



American  
Heart  
Association.

## Top Ten Things to Know 2018 Guideline on the Management of Blood Cholesterol

1. In all individuals, emphasize a heart-healthy lifestyle across the life course.
2. In patients with clinical atherosclerotic cardiovascular disease (ASCVD), reduce low-density lipoprotein cholesterol (LDL-C) with high-intensity statin therapy or maximally tolerated statin therapy.
3. In very high-risk ASCVD, use an LDL-C threshold of 70 mg/dL (1.8 mmol/L) to consider addition of non-statins to statin therapy.
4. In patients with severe primary hypercholesterolemia (LDL-C level  $\geq 190$  mg/dL ( $\geq 4.9$  mmol/L)), begin high-intensity statin therapy without calculating 10-year ASCVD risk.
5. In patients 40 to 75 years of age with diabetes mellitus and an LDL-C level of  $\geq 70$  mg/dL ( $\geq 1.8$  mmol/L), start moderate-intensity statins without calculating 10-year ASCVD risk.
6. In adults 40 to 75 years of age evaluated for primary ASCVD prevention, have a clinician-patient risk discussion before starting statin therapy.
7. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels  $\geq 70$  mg/dL ( $\geq 1.8$  mmol/L), at a 10-year ASCVD risk of  $\geq 7.5\%$ , start a moderate-intensity statin if a discussion of treatment options favors statin therapy.
8. In adults 40 to 75 years of age without diabetes mellitus and 10-year risk of 7.5%-19.9%, risk-enhancing factors favor initiation of statin therapy.
9. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels  $\geq 70$  mg/dL- 189 mg/dL ( $\geq 1.8$ -4.9 mmol/L), at a 10-year ASCVD risk of  $\geq 7.5\%$ - 19.9%, if a decision about statin therapy is uncertain, consider measuring coronary artery calcium (CAC).
10. Assess adherence and percentage response to LDL-C-lowering medications and lifestyle changes with repeat lipid measurement 4 to 12 weeks after statin initiation or dose adjustment, repeated every 3 to 12 months as needed.

### Other highlights:

1. For secondary prevention, at mid- 2018 list prices PCSK9 inhibitors have a low-cost value [ $> \$150,000$  per QALY (quality-adjusted life-year)] compared to good cost value [ $< \$50,000$  per QALY]. The guideline provides a full discussion of the dynamic interaction of different prices and clinical benefit.
2. This guideline provides recommendations for children and adolescents with lipid abnormalities.
3. Substantial advances in estimation of risk with CAC scoring have been made in the past 5 years. One purpose of CAC scoring is to reclassify risk identification of patients who will potentially benefit from statin therapy. This is especially useful when the clinician and patient are uncertain whether to start a statin.

Grundy SM, Stone NJ, Bailey AL, Beam C, Birtcher KK, Blumenthal RS, et al. [2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APha/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines](#) [published online ahead of print November 10, 2018]. *Circulation*. DOI: 10.1161/CIR.0000000000000625.