REBELLIOUS MEDIC · CARDIOLOGY ALGORITHM SERIES

Dyslipidemia Management

Risk-based statin initiation, severe hypercholesterolemia, secondary prevention, CAC-guided therapy, hypertriglyceridemia, and Lp(a).

2026
ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA
Dyslipidemia Guideline
Blumenthal et al. · JACC 2026;87(19):2624–2757

COR · I · Recommended · IIa · Reasonable · IIb · May Consider · III · No Benefit / Harm

1 Primary Prevention — Risk-Based Statin Initiation

Adults 30–79y, LDL-C 70–189mg/dL, no ASCVD/subclinical atherosclerosis — 10-yr PREVENT-ASCVD risk

10-YR RISK	ACTION	LDL-C / NON-HDL-C GOAL
Low (<3%)	Lifestyle counseling; moderate-intensity statin reasonable if LDL-C 160–189 or 30-yr risk ≥10% (age 30–59)	—
Borderline (3–<5%)	Moderate-intensity statin reasonable if therapy initiated (≥30–49% LDL-C reduction)	<100 / <130 mg/dL
Intermediate (5–<10%)	≥Moderate-intensity statin recommended; high-intensity at higher end of range	<100 / <130 mg/dL
High (≥10%)	High-intensity statin recommended (≥50% LDL-C reduction); add ezetimibe if goal not met	<70 / <100 mg/dL

2 Severe Hypercholesterolemia (LDL-C ≥190mg/dL) & Diabetes

I B-R — **LDL-C ≥190mg/dL,** no ASCVD, on max statin — add ezetimibe/PCSK9 mAb/bempedoic acid to reach goal LDL-C **<100mg/dL** (or <70 if HeFH/risk factors/subclinical atherosclerosis).

I A — Diabetes, age 40–75y, no clinical ASCVD — **moderate-intensity statin** indicated (30–49% LDL-C reduction), goal LDL-C <100 / non-HDL <130.

IIa B-R — Diabetes + **multiple ASCVD risk factors** — high-intensity statin reasonable (≥50% reduction), goal LDL-C <70 / non-HDL <100.

3 Secondary ASCVD Prevention — Statin Intensity, Goals & Add-On Therapy

I A — Clinical ASCVD, **not** at very high risk — high-intensity statin to achieve **≥50%** LDL-C reduction, goal LDL-C **<70** / non-HDL **<100mg/dL**.

IIa B-R — Not very high risk, on max statin — add ezetimibe, PCSK9 mAb, or bempedoic acid to reach goal LDL-C **<55** / non-HDL **<85mg/dL**.

IIa B-R — **Very high risk,** on max statin — add ezetimibe and/or PCSK9 mAb, plus **bempedoic acid** if goal not reached; **inclisiran** reasonable if PCSK9 mAb not tolerated/available. Goal LDL-C <55 / non-HDL <85mg/dL.

Very high risk = ≥2 major ASCVD events (ACS ≤12mo, prior MI, ischemic stroke, symptomatic PAD) OR 1 major event + multiple high-risk conditions (age >65, prior revascularization, current smoking, diabetes, HF, hypertension, LDL-C >100 despite max statin+ezetimibe).

4 Subclinical Atherosclerosis — CAC-Guided Therapy

Men ≥40y or women ≥45y, no prior ASCVD

CAC SCORE	THERAPY	LDL-C / NON-HDL-C GOAL
1–99 AU (<75th %ile)	Moderate-intensity statin reasonable (≥30–49% reduction)	<100 / <130 mg/dL
100–299 AU (or ≥75th %ile)	LDL-C–lowering therapy, statin first-line, recommended	<70 / <100 mg/dL
300–999 AU	Statin first-line; intensify or add ezetimibe/PCSK9 mAb/bempedoic acid if needed	<55 / <85 mg/dL
≥1000 AU	LDL-C–lowering therapy, statin first-line, recommended (≥50% reduction)	<55 / <85 mg/dL

5 Hypertriglyceridemia & Elevated Lp(a) Management

HYPERTRIGLYCERIDEMIA

I B-R — Clinical ASCVD, on max statin, LDL-C ≥55/non-HDL ≥85, persistent **TG 150–999mg/dL** — intensify LDL-C–lowering therapy.

I C-EO — Age 40–75y, no ASCVD/diabetes, persistent **TG 150–499mg/dL** — estimate 10-yr risk via PREVENT to guide lifestyle/statin discussion.

I B-NR — **Familial chylomicronemia,** fasting TG ≥1000mg/dL — **olezarsen** (apoC3 inhibitor) recommended to lower TG/pancreatitis risk.

ELEVATED LP(A) — ≥125 NMOL/L OR ≥50 MG/DL

I B-NR — **All individuals** with elevated Lp(a) — optimal early control of modifiable CV risk factors recommended.

I B-R — Clinical ASCVD + elevated Lp(a), not at goals on max statin — add a **PCSK9 mAb** with proven CV benefit.

Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia. *J Am Coll Cardiol.* 2026;87(19):2624–2757.