

2026 ACC/AHA Dyslipidemia Guidelines: A High-Level Overview

Laxmi Mehta, MD, MBA, FACC, FAHA, FNLA

Professor of Medicine

Chief Well-Being Leader

Faculty Director, Gabbe Well-Being Office

Associate Vice Chair of Wellness, Department of Internal Medicine

Director of Preventative Cardiology & Women's CV Health

Sarah Ross Soter Endowed Chair in Women's CV Health and Research

The Ohio State University Wexner Medical Center



Disclosures

No financial disclosures

Circulation

CLINICAL PRACTICE GUIDELINES

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

Developed in Collaboration With and Endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation, Association of Black Cardiologists, American College of Preventive Medicine, American Diabetes Association, American Geriatrics Society, American Pharmacists Association, American Society for Preventive Cardiology, National Lipid Association, and Preventive Cardiovascular Nurses Association

Writing Committee Members*

Roger S. Blumenthal, MD, FACC, FAHA, FASPC, FNLA, Chair; Pamela B. Morris, MD, FACC, FAHA, FASPC, FNLA, Vice Chair; Mario Gaudino, MD, FAHA, FACC, JC Liaison†; Heather M. Johnson, MD, MS, FAHA, FACC, FASPC, JC Liaison‡; Timothy S. Anderson, MD, MASS; Vera A. Bittner, MD, MSPH, FACC, FAHA, MNLA, MAACVPR‡; Ron Blankstein, MD, FACC; LaPrincess C. Brewer, MD, MPH, FACC, FAHA; Leslie Cho, MD, FACC¶; Sarah D. de Ferranti, MD, MPH, FAHA; Eugenia Gianos, MD, FACC, FAHA, FNLA; Ty J. Gluckman, MD, MHA, FACC, FAHA, FASPC; Kristen F. Gradney, MHA, RDN, LDN#; Ijeoma Isiadinso, MD, MPH, FACC*; Donald M. Lloyd-Jones, MD, ScM, FACC, FAHA, FASPC; Joel C. Marrs, PharmD, MPH, FAHA, FNLA††; Seth S. Martin, MD, MHS, FACC, FAHA, FASPC; Kellie H. McLain, ANP-BC, CLS, FNLA, AACC; Laxmi S. Mehta, MD, FACC, FAHA, FNLA; Samia Mora, MD, MHS, FACC, FAHA; Wudeneh M. Mulugeta, MD, MPH, MS, FACP, FACPM‡‡; Pradeep Natarajan, MD, MMSCFACC, FAHA; Ann Marie Navar, MD, PhD, FAHA, FACC, FASPC; Carl E. Orringer, MD, FACC, MNLA; Tamar S. Polonsky, MD, MSCI; Harmony R. Reynolds, MD, FACC, FAHA; Joseph J. Saseen, PharmD, MNLA, FACC, FAHA§§; Michael D. Shapiro, DO, MPH, FACC, FAHA, FASPC, FNLA¶¶; Daniel E. Soffer, MD, MNLA, FACP‡; Sheila A. Tynes, MHA, PMP¶¶¶; Chloé D. Villavaso, MN, APRN, ACNS-BC, FPCNA, AACCC#; Salim S. Virani, MD, PhD, FACC, FASPC***; John T. Wilkins, MD, MSc, FAHA



Lipid Lowering to Reduce ASCVD Risk

Screen
EARLIER



- Screen at **age $\geq 2y$** if family history of premature ASCVD, severe hypercholesterolemia, or FH
- Screen at **ages 9–11y** to identify FH and other lipid disorders

Check
REGULARLY



- Screen lipids again at age **19y**
- Recheck at least every **5y** and use PREVENT-ASCVD to identify risk

Aim for
LOWER LDL-C



- LDL-C goal:
- **<100 mg/dL** for PREVENT-ASCVD **<10%**
 - **<70 mg/dL** for PREVENT-ASCVD $\geq 10\%$, FH, DM with risk factors, CAC ≥ 100 AU
 - **<55 mg/dL** for clinical ASCVD at very high risk*

Treat
LONGER



- Check lipids **4–12wk** after start or dose change of lipid-lowering therapy, then **every 6–12mo** thereafter
- Benefits increase with longer therapy; tailor duration to individual risk

Promote lifelong healthy lifestyle behaviors

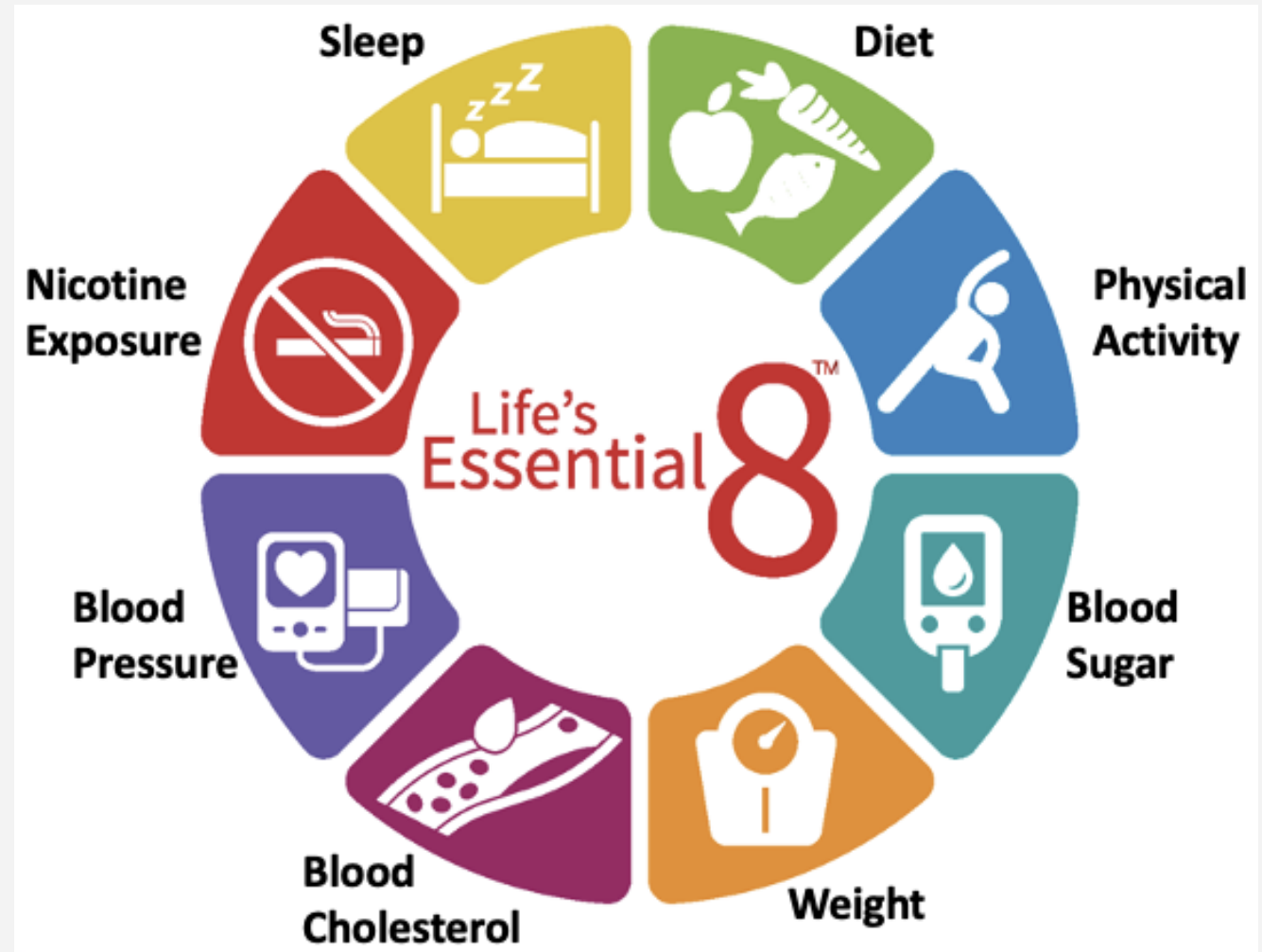
Wiggins BS, et al. JACC. 2026;■(■):■-■.



Kentucky
CHAPTER

It Starts With Lifestyle Changes

COR	RECOMMENDATIONS
1	In children and healthy adults, healthy dietary patterns, regular physical activity, maintenance of a healthy weight, healthy sleep, stress management, and avoidance of tobacco products should be promoted and reinforced lifelong to reduce the risk for dyslipidemia and ASCVD



Blumenthal RS, et al. J Am Coll Cardiol. 2026; Lloyd-Jones DM, et al. Circulation. 2022;146:e18-e43.

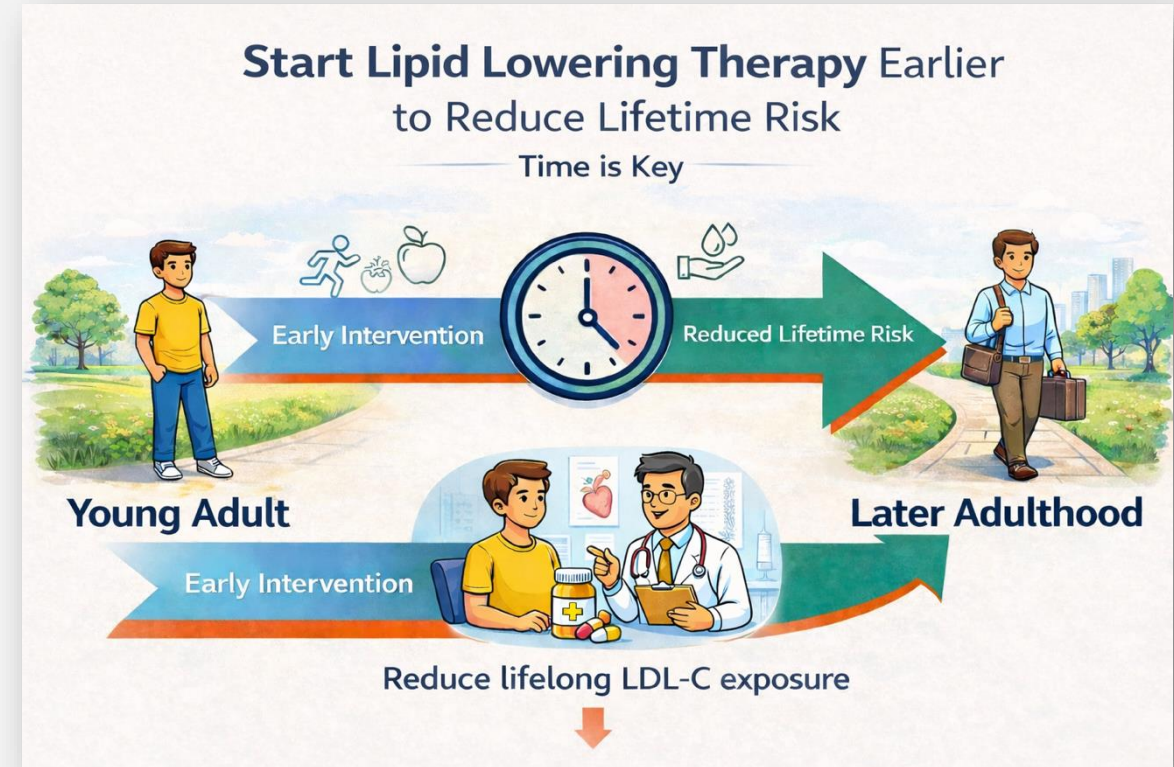


1

Start Earlier: Reduce Lifetime Exposure to LDL-C

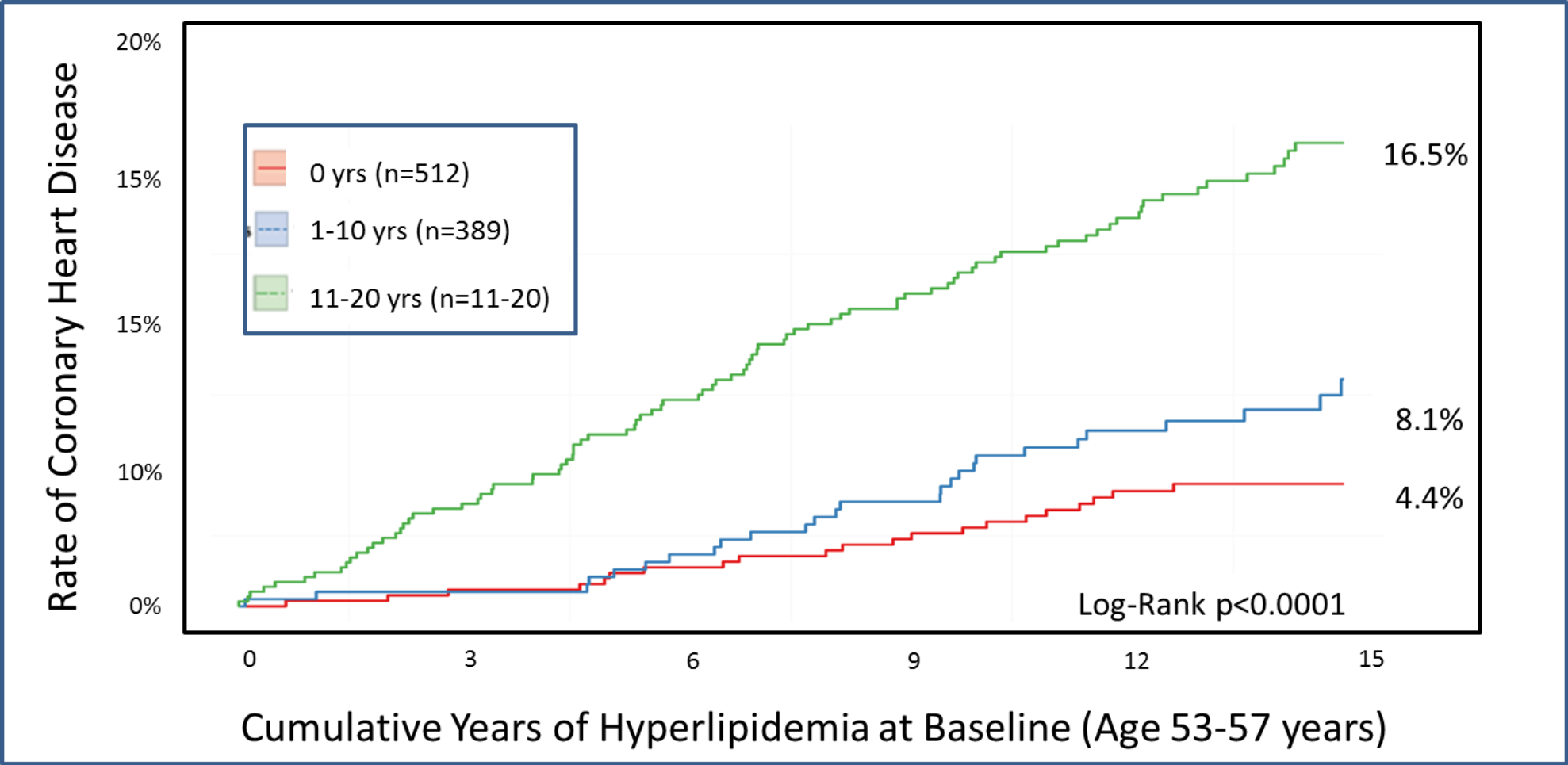
Start Statin Therapy for:

- All Adults with HeFH
- Age ≥ 30 :
 - LDL-C ≥ 160 mg/dL **OR**
 - Strong family history of premature ASCVD **OR**
 - High 30-year risk of ASCVD



Treat these groups early even if 10y risk is low to prevent long-term exposure to high LDL-C

Prolonged Exposure to High Cholesterol Increases Heart Disease Risk (Framingham Offspring)



Familial Hypercholesterolemia



Genetic Testing

- Identify individuals meeting clinical suspicion
- Prevalence 1:250 → underdiagnosed



Variants

- LDLR
- ApoB
- PCSK9



Risk Stratification & Treatment

- Higher ASCVD risk even with modest LDL
- Supports earlier LLT and cascade screening

COR

RECOMMENDATIONS

1

In adults with possible, probable, or definite FH, panel-based genetic testing for pathogenic/likely pathogenic rare variants for FH is beneficial to identify individuals at highest risk of cardiovascular events and to facilitate cascade screening.

2a

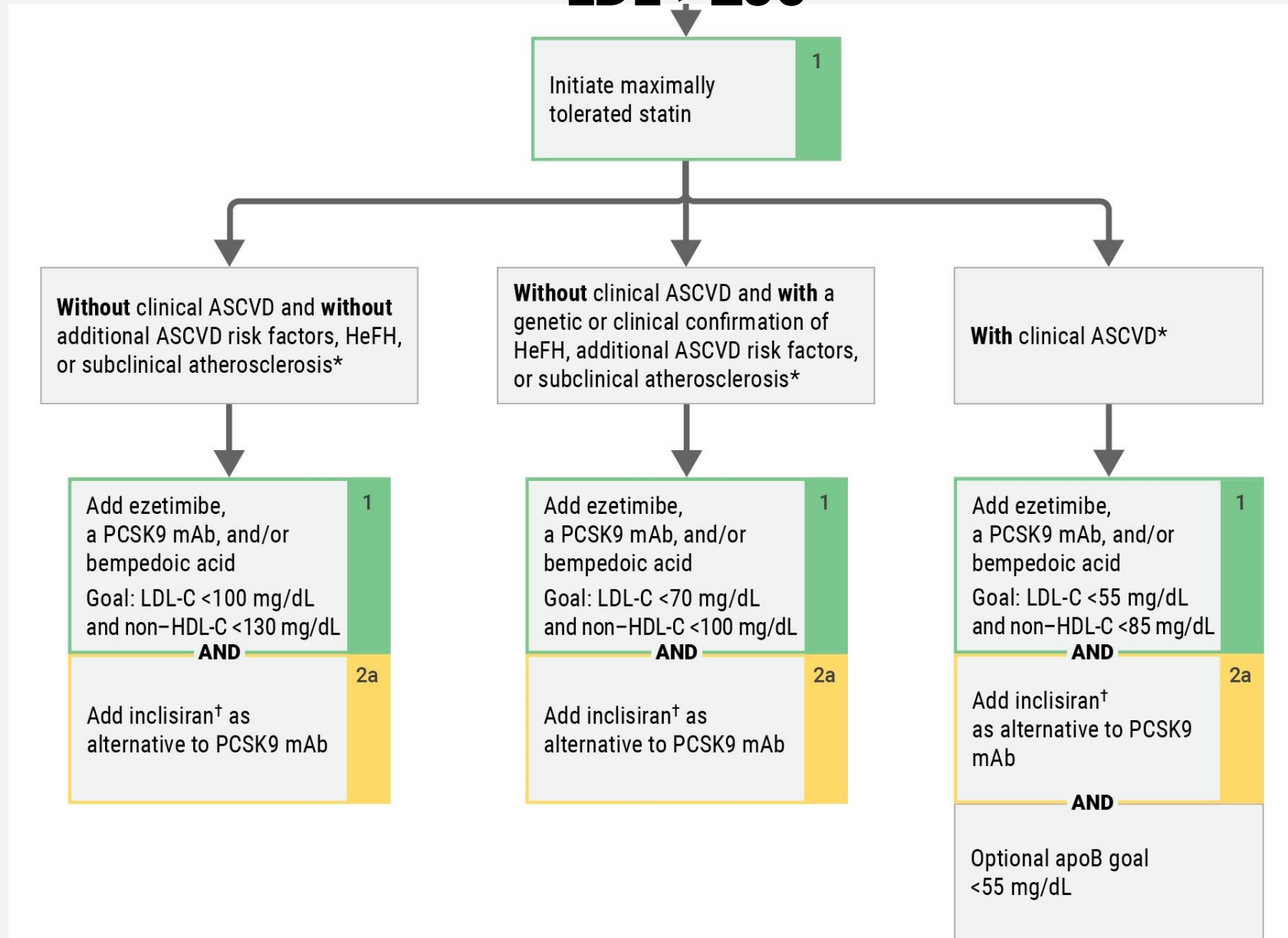
In adults with severe hypercholesterolemia with an LDL-C ≥ 190 mg/dL (4.9 mmol/L) without an identified secondary cause, panel-based genetic testing for pathogenic/likely pathogenic rare variants for FH can be useful to identify those with FH who are at higher risk of ASCVD events.

2b

In adults with an elevated LDL-C of 160 to 189 mg/dL (4.1-4.9 mmol/L) without an identified secondary cause, panel-based genetic testing for pathogenic/likely pathogenic rare variants for FH may be considered to identify those with FH who are at higher risk of events.



LDL >190



Blumenthal, R.S., Morris, P.B., et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. JACC



Lipid Goals in Patients with Diabetes Mellitus

- Most adults 40–75 years with DM are at **intermediate or high ASCVD risk**
- First CV events with DM carry **higher morbidity and mortality**

Diabetes-specific risk modifiers

- Long duration (≥ 10 years for type 2 diabetes or ≥ 20 years for type 1 diabetes)
- Albuminuria (≥ 30 mcg of albumin/mg creatinine)
- GFR < 60 ml/min/1.73 m²
- Retinopathy
- Neuropathy
- ABI < 0.9

	Patient Examples	LDL-C mg/dL	Non-HDL-C mg/dL	ApoB mg/dL
Diabetes mellitus	• Without ASCVD risk factors or diabetes-specific risk modifiers	<100	<130	<90
Diabetes mellitus	• With ASCVD risk factors or diabetes-specific risk modifiers	<70	<100	<70



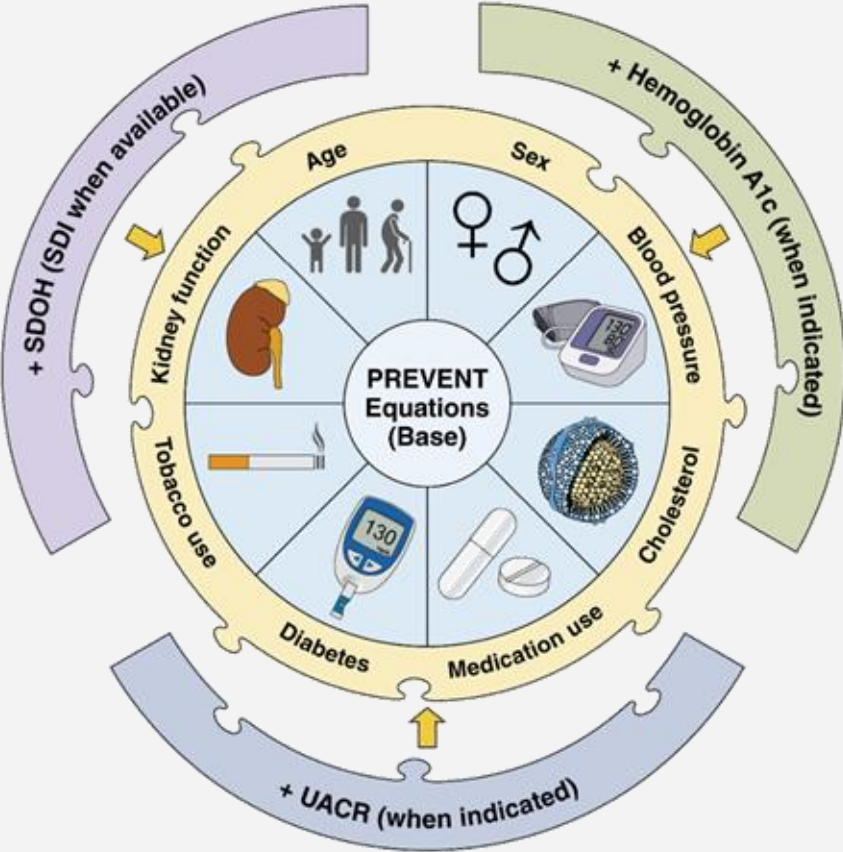
Older Adults

COR	RECOMMENDATIONS
1	<u>In older adults, the benefit-risk discussion</u> should include patient priorities, functional status, multimorbidity, frailty, polypharmacy, and life expectancy, and <u>should not be based solely on chronological age when considering the decision to discontinue LLT.</u>
2a	In adults <u>aged >75 years with an estimated life expectancy of at least 2.5 years</u> , it may be reasonable to initiate moderate-intensity <u>statin</u> therapy after a clinician–patient discussion of potential benefits and risks to reduce ASCVD risk.
2a	In patients with a life expectancy of <1 year, it may be reasonable to discontinue LDL-lowering therapy to avoid unnecessary medication use or adverse medication effects.
2b	In adults aged <u>>75 years with an estimated life expectancy of at least 2.5 years</u> , and for whom the <u>decision regarding LLT is uncertain</u> , it may be reasonable to <u>measure CAC to reclassify</u> those with minimal (1-10) or no CAC to avoid LLT.



2a

Use PREVENT-ASCVD for Risk Assessment



Calculate Risk (if no ASCVD or FH)

- 10-yr ASCVD risk if age 30-79
- 30-yr ASCVD risk if age 30-59

Low 10-year risk
(**<3%**)

Borderline 10-year risk
(**3%-<5%**)

Intermediate 10-year risk
(**5%-<10%**)

High 10-year risk
(**≥10%**)



2b

ASCVD Risk Enhancers to Guide Primary Prevention Risk Assessment



Demographic, Genetic and Family History

- **Family history of premature ASCVD**
Sibling or parent <55 y if M, <65 y if F
- **Higher-risk ancestry**
South Asian, Filipino
- **High polygenic risk**



Clinical Conditions that Increase ASCVD Risk

- **Chronic inflammatory diseases**
Systemic lupus, inflammatory arthritis, psoriasis
- **CKM syndrome**
- **Reproductive risk markers**
Early menopause (<45 y), preeclampsia, gestational DM



Biomarkers

- **hsCRP ≥ 2 mg/L**
on >1 measurement
- **Elevated TGs**
 ≥ 150 mg/dL fasting, ≥ 175 mg/dL nonfasting
- **Persistently elevated LDL-C (≥ 160 mg/dL),**
non-HDL-C (≥ 190 mg/dL) or ApoB (≥ 120 mg/dL)
- **Lp(a) ≥ 125 nmol/L or ≥ 50 mg/dL**



If present, risk enhancers favor statin therapy in borderline to intermediate risk individuals (10-year ASCVD risk 3-<10%)



Female Specific Factors

Adverse Pregnancy Outcomes with a Stronger Association with ASCVD Events

- Hypertensive disorders of pregnancy (preeclampsia, gestational hypertension)
- Gestational diabetes
- Small for gestational age (birthweight <10th percentile)
- Preterm delivery (before 37 weeks of gestation)
- Recurrent spontaneous pregnancy loss

Other Reproductive Risk Markers

- Early menarche (<10 yr old)
- Early menopause (<45 yr), especially if premature (<40 yr)
- Polycystic ovarian syndrome and irregular menses

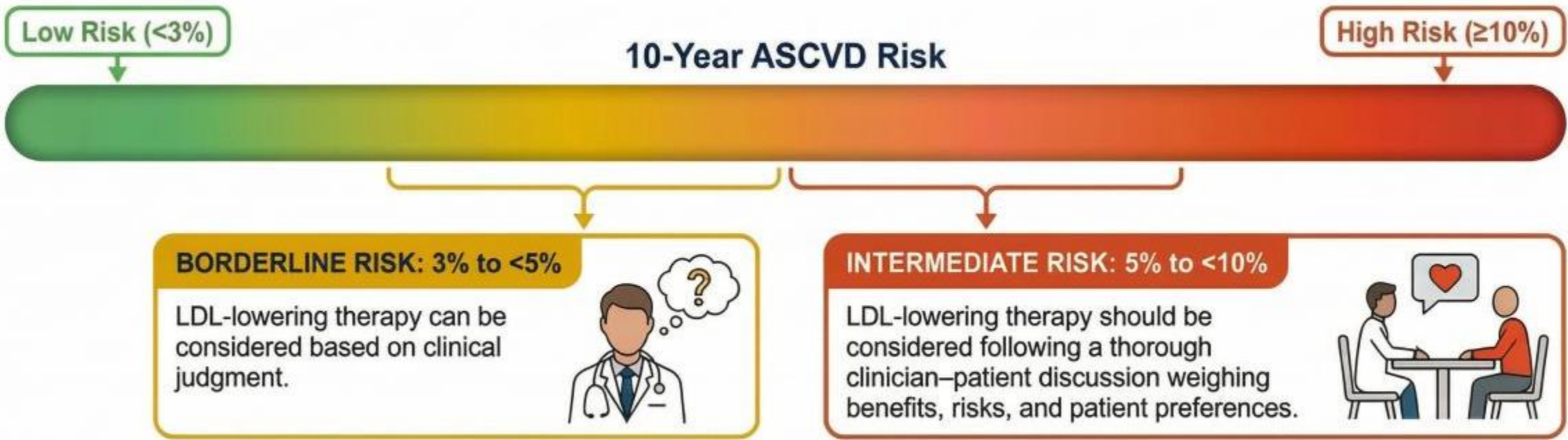


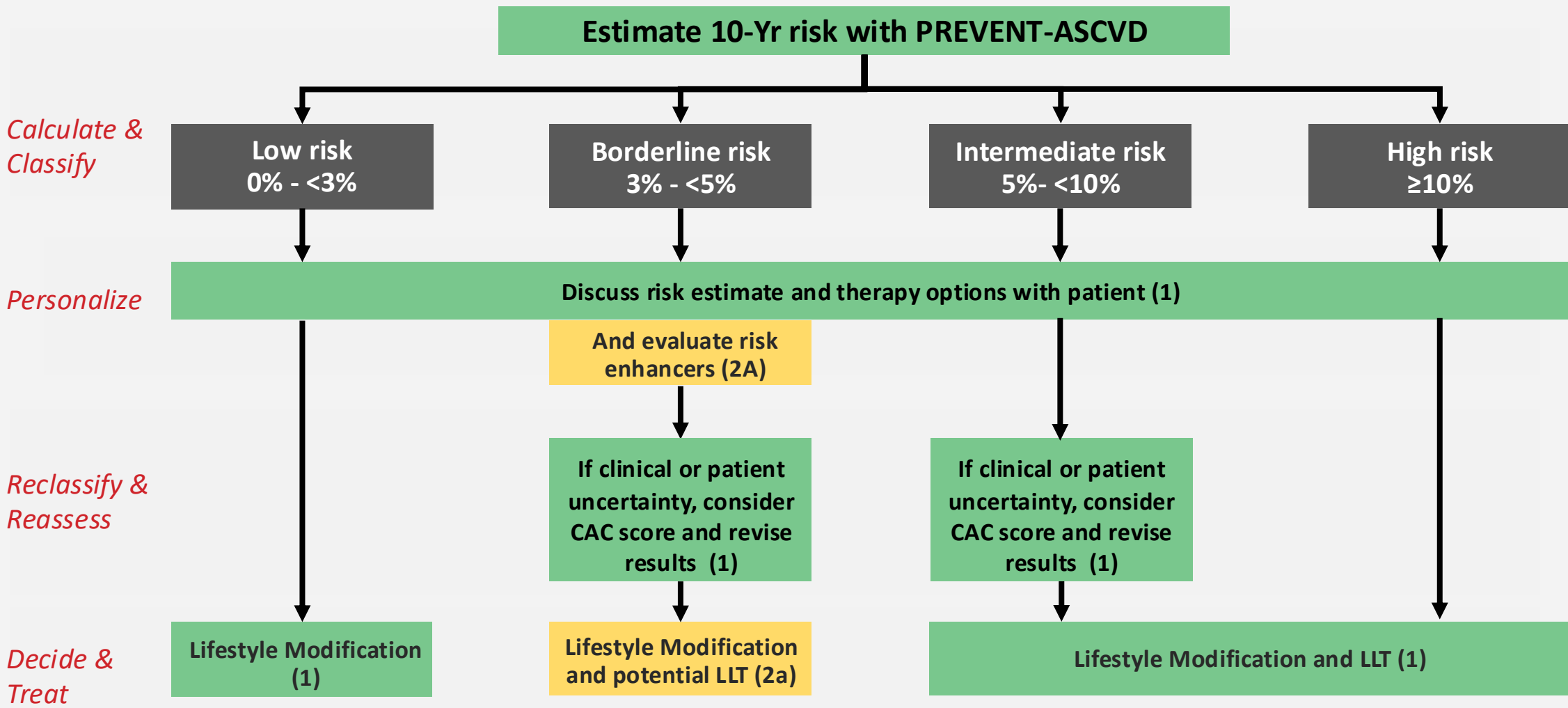
COR	RECOMMENDATIONS
2a	In adults without ASCVD, consideration of reproductive risk markers, such as early menopause (<45 years of age) and history of adverse pregnancy outcomes is reasonable to personalize ASCVD risk assessment when considering the potential benefit of initiating LLT as an adjunct to lifestyle management for primary ASCVD prevention.



LDL-Lowering in Primary Prevention: Risk-Guided Decision Making

Based on 10-Year PREVENT-ASCVD Risk Estimates





LDL-C & Non-HDL-C Goals are Back + ApoB Goals are Included

	Patient Examples	LDL-C mg/dL	Non-HDL-C mg/dL	ApoB mg/dL
Borderline to Intermediate Risk	<ul style="list-style-type: none"> • 3-<5% or 5-<10% 10y ASCVD Risk • <3% 10y ASCVD risk + (LDL-C $\geq$160 mg/dL or Fam Hx or 30y risk $\geq$10%) • Severe hypercholesterolemia without FH, RF or CAC • T2DM without ASCVD or Risk Factors • CAC 1-99 or mild incidental CAC 	< <u>100</u>	<130	<90
<u>High</u> Risk	<ul style="list-style-type: none"> • >10% 10-yr ASCVD Risk • T2DM + Risk Factors • HeFH without ASCVD • CAC $\geq$100 – 999 AU • Moderate to severe incidental CAC • Clinical ASCVD (not at very high risk) 	< <u>70</u>	<100	<70
<u>Very High</u> Risk	<ul style="list-style-type: none"> • Clinical ASCVD (optional if not very-high risk) • CAC $\geq$1000 AU (optional if $\geq$300 AU) 	< <u>55</u>	<85	<55

5

Use ApoB to Assess Residual Lipid-Related Risk

*Measures all
atherogenic particles*

*More accurate
compared to LDL-C*

Screening with Apolipoprotein B

In adults on LLT, particularly those with ASCVD, type 2 diabetes, and/or elevated TG, measurement of apoB is reasonable to guide decisions regarding further therapeutic intensification once LDL-C and/or Non-HDL-C goals are achieved. (2a)

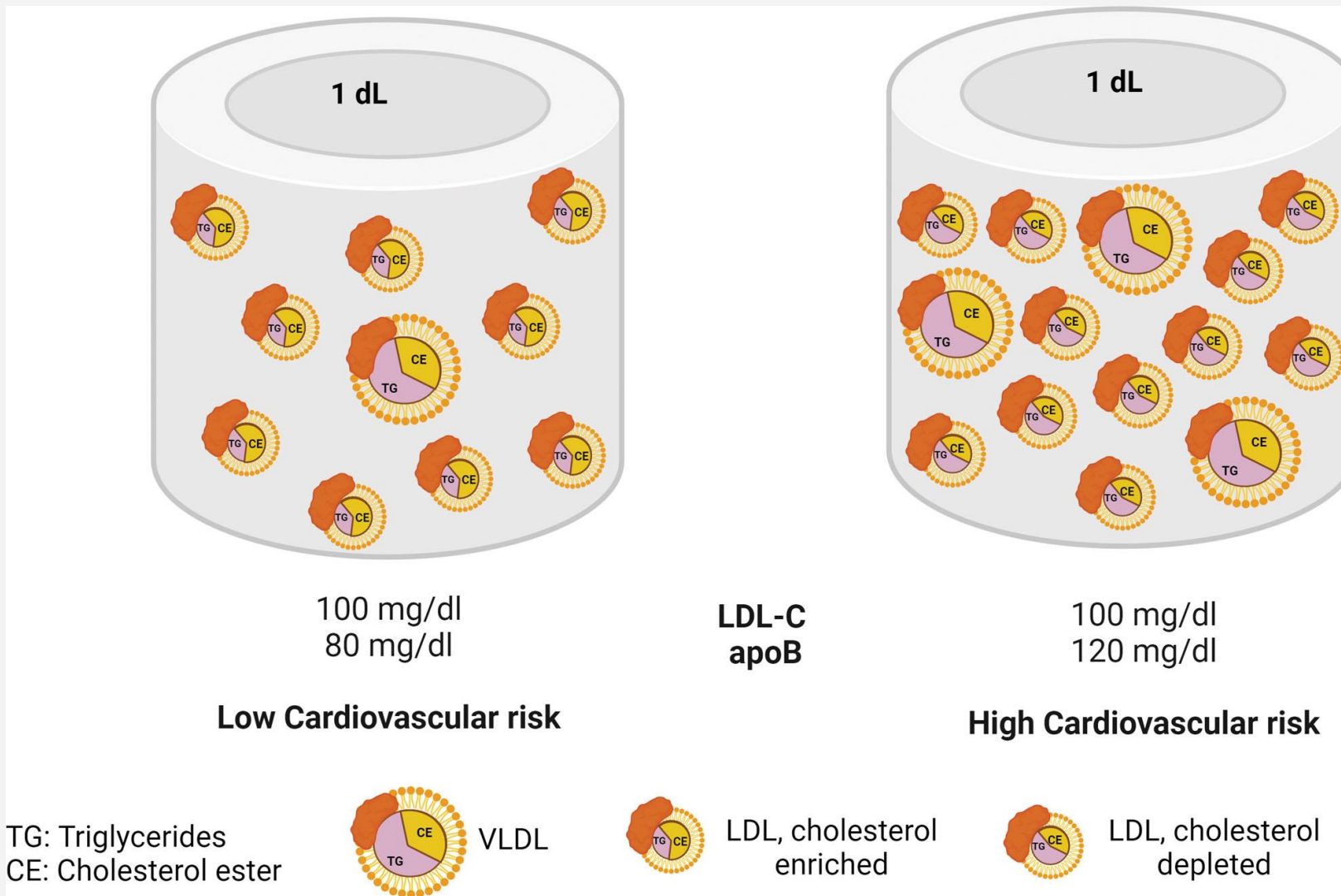
In adults not on LLT, measurement of apoB may be reasonable to enhance ASCVD risk assessment, guide initiation of LLT, and characterize inherited lipid disorders. (2b)

Particularly for secondary prevention, metabolic syndrome, diabetes, elevated triglyceride



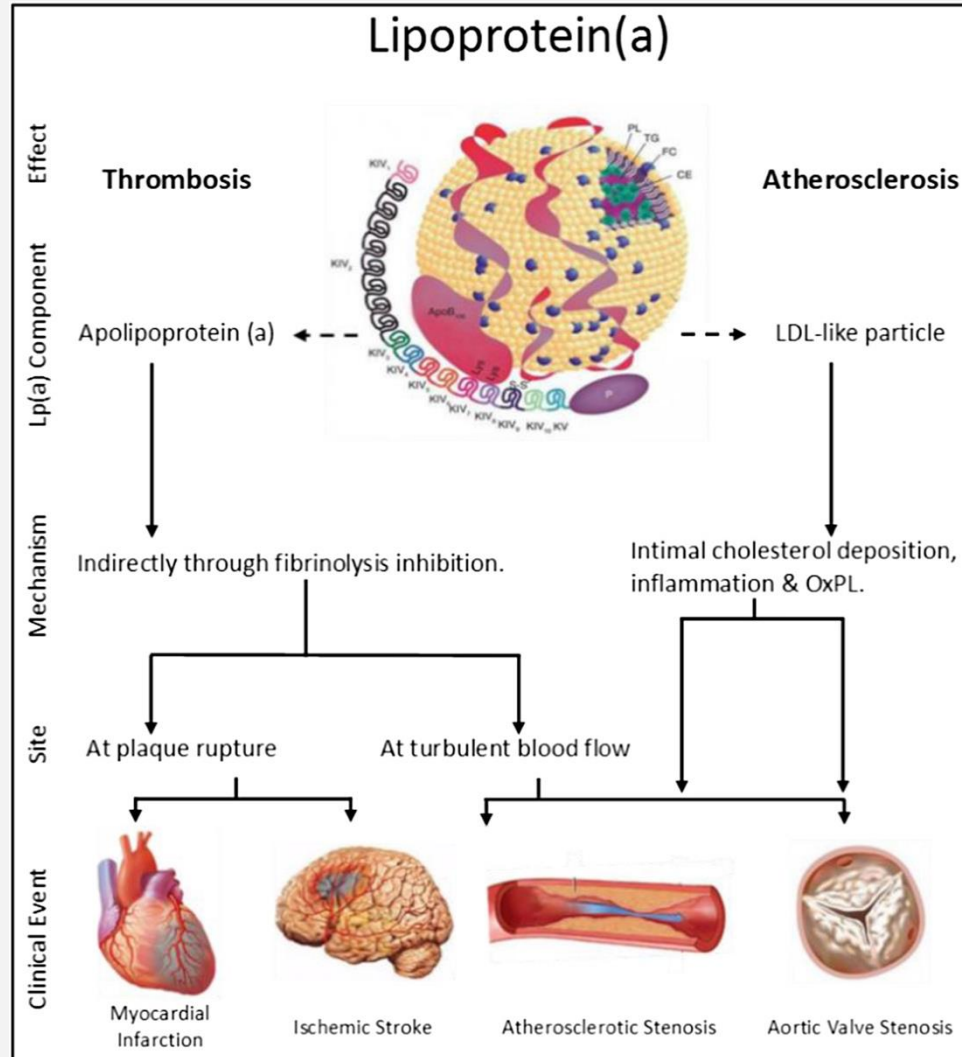
About ApoB:

All atherogenic lipoproteins have a single apoB100 protein. ApoB reflects the total # of atherogenic lipoproteins. ApoB is not affected by fasting.



6

Measure Lp(a) Once in All Adults



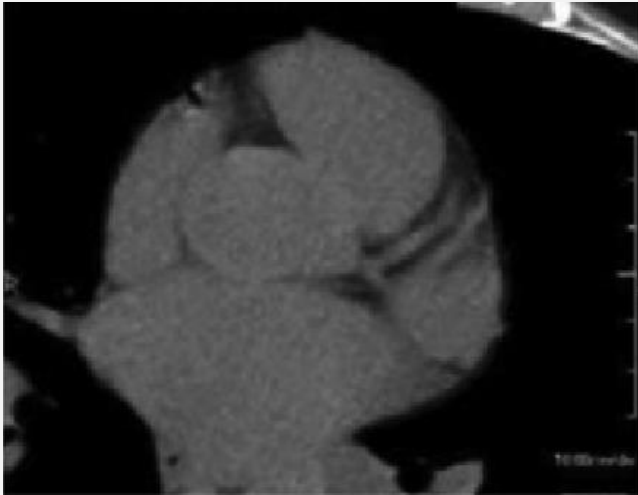
Increased ASCVD Risk By Lp(a) Levels



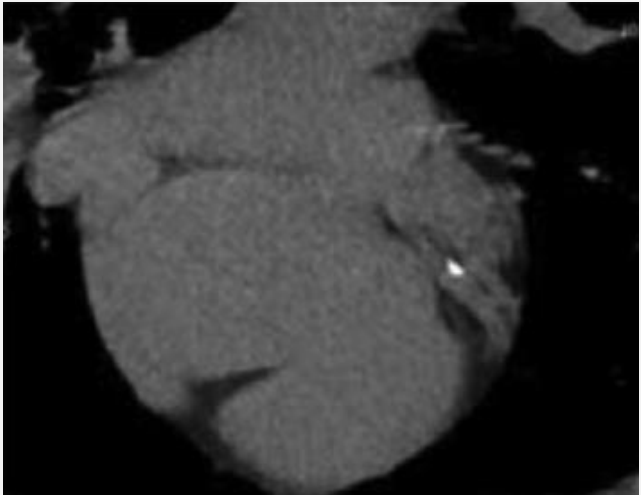
7

CAC Score Guided Rx of Subclinical Atherosclerosis

CAC: 0



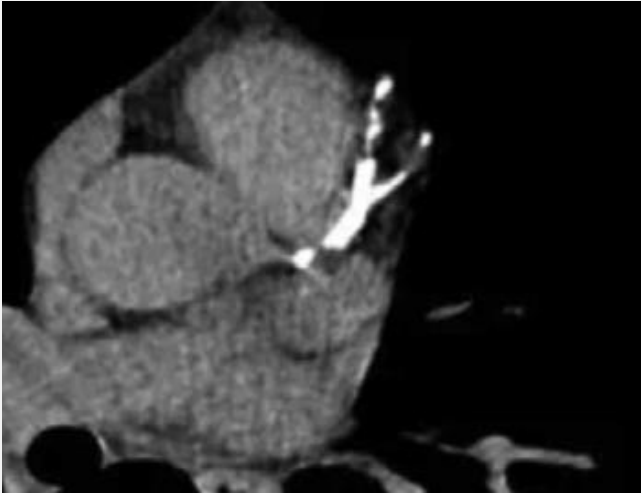
CAC: 1-99



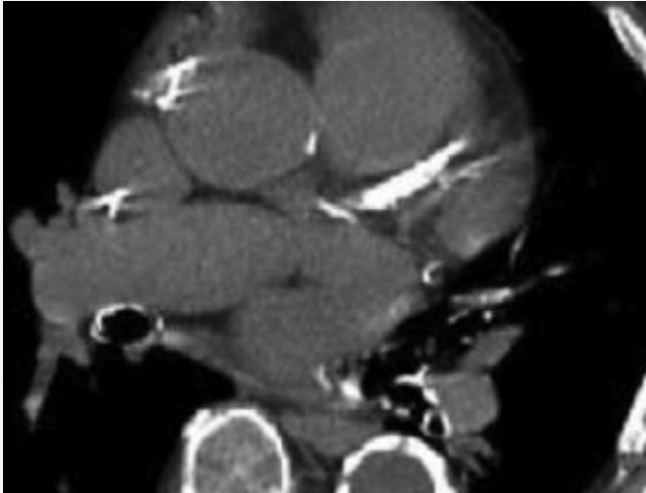
CAC: 100-299



CAC: 300-999



CAC ≥1000



CAC Scoring
Recommended if
Borderline (3-<5%) or
intermediate (5-
<10%) 10y ASCVD
Risk in Men ≥40,
Women ≥45 y.o.

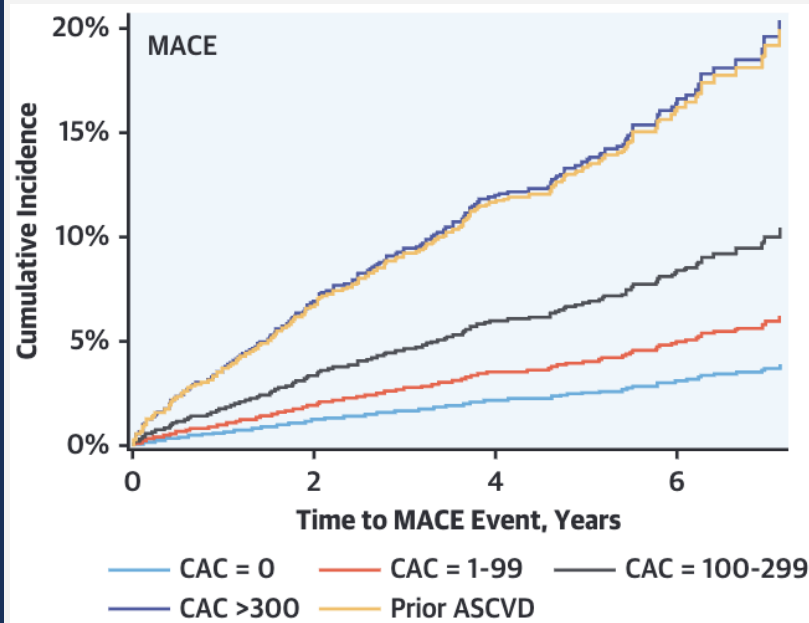
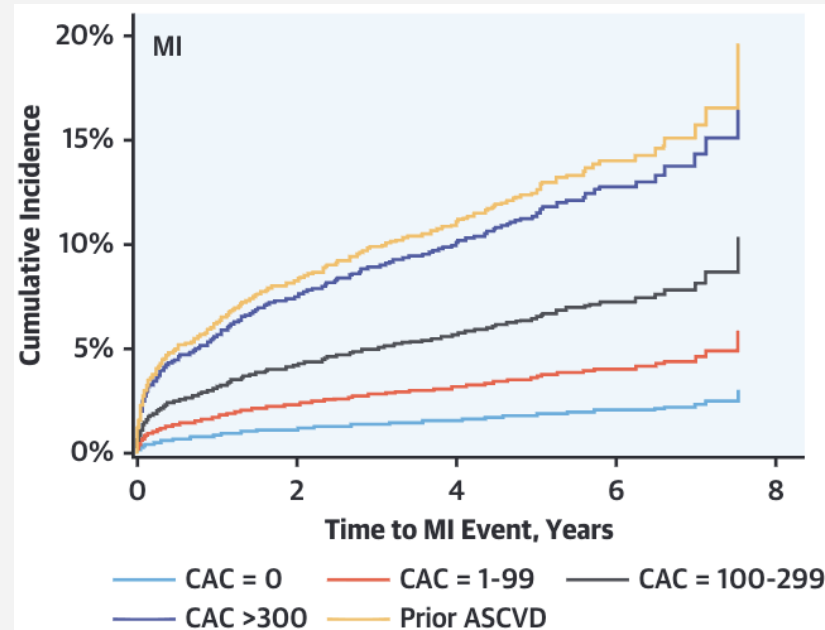
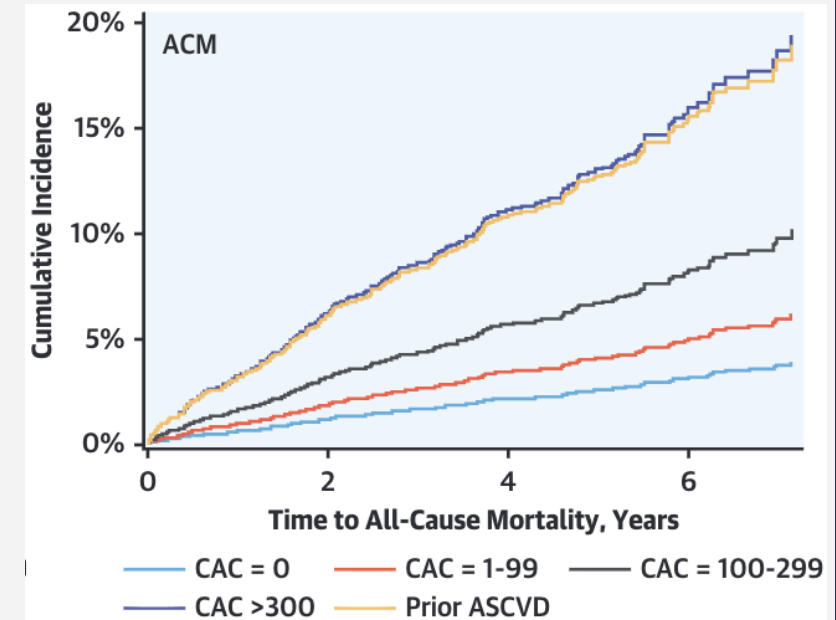
Adapted from Maron DJ, et al. JACC Adv. 2024;3:101287.



Kentucky
CHAPTER

Coronary Artery Calcium Scores and Cardiovascular Risk

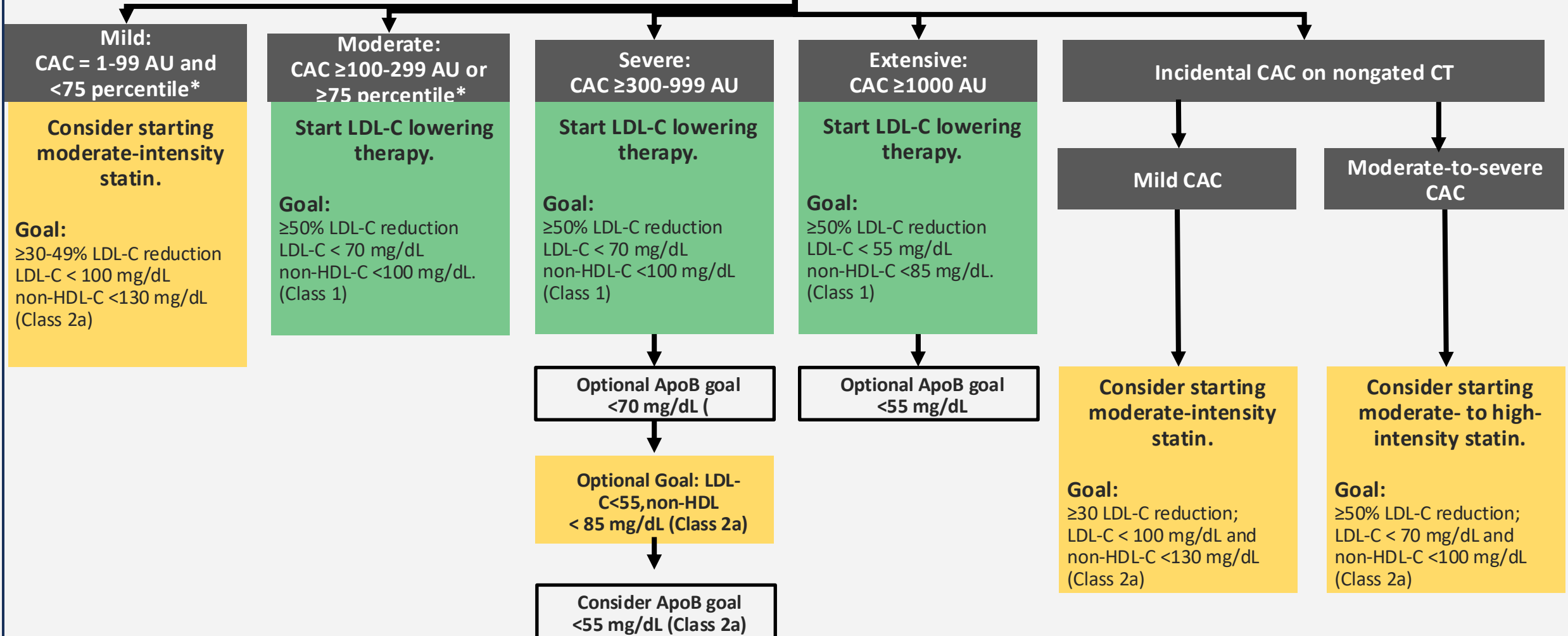
Observational analysis of 4511 individuals with an elevated coronary artery calcium score compared to 438 individuals with established ASCVD (CONFIRM registry)



Individuals with a CAC score ≥ 300 face cardiovascular risks similar to those with established ASCVD



Subclinical Coronary Atherosclerosis



JACC: CV Img, 2017

The Identification of Calcified Coronary Plaque Is Associated With Initiation and Continuation of Pharmacological and Lifestyle Preventive Therapies



A Systematic Review and Meta-Analysis

Ankur Gupta, MD, PhD,^a Emily Lau, MD,^a Ravi Varshney, MD,^a Edward A. Hulten, MD,^{a,b} Michael Cheezum, MD,^{a,c} Marcio S. Bittencourt, MD, PhD,^{a,d,e} Michael J. Blaha, MD, MPH,^f Nathan D. Wong, PhD,^g Roger S. Blumenthal, MD,^f Matthew J. Budoff, MD,^h Craig A. Umscheid, MD, MSCE,ⁱ Khurram Nasir, MD,^{f,j} Ron Blankstein, MD^a

When CAC identified:

↑rate initiation/ continuation of aspirin,
lipid lowering Rx, blood pressure
lowering Rx, increase in exercise,
dietary changes

JACC: CV IMG 2023

ORIGINAL RESEARCH

“Seeing is believing”

Impact of Patient Visualization of Cardiovascular Images on Modification of Cardiovascular Risk Factors



Systematic Review and Meta-Analysis

Kristyn Whitmore, BSN,^a Zhen Zhou, PhD,^a Niamh Chapman, PhD,^a Quan Huynh, PhD,^b Costan G. Magnussen, PhD,^{b,c,d} James E. Sharman, PhD,^a Thomas H. Marwick, MBBS, PhD, MPH^{a,b}

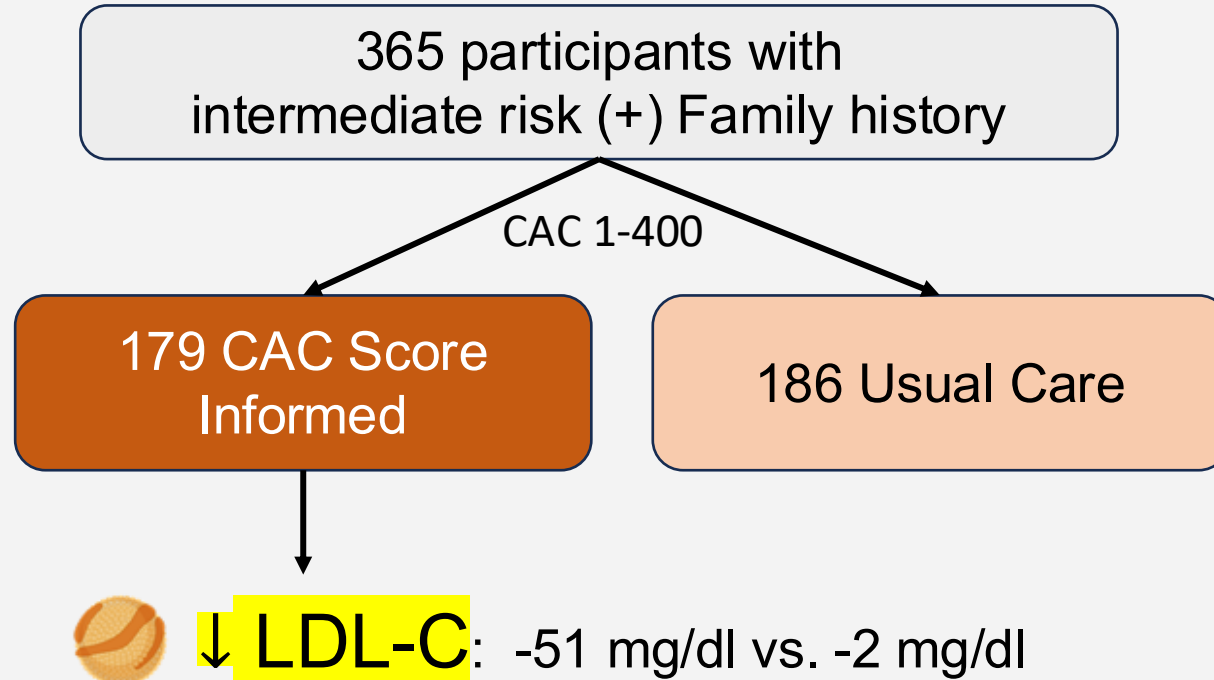
Patient visualization of CV imaging is
associated with overall CV risk reduction
and improvement of cholesterol and
systolic blood pressure



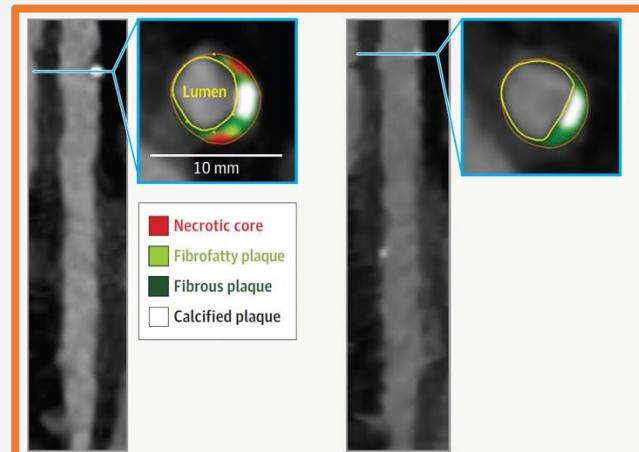
Kentucky
CHAPTER

Use Of CAC → More Treatment / Less Plaque Progression

CAUGHT CAD RCT, JAMA 2025



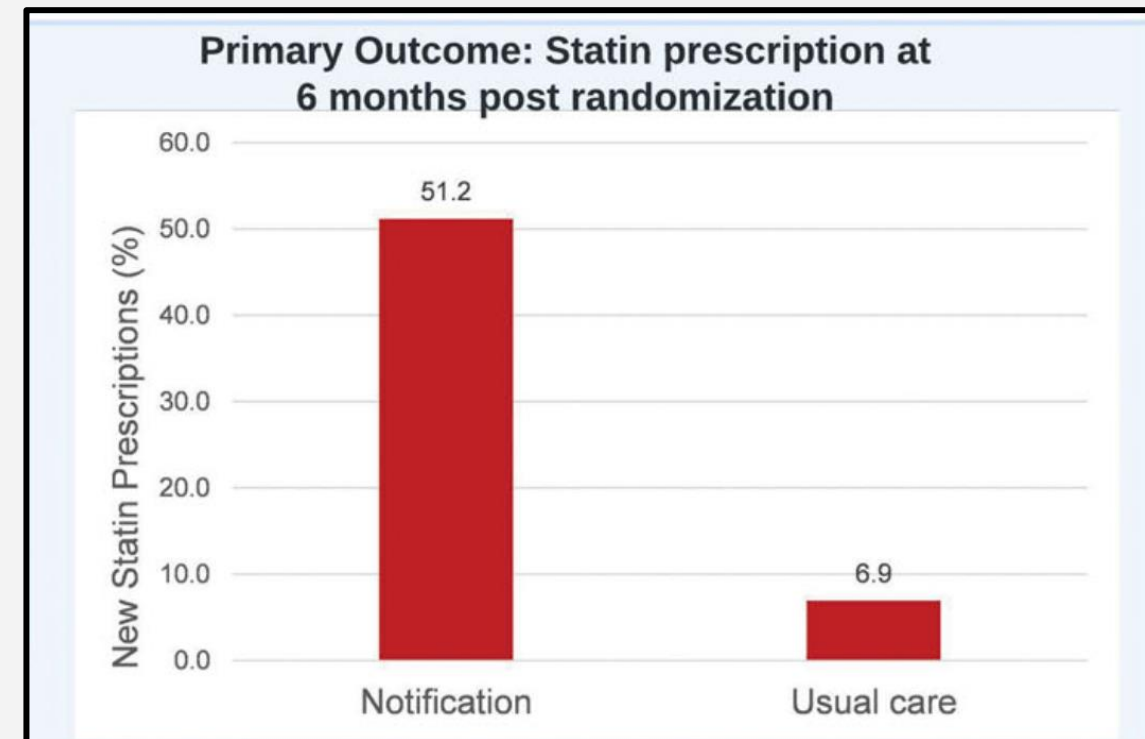
↓ Plaque progression on serial CCTA (Δ3 yrs)



NOTIFY1 Randomized Project, Circulation 2023

ORIGINAL RESEARCH ARTICLE

Incidental Coronary Artery Calcium: Opportunistic Screening of Previous Nongated Chest Computed Tomography Scans to Improve Statin Rates (NOTIFY-1 Project)



Nerlekar et al, JAMA 2025

Sandhu et al, Circulation 2023



KENTUCKY
COLLEGE OF MEDICINE
DEPARTMENT OF CARDIOLOGY

2a

B-NR

2. In adults at intermediate risk or select adults at borderline risk who undergo CAC testing, if the CAC score is 0 Agatston units (AU), and there is preference to avoid LLT and focus on lifestyle management, and no higher risk conditions (FH or severe hypercholesterolemia >190 mg/dL, diabetes and age >40 years, current cigarette smoking, strong family history of premature ASCVD) are present, it is reasonable to defer therapy and reassess with repeat CAC testing in 3 to 7 years to personalize management.⁵⁻⁸

It is never wrong to treat individuals with CAC=0
Deferring therapy is an option in specific cases



8

Special Considerations in Therapy



CKD

Stage 3-4

All Ages

Statin Therapy Recommended if
LDL-C ≥ 70 mg/dL



HIV

Age ≥ 40



Diabetes

Age ≥ 40



Cancer

Continue LLT
unless
contraindicated



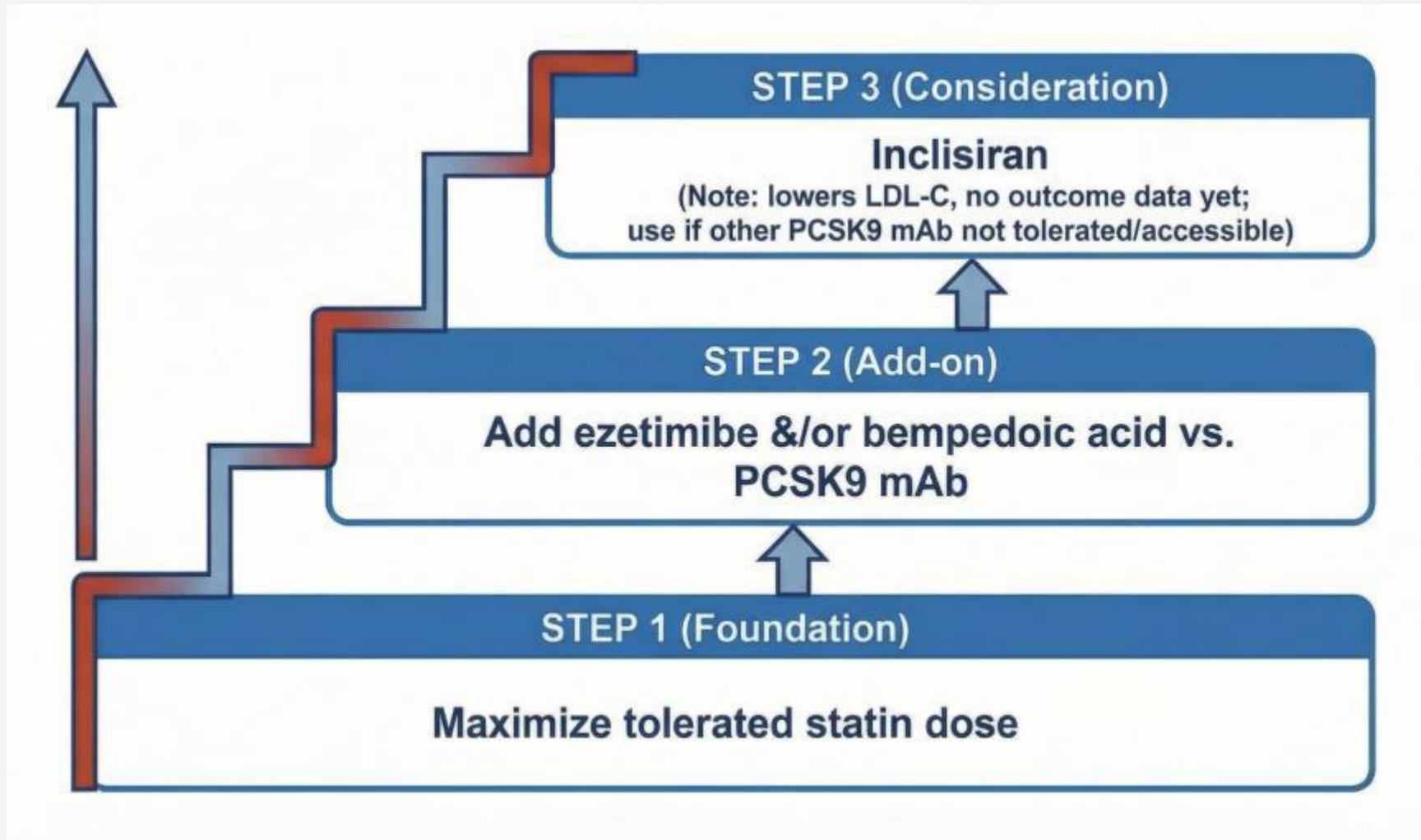
Pregnancy

Consult a dietitian and
defer most LLT

If TG are ≥ 500 mg/dL
(after 1st trimester),
consider fibrate
or omega-3 FA

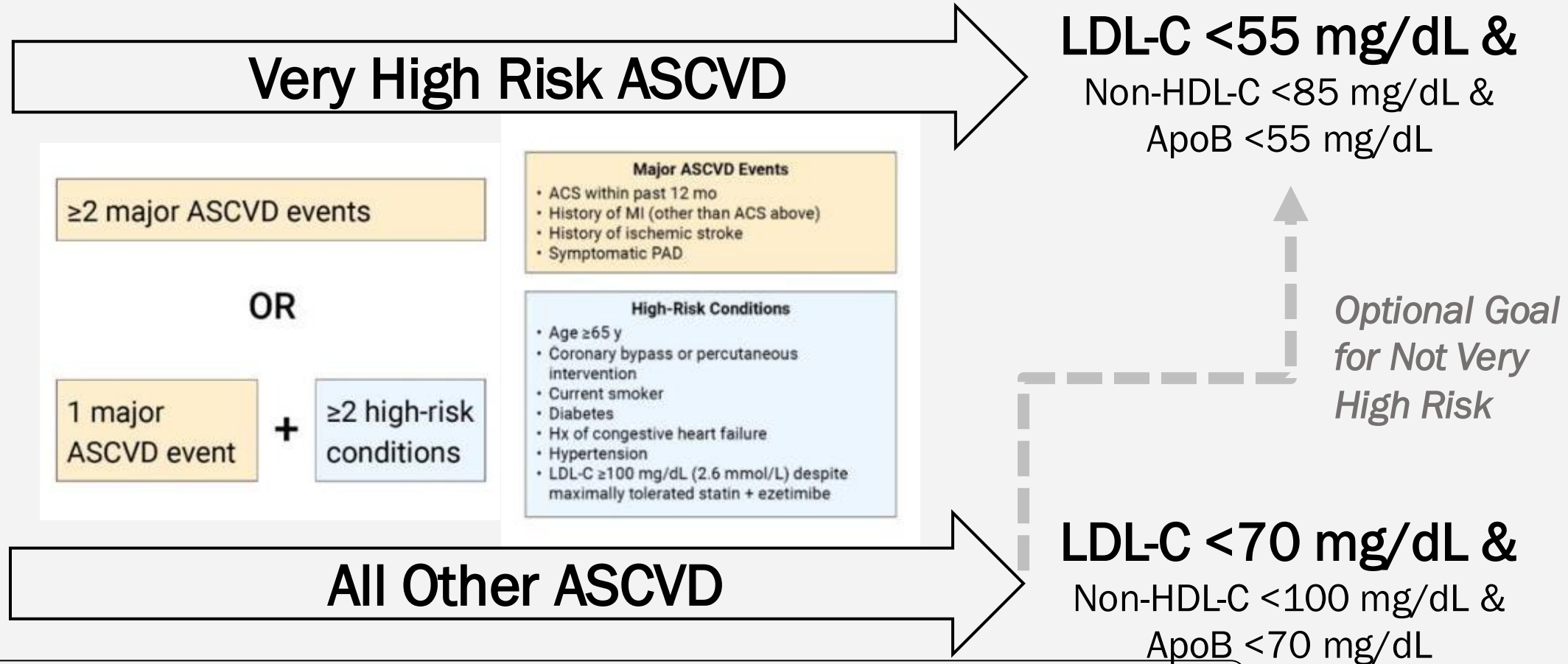
9

Lipid-Lowering Therapy Beyond Statins



9

Lipid Goals in Established ASCVD

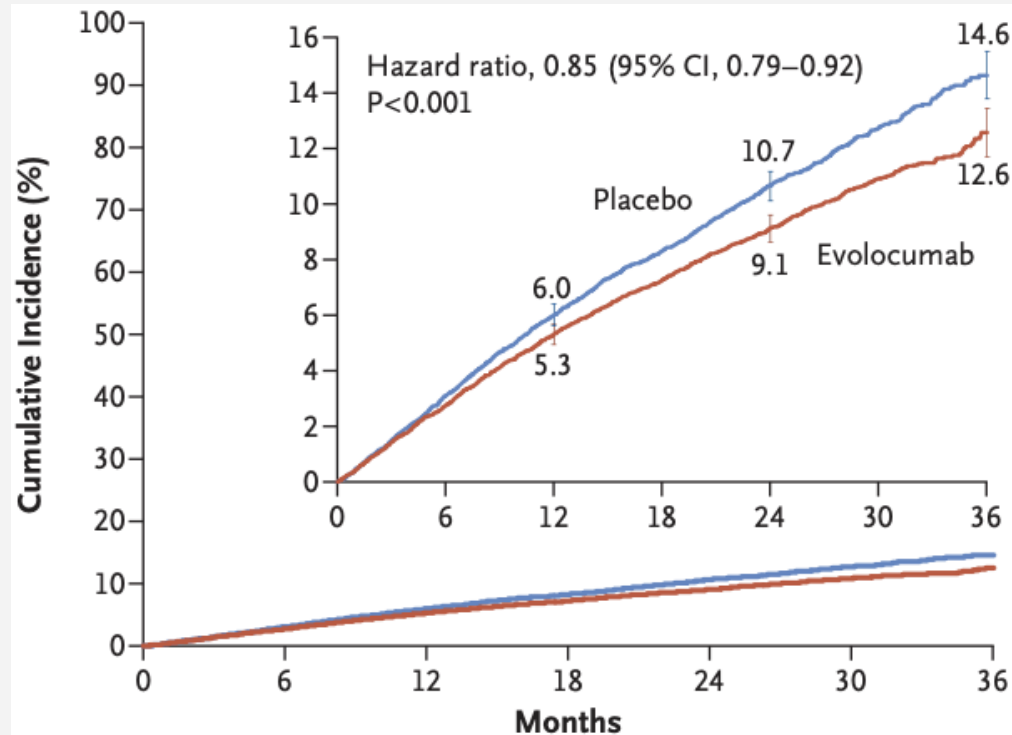


The majority of patients with established ASCVD are Very High Risk

Benefit of a Lower LDL-C Level in Clinical ASCVD

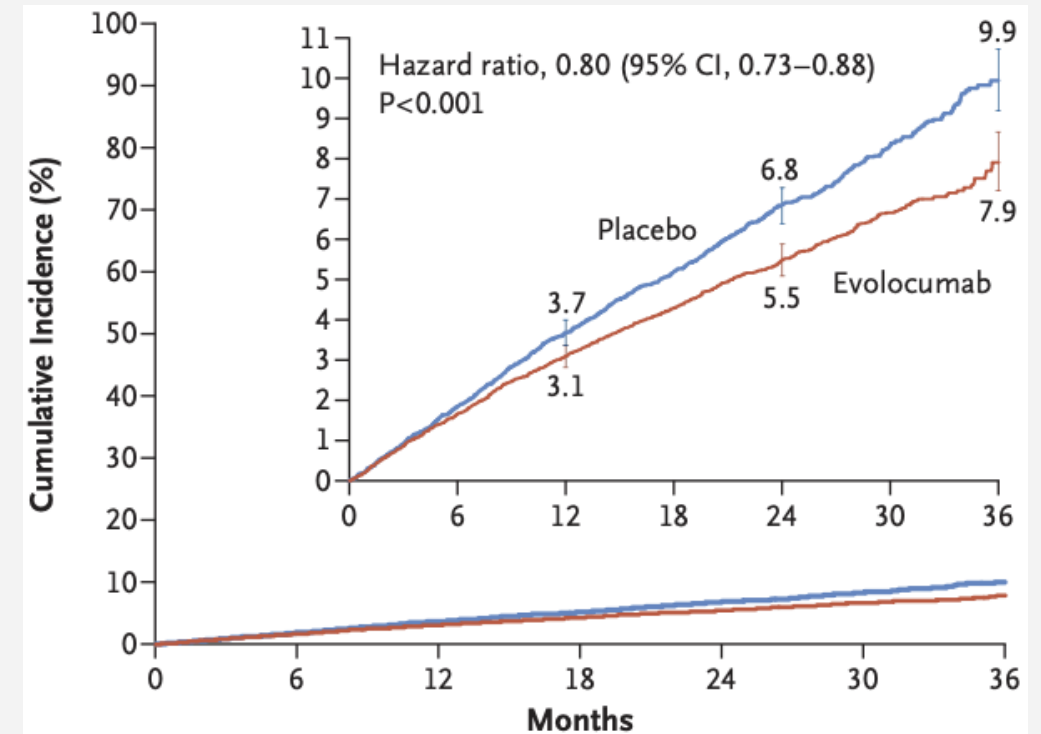
27,564 patients with ASCVD and an LDL-C ≥ 70 mg/dL randomized to evolocumab (either 140 mg every 2 weeks or 420 mg monthly) or placebo for a median of 2.2 years (FOURIER trial)

CV death, MI, stroke, hospitalization for unstable angina, or coronary revascularization



On-treatment median LDL-C of 30 mg/dL.

CV death, MI, or stroke



Sabatine MS, et al. N Engl J Med. 2017;376:1713-1722.



QUESTION Do high-risk primary prevention patients without known significant atherosclerosis and with diabetes benefit from intensive lowering of low-density lipoprotein cholesterol levels with PCSK9 inhibitor therapy?

CONCLUSION In high-risk patients without known significant atherosclerosis and with diabetes, the PCSK9 inhibitor evolocumab significantly reduced the risk of a first major cardiovascular event.

© AMA

POPULATION

2066 Females
1589 Males



Patients with no prior myocardial infarction or stroke and no known significant atherosclerosis, with diabetes and LDL-C level 90 mg/dL or greater

Median age: 65 years

LOCATIONS

774
Sites
worldwide



INTERVENTION

12 257 Patients randomized
3655 Patients qualified for this
substudy and were analyzed

1849

Evolocumab

Evolocumab (140 mg
subcutaneously every 2 weeks)



1806

Placebo

Matching placebo



PRIMARY OUTCOME

Dual composites of coronary heart disease death, myocardial infarction, or ischemic stroke (3-P MACE) and 3-P MACE plus ischemia-driven arterial revascularization (4-P MACE)

FINDINGS

5-Year estimates of patients
with 3-P MACE and 4-P MACE events

	Evolocumab	Placebo
3-P MACE	5.0%	7.1%
4-P MACE	7.6%	10.5%

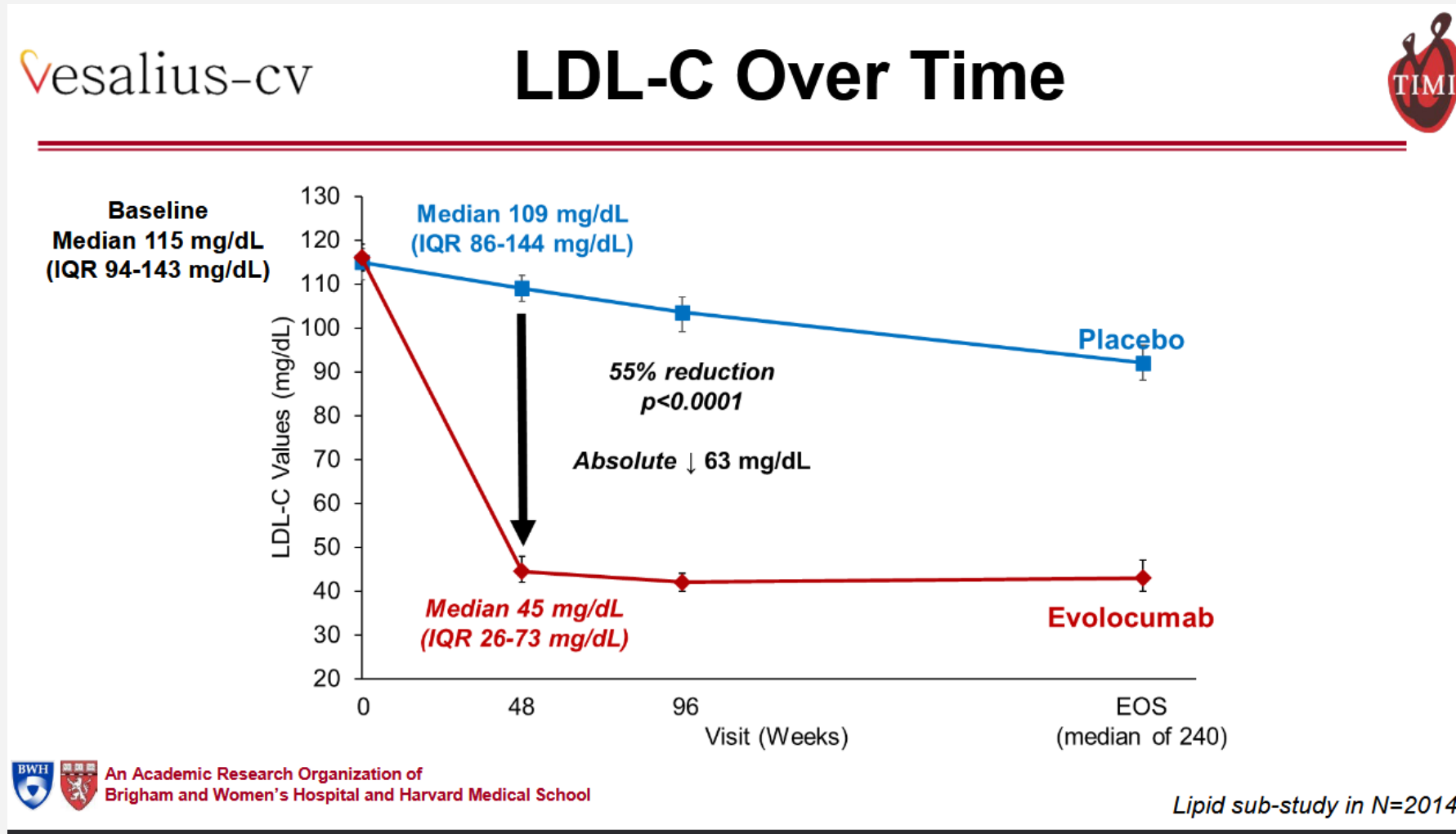
Evolocumab statistically significantly reduced risk of a first major cardiovascular event:

3-P MACE: HR, **0.69** (95% CI, 0.52 to 0.91); $P=.009$
Between-group difference, **2.1%** (95% CI, 0.4% to 3.8%)

4-P MACE: HR, **0.69** (95% CI, 0.55 to 0.86); $P=.001$
Between-group difference, **2.9%** (95% CI, 0.9% to 4.9%)

Marston NA, Bohula EA, Bhatia AK, et al; VESALIUS-CV Investigators. Evolocumab to reduce first major cardiovascular events in patients without known significant atherosclerosis and with diabetes: results from the VESALIUS-CV trial. *JAMA*. Published online March 28, 2026. doi:10.1001/jama.2026.3277

VASELIUS Came Out Too Late for This Guideline



No Known ASCVD

Known ASCVD

Increasing risk for development of ASCVD

Increasing severity of ASCVD

Low-CV Risk
(w/o known ASCVD)

High-CV Risk
(w/o known ASCVD)

Diabetes
+ risk enhancer

Atherosclerosis
w/o Prior Event

Coronary disease,
Cerebrovascular disease, or
Peripheral artery disease,
+ risk enhancer
No MI or Stroke

Major ASCVD
Event

Prior MI
Prior Stroke
Symptomatic PAD
+ risk enhancer

VESALIUS-CV

FOURIER
ODYSSEY-OUTCOMES

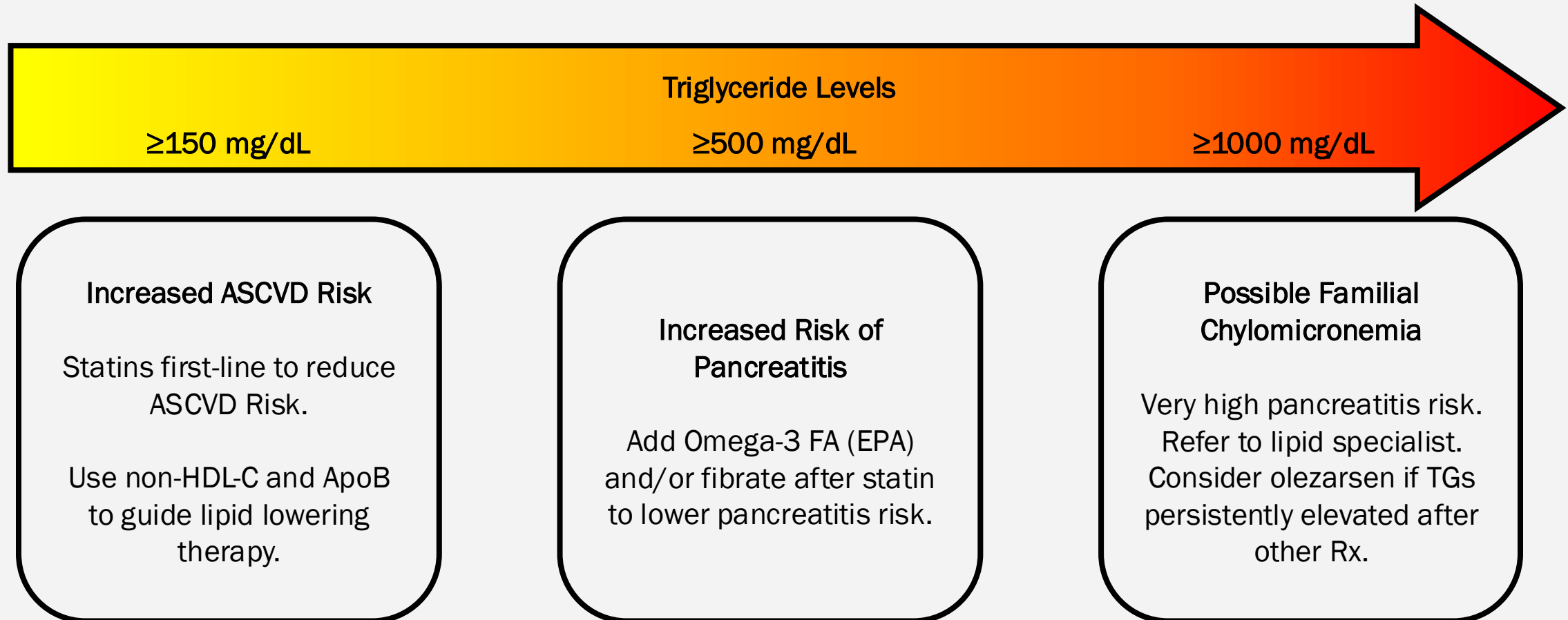
Dietary Interventions for Hypertriglyceridemia

Lifestyle is 1st Line for All With Elevated TGs:
 ≥5% weight loss, ≥150 min/week moderate intensity activity

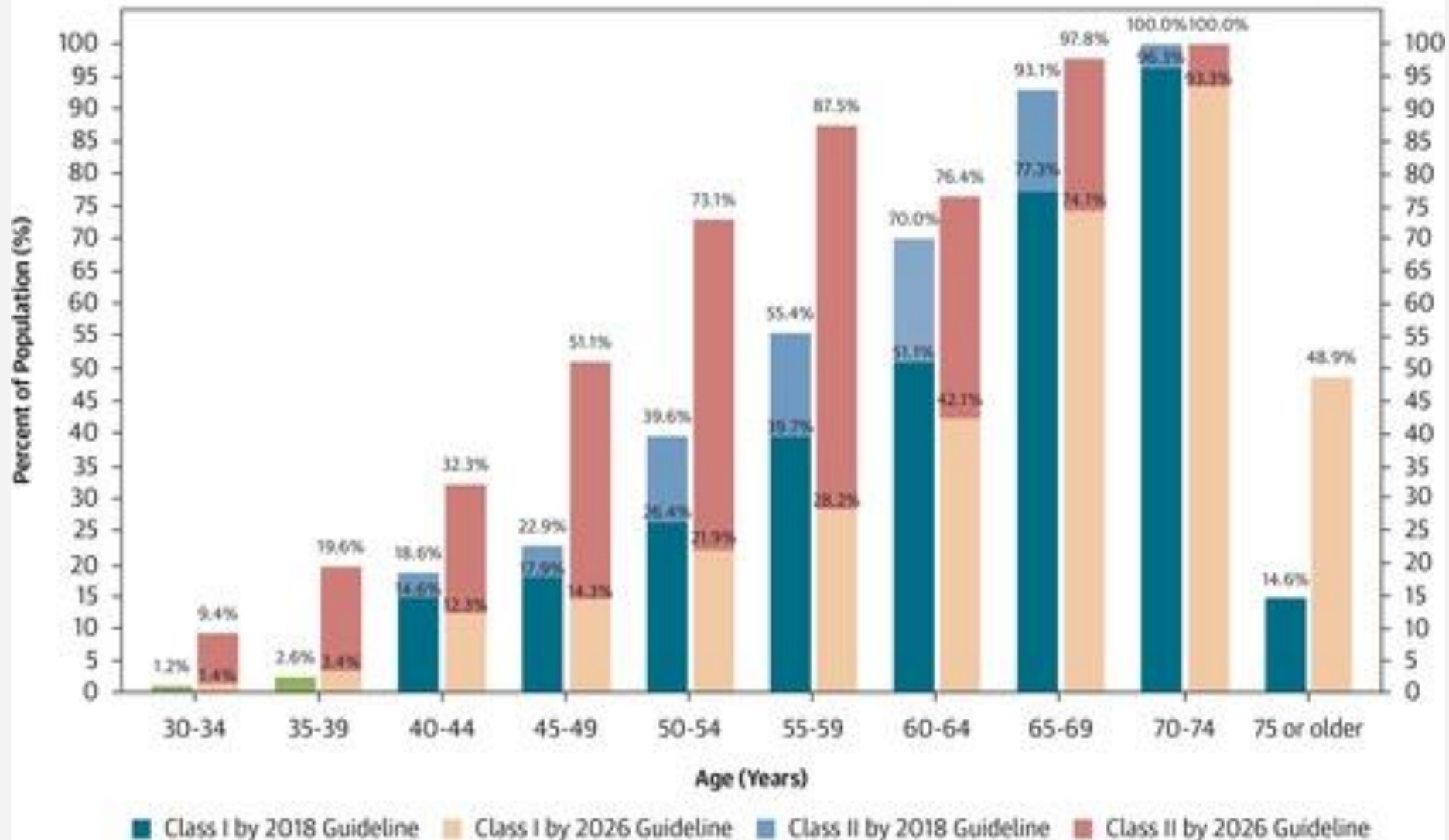
Implemented shared decision-making intervention	TG ≥150 to 499 mg/dL* (1.7 to <5.7 mmol/L)	TG ≥500 to 999 mg/dL* (5.7 to <11.3 mmol/L)	TG ≥1000 mg/dL [†] (≥11.3 mmol/L)
Added sugars (percent calories)	<6%	<5%	Eliminate
Total fat (percent calories)	30%–35%	20%–25% [‡]	10%–15% ^{§¶}
Alcohol	Avoid	Abstain completely	Abstain completely
Physical activity	At least 150 minutes/week of accumulated moderate-intensity or 75 minutes/week of vigorous intensity aerobic activity (or equivalent combination of both) and 2 days/week of upper and lower body resistance exercise		
Weight loss (percent body weight)	Recommended weight loss goal of 5%–10% for patients who are overweight or obese with elevated TG		

10b Pharmacologic Approach to Hypertriglyceridemia

Treatment of Hypertriglyceridemia based on ASCVD and Pancreatitis Risk



Proportion of U.S. Adults With Class 1 or 2 Recommendation for Statin Consideration Under the 2018 and 2026 ACC/AHA Guidelines by Age Group

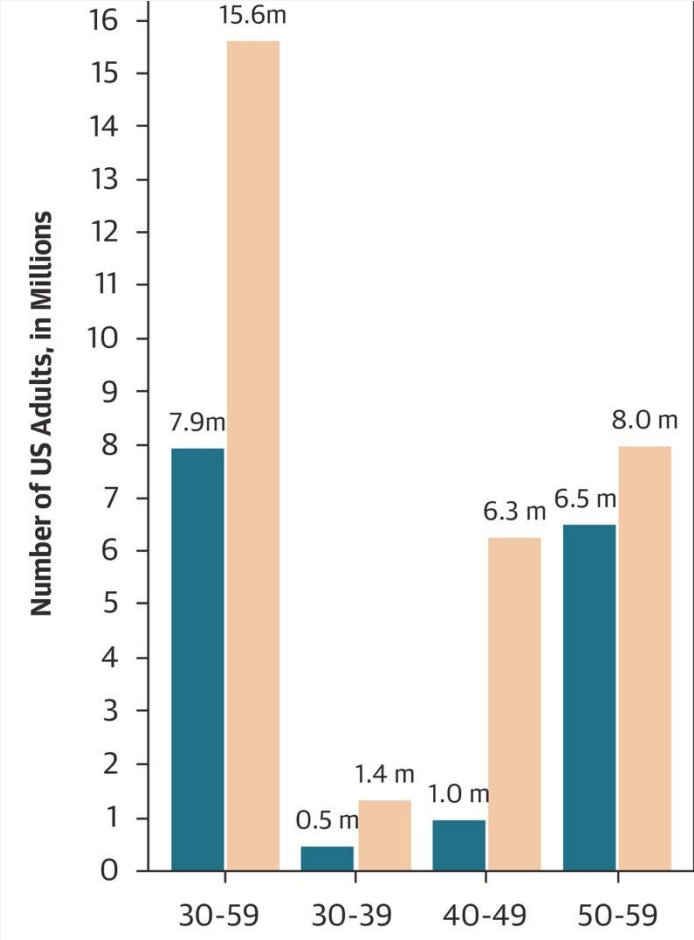
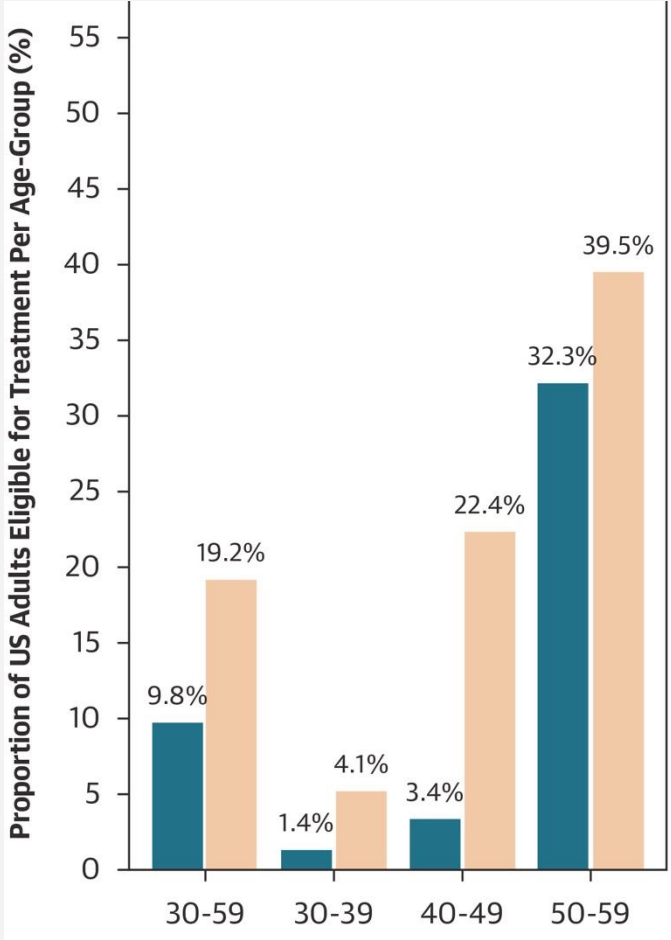


Sayed A, Peterson E, Navar M. JACC 2026

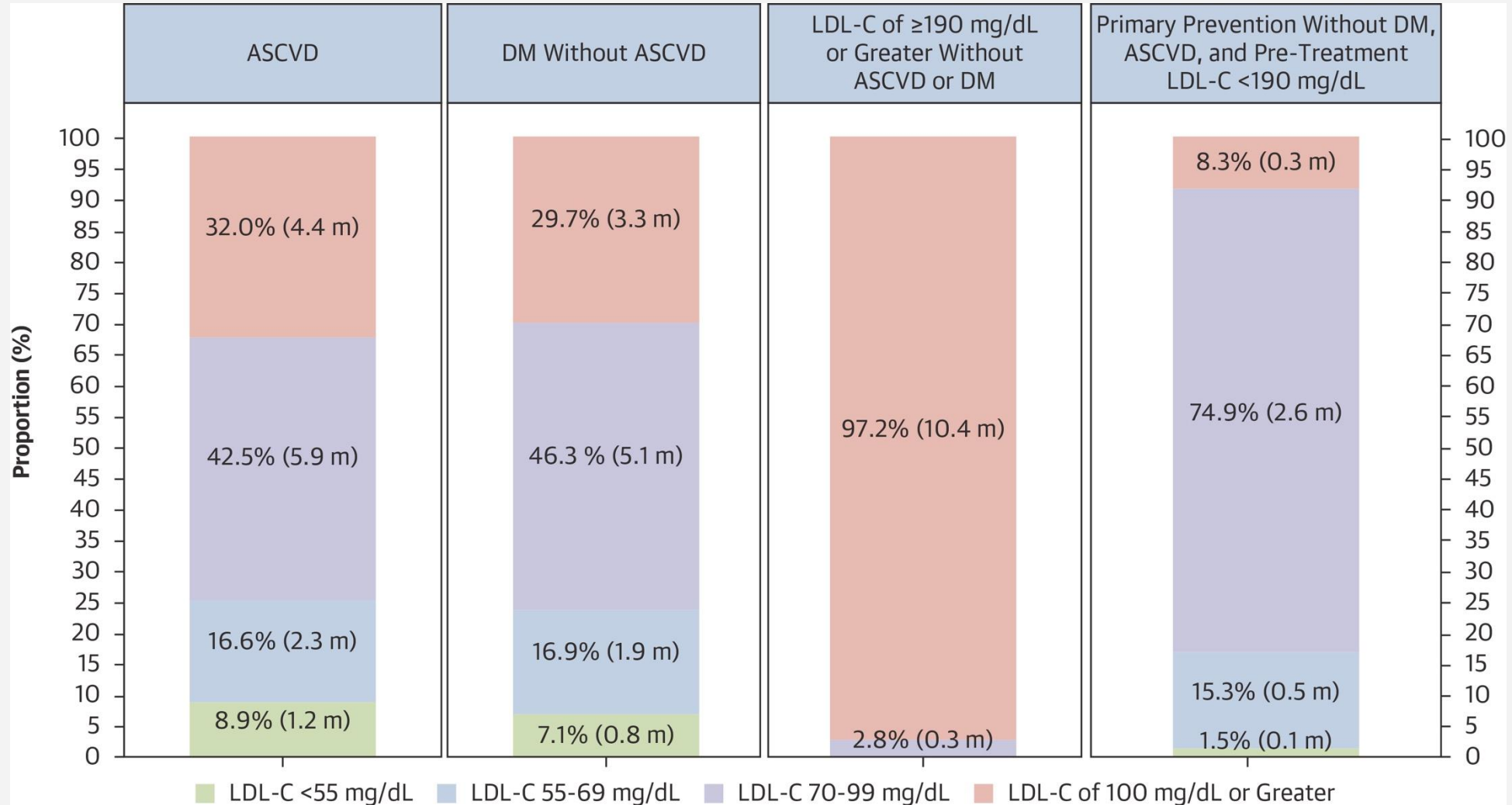


Kentucky
CHAPTER

Number and Proportion of Adults Aged 30 to 59 Years Eligible for Statins Based on 10-Year vs 30-Year PREVENT ASCVD Risk



LDL-C Levels Among U.S. Adults on Lipid-Lowering Therapy by Indication



Sayed A, Peterson E, Navar M. JACC 2026



Kentucky
CHAPTER

CARDIO SAFE

PROTECTING THE HEART OF CARE

Scan to learn more!



See how ACC's Cardio Safe is working to foster safer, more respectful health care environments.



**AMERICAN
COLLEGE of
CARDIOLOGY®**

Conclusions: Key Points



Risk assessment

Personalize risk with PREVENT-ASCVD and risk enhancers

Use CAC when treatment decisions remain uncertain

Measure Lp(a) at least once in every adult

Shared decision making



Treatment and prevention

Start earlier to reduce lifetime LDL-C exposure

Treat to LDL-C and non-HDL-C goals, using ApoB to assess residual risk

Keep statins as the foundation, adding nonstatin therapy when needed

Sustain lifestyle changes and individualized prevention over time

Lifestyle cornerstone



THANK YOU



Kentucky
CHAPTER

OCTOBER 17, 2026 • LOUISVILLE MARRIOTT EAST • LOUISVILLE, KY