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EXPERT CONSENSUS DECISION PATHWAY

2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk

A Report of the American College of Cardiology Task Force on Expert Consensus Decision Pathways

Endorsed by the National Lipid Association

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ABSTRACT FOR THE 2017 FOCUSED UPDATE TO THE 2016 EXPERT CONSENSUS DECISION PATHWAY

In 2016, the American College of Cardiology published the first expert consensus decision pathway (ECDP) on the role of non-statin therapies for low-density lipoprotein (LDL)-cholesterol lowering in the management of atherosclerotic cardiovascular disease (ASCVD) risk. Since the publication of that document, additional evidence and perspectives have emerged from randomized clinical trials and other sources, particularly considering the longer-term efficacy and safety of proprotein convertase subtilisin/kexin 9 (PCSK9) inhibitors in secondary prevention of ASCVD. Most notably, the FOURIER (Further Cardiovascular Outcomes Research with PCSK9 Inhibition in Subjects with Elevated Risk) trial and SPIRE-1 and -2 (Studies of PCSK9 Inhibition and the Reduction of Vascular Events), assessing evolocumab and bococizumab, respectively, have published final results of cardiovascular outcomes trials in patients with clinical ASCVD and in a smaller number of high-risk primary prevention patients. In addition, further evidence on the types of patients most likely to benefit from the use of ezetimibe in addition to statin therapy after acute coronary syndrome has been published. Based on results from these important analyses, the ECDP writing committee judged that it would be desirable to provide a focused update to help guide clinicians more clearly on decision making regarding the use of ezetimibe and PCSK9 inhibitors in patients with clinical ASCVD with or without comorbidities. In the following summary table, changes from the 2016 ECDP to the 2017 ECDP Focused Update are highlighted, and a brief rationale is provided. The content of the full document has been changed accordingly, with more extensive and detailed guidance regarding decision making provided both in the text and in the updated algorithms. Revised recommendations are provided for patients with clinical ASCVD with or without comorbidities on statin therapy for secondary prevention. The ECDP writing committee judged that these new data did not warrant changes to the decision pathways and algorithms regarding the use of ezetimibe or PCSK9 inhibitors in primary prevention patients with LDL-C <190 mg/dL with or without diabetes mellitus or patients without ASCVD and LDL-C ≥190 mg/dL not due to secondary causes. Based on feedback and further deliberation, the ECDP writing committee down-graded recommendations regarding bile acid sequestrant use, recommending bile acid sequestrants only as optional secondary agents for consideration in patients intolerant to ezetimibe. For clarification, the writing committee has also included new information on diagnostic categories of heterozygous and homozygous familial hypercholesterolemia, based on clinical criteria with and without genetic testing. Other changes to the original document were kept to a minimum to provide consistent guidance to clinicians, unless there was a compelling reason or new evidence, in which case justification is provided.

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