or when achieved **LDL < 70**. In those settings LDL-C understates particle number, so a patient "at goal" can still carry residual risk.

SPECIAL SITUATIONS *the ones that change the drug*

Situation	What to do, and why
TG ≥ 500	**Fenofibrate** to prevent pancreatitis. **Never gemfibrozil with a statin** (rhabdomyolysis). At **≥ 1000** the urgency is pancreatitis, not cardiovascular risk. **Statin remains the foundation** for ASCVD risk in high TG.
ASCVD, TG 150-499	**Icosapent ethyl** (REDUCE-IT). Pure EPA, **not interchangeable with OTC fish oil**. PROMINENT closed the door on fibrates for event reduction.
"Statin intolerant"	**Mostly nocebo**: SAMSON found identical symptoms on placebo. **Rechallenge with a different agent or alternate-day dosing before accepting the label**, which otherwise costs decades of protection. True intolerance: bempedoic acid, ezetimibe, PCSK9i.
Pregnancy	**Stop statins, ezetimibe, fibrates, niacin and PCSK9 inhibitors.** Bile acid sequestrants only, as they are not absorbed. Discuss contraception **before** starting a statin.
Dose caps	eGFR < 30: **rosuvastatin max 10 mg**. Asian ancestry: **start rosuvastatin 5 mg**. HIV: **pitavastatin**, minimal antiretroviral interaction.

MONITORING & PITFALLS

- **Recheck lipids 4-12 weeks after starting or changing**, then every 3-12 months. Not at goal is the trigger to add a second agent, not to wait another year.
- **Do not monitor LFTs or CK routinely.** Baseline ALT, then check CK **only if muscle symptoms** appear.
- **Exclude secondary causes before labeling primary dyslipidemia**: hypothyroidism, nephrotic syndrome, cholestasis, uncontrolled diabetes, alcohol, and drugs (thiazides, steroids, retinoids, antipsychotics).
- **Intensity is percent reduction, not milligrams.** Each dose doubling adds only about 6%.

References: 2026 ACC/AHA/Multisociety Dyslipidemia Guideline and ACC Guideline-at-a-Glance (JACC 2026;87:19) · PREVENT (AHA) · REDUCE-IT · REPRIEVE · SAMSON.

Educational aid; verify against current guidance, local formulary and patient factors.

roundsrx.com
roundsrx Infographic Series · #154