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CHOLESTEROL GUIDELINE: OVERVIEW TOOL

Based on the ACC/AHA/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol

Use this tool to reference some of the noteworthy changes between the 2013 and 2018 Cholesterol Guideline See the full Guideline for the complete updated recommendations.

Major Changes in Cholesterol Guideline Recommendations

Secondary ASCVD Prevention	
2013	**2018**
(No equivalent 2013 Recommendations)	Adds specific recommendations for patients considered "very high-risk ASCVD".
High and moderate intensity statin use recommendations did not specify LDL-C reduction targets but did recommend follow-up LDL-C testing for adherence and adequacy of statin effect. Class I	Specifies the importance of percentage reduction in LDL-C when prescribing high (≥50%) or moderate-intensity statins (30-49%) as well as follow-up LDL-C testing for adherence and effects of LDL-C lowering medication. Class I
Recommends that addition of non-statin cholesterol lowering drugs in adults at higher ASCVD risk receiving maximally tolerated statin therapy with less-than-anticipated therapeutic response may be considered Class IIb	Specifies that patients with ASCVD who are at very high-risk who are considered for PCSK9 inhibitor therapy, should first receive maximally tolerated statin therapy and ezetimibe. Class I
	Recommends that patients with ASCVD at very high-risk and on maximally tolerated LDL-C lowering therapy with LDL-C ≥70 mg/dL or non-HDL-C ≥100 mg/dL may consider a PCSK9 inhibitor following a clinician–patient discussion about the net benefit, safety, and cost Class IIa
Recommends use of non-statin cholesterol-lowering drugs in adults that are candidates for statins but are completely statin intolerant. Class IIa	Recommends that patients with clinical ASCVD on maximally tolerated statin therapy and are judged to be at very high risk and an LDL-C level of 70 mg/dL (≥1.8 mmol/L) or higher, may benefit from the addition of ezetimibe therapy. Class IIa
(No equivalent 2013 Recommendation)	Value statement on PCSK9 inhibitors

Class I | Class IIa | Class IIb | Not Included

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Severe Hypercholesteremia	
2013	**2018**
For adults 21-75 years with an LDL-C level of ≥ 190 mg/dL (≥4.9 mmol/L) after maximizing statin therapy, addition of a non- statin drug may be considered to further lower LDL-C *Class IIb*	Adds option of ezetimibe therapy in patients 20 to 75 years of age with an LDL-C level of ≥190 mg/dL (4.9 mmol/L) who achieve less than a 50% reduction in LDL-C while receiving maximally tolerated statin therapy and/or have an LDL-C level of ≥100 mg/dL (2.6 mmol/L). Class IIa
(No equivalent 2013 recommendation)	Adds option of a PCSK9 inhibitor in patients with a baseline LDL-C ≥ 220 mg/dL and who achieve an on-treatment LDL-C level of ≥130 mg/dL (≥3.4 mmol/L) while receiving maximally tolerated statin and ezetimibe therapy. Class IIb
(No equivalent 2013 recommendation)	Adds option of a PCSK9 inhibitor in patients 30 to 75 years of age with heterozygous FH and with an LDL-C level of ≥100 mg/dL (≥2.6 mmol/L) while taking maximally tolerated statin and ezetimibe therapy. Class IIb
(No equivalent 2013 recommendation)	Value statement on PCSK9 inhibitors

Class I | Class IIa | Class IIb | Not Included

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Primary Prevention in Adults 40-75 Years, LDL-C 70-189 mg/dL	
2013	**2018**
Uses pooled cohort equations to classify adults as low risk (<5%), borderline risk, (5% to <7.5%), and high-risk (≥7.5%)	Adds intermediate risk (≥7.5 to <20%) category and new definition of high-risk (≥20%) when classifying PCE risk. No change in low and borderline risk definitions. Class I
Recommends use of moderate to high-intensity statin therapy in adults with ASCVD 10-year risk ≥7.5% Class I	Further segments risk stratification and prescribing strategy - Intermediate risk (≥7.5– <20%), moderate intensity statin - High risk (≥20%), maximally tolerated/high intensity statin Class I
Recommends conducting a clinician and patient risk discussion to consider the potential for ASCVD risk reduction with statin therapy. Class IIa	Continues and expands on use of shared decision-making in the form of the patient-clinician risk discussion Class I
Recommends use of coronary artery calcium (CAC) score as one of several factors that may be considered to inform treatment decision making. Class IIb	Allows for use of coronary artery calcium (CAC) score in select adults if a risk-based treatment decision regarding initiation of statin therapy is uncertain. Class IIa
	Notes the value of a CAC score = 0 in selected intermediate risk patients can be useful to aid in the decision to withhold or postpone statin therapy, unless higher risk conditions such as diabetes, family history of premature CHD, or cigarette smoking are present. Class IIa
(No equivalent 2013 recommendation)	Adds option of non-statin drugs (ezetimibe or bile acid sequestrant) that may be considered in treatment of intermediate-risk adults who would benefit from more aggressive LDL-C lowering but in whom high-intensity statins are not tolerated." Class IIb

Class I | Class IIa | Class IIb | Not Included

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