CHRISTIE BALLANTYNE: Well, we have a new set of guidelines. Between the last one and this ones, we had an ACC pathway. But one of the very important things with this set of guidelines is making it clear to both physicians and patients that the LDL cholesterol level is important.

And you could call it a threshold. I think that's the way the wording that we had used in the pathway and in the guidelines. It's very important, yes, you start with a statin, and then you look at the response to therapy.

Now, the confusion created by the old set of guidelines was-- it clearly states you're supposed to get a 50% reduction. However, because there wasn't a numerical target, there was a misinterpretation that you didn't have to check lipids, you didn't need to check the LDL. And it wasn't very clear what you were to do if you didn't get a 50% reduction. So people said, well why do I do it anyway?

So unfortunately, if we take a look at the field of basically prevention, lipids in cardiology, the single biggest problem is actually adherence. People don't take their medications. And for those of us who have been practicing in this field for a long period of time, what encourages people to take their medications is success with therapy.

What does that mean? It means if you start a medication, you check the labs and you tell the patient, look, your LDL went from 180 down to 90. That's a terrific result. We got a 50% reduction. So they're very excited about that.

Now, what also unfortunately happens is, if they have terrible atherosclerosis, you have the message that even though that's good, we could do better if we went lower. So the issue that comes up is it's important. Percent reduction is useful. But basically, if you look at the way we practice medicine, you frequently don't know what the baseline number was.

And people also-- I'm from the generation that you actually did mental arithmetic, but no one does anymore. So no one can calculate in their head, anyway. So it doesn't get done. So it's very important to have a number in there. And then the patient sees it, the physician sees it. And so I think that's the one thing I'm happy about.

They actually took away-- since there were no numbers, people stopped doing-- in fact, out of all of the quality assessment programs, they dropped checking lipids, which is terrible. Because if you don't check the number, how are you going to even know if they're taking the medication? The only way you know about adherence is checking the level of LDL cholesterol.

So let's get clear. So the target of therapy is to lower LDL cholesterol. And that has been the case of all the guidelines. Now we come back that there should be-- in your high risk patients, you're very high risk patients, the patient that's got atherosclerotic cardiovascular disease, multiple events, someone who has ASCVD and more than one risk factor-- all right, on that patient, we know they're high risk. We've got to treat them aggressively.

So you check the level of LDL and if it's over 70, you need to take action. And some of that is depending how high is the level with it. But the issues that come in here, we now have the evidence that non-statin therapies-- so one can add ezetimibe or a PCSK9 inhibitor-- will lower LDL cholesterol and will also reduce cardiovascular events.

So I think this is a major step forwards, particularly to the cardiology community, a chief of cardiology. And it's important that cardiologists everywhere, if you're interventional or general cardiology, if you're treating atherosclerotic cardiovascular disease, we want to reduce the events as much as possible.

So that was a major step forward in clarification from these guidelines. And we see that the pathway in the guidelines now very much focus on follow up labs. See what the response is. Yes, start with a statin. Use a high intensity statin for the high-risk patient. Check the labs. See where they are. If their LDLs are still high, take action.