SPEAKER: In my general cardiology practice, some example of specific patients who I've prescribed PCSK9 inhibitors include a man who had an LDL cholesterol of about 70 on rosuvastatin plus ezetimibe, but suffered another mild, non-ST segment myocardial infarction. We regarded that as a warning sign that we'd better get his LDL cholesterol down further. And I prescribed PCSK9 inhibitors.

Of course, there are the patients who've tried three or four statins, who've had various adverse effects from them. Sometimes it's difficult to pin down any potential cause effect relationship with the statin. But when this is tried with a multitude of statins, all of which are configured biochemically in very different ways, it's hard to escape the reality that there must be something about the statin families that is affecting them in some way. That's certainly true for various muscle pains. Some of the softer issues, like fuzzy memory or other potential side effects that are listed on internet printouts, become more challenging to deal with.

But there does become a point in time where the patient has exhausted most statin options. Some patients actually report adverse effects to ezetimibe as well. And so those patients do need to go on, in many instances, for PCSK9 inhibitor. And then also, in my practice, patients who have a very strong family history of heart attack at an early age or stroke or family history of peripheral arterial disease that's severe, perhaps resulting in a partial leg amputation. Those patients I really want to get their LDL cholesterol as low as possible and we'll generally have to go beyond statins and ezetimibe and add a PCSK9 inhibitor.