ERIC STROES: So from a lipid specialist's point of view, I would say that our task is mainly that we should actually acknowledge that there is now overwhelming evidence of the selectivity of PCSK9, overwhelming evidence of the efficacy of PCSK9. And we actually learn now that the lower the better is so true that we should change the paradigm to coming to a lower threshold to actually go towards eradication of LDL.

And as lipid specialists, I think we have several issues which we need to evangelize to our colleagues. And that's, the first, the lower the better holds true until virtually unmeasurable levels. And since we, as lipid specialists, also have genetic disorders with LDLs no longer present, but patients doing very well, we are the ones that can feel comfortable about very low levels. So that's the first one.

The second thing where I think, as lipid specialists, we should target our attention to-- and I know there is disparity between the US and, for instance, Europe. But that's the important issue of statin intolerance.

A lot of cardiologists can't spend a lot of time with patients to come to a definite diagnosis of statin intolerance. Now, in Europe, there have been very nice consensus papers where we state and specify that if you want to consider unable to tolerate sufficient doses of statins, you have to have tried at least three, including one in a low dose, and really convincingly counsel the patient.

I think if we collaborate with our colleagues, we can actually deduct or reduce the number of so-called statin intolerant patients by 80% to 85%. But those remaining 15, we should vigorously treat them with safe and effective and potent therapy.

And I think, obviously, ezetimibe gives you a reduction. You can add some others, but if we want to go low, those patients actually qualify for PCSK9 plus ezetimibe therapy. And in our lipid clinic, we see a lot of those patients.

And the third is, obviously, that's genetic dyslipidemias. And familial hypercholesterolemia. And we all know it. It's nearly getting boring. But familial hypercholesterolemia is not really boring. Familial hypercholesterolemia is very high levels, where even rosuvastation 40 and ezetimibe 10, you still are facing very high levels. And there it's a no-brainer that these patients actually-- quite a substantial part of them need triple therapy.

And on triple therapy, you can revolutionize the perspective of FH. If I look at my outpatient clinic now-- and we have hundreds of subjects using PCSK9s of FH. And if I look at these patients, what I see in their lab is normal to low-normal LDL levels, which was basically-- five to six years ago was unheard of.

So I think these three categories-- there we should, as lipid specialists, put our interest. And for the rest, we should actually teach our colleagues that we do not need to see all PCSK9 users, because it's safe, effective, and simple.

We should convey the message that if they have very high risk subjects, high residual LDL, statin intolerance, consider PCSK9. And maybe for the first time, if you're not used to it, consult a lipid specialist. But for the rest, I think it's straightforward. And within a couple of years, it will be routine in an [INAUDIBLE].