You know, they do establish a threshold it seems for almost every patient class. I'm not aware of any patient class that has a higher threshold now. And that's really a good threshold.

I think for patients who had acute coronary syndromes, and probably type 2 diabetic patients, I think we should go lower. I think 50-- 45 to 50-- is an important goal. It's supported by evidence from the PCSK9 studies and the IMPROVE-IT trial, which tested as ezetimibe with simvastatin versus simvastatin alone.

So two different types of medications used to lower LDL on top of statins, both showed the same benefit-- that lowering LDL beyond 70 offers additional incremental risk reduction.

Let's not mistake though one thing-- the studies are not comparing drug A versus drug B. They're comparing strategies of LDL lowering. So in your toolkit now as a clinician, you have three, at least three, maybe four different strategies to lower LDL.

You have lifestyle, which is critically important-- often forgotten and not talked about, it's assumed you're doing it. But don't forget that. And then the other three strategies include statins, ezetimibe, and PCSK9 drugs.

And so you have to tailor those to the individual patients. You may decide, for example, to use a low dose of a statin because you don't want to trigger potential muscle side effects, like myalgias. But you can do that. And then you can add ezetimibe and a PCSK9 in those patients.

You don't always have to use the highest dose of statin. I tend to use 40 milligrams of atorvastatin or rosuvastatin in my practice. But I'm a cardiologist. So I see patients who have the most extreme type of coronary artery disease rather than the primary care physician, who may see a spectrum of patients for whom using an intermediate dose of any type of statin is more appropriate.