

That's a really good grouping of four distinct categories, and I like that. If you're an interventional cardiologist and you're putting a stent in a patient, or two or three stents, or you've just treated someone with an acute coronary syndrome. Their LDL goal should be below 50. With 4ea we saw that down to 10, 20 is very good, very effective.

And with odyssey outcomes below 40 was very effective. I haven't seen their very ultra low LDL data yet. So in your patient population, nearly everyone should have an LDL target below 50. And how do you get there? You start with a statin, and then you can add Ezetimibe if you choose, or go straight to PCSK9. So the great majority 80%, 90% of your patients as an interventional cardiologist doing PCI, will need aggressive lipid lowering. And you need to consider as part of your toolkit the PCSK9 drug.

If you're someone treating a lot of diabetes patients as a cardiologist, lipidologist, or a primary care provider, remember, they have events at twice the rate of other patients. So they should have an LDL at least at 70 per the guidelines, but I like them at 50. And I think we know that getting them lower reduces the cardiovascular risks for diabetic patients. We need to treat the diabetes, too, with appropriate therapies that both reduce CV risks as well as microvascular risks.

So there is a role for glucose lowering for microvascular disease, but statins and the SGLT-2s and the GLP-1s and metformin all play a role at reducing cardiovascular risks. If you're a medical cardiologist, I think you look at the risk your patients bring. If you're seeing a primary prevention patient with an LDL of 130, 140, then 70 is a good target. It's an easy target to get to with whatever tool you choose-- PCSK9 with statin, statin plus Ezetimibe, or all three, the trifecta.

If you're seeing someone who has a large disease burden, maybe a type-2 diabetic who's had a small non-stemming in the past whose LDL is 85, well, I think offer them aggressive lipid lowering, an LDL of 50 or 40. Take them low, and I think you'll see their disease burden is much lower in the long run, and they may live a decade longer if all works well for them. If you're seeing patients who have simply hypertension with an elevated cholesterol, then we know from the Ascot lipid lowering trial that an LDL below 100 works. And now the guidelines would say to take them to 70 or lower, So again, use in your tool kit whichever therapies these patients seem to tolerate.

And finally, if you're seeing someone with a really high LDL, let's say 170, 180 maybe even just below the threshold of FH, recognize that you're going to have to lower that LDL more than 60% to get it at goal of 70 or lower. And so you're going to need dual therapy at least, a statin and a PCSK9 drug. And I would tend to start them both at about the same time. Because patients have shown who start them simultaneously they tolerate them very well.

And finally, if you're a lipidologist, you know this better than I do. You're going to treat all of the patients and take them to a goal of 70 or lower for primary prevention and probably 50 or lower for secondary prevention, again, using any of the three tools we have, statin, PCSK9 and Ezetimibe.