

2018 AHA/ACC Cholesterol Guidelines

Very recently the long awaited 2018 AHA/ACC update of the “guideline on the management of blood cholesterol” was announced and simultaneously published. The last ACC/AHA update in 2013 eliminated LDL-C treatment goals resulting in considerable debate among clinicians and in many scenarios disregard or little attention given to the recommendations.

The 2018 update, fortunately, attempts to close the gap by establishing “thresholds” for intervention. These represent points at which additional therapy should be considered and is, in fact, recommended. There are still no LDL goals established but in many cases treating as recommended at or near the threshold of 70 mg/dl could result in an LDL at or below goals recommended by other more aggressive guidelines such as those from AACE in patients at extreme risk whose LDL goal is <55 mg/dl. However, without LDL goals patients at very high risk with a threshold of 70 or higher for add-on therapy to maximal statin and in whom an LDL is 120 mg/dl or higher and treated as recommended without a treatment LDL goal or if the LDL is lowered by 50% would still remain well above the LDL levels associated with the greatest reduction in CV events as seen in IMPROVE-IT and in the pre-specified outcome analysis of on-treatment LDL in FOURIER.

There are some additional points worth noting. “Major ASCVD Events” does not include CABG or TIA. The former is categorized under “High Risk Conditions” and the latter does not appear under either category despite the AHA classification of TIA as clinical cardiovascular disease. Both these points are clearly arguable. Many clinicians may well view CABG as a major ASCVD event. Furthermore, a patient with an MI and diabetes or an MI and CKD without another major ASCVD event

or another high risk condition is “not at very high risk.” The use of PCSKi agents is not included in the not at very high risk treatment plan. AACE classifies these two groups as Extreme Risk with a lower LDL goal given the data on ASCVD in diabetes and CKD.

Nevertheless, the new ACC/AHA Guidelines reflect a step forward for clinicians. The discussion of assessing risk particularly with CAC scoring is very useful. The re-focus on an important threshold number (70 mg/dl or higher) will benefit many patients. Embracing combination and PCSK 9i therapy is clearly welcome. In the view of many, while these guidelines are welcome and much improved over 2013 they simply do not go far enough. Establishing thresholds for treatment is a useful approach but after enhancing treatment what is the goal? Where do you stop? The data supporting “lower is better” is very strong. Many patients benefit from very low LDL levels. Treatment goals could effectively be added to these threshold recommendations.

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