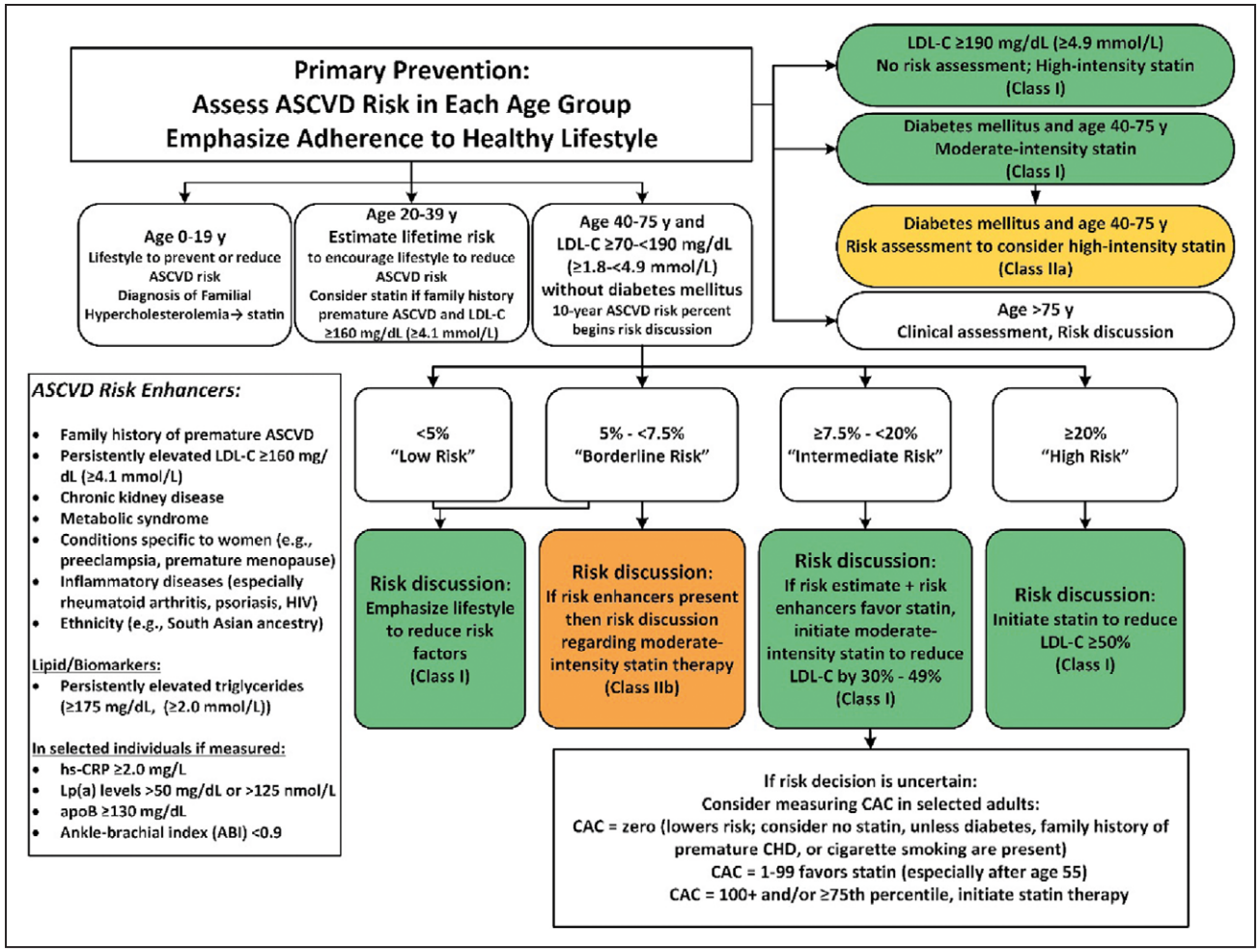

Figure 3. Primary prevention.
Colors correspond to Class of Recommendation in Table 1. ABI indicates ankle-brachial index; apoB, apolipoprotein B; ASCVD, atherosclerotic cardiovascular disease; CAC, coronary artery calcium; CHD, coronary heart disease; HIV, human immunodeficiency virus; hs-CRP, high-sensitivity C-reactive protein; LDL-C, low-density lipoprotein cholesterol; and Lp(a), lipoprotein (a). Reproduced with permission from Grundy et al.[S4.3-1] Copyright © 2018, American Heart Association, Inc., and American College of Cardiology Foundation.

Synopsis

Primary ASCVD prevention requires attention to ASCVD risk factors beginning early in life (Figure 3). This guideline addresses major issues related to cholesterol management and primary ASCVD prevention, which are also addressed in the recently published 2018 Cholesterol Clinical Practice Guidelines.[S4.3-1] Therefore, the relevant subset of those recommendations is presented here, along with its accompanying supportive text. This writing committee agrees that for young adults (20 to 39 years of age), priority should be given to estimating lifetime risk and promoting a healthy lifestyle. Only in select patients with moderately high LDL-C (≥160 mg/dL) or those with very high LDL-C (≥190 mg/dL) is drug therapy indicated. In adults 40 to 75 years of age, 10-year ASCVD risk should guide therapeutic considerations. The higher the estimated risk, the more likely the patient is to benefit from statin treatment. For patients >75 years of age, assessment of risk status and a clinician patient risk discussion are needed to decide whether to continue or initiate statin treatment. For a detailed discussion of statin safety and management of statin-associated side effects, please refer to Section 5 of the 2018 Cholesterol Clinical Practice Guidelines.[S4.3-1]

Recommendation-Specific Supportive Text

1. Large-scale RCTs in primary prevention demonstrated ASCVD risk reduction with moderate-intensity[S4.3-6,S4.3-36] and high-intensity statin therapy[S4.3-7] that outweighed the observable risks. Subsequently, a large-scale RCT in an ethnically and racially diverse population confirmed statin benefit from a moderate-intensity statin therapy, as compared with placebo, in intermediate-risk patients. That RCT enrolled men ≥55 years of age and women ≥65 years of age with at least 1 cardiovascular risk factor. In the placebo