Dr. RIDKER: So we have guidelines. And that's what they are, they're guidelines. Then we have our actual clinic. And all of us recognize that we have different patient groups in our clinics, even in patients who had prior myocardial infarction. That's pretty much my clinic. If you had a prior MI, you're very likely to be someone I might see.

But even in that group, I've got 15% or 20% of people. I know exactly who they are. Because they're on my schedule constantly. They seem to come back. They seem to get another stent, another [INAUDIBLE]. They end up in my cath lab, which is you. So Deepok puts another stent in them.

And sometimes they come back with another infarct. And the spouse is saying, I don't understand. Why is my loved one having this problem? So those people, to me, is also a big target for getting them onto a PCSK9 inhibitor. And I would probably do that independent of their baseline LDL. Something is happening in them. And if I can drive the biology down for them, I'm going to try to get them on this therapy.

Dr. BHATT: Yeah. I totally agree with that approach. I think patients with recurrent ischemic events are extremely high risk. And those folks, sometimes we call them frequent fliers. I don't know if that term is still so popular on the wards. But we've got to do something there. And I think that's a target population where therapy such as PCSK9 inhibitors or sort of novel expensive therapies can be useful, determined by what their dominant risk is. So I think that's really useful.

And I think from an interventional perspective, we see a lot of these patients. We identify them in the cath lab. They come in with an acute coronary syndrome. They come in again. Come in with accelerating angina, multiple procedures.

And I think those sort of folks, first of all, I want to assure that they're adherent to their lifestyle and generic statin, and that sort of thing. But assuming that they are and they keep coming back, that's a time I think it's a good patient to escalate therapy, ratchet things up a little bit.

Dr. RIDKER: So I think it also affects how we think about cost effective analysis. Because we do, as you did, you were looking at the global picture for the entire population. We all recognize we have certain patients who chew up a lot of cost.

And if they keep coming back to the cath lab, suddenly I'm going to say, look, maybe their diabetic medication should be shifted over to an SGL2. Maybe their lipid lowering should be much more aggressive. Maybe if there is an anti-inflammatory approach, we should be using it.

Because there are patients, individual patients, who chew up an enormous amount of our budget because they have this progressive disease. And I think trying to find them and focus on them is part of what we argue with our payers.

Dr. BHATT: I totally agree. And one other group that's sort of like that is folks with polyvascular disease. And by that term, I mean people that have high atherosclerotic burden. That is folks with unstable angina in the past, but they've also had a TIA or they've got peripheral artery disease, in particular when it's symptomatic.

So I think folks that have symptomatic atherosclerosis in two or especially three beds, those sorts of patients are also frequently coming back in multiple times. That's another attractive population for therapy such as PCSK9. But also, that paradigm could apply for things like rivaroxaban on the compass data. But really need to focus on those patients and escalate their care.