SPEAKER 1: The story of statin intolerance, whatever that means, is a difficult one. It is a difficult one because, basically, if you exclude the lab results, the readouts, like liver enzymes and other things you can detect, which are present, are not so infrequent, also, with statins. The pain, muscle pains, are a difficult thing.

If you look at the surveys, they come up with 15-20% of people taking statin complaining of muscle pains, one way or another. If you look at randomized clinical trial, the signal, if present, is very minor. In addition to that, a recent analysis from a trial, when the patients were told whether they were on the statin or in placebo, all of a sudden, the people who were in statin started to complain for, knowing being a statin, started for complain for muscle pains.

So it's a difficult diagnosis for the physician as, basically, it's not a diagnosis that is put there by physician. It is a patient-driven diagnosis. So that's the first point. The second point is, no matter what, the patient is not going to take a statin. And the patient who will benefit from it-- I'm talking about the high-risk patient who cannot take or do not wish to take a statin-- they will still have to take another drug.

And the alternatives, we know, are ezetimibe or PCSK9 inhibitors. Well, the strategy-- the strategy is to recommend a physician to make, as much as possible, the efforts to convince and keep the patient on a statin therapy with the maximum tolerated dose by that given patient, one by one. And then if the results is not satisfactory, then you can consider the addition of other drugs.

But again, it is a difficult task, can not be ruled by anything in writing, has to be a one to one relationship-- patients with physician. And the physician has to be aware that, in many cases, this is not completely a true physiological effect.