Assessing the 2026 ACC/AHA Guideline on the Management of Dyslipidemia

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Cardiovascular disease kills more people than all forms of cancer and respiratory disease combined and remains the leading cause of death in the United States.[1,2] Atherosclerosis develops as early as 2 years of age with the growth of intimal fatty streaks and cumulative lifetime exposure to elevated low-density lipoprotein (LDL) cholesterol. The condition is compounded by catalysts of inflammation and vascular reactivity such as smoking, elevated glucose, elevated blood pressure, and obesity, which increase the rate of plaque growth and vascular damage.[3,4] The fact that atherosclerosis does not start in late adulthood is a critical contextual issue driving the need for earlier and more sustained preventive interventions focused on lifestyle optimization for all and medications for some. Against this background, the American College of Cardiology/American Heart Association (ACC/AHA) released a new guideline on the management of dyslipidemia in March 2026.[2]

The guideline includes more than 50 recommendations and is worth a review that focuses on the top take-home messages and key algorithms for primary and secondary prevention. It includes several significant updates: switching from use of older risk calculators to the PREVENT (Predicting Risk of Cardiovascular Disease Events) equations, emphasizing long-term lifestyle changes (described in the AHA's Life's Essential 8), ensuring response to lipid-lowering therapy with a lipid profile within 12 weeks of initiation, and lowering LDL cholesterol to no more than 55 mg/dL (1.42 mmol/L) for patients with atherosclerotic cardiovascular disease who have very high risk for cardiovascular events.

Many of the recommendations are grounded in excellent patient-oriented evidence, whereas some use current disease-oriented evidence. A key concern with the guideline update is that some points with a level 1 strength of recommendation (the highest) are supported only by nonrandomized studies or expert opinion. For example, most of the treatment recommendations regarding the intensity of lipid-lowering therapy in patients who have diabetes but no established atherosclerotic cardiovascular disease are based on expert opinion and very limited data.

In comparison, a guideline on lipid management released in December 2025 by the US Department of Veterans Affairs/US Department of Defense (VA/DoD) explicitly used a more rigorous evidence assessment scheme that excluded recommendations based on expert opinion alone.[5] The strength of each of its 24 recommendations was determined by assessing four domains: balance of desirable and undesirable outcomes, confidence in the quality of the evidence, patient or clinician values and preferences, and implications for care such as use of resources, feasibility, and acceptability.[5] Another notable distinction is that the VA/DoD guideline recommends drug treatments based on their intensity (moderate or high) rather than treating to a target LDL cholesterol level, as in the ACC/AHA recommendations. The VA/DoD guideline also provides a single management algorithm encompassing both primary and secondary prevention.[5]

Given the variance between the newer ACC/AHA guideline and the VA/DoD recommendations, how can a clinician decide which points to implement immediately and which should prompt shared decision-making?

In my review, I believe that for a recommendation to be implemented immediately, it needed to be based on rigorous evidence, likely beneficial for patients, and feasible in a typical primary care practice. Recommendations that should prompt shared decision-making would still have a clear likely benefit but be supported by weaker evidence. A shared decision-making conversation often requires two visits: one for a discussion and a second to clarify points of confusion and finalize a decision. This can often be difficult to coordinate, but the benefits of increased patient adherence and understanding of their treatment plan are of great importance.[6]

Table 1 summarizes the most effective and practical recommendations from the ACC/AHA guideline.[2,5,7-10] Of these 10 key recommendations, six are worthy of rapid implementation, and four should prompt shared decision-making. These recommendations were chosen due to ease of implementation, supporting evidence, and prevalence of these issues and conditions in family medicine practice.

Regardless of how the individual clinician chooses to implement the new ACC/AHA recommendations, enhanced prevention of cardiovascular disease is absolutely possible and worth

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TABLE 1

Most Effective and Practical Recommendations From ACC/AHA Dyslipidemia Guidelines

ACC/AHA recommendation	ACC/AHA strength of recommendation – level of evidence*	VA/DoD recommendation	Rationale and comments
Implement now			
Use the PREVENT equations to perform an individual 10- and 30-year risk assessment.[7]	1 – B	Weak for	The PREVENT equations are contemporary and based on a diverse patient cohort of 3.3 million people, incorporate socioeconomic risk, and provide short-term (10-year) and long-term (30-year) assessments in patients from 30-79 years of age. The PREVENT equations are less likely to overestimate risk compared with the Pooled Cohort Equations.
Emphasize a healthy lifestyle grounded in Life's Essential 8 across the entire lifespan.[8]	1 – A	Weak for	Life's Essential 8 (healthy diet, regular exercise, healthy weight, regular sleep, tobacco avoidance, and optimal glucose, lipid, and blood pressure levels) provides a validated foundation for cardiovascular disease prevention. VA/DoD guidelines also include stress management and increased socialization.
Ensure response to lipid-lowering therapy with a lipid profile within 12 weeks of initiation and annually thereafter.	1 – A	Not reviewed	Ensuring response enables assessment of response and adherence to therapy. Repeat lipid testing can be performed in patients without severe hypertriglyceridemia who are fasting or nonfasting.
Patients with known atherosclerotic cardiovascular disease at very high risk should be treated to an LDL goal of < 55 mg/dL (1.42 mmol/L) for secondary prevention.[9]	1 – A	Weak for (continue therapy if LDL < 30 mg/dL [0.78 mmol/L])	LDL cholesterol should be lowered with statins, ezetimibe, bempedoic acid (Nexletol), PCSK9 inhibitors, or inclisiran (Leqvio) if needed to lower LDL cholesterol by up to 50% and < 55 mg/dL. VA/DoD recommends combination therapy with statin/ezetimibe, statin/PCSK9 inhibitor, or statin/PCSK9 inhibitor/ezetimibe with no LDL cholesterol goal.
In adults 40-75 years of age with diabetes but without atherosclerotic cardiovascular disease, statin therapy is indicated to achieve LDL cholesterol < 100 mg/dL (2.59 mmol/L) for primary prevention.	1 – A	Strong for	Multiple trials have shown the benefits of lowering LDL cholesterol with statins in patients with diabetes. VA/DoD recommends at least a moderate-intensity statin with no LDL cholesterol goal.

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ACC/AHA = American College of Cardiology/American Heart Association; LDL = low-density lipoprotein; PCSK9 = proprotein convertase subtilisin/kexin type 9; PREVENT = Preventing Risk of Cardiovascular Disease Events; VA/DoD = US Department of Veterans Affairs/US Department of Defense.

*—Class 1 represents strong recommendations; class 2 includes moderate (2 – A) and weak (2 – B) recommendations. Evidence level A is high quality; level B is moderate quality.

TABLE 1 (continued)

Most Effective and Practical Recommendations From ACC/AHA Dyslipidemia Guidelines

ACC/AHA recommendation	ACC/AHA strength of recommendation – level of evidence*	VA/DoD recommendation	Rationale
Implement now			
In adults 40-75 years of age with HIV, statin therapy is indicated for primary prevention.	1 – B	Weak for	HIV is an inflammatory state that increases the rate of atherosclerosis. Lowering LDL cholesterol can reduce this risk. VA/DoD recommends use of a moderate-intensity statin even when 10-year risk of cardiovascular disease is < 5%.
Shared decision-making			
Lipoprotein(a) should be measured once to identify patients with higher risk for premature atherosclerotic disease.	1 – B	Weak for	A robust link is found between lipoprotein(a) level ≥ 50 mg/dL (125 nmol/L) and increased cardiovascular risk.[10] Identification of elevated lipoprotein(a) permits cascade screening of relatives and optimization of cardiovascular risk. Medications to directly lower lipoprotein(a) have completed phase 3 trials, and findings about their ability to reduce cardiovascular events will be available soon.
Lowering LDL cholesterol can be considered with a 10-year PREVENT risk 3%-5% and should be considered when risk is > 5% for primary prevention.	1 – B	Weak for	Statins are effective, inexpensive, and safe for primary prevention. The greater the individual patient risk, the more likely the benefit, but the exact level of risk has not been defined in a randomized trial. VA/DoD recommends statins when risk is > 5%.
Reintroduce LDL cholesterol targets in primary prevention.	2 – B	Neither for nor against	Goal LDL cholesterol in primary prevention is < 100 mg/dL in those with a 10-year risk < 10% and < 70 mg/dL (1.81 mmol/L) in those with a 10-year risk ≥ 10%. In the absence of randomized controlled trial evidence, rationale is based in radiologic and pathophysiologic studies showing arrest of atherosclerotic cardiovascular disease progression at LDL < 100 mg/dL and reversal at 70 mg/dL.
Counsel women on risk factors, including early menopause, gestational hypertension, preeclampsia, and gestational diabetes.	2 – B	Not reviewed	Women of reproductive age should be counseled on the importance of risk reduction with lifestyle and, if needed, medications. Statins must be stopped preconception. Pregnancy complications should prompt more intense interventions for risk reduction.

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Information from references 2, 5, and 7-10.

the time and effort.

Disclaimer: This editorial represents the views of the author and does not represent the views of Uniformed Services University or the US Department of Defense.

REFERENCES

1. Palaniappan LP, Allen NB, Almarzooq ZI, et al. 2026 Heart disease and stroke statistics: a report of US and global data from the American Heart Association. *Circulation*. 2026;153(9):e275-e906.
2. Blumenthal RS, Morris PB, Gaudino M, et al. 2026 Guideline on the management of dyslipidemia: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. 2026;153(17):e1154-e1276.
3. Libby P, Ridker PM, Hansson GK. Progress and challenges in translating the biology of atherosclerosis. *Nature*. 2011;473(7347):317-325.
4. Domanski MJ, Tian X, Wu CO, et al. Time course of LDL cholesterol exposure and cardiovascular disease event risk. *J Am Coll Cardiol*. 2020;76(13):1507-1516.
5. US Department of Veterans Affairs/US Department of Defense. VA/DOD clinical practice guidelines. Lipid management for cardiovascular disease risk reduction. December 2025. Accessed January 16, 2026. https://www.healthquality.va.gov/guidelines/cd/lipids/
6. Deniz S, Akbolat M, Çimen M, et al. The mediating role of shared decision-making in the effect of the patient-physician relationship on compliance with treatment. *J Patient Exp*. 2021;8:23743735211018066.
7. American Heart Association. PREVENT online calculator. Accessed February 2, 2026. https://professional.heart.org/en/guidelines-and-statements/prevent-calculator
8. American Heart Association. Life's Essential 8. Accessed February 2, 2026. https://www.heart.org/en/healthy-living/healthy-lifestyle/lifes-essential-8
9. Lee YJ, Lee SJ, Kim JW, et al.; Ez-PAVE Investigators. Intensive LDL cholesterol targeting in atherosclerotic cardiovascular disease. *N Engl J Med*. 2026;394(14):1365-1375.
10. MacDougall DE, Tybjærg-Hansen A, Knowles JW, et al. Lipoprotein(a) and recurrent atherosclerotic cardiovascular events: the US Family Heart Database. *Eur Heart J*. 2025;46(44):4762-4775.