JACC
VOL. ■, NO. ■, 2026

SOCIETAL STATEMENT

2026 Dyslipidemia Guideline-at-a-Glance

Barbara S. Wiggins, PharmD, FACC*
Ana Barac, MD, PhD, FACC†
Catherine P. Benziger, MD, MPH, FAHA, FACC‡
Roger S. Blumenthal, MD, FACC, FAHA, FASPC, FNLA§
Morgane Cibotti-Sun, MPH
Mykela M. Moore, MPH
Pamela B. Morris, MD, FACC, FAHA, FASPC, FNLA§‖

*ACC Solution Set Oversight Committee representative;
†ACC Science and Quality Committee representative;
‡ACC Prevention of Cardiovascular Disease Member Section representative;
§Guideline Writing Committee representative;
‖JACC Representative

INTRODUCTION

The 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia[1] (ACC/AHA/Multisociety Dyslipidemia Guideline) focuses on the implementation of new therapies and the evaluation of associated risk for individuals with dyslipidemia in primary and secondary prevention settings. The guideline advances a new approach to risk assessment through a novel risk score, sets lower low-density lipoprotein cholesterol (LDL-C) and non-high-density lipoprotein cholesterol (HDL-C) treatment goals for patients with established atherosclerotic cardiovascular disease (ASCVD), and recommends measuring lipoprotein(a) [Lp(a)] at least once to identify individuals at higher risk of ASCVD.

The ACC/AHA/Multisociety Dyslipidemia Guideline was retitled and contains updated, evidence-based recommendations that replace those from the 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol (2018 AHA/ACC Multisociety Blood Cholesterol Guideline) to reflect the evolving understanding of ASCVD associated with atherogenic lipoproteins beyond low-density lipoprotein (LDL). This Guideline-at-a-Glance highlights practice-changing recommendations from the guideline to accelerate adoption.

American College of Cardiology (ACC) guideline dissemination is an organization-wide effort facilitated by the Solution Set Oversight Committee to ensure the integration of guideline content throughout ACC's clinical policy, education, registry, membership, and advocacy initiatives. For each guideline, an individual ACC Guideline Dissemination Workgroup is created to influence dissemination strategy and to develop tools to facilitate the implementation of key changes in practice. This multidisciplinary committee of subject-matter experts was appointed by the Solution Set Oversight Committee. The guideline dissemination tools include a **Central Illustration** to graphically convey key concepts, as well as tables highlighting updates in the ACC/AHA/Multisociety Dyslipidemia Guideline and comparisons to the 2025 European Society of Cardiology (ESC)/European Atherosclerosis Society (EAS) Focused Update of the 2019 Guidelines for the Management of Dyslipidaemias.[2]

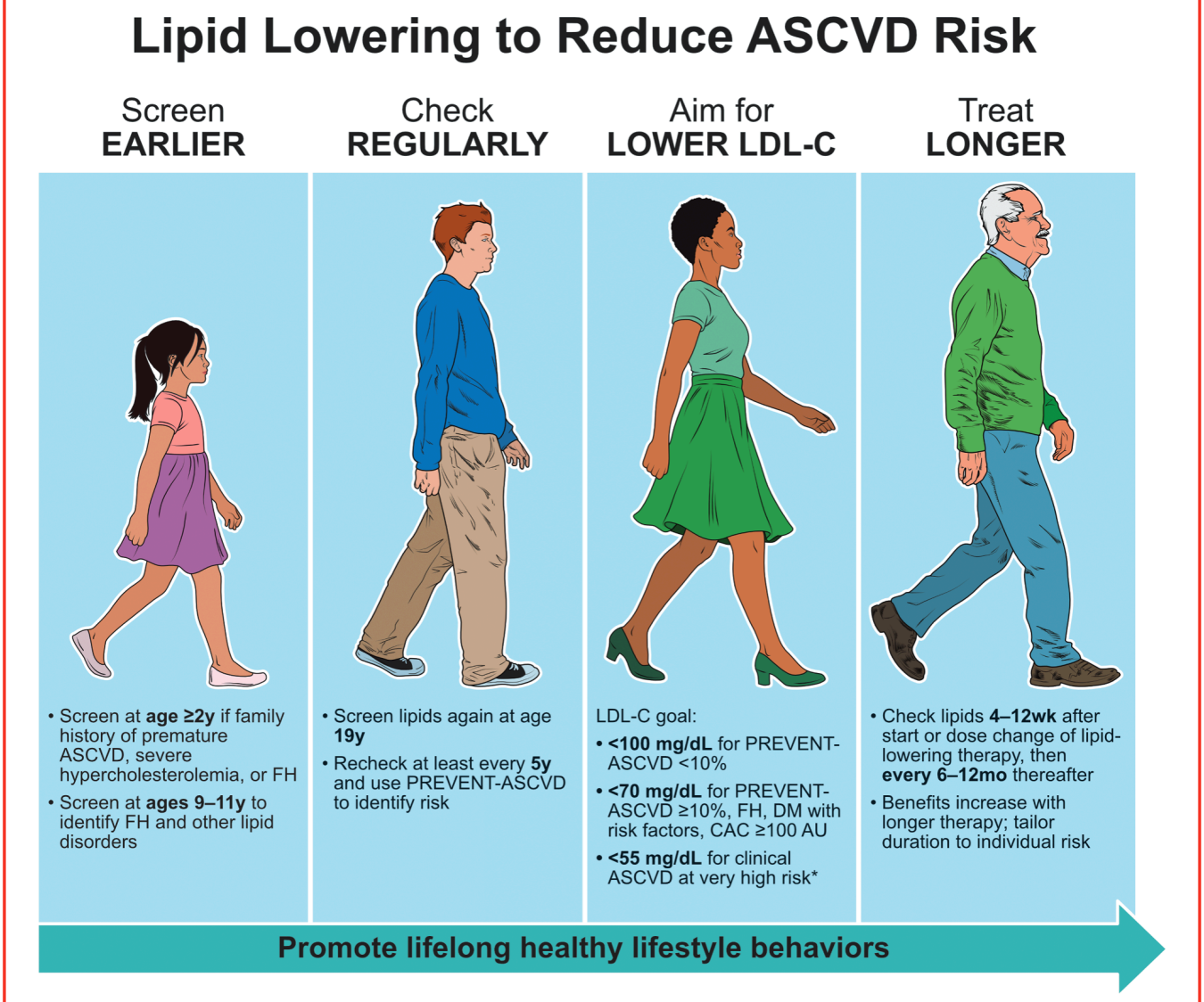
TOP TAKE-HOME MESSAGES

The following Top Take-Home Messages are taken directly from the ACC/AHA/Multisociety Dyslipidemia Guideline.[1] Messages 2, 4, and 6 (in **bold** in the following text) were selected as key themes by the ACC Dyslipidemia Dissemination Workgroup for this Guideline-at-a-Glance as they represent the most impactful changes and address established gaps in clinical practice.

1. Treat dyslipidemia earlier to reduce lifelong risk of prolonged exposure to atherogenic lipoproteins. Health behavior counseling to support lifestyle optimization should start in youth, with

ISSN 0735-1097/$36.00
https://doi.org/10.1016/j.jacc.2026.02.4872

CENTRAL ILLUSTRATION **2026 Dyslipidemia Guideline-at-a-Glance**



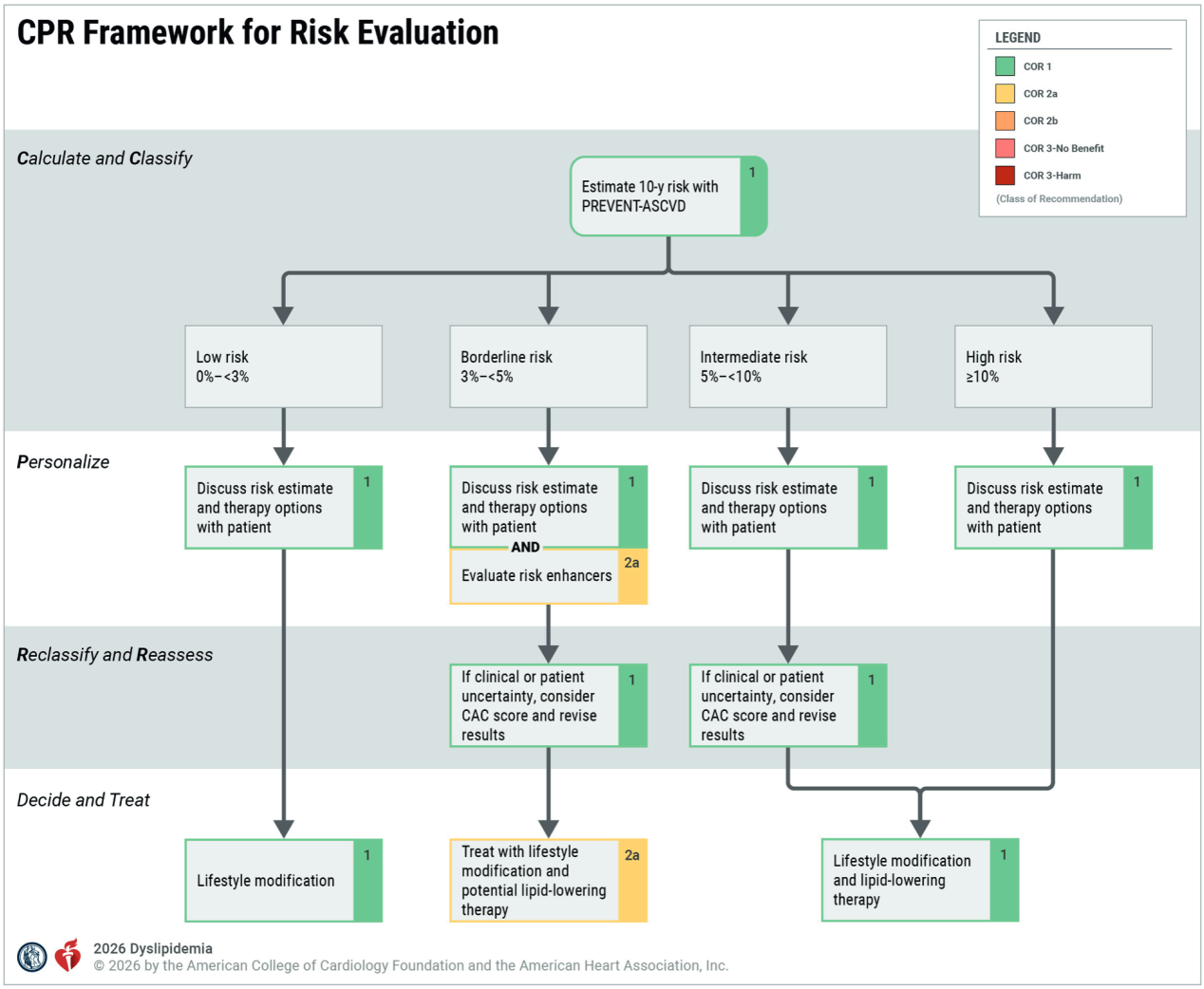
Wiggins BS, et al. JACC. 2026;■(■):■-■.

*Very high risk includes a history of multiple major ASCVD events (ACS within the past 12 months; prior myocardial infarction [other than ACS above]; prior ischemic stroke; or symptomatic peripheral artery disease) or 1 major ASCVD event and multiple high-risk conditions (age >65 years of age; prior coronary artery revascularization; current smoking; diabetes; history of heart failure; hypertension; or LDL-C >100 mg/dL despite maximally tolerated statin plus ezetimibe). ACS = acute coronary syndrome; ASCVD = atherosclerotic cardiovascular disease; CAC = coronary artery calcium; DM = diabetes mellitus; FH =familial hypercholesterolemia; LDL-C = low-density lipoprotein cholesterol; PREVENT = Predicting Risk of cardiovascular disease EVENTs.

early consideration of pharmacotherapy in youth with familial hypercholesterolemia and in young adulthood in individuals with LDL-C ≥160 mg/dL or a strong family history of premature ASCVD.

2. **Use the more contemporary American Heart Association Predicting Risk of cardiovascular disease EVENTs (PREVENT™) equations instead of the older Pooled Cohort Equations for 10- and 30-year risk assessment to guide lipid-lowering therapy in primary prevention in adults aged 30 to 79 years. Use the "CPR" Model: A) *Calculate* 10-year ASCVD risk; B) *Personalize* the estimated risk to the specific patient by considering factors not included in PREVENT-ASCVD equations; and C) possibly *Reclassify* with selective use of coronary artery calcium (CAC) and *Reassess* treatment recommendations.**
3. LDL-lowering therapy can be considered in adults for primary prevention of ASCVD with a 10-year PREVENT-ASCVD risk estimate of 3% to <5%

FIGURE 1 **CPR Framework for Risk Evaluation**



ASCVD = Atherosclerotic Cardiovascular Disease; CAC = coronary artery calcium; COR = Class of Recommendation; CPR = Calculate-Personalize-Reclassify; PREVENT = Predicting Risk of Cardiovascular Disease EVENTs.

(borderline risk) and should be considered for those at 5% to <10% (intermediate risk) 10-year risk after a clinician-patient discussion.

4. **LDL-C and non-HDL-C treatment goals are back to guide lipid-lowering therapy. Percentage reduction in LDL-C remains a priority for all individuals as well, with goal for % reduction depending on the level of ASCVD risk.**
5. Apolipoprotein B (ApoB) testing can be useful to improve risk assessment and guide therapy once LDL-C and non-HDL-C goals are met, particularly in those with elevated triglycerides (TG) (>200 mg/dL), diabetes, or low achieved LDL-C (<70 mg/dL). ApoB measurement helps identify adults with residual elevated lipoprotein-related risk that may be underestimated by the standard lipid profile alone and may be useful in the diagnosis of specific lipid and lipoprotein disorders.
6. **Lp(a) should be measured at least once to identify those individuals at higher risk of ASCVD. It is considered as a risk-enhancing factor at levels ≥125 nmol/L (50 mg/dL), which is associated with about a 1.4-fold increased ASCVD risk, and values ≥250 nmol/L (100 mg/dL) are associated with ≥2-fold higher estimated risk. The presence of elevated Lp(a) should be an indication for more intensified LDL-C lowering and management of other risk factors.**

7. CAC scoring in men at least 40 years of age and women at least 45 years of age can improve risk assessment and guide LDL-C and non-HDL-C goals. Both the absolute amount of CAC and the corresponding standardized percentile (currently based on age, sex, and race) have prognostic importance and help to reclassify risk in adults.
8. LDL-lowering therapy is recommended for primary prevention in adults aged 40 to 75 years with diabetes, chronic kidney disease stage 3 or 4, or human immunodeficiency virus, regardless of LDL-C level. After age 75 years, LDL-C–lowering pharmacotherapy can be considered in conjunction with lifestyle interventions to reduce ASCVD risk.
9. In secondary prevention, a goal of LDL-C <55 mg/dL (1.4 mmol/L) and non-HDL-C <85 mg/dL (2.2 mmol/L) is recommended for those at very high risk of ASCVD events. Although a smaller number of patients with ASCVD not at very high risk have an LDL-C goal of at least <70 mg/dL, the majority of those with a history of ASCVD events will likely qualify for an LDL-C goal of <55 mg/dL.
10. In patients with persistently elevated TG, statin therapy remains the foundation of pharmacotherapy as an adjunct to lifestyle intervention to reduce ASCVD risk. Treatment for prevention of pancreatitis may also include TG-lowering therapies, especially in individuals with TG levels ≥1000 mg/dL (11.3 mmol/L).

CPR FRAMEWORK FOR RISK EVALUATION

The ACC/AHA/Multisociety Dyslipidemia Guideline highlights the use of the CPR framework (Calculate-Personalize-Reclassify and Reassess) for primary prevention in adults. The framework begins with calculation of 10-year ASCVD risk in adults by using the PREVENT-ASCVD equations to support benefit-risk discussions regarding lipid-lowering therapy. **Figure 1**, "CPR Framework for Risk Evaluation," is reproduced directly from the guideline[1] for reference.

CENTRAL ILLUSTRATION: LIPID LOWERING TO REDUCE ASCVD RISK

The 2026 Dyslipidemia Guideline-at-a-Glance **Central Illustration** serves as a call to action for clinicians to treat patients with dyslipidemia in primary and secondary prevention settings by initiating lipid-lowering therapy earlier and more aggressively. The **Central Illustration** emphasizes an "earlier and lower for longer" strategy, highlighting the necessity of lifelong screening and more intensive LDL-C targets—particularly in the presence of risk factors or subclinical diseases—to maximize long-term cardiovascular risk reduction in conjunction with a heart-healthy lifestyle.

COMPARISON OF PREVIOUS ACC/AHA GUIDELINES

The 2026 ACC/AHA/Multisociety Dyslipidemia Guideline updates content previously covered in the 2018 Blood Cholesterol Guideline. **Table 1** compares recommendations on risk assessment, absolute LDL-C target goals, and Lp(a) measurement between the 2018 and 2026 versions of the guideline. The table focuses on Top Take-Home Messages, 2, 4, and 6.

For further details, refer to the corresponding sections of the ACC/AHA/Multisociety Dyslipidemia Guideline[1]:

- Section 3.4. "Measurement of Lp(a)"
- Section 4.2.3.2. "PREVENT-ASCVD Equations"
- Section 4.2.3.3. "Risk Enhancers"
- Section 4.2.3.6. "Selective Imaging of Subclinical Atherosclerosis (Men ≥40 or Women ≥45 Years)"
- Section 4.2.3.7. "Primary Prevention in Adults 30 to 79 Years of Age With LDL-C Levels 70 to 189 mg/dL (1.8-4.9 mmol/L)"
- Section 4.2.6. "Secondary ASCVD Prevention"
- Section 4.2.10. "Approach to Patients With Elevated Lp(a)"

COMPARISON OF ACC/AHA/MULTISOCIETY DYSLIPIDEMIA GUIDELINE WITH ESC GUIDELINES

Table 2 compares recommendations on risk assessment, absolute LDL-C target goals, and Lp(a) measurement across the 2026 ACC/AHA Dyslipidemia Guideline,[1] the 2019 ESC Dyslipidaemias Guideline,[4] and 2025 ESC Focused Update.[2] Although the guidelines are largely concordant, specific points of similarities and differences were selected to illustrate areas of alignment and distinction. The table focuses on Top Take-Home Messages, 2, 4, and 6.

For further details, refer to the corresponding sections of the 2019 ESC Dyslipidaemias Guideline[4]:

- Section 6. "Treatment Target Goals"
- Section 7. "Lifestyle Modifications to Improve the Plasma Lipid Profile"

TABLE 1 Select Comparison of 2018 and 2026 ACC/AHA/Multisociety Dyslipidemia Guidelines

	2018 AHA/ACC/Multisociety Guideline[3]		2026 ACC/AHA/Multisociety Guideline[1]	
	COR*	Old Recommendations	COR*	New Recommendations
Risk assessment (Top Take-Home Message 2)	1	For the primary prevention of clinical ASCVD† in adults 40 to 75 years of age without diabetes mellitus and with an LDL-C level of 70 to 189 mg/dL (1.7-4.8 mmol/L), the 10-year ASCVD risk of a first "hard" ASCVD event (fatal and nonfatal MI or stroke) should be estimated by using the race- and sex-specific PCE, and adults should be categorized as being at low risk (<5%), borderline risk (5% to <7.5%), intermediate risk (≥7.5% to <20%), and high-risk (≥20%).	1	In adults aged 30 to 79 years without ASCVD or subclinical atherosclerosis and with an LDL-C level between 70 and 189 mg/dL (1.8-4.9 mmol/L), the PREVENT-ASCVD equations should be used to estimate 10-year ASCVD risk, with categorization as having low (<3%), borderline (3% to <5%), intermediate (5% to <10%), or high (≥10%) 10-year estimated ASCVD risk.
	2b	In patients at borderline risk, in risk discussion, the presence of risk-enhancing factors may justify initiation of moderate-intensity statin therapy.	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 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.	1	In adults at intermediate risk and select adults at borderline risk 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.
		No corresponding guideline recommendation	1	In adults aged 30 to 59 years, at low (<3%) 10-year estimated risk for ASCVD who have an LDL-C <160 mg/dL (4.1 mmol/L) and a 30-year risk estimate of <10%, counseling on health behaviors is recommended to reduce LDL-C and risk for ASCVD.
Absolute LDL-C treatment goals (Top Take-Home Message 4)	1	In intermediate-risk patients, LDL-C levels should be reduced by 30% or more, and for optimal ASCVD risk reduction, especially in high-risk patients, levels should be reduced by 50% or more.	2a	In adults at borderline (3% to <5%) or intermediate (5% to <10%) 10-year estimated risk for ASCVD in whom statin therapy is initiated, it is reasonable to treat to a goal of LDL-C <100 mg/dL (2.6 mmol/L) and non-HDL-C <130 mg/dL (3.4 mmol/L) to reduce ASCVD risk.
			2a	In adults at high (≥10%) 10-year risk for ASCVD in whom a decision to initiate statin therapy is made, it is reasonable to treat to a goal of LDL-C <70 mg/dL (1.8 mmol/L) and non-HDL-C <100 mg/dL (2.6 mmol/L) to reduce ASCVD risk.
	1	In patients with clinical ASCVD in whom high-intensity statin therapy is contraindicated or who experience statin-associated side effects, moderate-intensity statin therapy should be initiated or continued with the aim of achieving a 30% to 49% reduction in LDL-C level.	1	In adults with clinical ASCVD‡ who are at very high risk, high-intensity statin therapy should be initiated to achieve a ≥50% reduction in LDL-C and a goal LDL-C <55 mg/dL (1.4 mmol/L) and non-HDL-C <85 mg/dL (2.2 mmol/L) and to reduce the risk of ASCVD events.
Lp(a) measurement (Top Take-Home Message 6)		No corresponding guideline recommendation	1	In all adults, measurement of Lp(a) concentration is recommended at least once for ASCVD risk assessment.
		No corresponding guideline recommendations	1	In individuals with FH, premature ASCVD, or high Lp(a), cascade testing of first-degree family members for high Lp(a) concentration is recommended to identify those at increased ASCVD risk.
		No corresponding guideline recommendation	1	In all individuals with elevated Lp(a) (≥125 nmol/L or ≥50 mg/dL), optimal early control of modifiable cardiovascular risk factors is recommended to reduce ASCVD risk.
		No corresponding guideline recommendation	1	In individuals with clinical ASCVD and elevated Lp(a) who have not achieved LDL-C and non-HDL-C treatment goals on maximally tolerated statin therapy, the addition of a PCSK9 mAb with proven cardiovascular benefit is recommended to achieve treatment goals and reduce ASCVD risk.

*Colors in this table align with the classification system found in Table 3, "Applying American College of Cardiology/American Heart Association Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care," in the ACC/AHA/Multisociety Dyslipidemia Guideline.[1]
†Clinical ASCVD includes ACS, those with history of MI, stable or unstable angina or coronary or other arterial revascularization, stroke, TIA, or PAD including aortic aneurysm, all of atherosclerotic origin.
‡The majority of patients with clinical ASCVD are likely to be at very high risk. Very high risk includes a history of multiple major ASCVD events (ACS within past 12 months, history of MI [other than ACS above], history of ischemic stroke, symptomatic PAD) or 1 major ASCVD event and multiple high-risk conditions (age >65 years of age, coronary artery revascularization, current smoker, diabetes, history of HF, hypertension, LDL-C >100 mg/dL despite maximally tolerated statin + ezetimibe).

ACC = American College of Cardiology; ACS = acute coronary syndrome; AHA = American Heart Association; ASCVD = atherosclerotic cardiovascular disease; CAC = coronary artery calcium; COR = Class of Recommendation; FH = familial hypercholesterolemia; HDL-C = high-density lipoprotein cholesterol; HF = heart failure; LDL-C = low-density lipoprotein cholesterol; LLT = lipid-lowering therapy; Lp(a) = lipoprotein(a); mAbs = monoclonal antibodies; MI = myocardial infarction; PAD = peripheral artery disease; PCE = pooled cohort equations; PCSK9 = proprotein convertase subtilisin/kexin type 9; PREVENT = Predicting Risk of cardiovascular disease EVENTs; TIA = transient ischemic attack.

TABLE 2 Select Comparison of 2026 ACC/AHA/Multisociety Dyslipidemia, 2019 ESC Dyslipidaemias, and 2025 ESC Focused Update Guidelines

	2019/2025 ESC Guidelines[2,4]		2026 ACC/AHA/Multisociety Guideline[1]	
	COR*	ESC recommendations	COR*	New recommendations
Risk assessment (Top Take-Home Message 2)	1	SCORE2 is recommended in apparently healthy people <70 years of age without established ASCVD, DM, CKD, or genetic/rare lipid or BP disorders for estimation of 10-year fatal and nonfatal CVD risk.[2,†]	1	In adults aged 30 to 79 years without ASCVD or subclinical atherosclerosis and with an LDL-C level between 70 and 189 mg/dL (1.8-4.9 mmol/L), the PREVENT-ASCVD equations should be used to estimate 10-year ASCVD risk, with categorization as having low (<3%), borderline (3% to <5%), intermediate (5% to <10%), or high (≥10%) 10-year estimated ASCVD risk.
	1	SCORE2-OP is recommended in apparently healthy people ≥70 years of age without established ASCVD, DM, CKD, or genetic/rare lipid or BP disorders for estimation of 10-year fatal and nonfatal CVD risk.[2,†]		
	1	In primary prevention,[‡] pharmacological LDL-C–lowering therapy is recommended in persons: ■ At very high risk and LDL-C ≥1.8 mmol/L (70 mg/dL), or ■ At high risk and LDL-C ≥2.6 mmol/L (100 mg/dL) despite optimization of nonpharmacological measures, to lower CVD risk.[2]		
	2a	Presence of subclinical coronary atherosclerosis by imaging or increased CAC score by CT should be considered as risk modifiers in individuals at moderate risk or individuals around treatment decision thresholds to improve risk classification.[2,§]	1	In adults at intermediate risk and select adults at borderline risk 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.
			2a	Among adults with no prior ASCVD who have moderate-to-severe incidental coronary atherosclerosis identified on noncardiac CT scans (eg, by visual estimation or a validated artificial intelligence-based algorithm), it is reasonable to initiate high-intensity statin therapy to achieve at least a ≥50% reduction in LDL-C and a goal of LDL-C <70 mg/dL (1.8 mmol/L) and non-HDL-C <100 mg/dL (2.6 mmol/L); if mild incidental CAC, moderate-intensity statin therapy is reasonable to achieve a ≥30% to 49% reduction in LDL-C and a goal of LDL-C <100 mg/dL (2.6 mmol/L) and non-HDL-C goal <130 mg/dL.
Absolute LDL-C treatment goals (Top Take-Home Message 4)	2a	In primary prevention,[‡] pharmacological LDL-C–lowering therapy should be considered in persons: ■ At very high risk and LDL-C ≥1.4 mmol/L (55 mg/dL) but <1.8 mmol/L (70 mg/dL), or ■ At high risk and LDL-C ≥1.8 mmol/L (70 mg/dL) but <2.6 mmol/L (100 mg/dL), or ■ At moderate risk and LDL-C ≥2.6 mmol/L (100 mg/dL) but <4.9 mmol/L (190 mg/dL), or ■ At low risk and LDL-C ≥3.0 mmol/L (116 mg/dL) but <4.9 mmol/L (190 mg/dL) despite optimization of nonpharmacological measures, to lower CVD risk.[2]	2a	In adults at borderline (3% to <5%) or intermediate (5% to <10%) 10-year estimated risk for ASCVD in whom statin therapy is initiated, it is reasonable to treat to a goal of LDL-C <100 mg/dL (2.6 mmol/L) and non-HDL-C <130 mg/dL (3.4 mmol/L) to reduce ASCVD risk.
			2a	In adults at high (≥10%) 10-year risk for ASCVD in whom a decision to initiate statin therapy is made, it is reasonable to treat to a goal of LDL-C <70 mg/dL (1.8 mmol/L) and non-HDL-C <100 mg/dL (2.6 mmol/L) to reduce ASCVD risk.
	1	In secondary prevention for patients at very-high risk, an LDL-C reduction of ≥50% from baseline[‖] and an LDL-C goal of <1.4 mmol/L (<55 mg/dL) are recommended.[4]	1	In adults with clinical ASCVD[¶] who are at very high risk, high-intensity statin therapy should be initiated to achieve a ≥50% reduction in LDL-C and a goal LDL-C <55 mg/dL (1.4 mmol/L) and non-HDL-C <85 mg/dL (2.2 mmol/L) and to reduce the risk of ASCVD events.

Continued on the next page

TABLE 2 Continued

	2019/2025 ESC Guidelines[2,4]		2026 ACC/AHA/Multisociety Guideline[1]	
	COR*	ESC recommendations	COR*	New recommendations
Lp(a) measurement (Top Take-Home Message 6)	2a	Lp(a) measurement should be considered at least once in each adult person's lifetime to identify those with very high inherited Lp(a) levels >180 mg/dL (>430 nmol/L) who may have a lifetime risk of ASCVD equivalent to the risk associated with heterozygous FH.[4]	1	In all adults, measurement of Lp(a) concentration is recommended at least once for ASCVD risk assessment.
	2a	Lp(a) levels above 50 mg/dL (105 nmol/L) should be considered in all adults as a CV risk-enhancing factor, with higher Lp(a) levels associated with a greater increase in risk.[2]		
	2a	Lp(a) should be considered in selected patients with a family history of premature CVD, and for reclassification in people who are borderline between moderate and high risk.[4]	1	In individuals with FH, premature ASCVD, or high Lp(a), cascade testing of first-degree family members for high Lp(a) concentration is recommended to identify those at increased ASCVD risk.
		No corresponding guideline recommendation	1	In all individuals with elevated Lp(a) (≥125 nmol/L or ≥50 mg/dL), optimal early control of modifiable cardiovascular risk factors is recommended to reduce ASCVD risk.
		No corresponding guideline recommendation	1	In individuals with clinical ASCVD and elevated Lp(a) who have not achieved LDL-C and non–HDL-C treatment goals on maximally tolerated statin therapy, the addition of a PCSK9 mAb with proven cardiovascular benefit is recommended to achieve treatment goals and reduce ASCVD risk.

*Colors in this table align with the classification system found in Table 3, "Applying American College of Cardiology/American Heart Association Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care," in the ACC/AHA/Multisociety Dyslipidemia Guideline.[1]
†Revised recommendation replacing the respective recommendation based on SCORE in the 2019 ESC/EAS Guidelines.
‡Persons without known clinical ASCVD.
§Revised recommendation replacing the recommendation on CAC score for cardiovascular risk assessment in the 2019 ESC/EAS Guidelines.
‖The term 'baseline' refers to the LDL-C level in a person not taking any LDL-C–lowering medication. In people who are taking LDL-C–lowering medication(s), the projected baseline (untreated) LDL-C levels should be estimated, based on the average LDL-C–lowering efficacy of the given medication or combination of medications.
¶The majority of patients with clinical ASCVD are likely to be at very high risk. Very high risk includes a history of multiple major ASCVD events (ACS within past 12 months, history of MI [other than ACS above], history of ischemic stroke, symptomatic PAD) or 1 major ASCVD event and multiple high-risk conditions (age >65 years of age, coronary artery revascularization, current smoker, diabetes, history of HF, hypertension, LDL-C >100 mg/dL despite maximally tolerated statin + ezetimibe).

ACC = American College of Cardiology; ACS = acute coronary syndrome; AHA = American Heart Association; ASCVD = atherosclerotic cardiovascular disease; BP = blood pressure; CAC = coronary artery calcium; CKD = chronic kidney disease; COR = Class of Recommendation; CT = computed tomography; CV = cardiovascular; CVD = cardiovascular disease; DM = diabetes mellitus; ESC = European Society of Cardiology; FH = familial hypercholesterolemia; HDL-C = high-density lipoprotein cholesterol; HF = heart failure; LDL-C = low-density lipoprotein cholesterol; LLT = lipid-lowering therapy; Lp(a) = lipoprotein(a); mAb = monoclonal antibody; MI = myocardial infarction; PAD = peripheral artery disease; PCSK9 = proprotein convertase subtilisin/kexin type 9; PREVENT = Predicting Risk of cardiovascular disease EVENTs; SCORE2 = Systematic Coronary Risk Evaluation 2; SCORE2-OP = Systematic Coronary Risk Evaluation 2-Older.

For further details, refer to the corresponding sections of the 2025 ESC Focused Update Dyslipidaemias Guideline[2]:

- Section 4. "New Low-Density Lipoprotein Cholesterol-Lowering Therapies"
- Section 6. "Lipoprotein(a)"

ACKNOWLEDGMENTS The authors would like to thank the ACC Solution Set Oversight Committee: Gurusher S. Panjrath, MBBS, FACC, *Chair*; Katie Bates, ARNP, DNP, FACC; Eugene H. Chung, MD, MPH, FACC; David M. Dudzinski, MD, JD, FACC; Martha Gulati, MD, MS, FACC; Robert Hendel, MD, MACC; Chayakrit Krittanawong, MD, FACC; Viet T. Le, PA, FACC—*Ex Officio*.

REFERENCES

1. Blumenthal RS, Morris PB, Guadino M, Johnson HM. 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. *J Am Coll Cardiol*. Published online March 13, 2026. https://doi.org/10.1016/j.jacc.2026.11.016

2. Mach F, Koskinas KC, Roeters van Lennep JE, et al. 2025 focused update of the 2019 ESC/EAS guidelines for the management of dyslipidaemias. *Eur Heart J*. 2025:ehaf190.

3. Grundy SM, Stone NJ, Bailey AL, 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. *J Am Coll Cardiol*. 2019;73:e285–e350.

4. Mach F, Baigent C, Catapano AL, et al. 2019 ESC/EAS guidelines for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk. *Eur Heart J*. 2020;41:111–188.