Excerpts From:

2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia

Highlights For Lipoprotein (a) [Lp(a)]

Blumenthal, RS, Morris, PB, Gaudino, M, Johnson, HM, Anderson, TS, Bittner, VA, Blankstein, R, Brewer, LC, Cho, L, de Ferranti, SD, Gianos, E, Gluckman, TJ, Gradney, K, Isiadinso, I, Lloyd-Jones, DM, Marrs, JC, Martin, SS, McLain, KH, Mehta, LS, Mora, S, Mulugeta, WM, Natarajan, P, Navar, AM, Orringer, CE, Polonsky, TS, Reynolds, HR, Saseen, JJ, Shapiro, MD, Soffer, DE, Tynes, SA, Villavaso, CD, Virani, SS, Wilkins, JT.
2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of dyslipidemia: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines.
[published online ahead of print March 13, 2026].
J Am Coll Cardiol. doi: 10.1016/j.jacc.2025.11.016.

Copublished in *Circulation*. doi: 10.1161/CIR.0000000000001423.

American College of Cardiology
www.acc.org

The American Heart Association
professional.heart.org

Full-text guidelines available in both *Circulation* and *JACC*.

➘ Introduction

Note: The numbering of the following tables and figures may differ from that of the Clinical Practice Guideline.

Colors in tables and figures correspond to Class of Recommendations and Level of Evidence tables.

2.1. Select Definitions

- **Clinical ASCVD:** ASCVD includes history of acute coronary syndromes (ACS), myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA), or peripheral artery disease (PAD). ASCVD at very high risk is defined as ≥2 major ASCVD events (ACS within the past 12 months, history of MI [other than recent ACS], history of ischemic stroke, symptomatic PAD) or with 1 major ASCVD event and ≥2 high-risk features (age ≥65 years, coronary bypass or percutaneous intervention, current smoker, diabetes, history of heart failure [HF], hypertension, LDL-C ≥100 mg/dL [2.6 mmol/L] despite maximally tolerated statin plus ezetimibe).
- **Dyslipidemias:** Dyslipidemias considered in this guideline include elevated blood cholesterol, hypertriglyceridemia, and elevated Lp(a).

Select Top Take-Home Messages

1. **Treat dyslipidemia earlier to reduce lifelong risk of prolonged exposure to atherogenic lipoproteins. Health behavior counseling to support lifestyle optimization should start in youth, with early consideration of pharmacotherapy in youth with familial hypercholesterolemia (FH) and in young adulthood in individuals with low-density lipoprotein cholesterol (LDL-C) ≥160 mg/dL or a strong family history of premature atherosclerotic cardiovascular disease (ASCVD).**

6. **Lipoprotein(a) [Lp(a)] should be measured at least once to identify those individuals at higher risk of ASCVD. It is considered as a risk-enhancing factor at levels ≥125 nmol/L (50 mg/dL), which is associated with about a 1.4-fold increased ASCVD risk, and values ≥250 nmol/L (100 mg/dL) are associated with ≥2-fold higher estimated risk. The presence of elevated Lp(a) should be an indication for more intensified LDL-C lowering and management of other risk factors.**

3.4. Measurement of Lipoprotein (a)

COR	LOE	Recommendations
1	B-NR	1. In all adults, measurement of Lp(a) concentration is recommended at least once for ASCVD risk assessment.
1	B-NR	2. In individuals with FH, premature ASCVD, or high Lp(a), cascade testing of first-degree family members for high Lp(a) concentration is recommended to identify those at increased ASCVD risk.
1	B-NR	3. For individuals undergoing measurement of Lp(a), use of laboratories employing assays that are insensitive to apolipoprotein(a) [apo(a)] isoforms and traceable to official reference standard materials is recommended to more accurately measure Lp(a) and characterize ASCVD risk.

Table 4. ASCVD Risk Related to Lp(a) Concentrations*

Lp(a) Concentration nmol/L (mg/dL)	ASCVD Relative Risk: Increase Compared With Population Median (20 nmol/L, 7 mg/dL)
430 nmol/L (180 mg/dL)	4-fold
350 nmol/L (150 mg/dL)	3-fold
250 nmol/L (100 mg/dL)	2-fold
125 nmol/L (50 mg/dL)	1.4-fold
75–124 nmol/L (30–49 mg/dL)	1.2-fold
<75 nmol/L (<30 mg/dL)	Reference

* Lp(a) concentrations in this threshold range may be considered for repeat testing.

Data in the table are derived from the UK Biobank Study, are intended as a general guide and may differ in other populations. For example, relative risk of 2-fold has been observed for levels of 200 nmol/L in some populations. Equivalence of levels between nmol/L and mg/dL is approximate. An Lp(a) level of 50 mg/dL (125 nmol/L, ~80th percentile) is associated with an ~40% relative risk increase in ASCVD compared with 7 mg/dL (20 nmol/L, median in a reference population). An Lp(a) level of 100 mg/dL (≥250 nmol/L, ~95th percentile) approximately doubles the ASCVD risk. An Lp(a) level of 180 mg/dL (≥430 nmol/L, ~99th percentile) increases the ASCVD risk by ~4-fold, similar to the risk of heterozygous familial hypercholesterolemia.

ASCVD indicates atherosclerotic cardiovascular disease; and Lp(a), lipoprotein (a).

Class of Recommendations and Level of Evidence*

CLASS (STRENGTH) OF RECOMMENDATION

CLASS 1 (STRONG) — **Benefit >>> Risk**

Suggested phrases for writing recommendations:

- Is recommended
- Is indicated/useful/effective/beneficial
- Should be performed/administered/other
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is recommended/indicated in preference to treatment B
  - Treatment A should be chosen over treatment B

CLASS 2a (MODERATE) — **Benefit >> Risk**

Suggested phrases for writing recommendations:

- Is reasonable
- Can be useful/effective/beneficial
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is probably recommended/indicated in preference to treatment B
  - It is reasonable to choose treatment A over treatment B

CLASS 2b (WEAK) — **Benefit ≥ Risk**

Suggested phrases for writing recommendations:

- May/might be reasonable
- May/might be considered
- Usefulness/effectiveness is unknown/unclear/uncertain or not well-established

CLASS 3: No Benefit (MODERATE) — **Benefit = Risk**

(Generally, LOE A or B use only)

Suggested phrases for writing recommendations:

- Is not recommended
- Is not indicated/useful/effective/beneficial
- Should not be performed/administered/other

CLASS 3: Harm (STRONG) — **Risk > Benefit**

Suggested phrases for writing recommendations:

- Potentially harmful
- Causes harm
- Associated with excess morbidity/mortality
- Should not be performed/administered/other

Class of Recommendations and Level of Evidence*

LEVEL (QUALITY) OF EVIDENCE‡
LEVEL A
■ High-quality evidence‡ from more than 1 RCT ■ Meta-analyses of high-quality RCTs ■ One or more RCTs corroborated by high-quality registry studies
LEVEL B-R (Randomized)
■ Moderate-quality evidence‡ from 1 or more RCTs ■ Meta-analyses of moderate-quality RCTs
LEVEL B-NR (Nonrandomized)
■ Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies ■ Meta-analyses of such studies
LEVEL C-LD (Limited Data)
■ Randomized or nonrandomized observational or registry studies with limitations of design or execution ■ Meta-analyses of such studies ■ Physiological or mechanistic studies in human subjects
LEVEL C-EO (Expert Opinion)
Consensus of expert opinion based on clinical experience

COR and LOE are determined independently (any COR may be paired with any LOE).

A recommendation with LOE C does not imply that the recommendation is weak. Many important clinical questions addressed in guidelines do not lend themselves to clinical trials. Although RCTs are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

* The outcome or result of the intervention should be specified (an improved clinical outcome or increased diagnostic accuracy or incremental prognostic information).

† For comparative-effectiveness recommendations (COR 1 and 2a; LOE A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

‡ The method of assessing quality is evolving, including the application of standardized, widely used, and preferably validated evidence grading tools; and for systematic reviews, the incorporation of an Evidence Review Committee.

COR indicates Class of Recommendation; EO, expert opinion; LD, limited data; LOE, Level of Evidence; NR, nonrandomized; R, randomized; RCT, randomized controlled trial.

Abbreviations

ACS, acute coronary syndrome; **ASCVD**, atherosclerotic cardiovascular disease; **FH**, familial hypercholesterolemia; **HF**, heart failure; **LDL**, low-density lipoprotein; **LDL-C**, low-density lipoprotein-cholesterol; **Lp(a)**, lipoprotein (a); **MI**, myocardial infarction; **PAD**, peripheral artery disease; **RCT**, randomized controlled trial

NOVARTIS

The printing and distribution of this educational resource was supported by Novartis Pharmaceuticals Corporation.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

3/26 FA-11600146-1

Source

Blumenthal, RS, Morris, PB, Gaudino, M, Johnson, HM, Anderson, TS, Bittner, VA, Blankstein, R, Brewer, LC, Cho, L, de Ferranti, SD, Gianos, E, Gluckman, TJ, Gradney, K, Isiadinso, I, Lloyd-Jones, DM, Marrs, JC, Martin, SS, McLain, KH, Mehta, LS, Mora, S, Mulugeta, WM, Natarajan, P, Navar, AM, Orringer, CE, Polonsky, TS, Reynolxds, HR, Saseen, JJ, Shapiro, MD, Soffer, DE, Tynes, SA, Villavaso, CD, Virani, SS, Wilkins, JT. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of dyslipidemia: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. [published online ahead of print March 13, 2026]. *J Am Coll Cardiol*. doi: 10.1016/j.jacc.2025.11.016.

Copublished in *Circulation*. doi: 10.1161/CIR.0000000000001423.

Disclaimer

This resource is for informational purposes only, intended as a quick-reference tool based on the cited source guideline(s), and should not be used as a substitute for the independent professional judgment of healthcare providers. Practice guidelines are unable to account for every individual variation among patients or take the place of clinician judgment, and the ultimate decision concerning the propriety of any course of conduct must be made by healthcare providers after consideration of each individual patient situation. Guideline Central does not endorse any specific guideline(s) or guideline recommendations and has not independently verified the accuracy hereof. Any use of this resource or any other Guideline Central resources is strictly voluntary.

GuidelineCentral.com®
TEL: 407.878.7606