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

A Paradigm Shift in Cardiovascular Risk Management — Clinical Reference

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Executive Summary

The 2026 ACC/AHA Dyslipidemia Guideline is the most significant update to lipid management in nearly a decade. It restores absolute LDL-C targets, mandates universal Lp(a) screening (COR 1), replaces the PCE with the PREVENT-ASCVD equations, elevates CAC scoring to a definitive decision tool (COR 1), and formalizes a 4-step escalation pathway for both primary and secondary prevention. It also aligns substantially with ESC 2019/2025 targets.

Key Pillars at a Glance

#	Pillar	Key Recommendation	Clinical Impact
1	**Earlier Treatment**	Screen from age 19; pharmacotherapy consideration from age 30 in high-risk adults	Reduces lifelong atherogenic exposure
2	**New Risk Calculator**	PREVENT-ASCVD replaces PCE — age 30–79, race-free, includes eGFR/HbA1c, 10- and 30-year estimates	More accurate in diverse populations
3	**Universal Lp(a) Screening**	Measure at least once in ALL adults — COR 1	Identifies ~20% population at elevated inherited risk

#	Pillar	Key Recommendation	Clinical Impact
4	**ApoB for Residual Risk**	Useful when TG >200 mg/dL, diabetes, or achieved LDL-C <70 mg/dL (after goals met)	Unmasks hidden atherogenic particle burden
5	**Absolute LDL-C Targets Restored**	< 55, < 70, or < 100 mg/dL based on risk tier + Non-HDL-C co-targets	Dual-metric treat-to-target strategy
6	**CAC as Definitive Tool**	COR 1: 0 / 1–99 / ≥100 / ≥300 — tiered thresholds; applies to men ≥40 yr, women ≥45 yr	Guides statin initiation/intensification
7	**4-Step Escalation**	Statin → Ezetimibe → PCSK9 inhibitor or Bempedoic acid → Inclisiran	No patient left at uncontrolled LDL
8	**Expanded Drug Arsenal**	Bempedoic acid (CLEAR Outcomes 2023), Inclisiran (siRNA), Evinacumab (HoFH)	Multiple mechanisms for statin-intolerant patients
9	**Sex-Specific Risk Enhancers**	Preeclampsia, gestational DM, preterm delivery, early menopause (<45 yr)	Women's CV risk formally recognized
10	**CKM Syndrome**	New unifying construct: cardiovascular-kidney-metabolic risk	Replaces metabolic syndrome as a risk enhancer

2018 vs 2026 — Master Comparison

Dimension	2018 Guidelines	2026 Guidelines ✓
Philosophy	"Fire and forget" — prescribe statin intensity, no numeric targets	"Treat to Target" — absolute LDL-C goals restored at all risk tiers
Risk Calculator	Pooled Cohort Equations (PCE) — ages 40–75, includes race variable	PREVENT-ASCVD — ages 30–79, race-free, includes eGFR, HbA1c, 10- and 30-year risk
High-Risk Threshold	≥20% 10-year ASCVD risk	≥10% 10-year ASCVD risk (more patients qualify)
LDL-C Targets	Percentage reductions only (≥50% or ≥30–49%)	Absolute targets: <100, <70, <55 mg/dL + retained % reduction as complementary metric
Non-HDL-C Targets	Not formalized as co-primary targets	Co-primary targets: <130, <100, <85 mg/dL mirroring LDL-C tiers
Lp(a)	Optional risk enhancer; no universal screening	COR 1: Measure at least once in ALL adults; ≥125 nmol/L (≥50 mg/dL) = elevated risk
ApoB	Mentioned as optional	Formally recommended: when TG >200 mg/dL, diabetes, or achieved LDL-C <70 mg/dL
CAC Scoring	Reasonable tiebreaker (COR 2a); no tiered thresholds	COR 1: Integral step in CPR model; tiered: 0 / 1–99 / ≥100 / ≥300; men ≥40 yr, women ≥45 yr
Non-Statin Therapies	Limited evidence, weak recommendations	4-step: Statin → Ezetimibe → PCSK9i or bempedoic acid → Inclisiran
Risk Enhancers	Basic list (CKD, HIV, hs-CRP, FH, Lp(a))	Expanded: CKM syndrome, pregnancy complications, early menopause, South Asian ancestry via PREVENT
Supplements	Not formally addressed	COR 3 (No Benefit): NOT recommended (fish oil, niacin, CoQ10, etc.)
Pediatric Screening	Ages 9–11 (consistent)	Ages 9–11 universal; age ≥2 if high-risk family history; FH genetic testing formalized

Dimension	2018 Guidelines	2026 Guidelines ✓
Global Alignment	Divergent from ESC	Convergent with ESC 2019/2025 on absolute LDL targets, Lp(a) screening, structured escalation

1. Screening: Earlier and More Systematic

Lipid profile screening begins at age ≥19 in adults (every 5 years if normal). Universal pediatric screening at ages 9–11; earlier (age ≥2) if high-risk family history.

Feature	2018 Guidelines	2026 Guidelines
Adult Screening Initiation	Age ≥20 (general recommendation)	Age ≥19 — one year earlier; standardized
Screening Frequency	Periodic — no defined interval for low-risk	Every 5 years if results normal — formalized
Pediatric Universal Screening	Ages 9–11	Ages 9–11 — maintained with emphasis on FH detection
High-Risk Family History (Children)	Age ≥2 years	Age ≥2 years — maintained; genetic cascade screening added
FH Genetic Testing	Not addressed	COR 1: Cascade screening of first-degree relatives of FH, premature ASCVD, or high Lp(a)

2. Risk Assessment: PREVENT-ASCVD Replaces PCE

PREVENT-ASCVD equations: age 30–79, race-free, incorporates eGFR and HbA1c. Decision framework: CPR Model — Calculate → Personalize → Reclassify with CAC.

Feature	2018 Guidelines	2026 Guidelines
Risk Calculator	Pooled Cohort Equations (PCE)	PREVENT-ASCVD (AHA equations)

Feature	2018 Guidelines	2026 Guidelines
Age Range	40–75 years	30–79 years (both ends expanded)
Race Variable	Included as biological variable	Removed — race-free equations
Additional Variables	Traditional risk factors only	Adds eGFR, HbA1c; social determinants considered
Risk Categories (10-yr)	Low (<5%), Borderline (5–<7.5%), Intermediate (7.5–<20%), High (≥20%)	Low (<3%), Borderline (3–<5%), Intermediate (5–<10%), High (≥10%)
Outcomes Predicted	Hard ASCVD (MI, stroke)	ASCVD + heart failure included in the model
Long-Term Risk	Not incorporated	30-year risk estimable in adults aged 30–59 years
Decision Framework	Risk-based discussion — no formal model	CPR Model: Calculate → Personalize → Reclassify with CAC

3. LDL-C and Non-HDL-C Targets: Treat to Target Restored

CRITICAL: LDL-C <55 mg/dL applies ONLY to very high-risk ASCVD (≥2 major events, OR 1 major event + ≥2 high-risk features). ASCVD not at very high risk targets <70 mg/dL. Non-HDL-C co-targets are now co-primary.

Risk Group	Risk Level	LDL-C Target	Non-HDL-C Target	% Reduction Goal
Very High-Risk ASCVD*	Secondary prevention	**< 55 mg/dL (1.4 mmol/L)**	< 85 mg/dL (2.2 mmol/L)	**≥50%**
ASCVD — Not Very High Risk	Secondary prevention	**< 70 mg/dL (1.8 mmol/L)**	< 100 mg/dL (2.6 mmol/L)	**≥50%**
High-Risk Primary Prevention	10-yr risk ≥10% or Diabetes	**< 70 mg/dL (1.8 mmol/L)**	< 100 mg/dL (2.6 mmol/L)	**≥50%**
Intermediate Risk	10-yr risk 5–<10%	**< 100 mg/dL (2.6 mmol/L)**	< 130 mg/dL (3.4 mmol/L)	≥30–49%
Severe Hypercholesterolemia	LDL ≥190 mg/dL	**< 100 mg/dL (2.6 mmol/L)**	< 130 mg/dL (3.4 mmol/L)	≥50%
Low Risk	10-yr risk <3%	**Lifestyle modification — no pharmacotherapy target**	—	—

* Very High-Risk ASCVD Definition: (A) ≥2 major ASCVD events [ACS within past 12 months; prior MI; ischemic stroke; symptomatic PAD], OR (B) 1 major ASCVD event + ≥2 high-risk features [age ≥65 yr, prior CABG/PCI, current smoker, diabetes, HF, HTN, or LDL-C ≥100 mg/dL despite maximally tolerated statin + ezetimibe].

4. Biomarkers: Lp(a) and ApoB

Lp(a): COR 1 — measure at least once in ALL adults. Two risk thresholds. ApoB: recommended in specific clinical scenarios (not universal).

Biomarker	2018 Guidelines	2026 Guidelines
Lp(a) — Screening	Not routinely recommended for all adults	COR 1: Measure at least once in ALL adults
Lp(a) — Threshold (Elevated)	Not formally defined	≥125 nmol/L (≥50 mg/dL) → ~1.4× increased ASCVD risk
Lp(a) — Threshold (High)	Not formally defined	≥250 nmol/L (≥100 mg/dL) → ≥2× estimated ASCVD risk
Lp(a) — Repeat Testing	Not addressed	Not required — Lp(a) is genetically determined and stable
Lp(a) — Management Impact	Not specified	Indication for more aggressive LDL-C lowering + management of other risk factors
ApoB — Indication	Mentioned as optional	Recommended when: TG >200 mg/dL, OR diabetes, OR achieved LDL-C <70 mg/dL (after goals met)
ApoB — Purpose	Not specified	Identifies residual atherogenic particle burden not captured by standard lipid panel
Cascade Screening	Not addressed	COR 1: First-degree relatives of individuals with FH, premature ASCVD, or high Lp(a) should be tested

5. Coronary Artery Calcium (CAC): Upgraded to COR 1

CAC scoring: COR 1 — integral to the CPR reclassification step. Applies to men ≥40 years and women ≥45 years. Tiered clinical actions by score. Incidental CAC (including AI-detected) should inform LLT decisions.

CAC Score	Percentile Context	2018 Recommendation	2026 Recommendation (COR 1)
0	Very low	Could defer statin (COR 2a)	**May defer statin therapy — formally integrated into CPR model**
1–99	Low–moderate	Favored statin initiation (informal)	**Consider statin initiation (formalized)**
≥100	High	Favored statin (informal)	**Start statin therapy — COR 1 explicit recommendation**
≥300	Very high	Not explicitly tiered	**Intensify therapy — new dedicated threshold; extensive subclinical atherosclerosis**
Incidental CAC	Any	Not addressed	**COR 1: Incidental CAC (including AI-detected on non-cardiac CT) should inform LLT decisions**

6. Primary Prevention: Risk-Stratified Algorithm

For adults with LDL-C 70–189 mg/dL. High-risk threshold lowered to ≥10% (was ≥20%) — significantly more patients now qualify for high-intensity statin.

Risk Level (2026 Threshold)	2018 Approach	2026 Approach
Low (<3% — was <5%)	Lifestyle modification only	Lifestyle modification only
Borderline (3–<5% — was 5–<7.5%)	Consider moderate-intensity statin if risk enhancers present	Consider statin if risk enhancers present (same approach, lower threshold)
Intermediate (5–<10% — was 7.5–<20%)	Moderate-intensity statin	Moderate-intensity statin; CAC to guide if uncertain
High (≥10% — was ≥20%)	High-intensity statin	High-intensity statin → LDL-C <70 mg/dL target
Adults aged 30–59 at high long-term risk	Not addressed	Pharmacotherapy may be considered; 30-year risk estimable

7 & 8. Escalation Pathways: Severe Hypercholesterolemia & Secondary Prevention

Step	COR	Severe Hypercholesterolemia (LDL ≥190 mg/dL) → Goal: LDL <100 mg/dL	Secondary Prevention (ASCVD) → Very High-Risk: <55 | Not VHR: <70 mg/dL
1	COR 1	High-intensity statin (maximally tolerated)	High-intensity statin (maximally tolerated)
2	COR 1	Add Ezetimibe	Add Ezetimibe
3	COR 1	Add PCSK9 inhibitor (evolocumab / alirocumab)	Add PCSK9 inhibitor (evolocumab / alirocumab)
3b	COR 2a	OR: Add Bempedoic acid (if PCSK9i not tolerated/available — CLEAR Outcomes 2023)	OR: Consider Bempedoic acid
4	COR 2b	Consider Inclisiran (siRNA — twice yearly injection)	Consider Inclisiran
Special	COR 1	Evinacumab: for Homozygous FH (HoFH) refractory to above	—

9. Hypertriglyceridemia: Tiered Management

Statin is the foundation for ASCVD risk reduction in hypertriglyceridemia. TG-lowering therapies primarily indicated for pancreatitis prevention at TG ≥1000 mg/dL.

TG Level	2018 Management	2026 Management
150–199 mg/dL (Borderline High)	Lifestyle modification; address secondary causes	Lifestyle modification; treat secondary causes

TG Level	2018 Management	2026 Management
200–499 mg/dL (High)	Lifestyle + statin if ASCVD risk elevated	Statin + lifestyle (ASCVD risk reduction focus)
≥500 mg/dL (Very High)	Very low-fat diet; fibrate or omega-3	Prevent pancreatitis — structured approach; fibrate or icosapentaenoic acid
≥1000 mg/dL (Severe)	Not explicitly tiered separately	NEW TIER: Intensive TG lowering — urgent; TG-lowering therapies for pancreatitis prevention (COR 1)

10. Risk Enhancers: Expanded and Updated

New additions: CKM syndrome, pregnancy complications, early menopause (<45 yr). Risk enhancers shift borderline-risk patients toward statin therapy.

Risk Enhancer	2018	2026	Clinical Note
Family history of premature ASCVD	✓	✓	First-degree relative with ASCVD <55 yr (M) or <65 yr (F)
Lp(a) elevation (≥125 nmol/L / ≥50 mg/dL)	Mentioned	✓ COR 1	Now also a universal screening target — independently causal for ASCVD and aortic stenosis
CKM Syndrome (NEW)	—	✓ NEW	New construct unifying cardiovascular-kidney-metabolic risk; replaces metabolic syndrome
Chronic Kidney Disease (CKD)	Mentioned	✓	GFR <60 or proteinuria — enhanced atherogenic risk
HIV infection	Mentioned	✓	Accelerated atherosclerosis from chronic inflammation and antiretroviral effects
Pregnancy complications (NEW)	—	✓ NEW	Preeclampsia, gestational hypertension, gestational DM, preterm delivery — windows into future cardiometabolic risk
Early menopause <45 yr (NEW)	—	✓ NEW	Loss of estrogen-mediated CV protection earlier than average
hs-CRP ≥2 mg/L	Mentioned	✓	Marker of chronic vascular inflammation
South Asian ancestry	Mentioned	Integrated into PREVENT	Higher ASCVD risk adjusted within PREVENT equations
Ankle-Brachial Index <0.9	Mentioned	✓	Indicator of subclinical peripheral arterial disease

11. Global Convergence: ACC/AHA 2026 vs ESC 2019/2025

The 2026 ACC/AHA guidelines are substantially aligned with ESC for the first time — shared absolute targets, universal Lp(a) screening, and structured escalation pathways.

Feature	ESC 2019	ESC 2025 Update	ACC/AHA 2026	Notes on Differences
Absolute LDL-C targets	✓ Yes	✓ Yes	**✓ Yes**	Full alignment — ACC/AHA returns to absolute targets after 2013–2018 period without them
<55 mg/dL for very high risk	✓ Yes	✓ Yes	**✓ Yes**	Complete harmonization on most aggressive target
<45 mg/dL (very high risk)	— No	✓ ESC 2025 added	**— No**	ESC 2025 goes lower; ACC/AHA 2026 stops at <55 mg/dL (VESALIUS-CV data not yet incorporated)
Universal Lp(a) screening	✓ Recommended	✓ Maintained	**✓ COR 1**	Strong convergence — both guidelines mandate universal screening
Non-HDL-C co-primary target	✓ Yes	✓ Yes	**✓ Yes**	Newly added in ACC/AHA 2026 — previously not formalized
Structured escalation pathway	✓ Yes	✓ Yes	**✓ Yes**	ACC/AHA 2026 now mirrors ESC stepwise approach
PCSK9 inhibitors in primary prevention	COR 2a (high-risk)	Expanded indications	**COR 1 (secondary only); 2a primary high-risk**	Some residual differences in primary prevention thresholds

Conclusion: A New Era of Precision Lipidology

The 2026 ACC/AHA Dyslipidemia Guidelines mark the end of the 'fire and forget' era. The mandate is now clear: screen earlier, stratify precisely, measure Lp(a) in everyone, use CAC when uncertain, and escalate therapy until absolute LDL-C targets are reached — with non-HDL-C as a co-primary metric.

Key Clinical Messages for Practice	What Has NOT Changed
✓ Treat to absolute LDL-C targets — <55, <70, or <100 mg/dL by risk tier	→ High-intensity statins remain first-line therapy
✓ Measure Lp(a) once in every adult — COR 1	→ Lifestyle modification is the foundation at every risk level
✓ Use PREVENT-ASCVD (not PCE) for 10- and 30-year risk estimation	→ Ezetimibe remains the preferred first add-on to statin therapy
✓ CAC = 0 allows deferral of statin in borderline/intermediate-risk patients	→ Pediatric screening at ages 9–11 maintained
✓ Very high-risk ASCVD definition must be applied before targeting <55 mg/dL	→ CKD, HIV, hs-CRP, FH history remain established risk enhancers
✓ Non-HDL-C is a co-primary target alongside LDL-C	→ Shared decision-making remains central to treatment initiation
✓ Supplements (fish oil, niacin, CoQ10): COR 3 — NOT recommended	→ Fibrates retained for severe hypertriglyceridemia (TG ≥500 mg/dL)

Sources: 2026 ACC/AHA/Multisociety Guideline on the Management of Dyslipidemia — Blumenthal RS et al. JACC 2026 (doi:10.1016/j.jacc.2025.11.016) & Circulation 2026 (doi:10.1161/CIR.0000000000001423) | JACC Guideline-at-a-Glance | NLA Summary | Family Heart Foundation | UT Southwestern Commentary

مركز المعلومات الدوائية
د. أحمد خالد

رئيس قسم الصيدلة الإكلينيكية
د. محمد طايع

مدير الصيدلية
د.رحاب طايع

مدير عام المستشفى
د. أحمد سمير