



# Where Life's Flow Never Stops

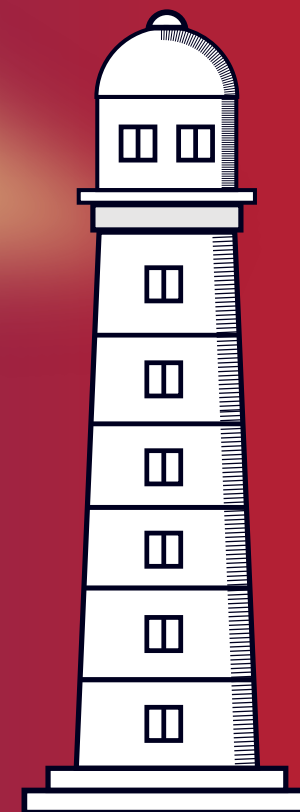
Endeavor to an Atherosclerosis-Free Life

# Intensive Lipid-Lowering Strategies: Maximizing Cardiovascular Risk Reduction

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# Hyperlipidemia Management



**LOWER IS BETTER,  
EARLIER IS BETTER.**

# High LDL-C level contributes significantly to cardiovascular morbidity and mortality

High cholesterol\*  
WHO



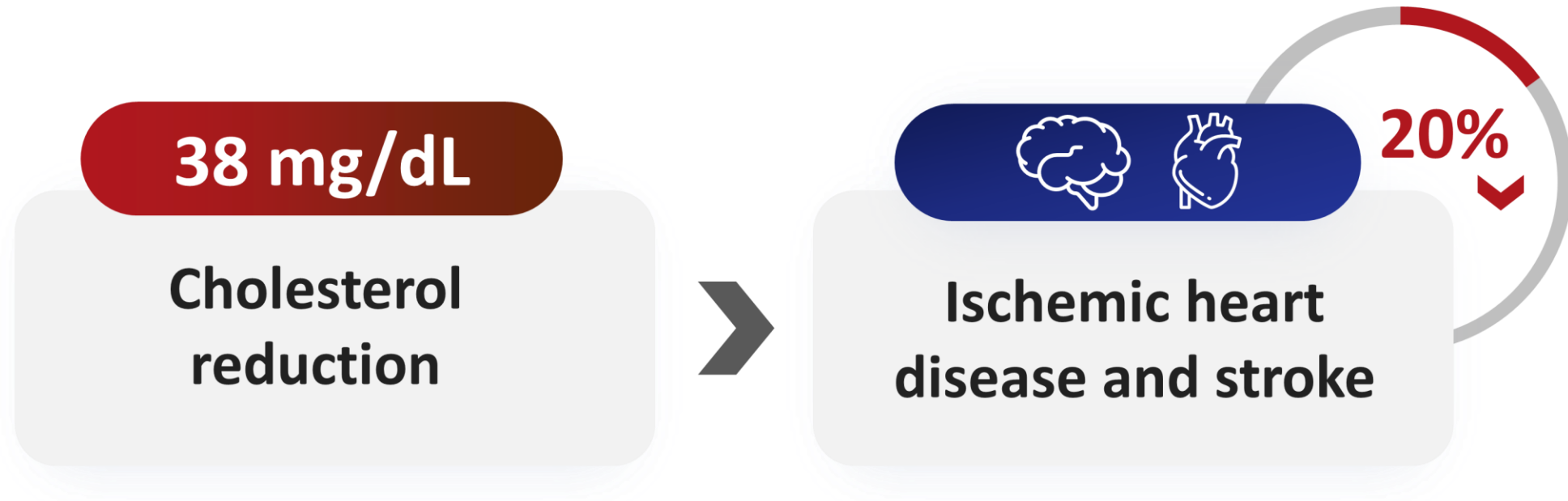
Cause of **44%** of ischemic heart disease, **globally**.

High LDL-C in recent 30 yrs. †

**4.4** million deaths

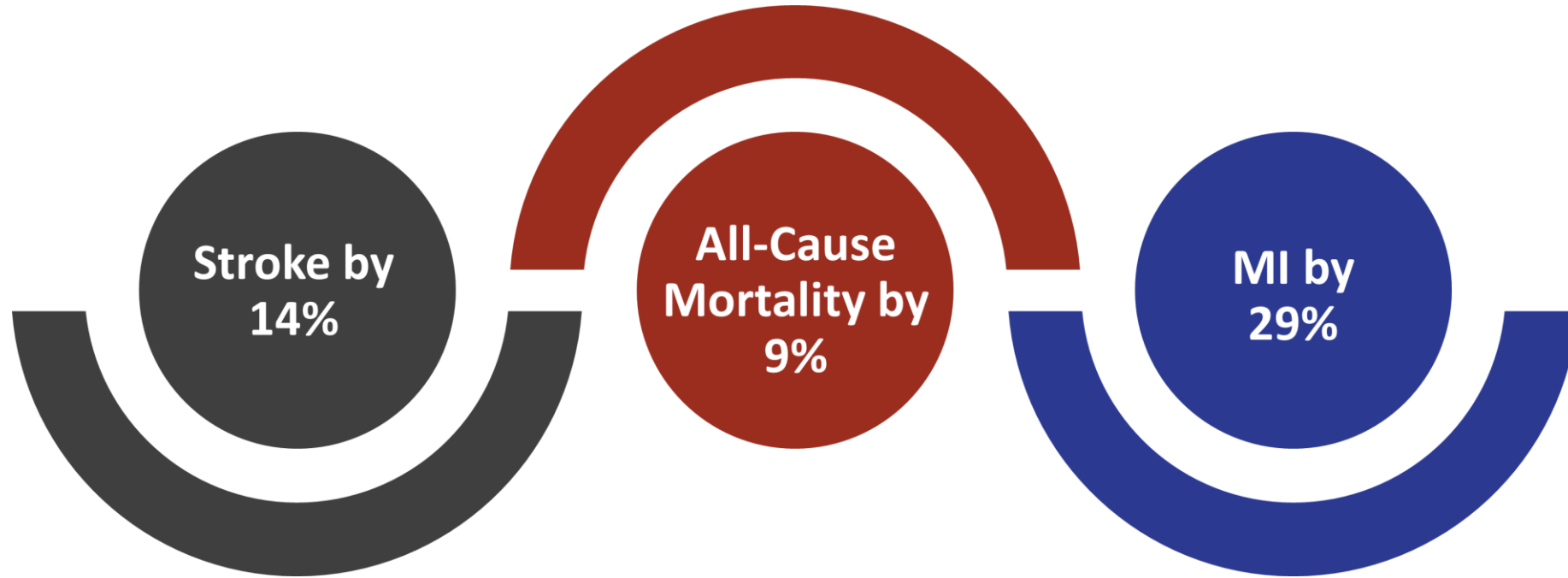
\*Cholesterol  $\geq$  190 mg/dL, †LDL-C values  $>1.3$  mmol/L from Global Health Data Exchange registry.

# Lowering cholesterol reduces the annual rate of ischemic heart disease and stroke



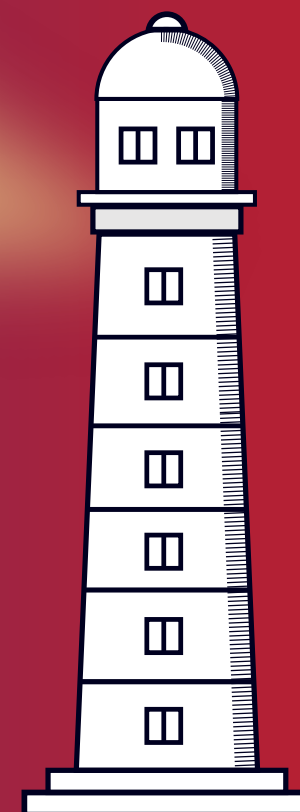
# Statins could reduce:

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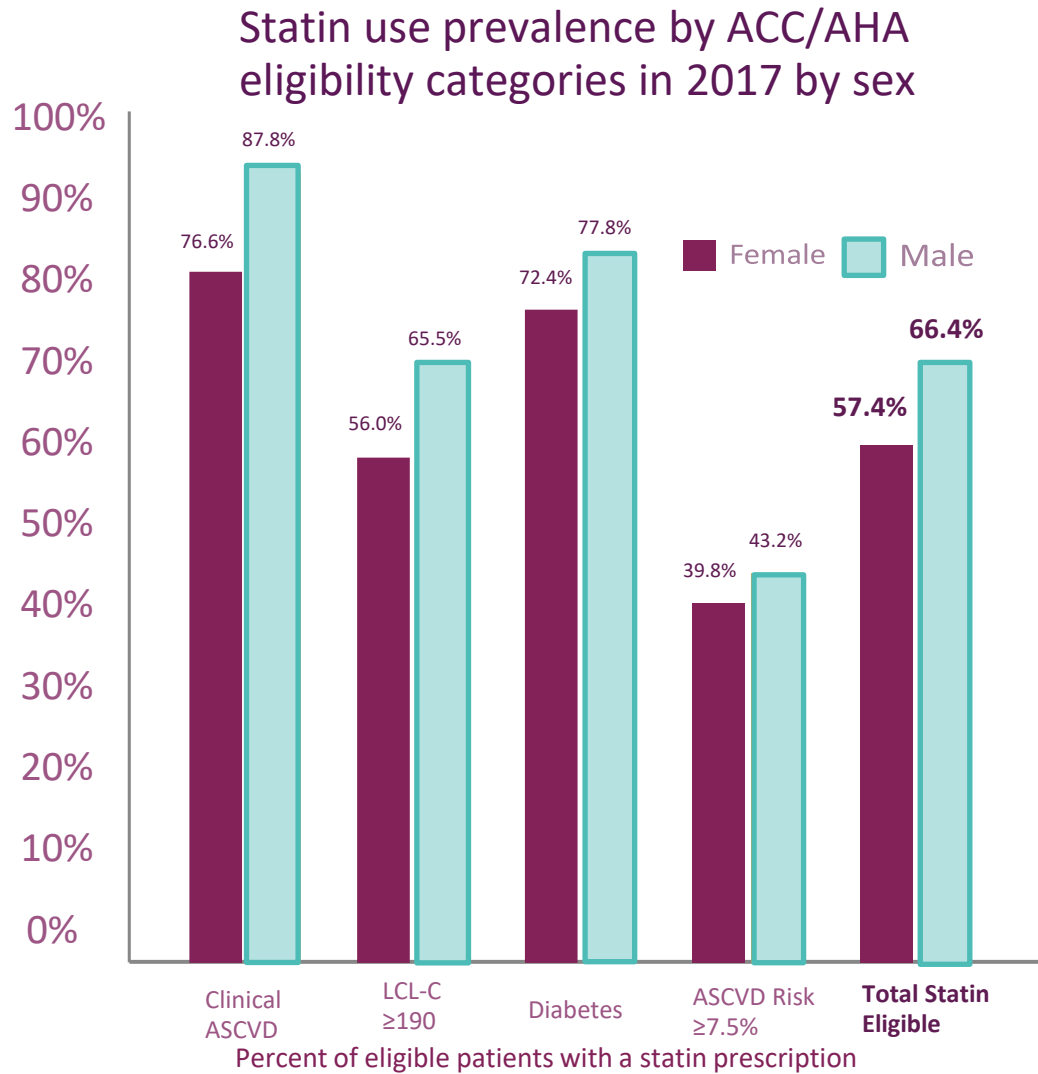




# Current Status of Hyperlipidemia Management



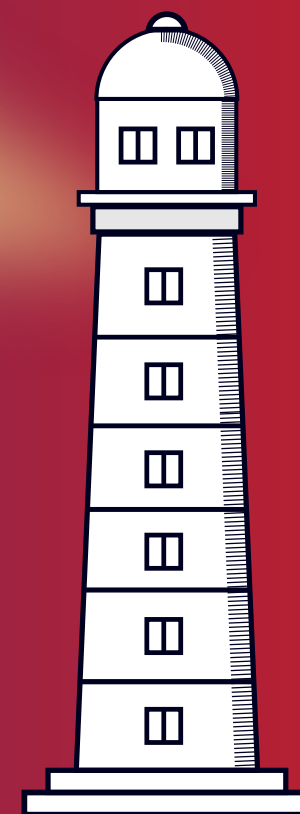
# Large gap between guideline recommendations and statin practice causes sub-optimal statin therapy



**Around 40%**  
of total statin-eligible  
not prescribed a statin.



## Fasting or Non-Fasting Lipid Tests?



# Measurement of lipid profile

| COR | RECOMMENDATIONS                                                                                                                                                                                                                                                                       |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1   | A standard non-fasting or fasting lipid profile is recommended to document baseline lipid levels, estimate ASCVD risk, and guide initiation of LLT.                                                                                                                                   |
| 1   | With a family history of dyslipidemia or premature ASCVD, a personally known or suspected disorder in TG metabolism, or whose non-fasting lipid profile reveals a TG level $\geq 400$ mg/dL, a fasting lipid profile should be performed to more accurately estimate the LDL-C level. |

Circulation. 2026;153:e1154–e1276.

# Screening of lipid profile

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| COR | RECOMMENDATIONS                                                                                                                                                                                                                                                                |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1   | In adults, screening with a lipid profile is recommended <b><u>beginning at age 19 years</u></b> and <b><u>at least every 5 years</u></b> thereafter to identify treatable ASCVD risk, with frequent screening recommended for individuals with additional ASCVD risk factors. |
| 2a  | In individuals with first- or second-degree relatives with premature ASCVD, severe hypercholesterolemia, or FH, it is reasonable to perform screening with a single lipid profile (eg, cascade screening) starting at $\geq 2$ years of age to identify FH.                    |

# Lipid Lowering Formulas:

## Friedewald

$$\text{F-LDL-C (mg/dL)} = \text{TC} - \text{HDL-C} - \text{TG}/5$$

## Sampson

$$\text{LDL-C} = \frac{\text{Total Cholesterol}}{0.948} - \frac{\text{HDL-C}}{0.971} - \left( \frac{\text{Triglycerides}}{8.56} + \frac{\text{Triglycerides} \times (\text{Non-HDL-C})}{2140} - \frac{\text{Triglycerides}^2}{16100} \right) - 9.44$$

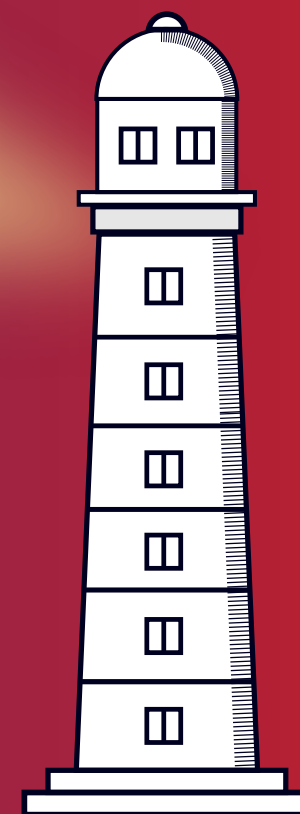
## Martin–Hopkins

$$\text{MH-LDL-C (mmol/L)} = \text{TC} - \text{HDL-C} - \text{TG}/\text{adjustable factor}$$

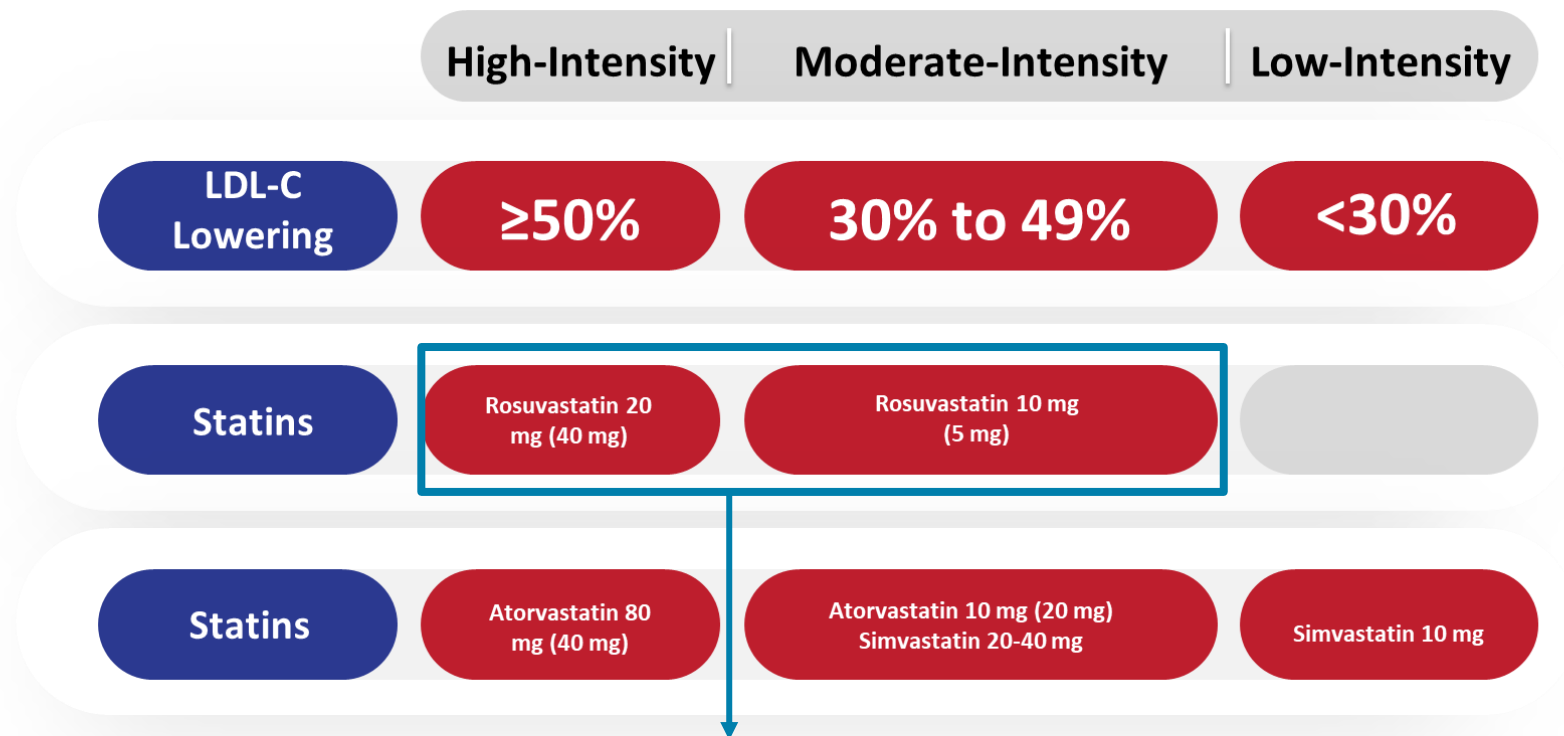
In adults and children who have undergone a standard lipid profile, use of either the Martin/Hopkins equation or the Sampson/NIH equation is preferred over calculation by the Friedewald equation to estimate LDL-C (COR1).



# Lipid Lowering Treatments



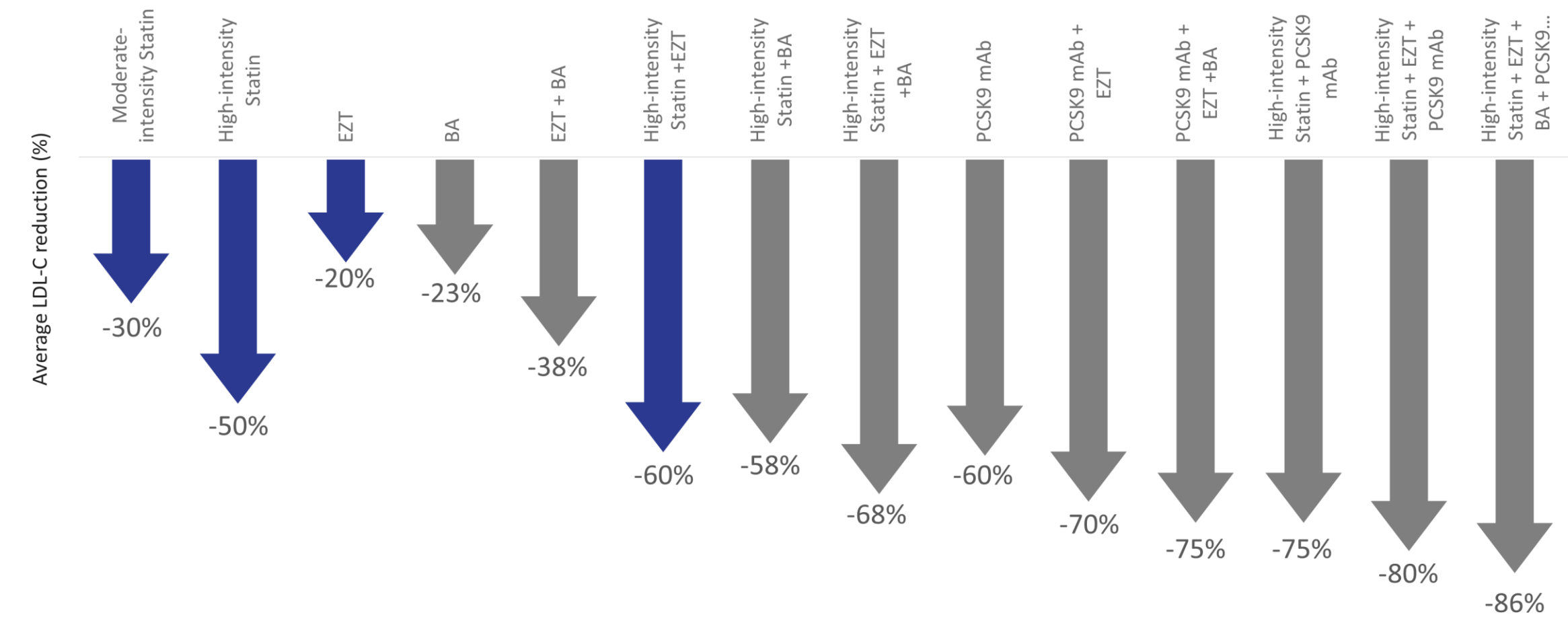
# Statin intensity is important for clinical benefits expected



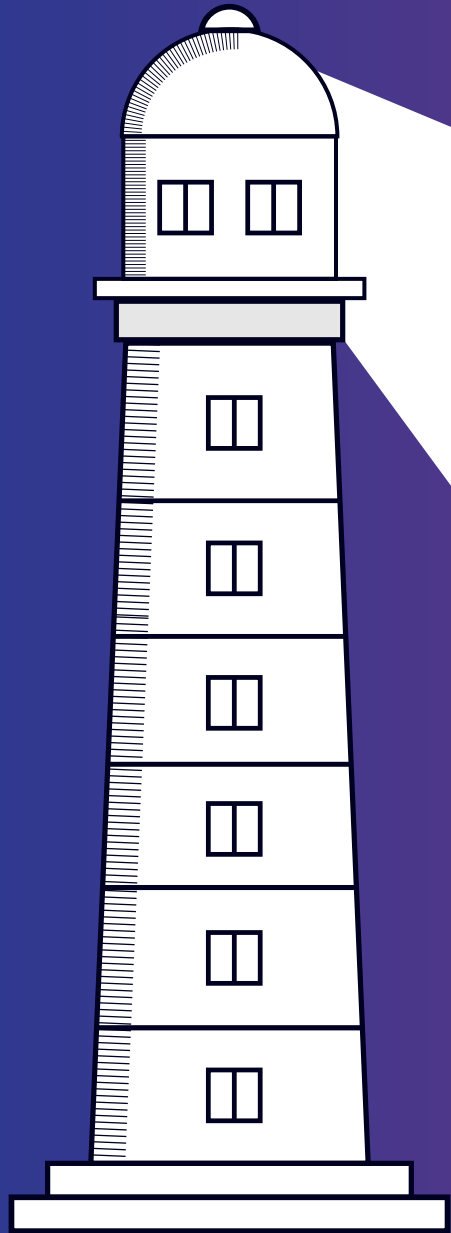
The usual starting dose is 10 to 20 mg once daily.

- Use 40 mg dose only for patients not reaching LDL-C goal with 20 mg.
- In severe renal impairment (CrCl <30 mL/min/1.73 m<sup>2</sup>) not on hemodialysis, dosing of Rosuvastatin should be started at 5 mg once daily and not exceed 10 mg once daily.

# Average LDL-C lowering of proven cardiovascular benefit



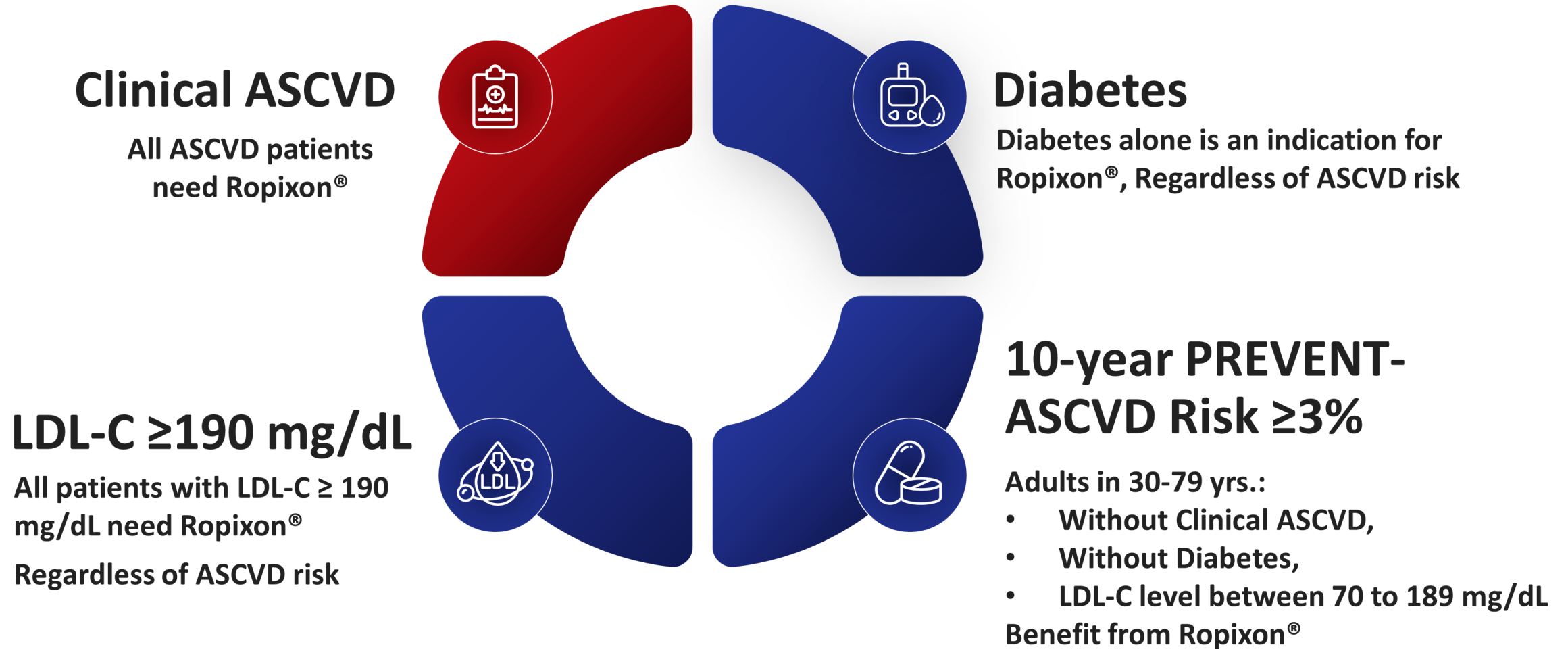
Eur Heart J. 2026 Feb 11;47:697.



## Who Needs Treatment for Hyperlipidemia?

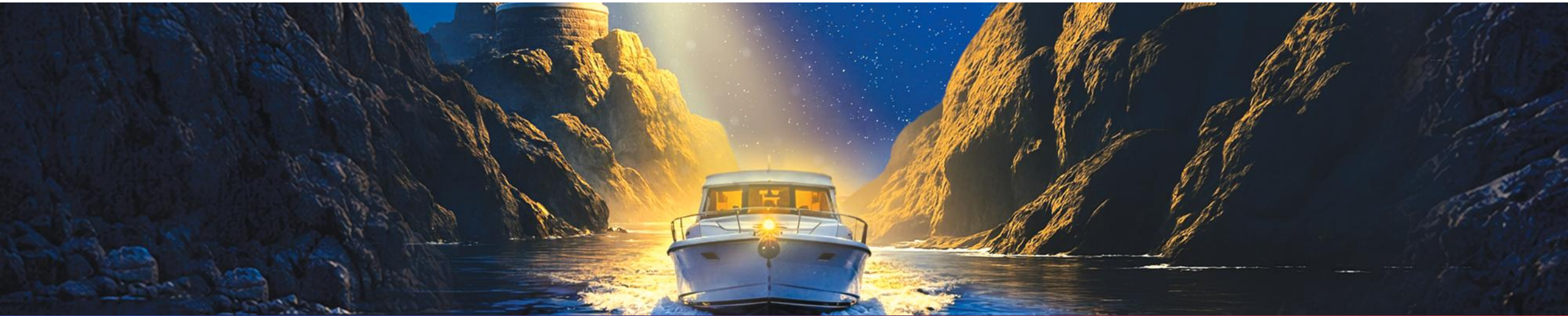


# Four groups are guideline recommended statin benefit groups



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# 1.Clinical ASCVD

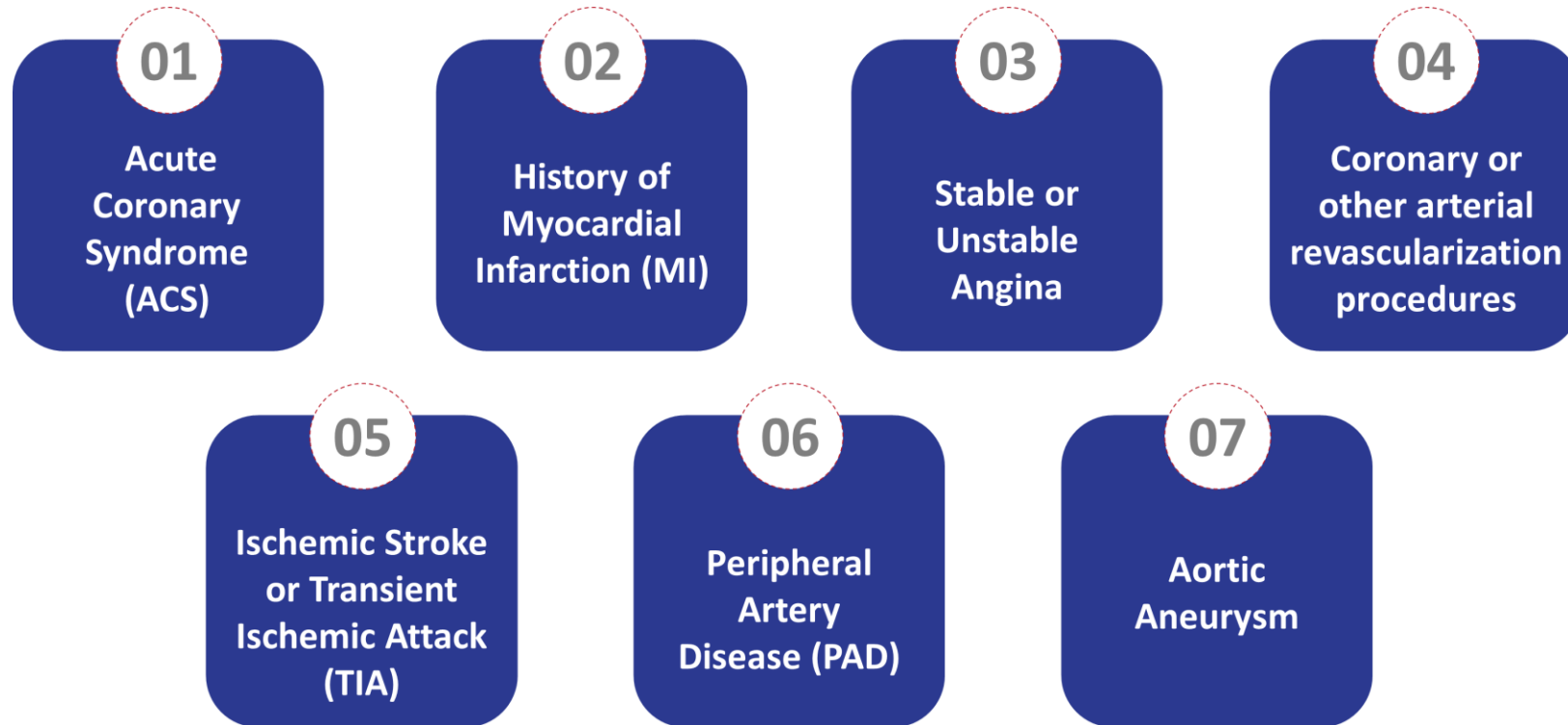




Circulation. 2026;153:e1154–e1276.

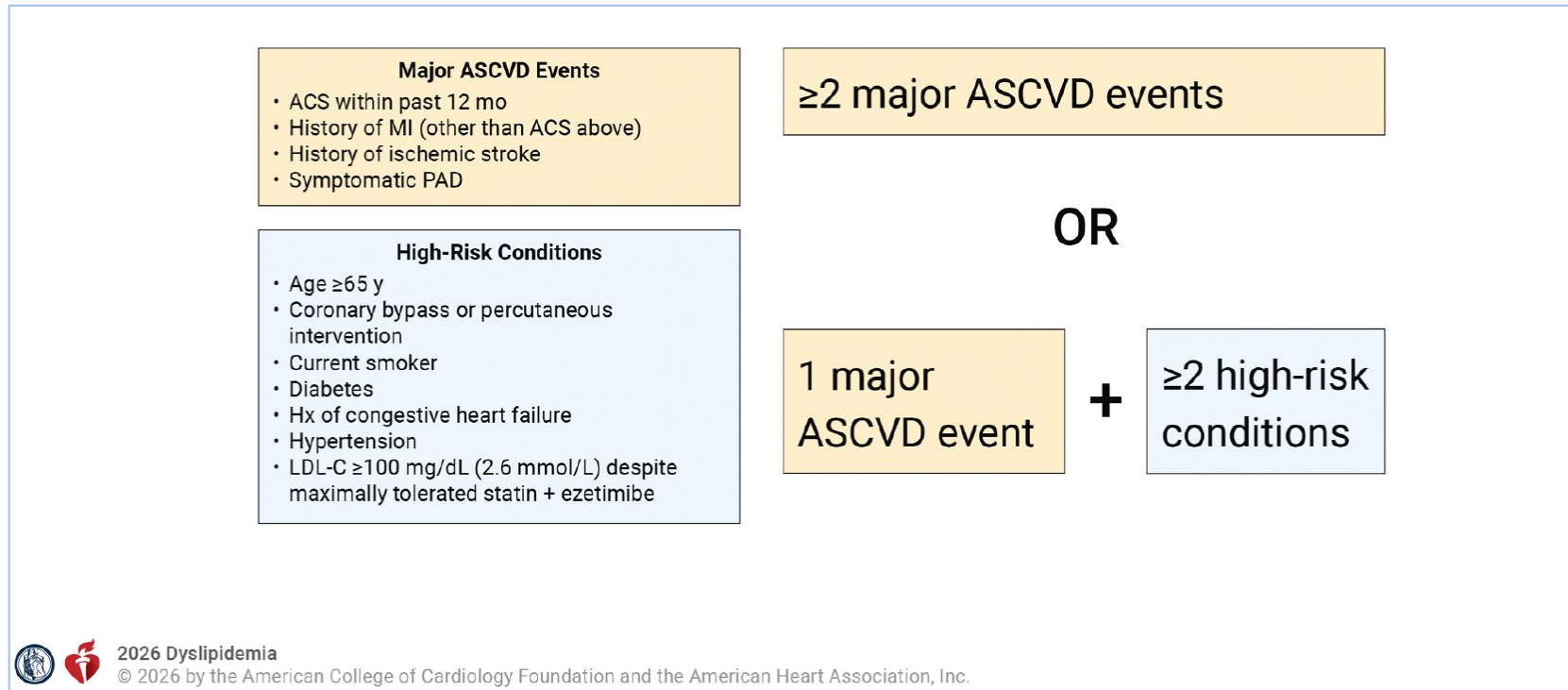
# Clinical ASCVD includes the following atherosclerotic origin conditions

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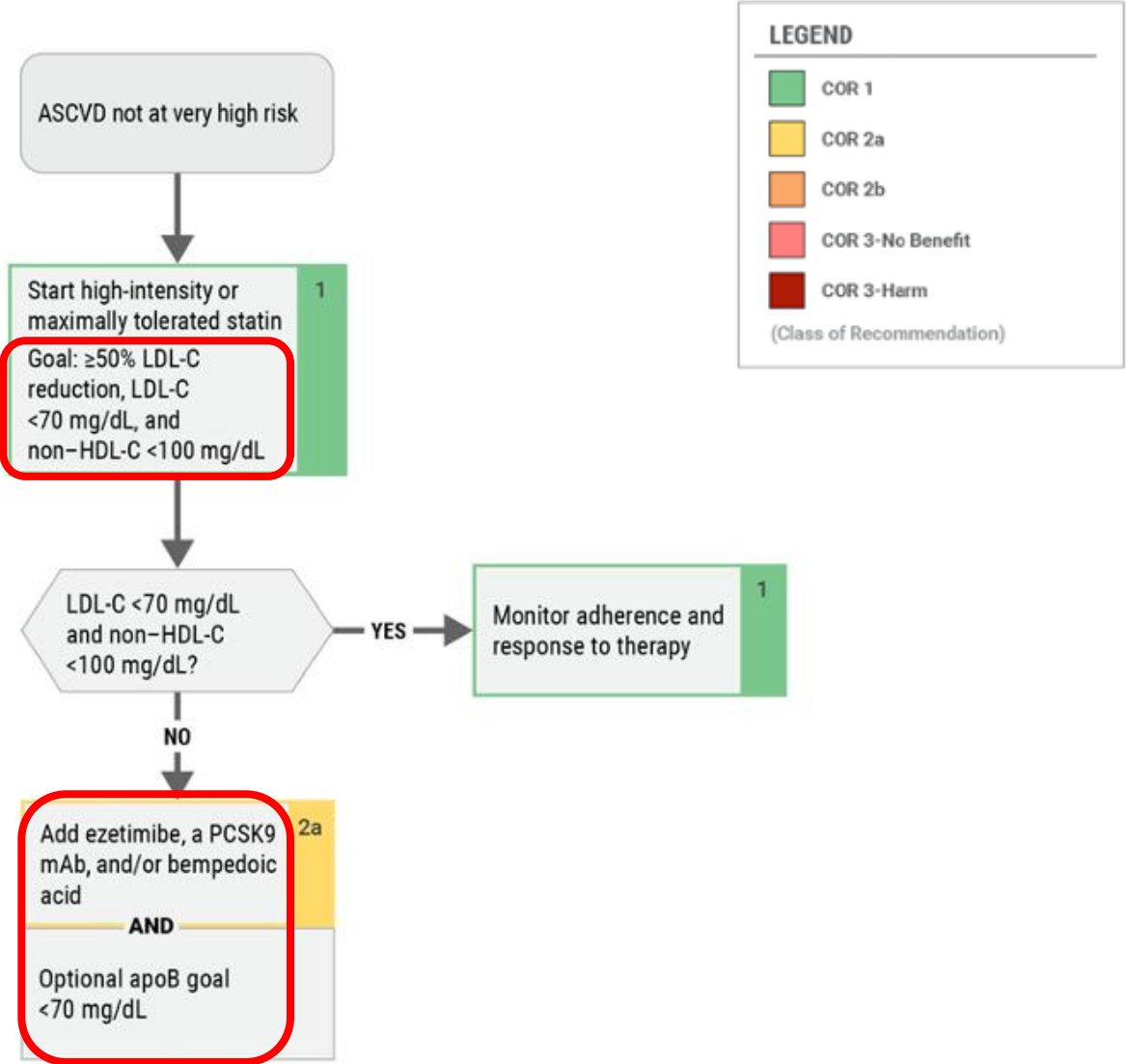
# The majority of patients with clinical ASCVD are likely to be at very high risk

## Clinical ASCVD: Criteria for Defining “At Very High Risk” in Adults



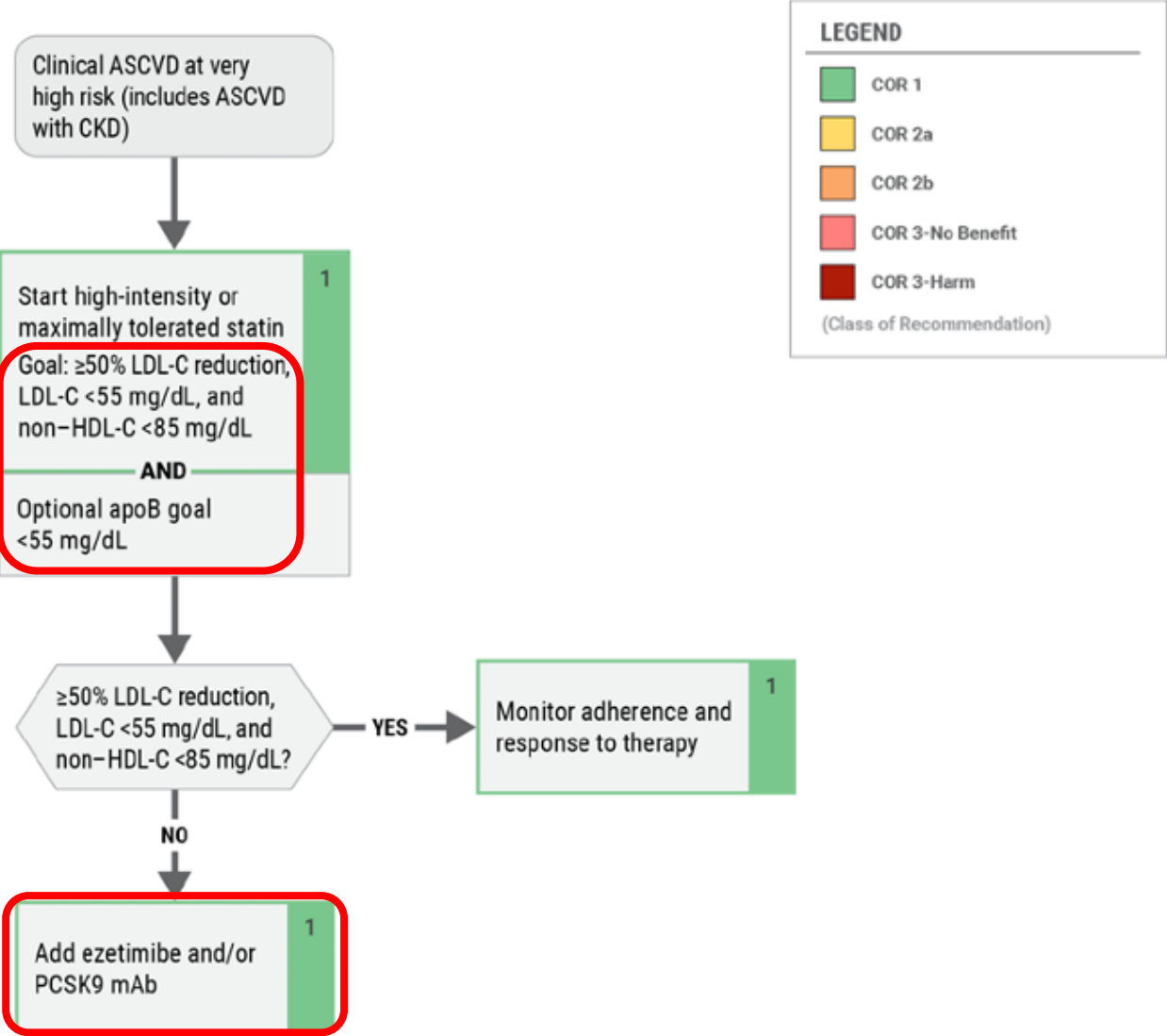
ACS indicates acute coronary syndrome; ASCVD, atherosclerotic cardiovascular disease; Hx, history; LDL-C, low-density lipoprotein cholesterol; MI, myocardial infarction; and PAD, peripheral artery disease.

# Secondary ASCVD Prevention for Adults at Not Very High Risk



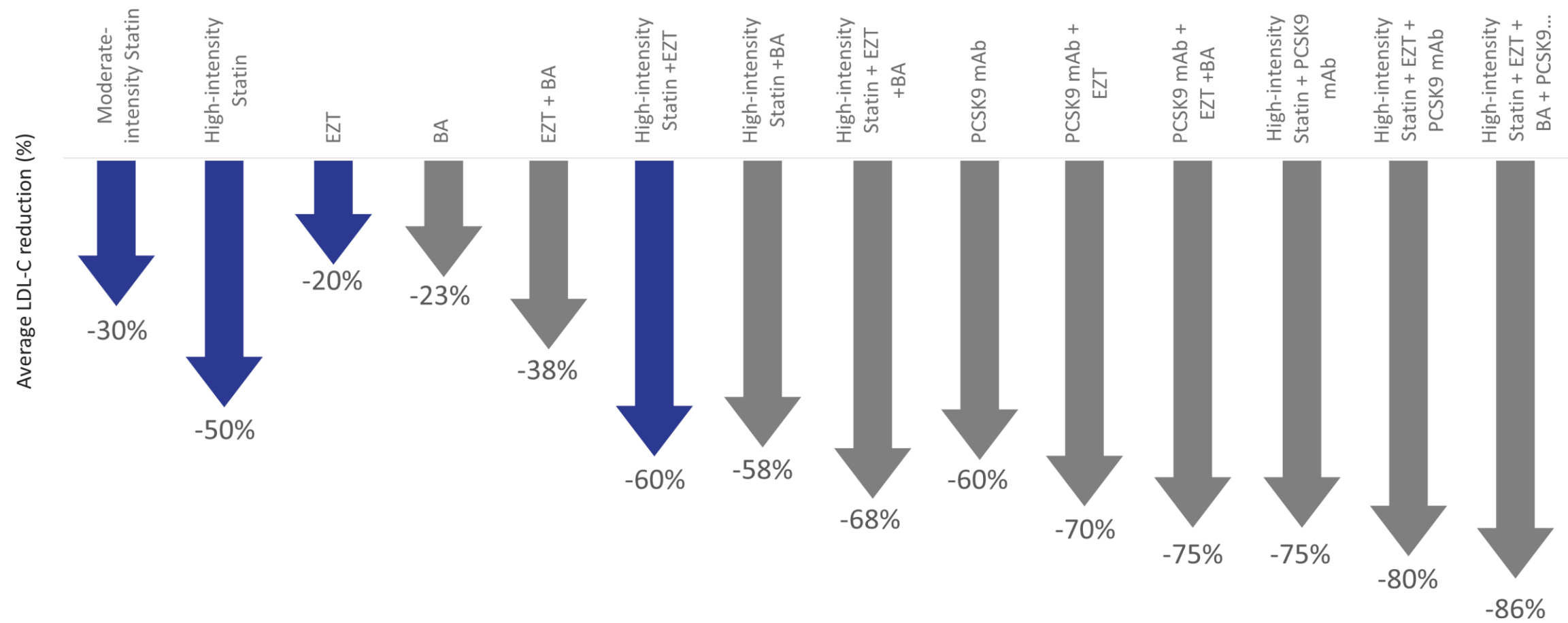
Circulation. 2026;153:e1154–e1276.

# Secondary ASCVD Prevention for Adults at Very High Risk



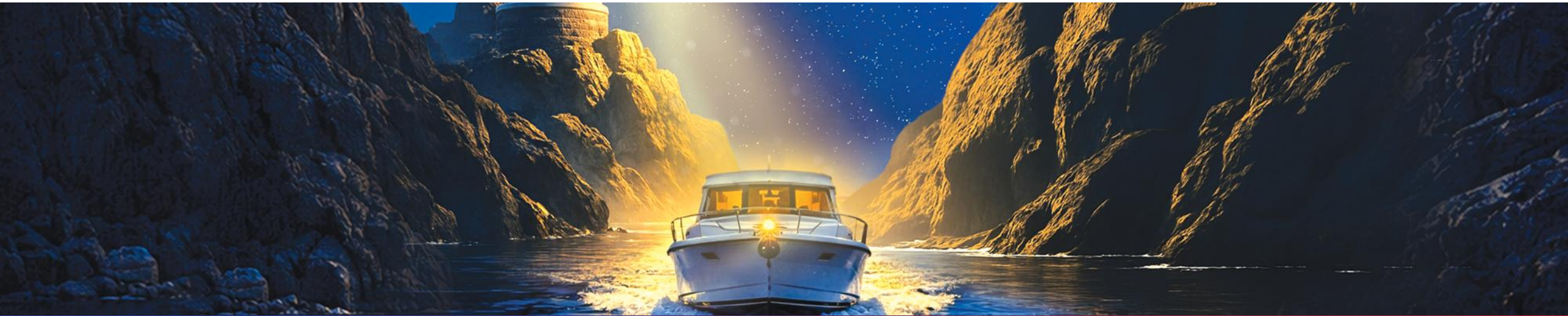
Circulation. 2026;153:e1154–e1276.

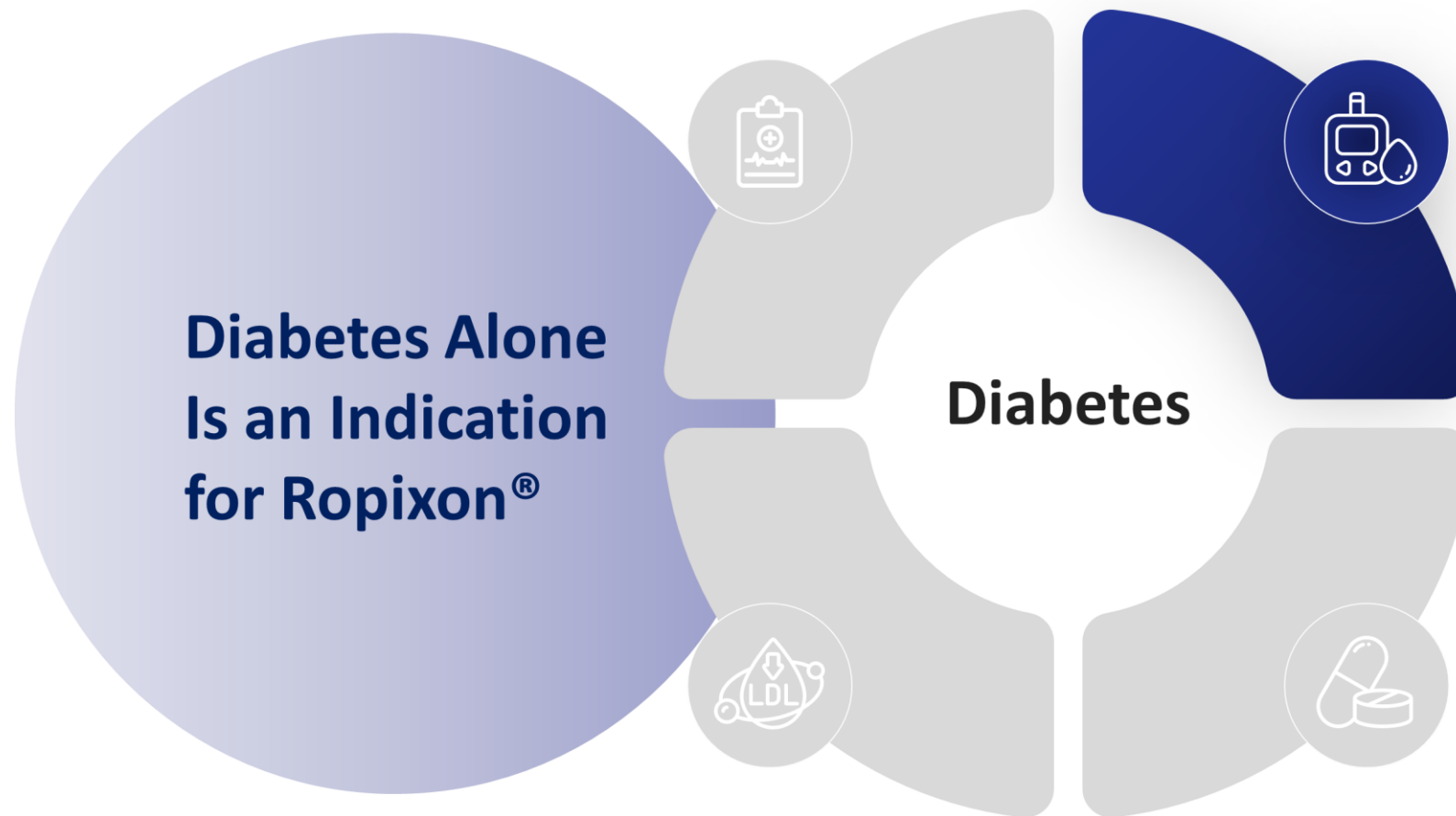
# Average LDL-C lowering of proven cardiovascular benefit



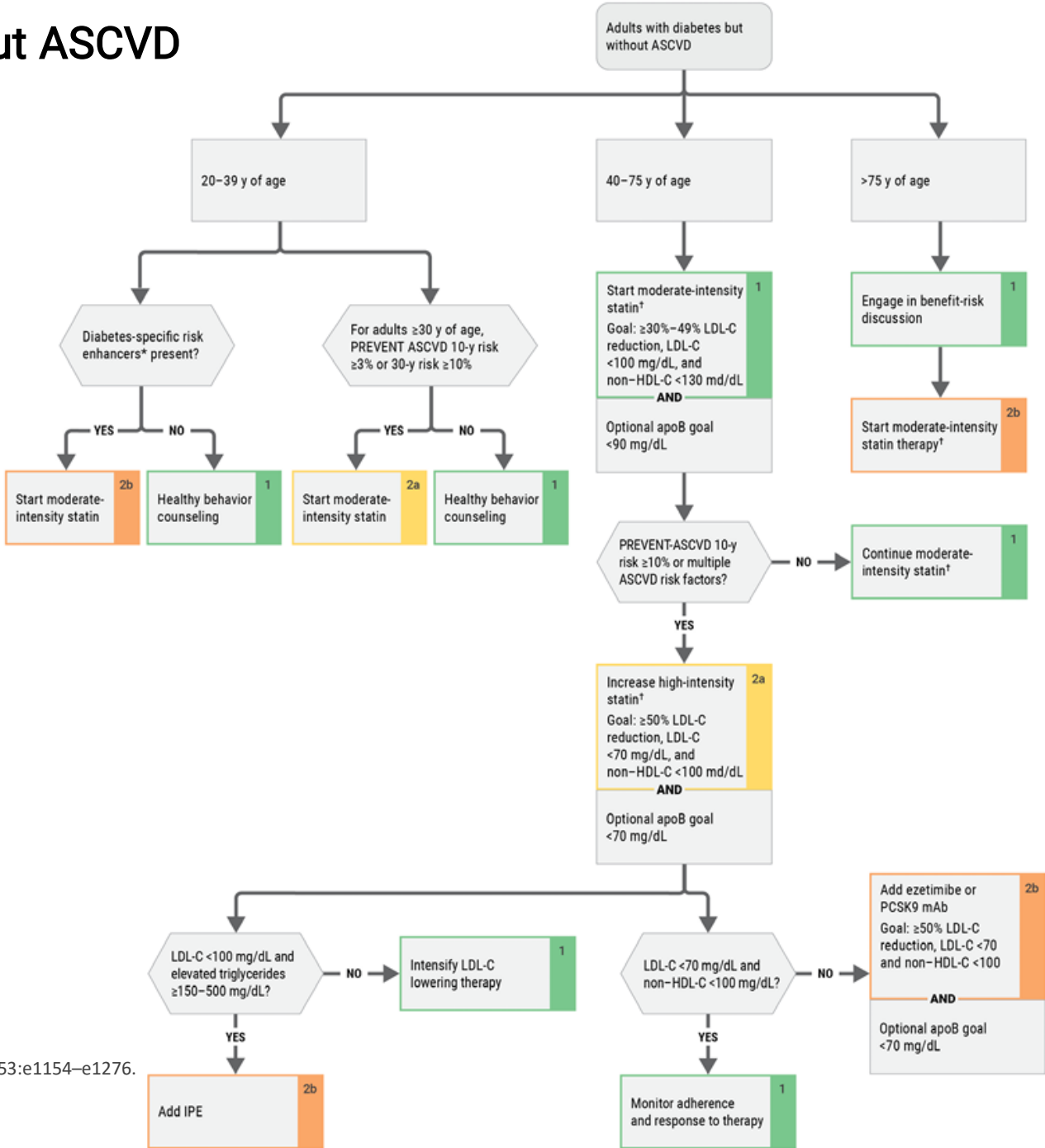
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## 2. Diabetes





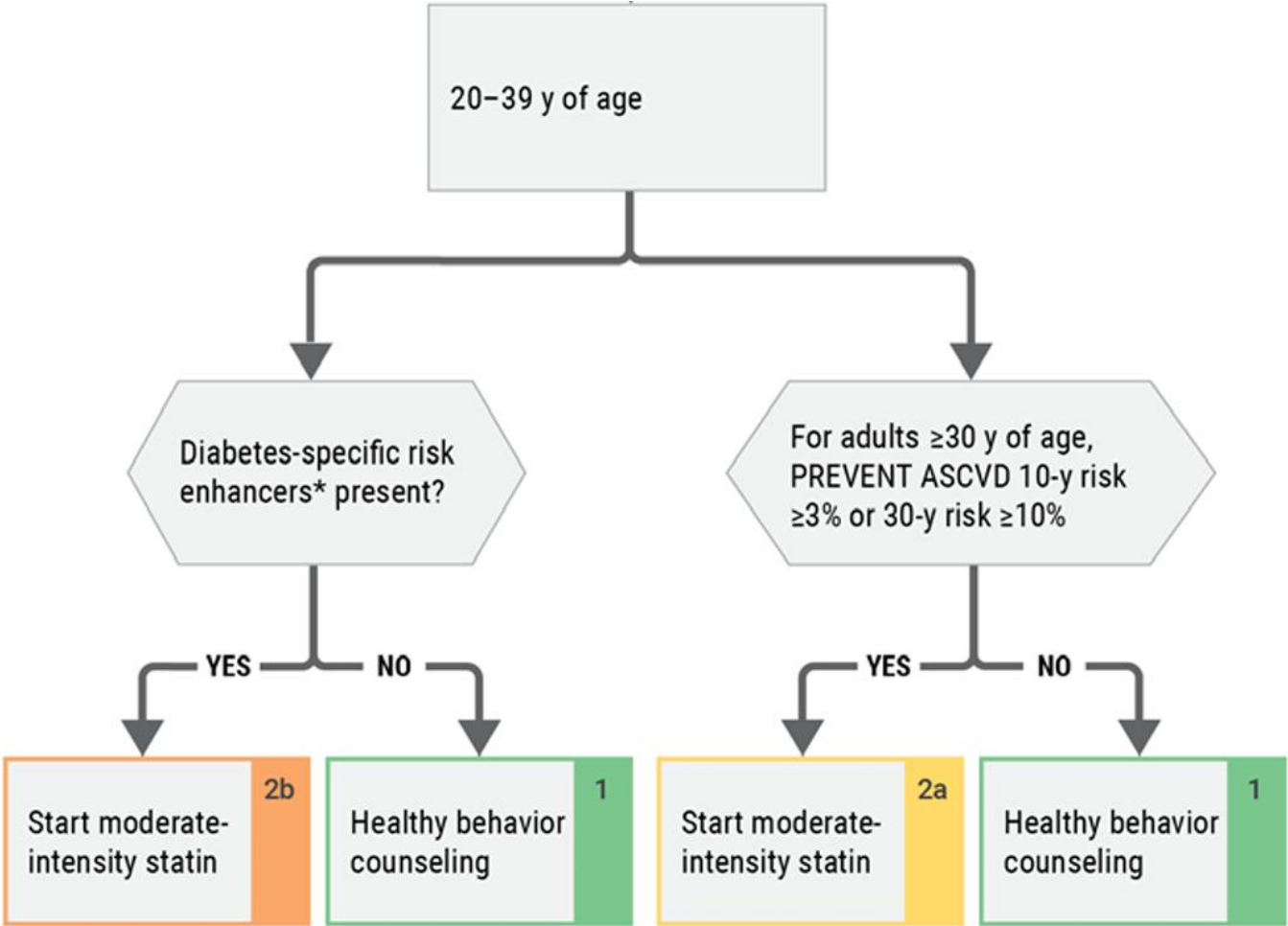
# Adults with diabetes and without ASCVD



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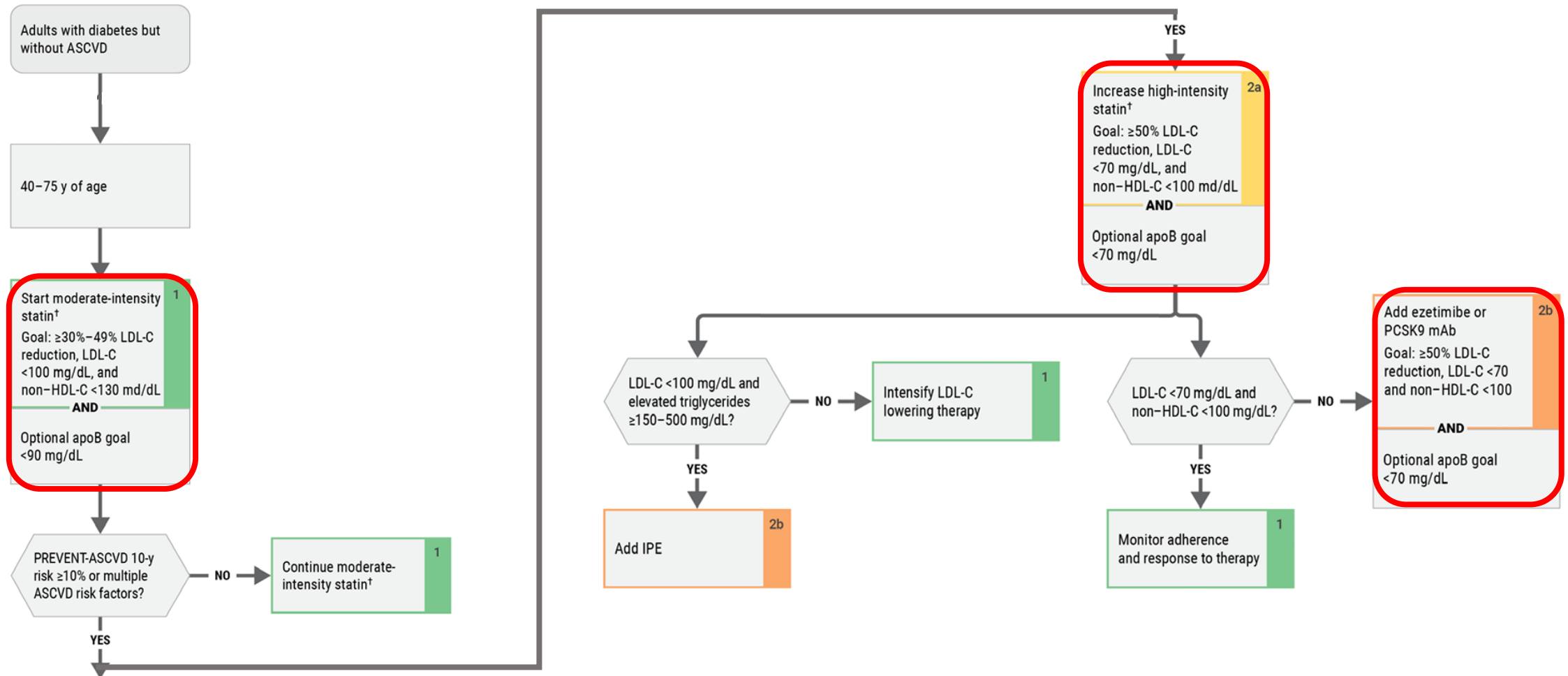
# Adults with diabetes and without ASCVD (20-39 years)

| Risk Enhancers                                                         |
|------------------------------------------------------------------------|
| Long duration (≥10 y for type 2 diabetes or ≥20 y for type 1 diabetes) |
| Albuminuria ≥30 µg of albumin/mg creatinine                            |
| eGFR <60 mL/min/1.73 m <sup>2</sup>                                    |
| Retinopathy                                                            |
| Neuropathy                                                             |
| ABI <0.9                                                               |



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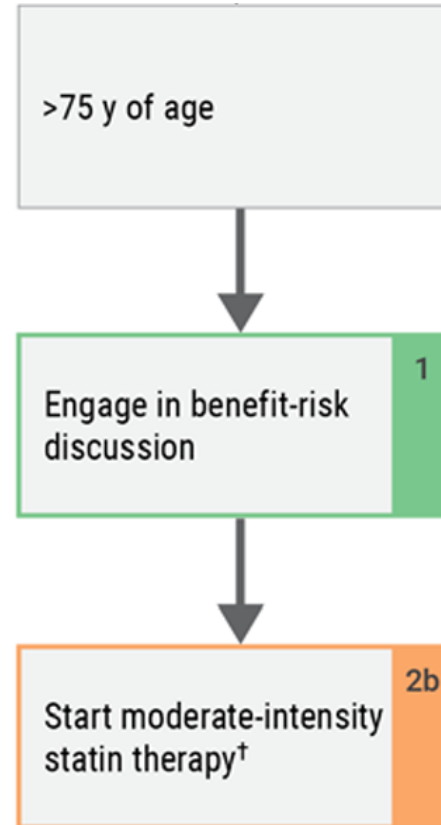
# Adults with diabetes and without ASCVD (40-75 years)



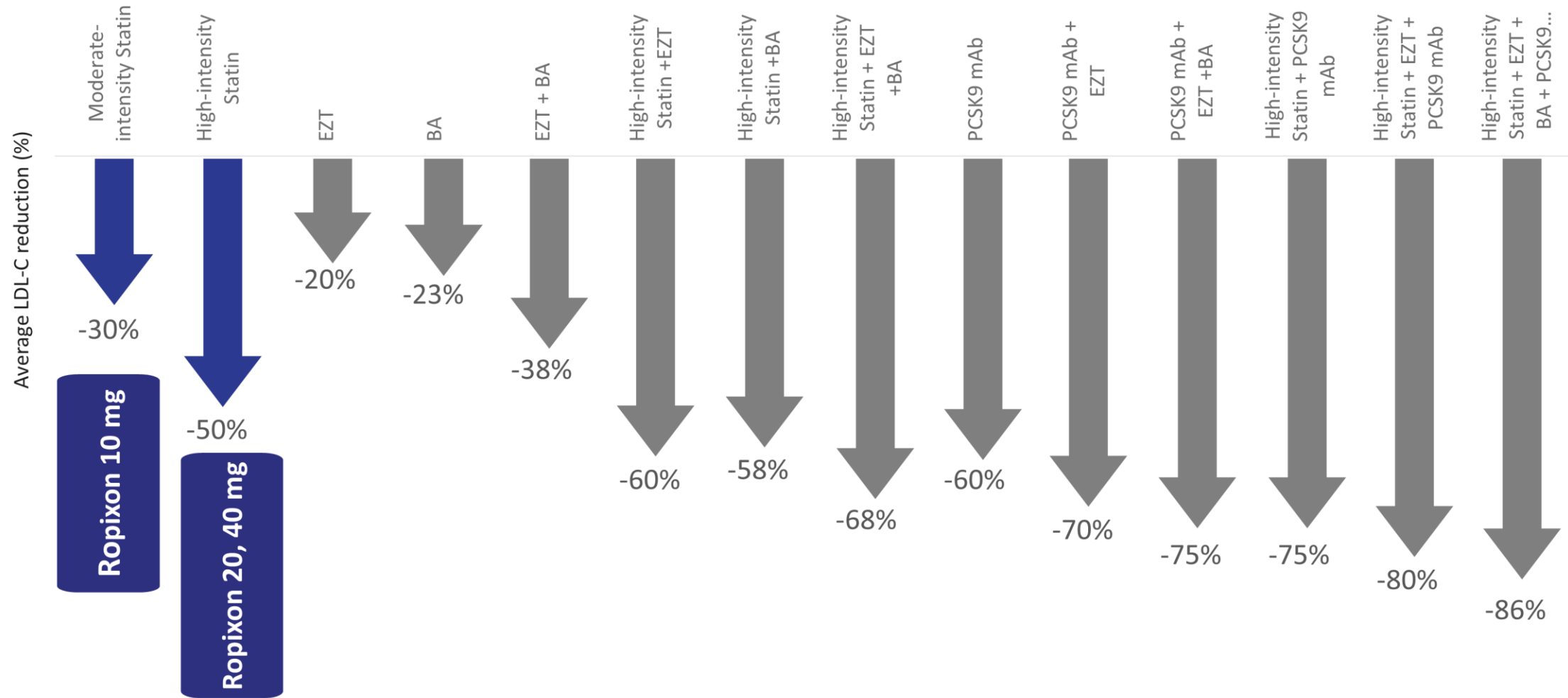
Circulation. 2026;153:e1154–e1276.

# Adults with diabetes and without ASCVD (>75 years)

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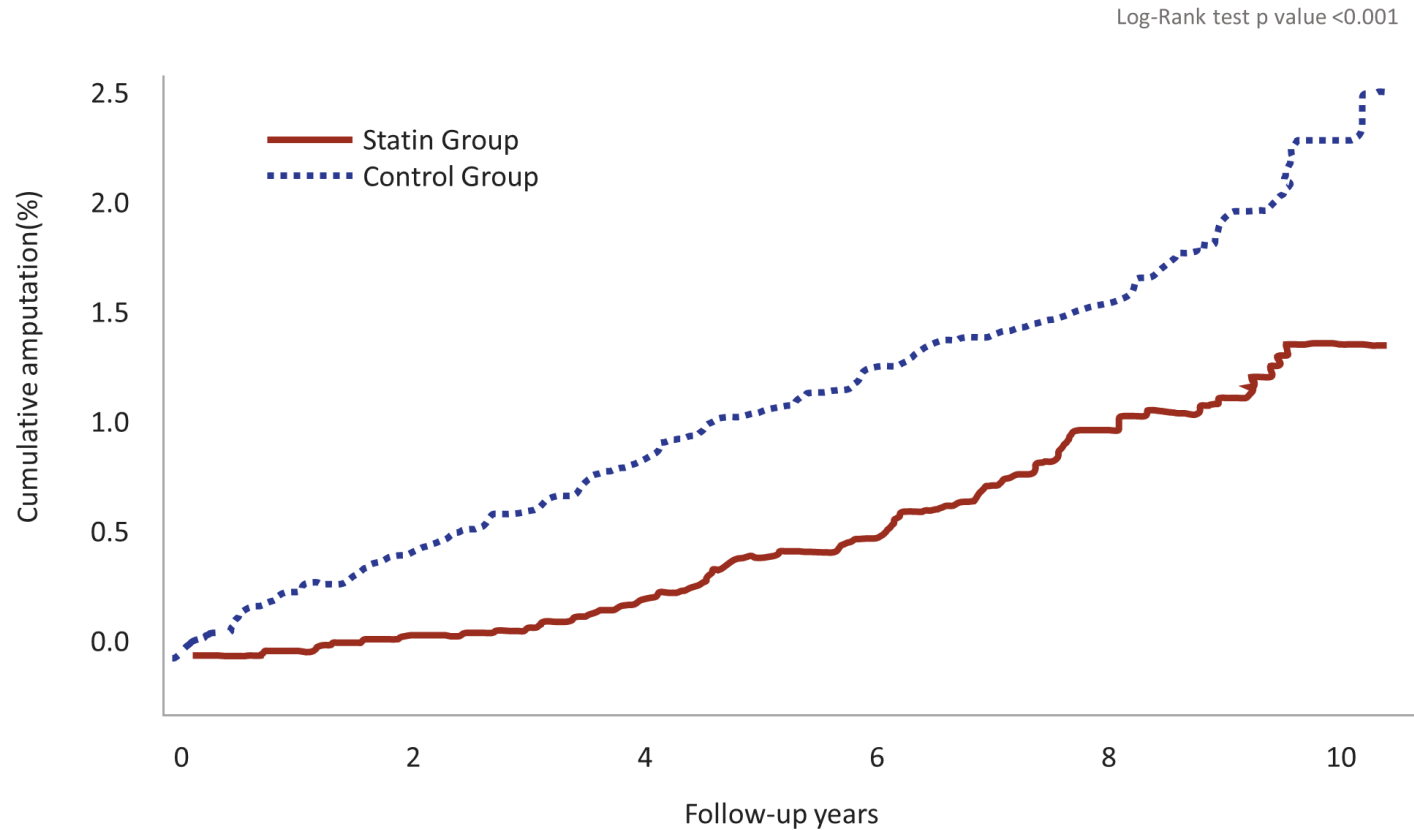


# Average LDL-C lowering of proven cardiovascular benefit



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# 52% amputation risk reduction with statin use in people with diabetes



**38,973 patients with DM**

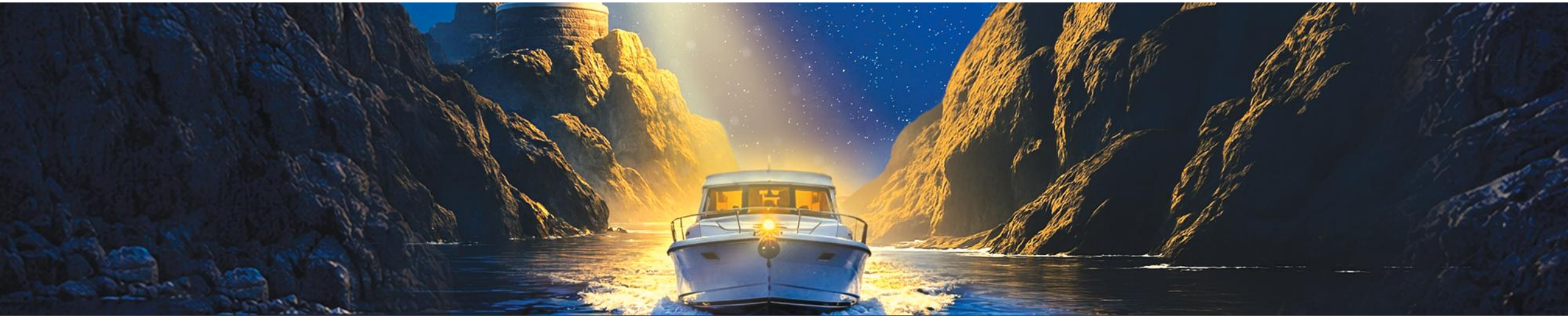
51.97% patients taking Statin

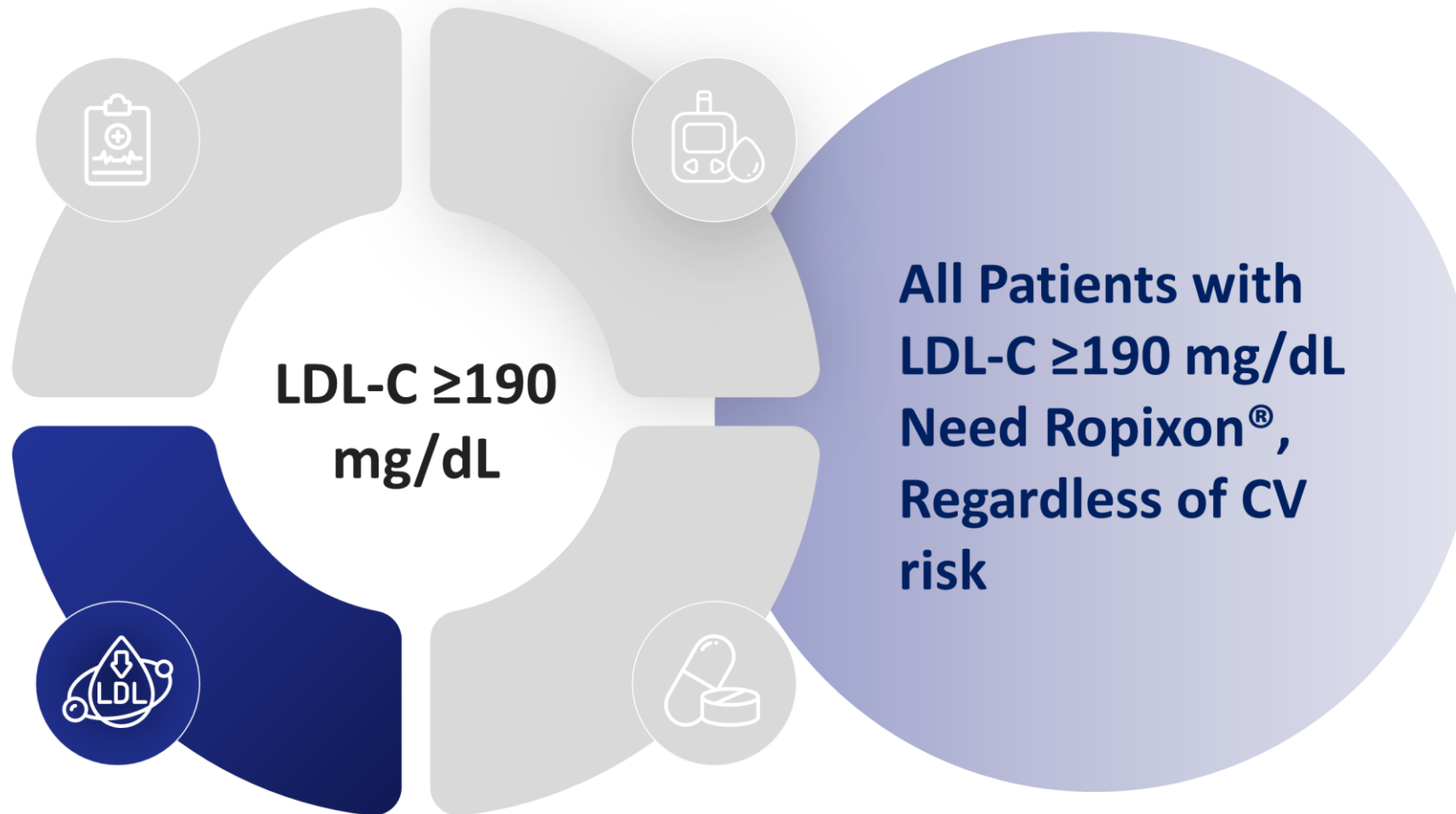
49.03% not taking Statin

5.2 years follow-up

The statin group had a significantly lower risk of lower-extremity amputation than the control group. (0.6% vs. 1.1%; log-rank P < 0.001)

### 3. LDL $\geq 190$ mg/dL





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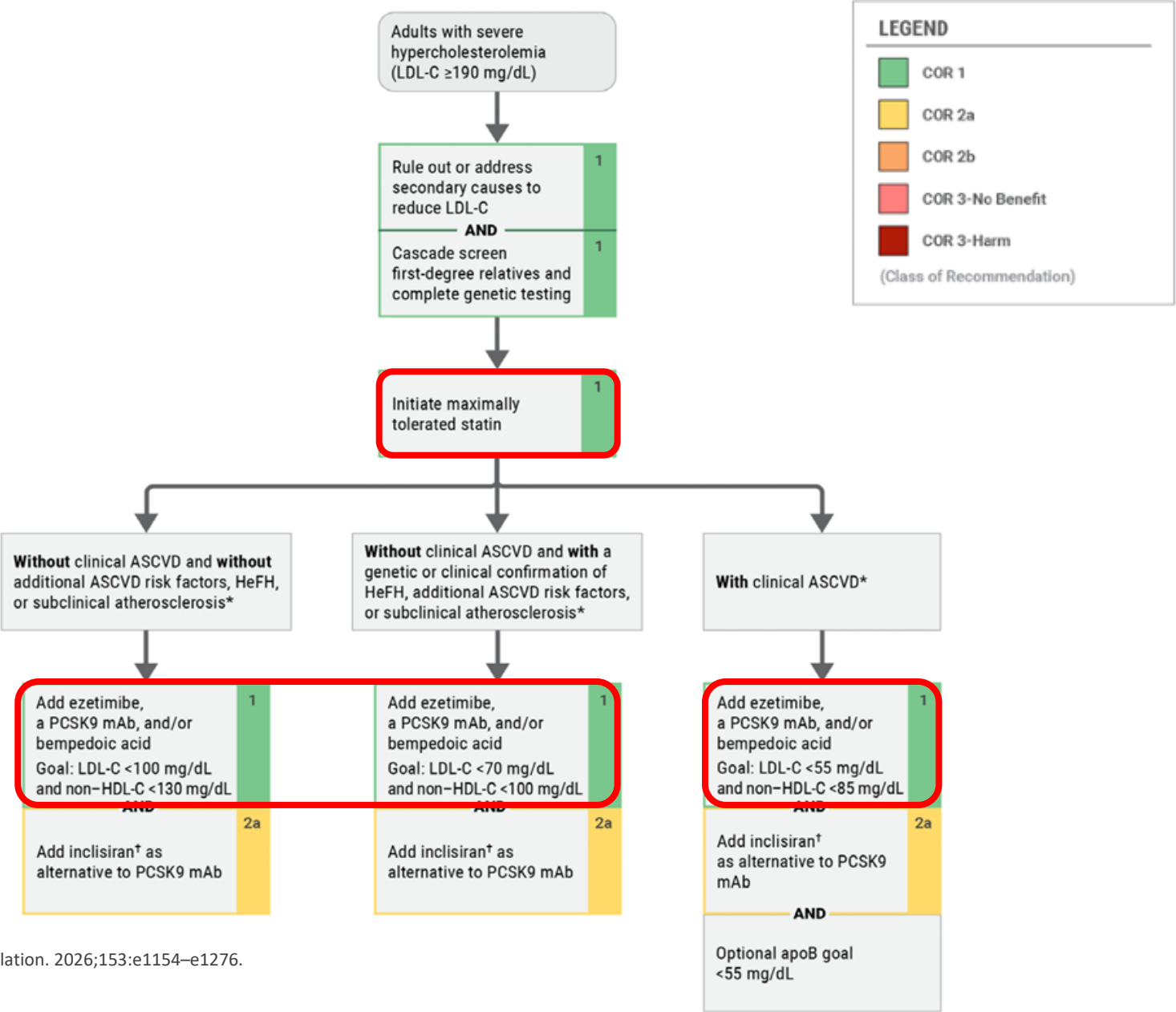
# Immediate Statin Initiation in Severe Hypercholesterolemia Is Critical

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**LDL-C  $\geq$ 190 mg/dL, High-risk of:**

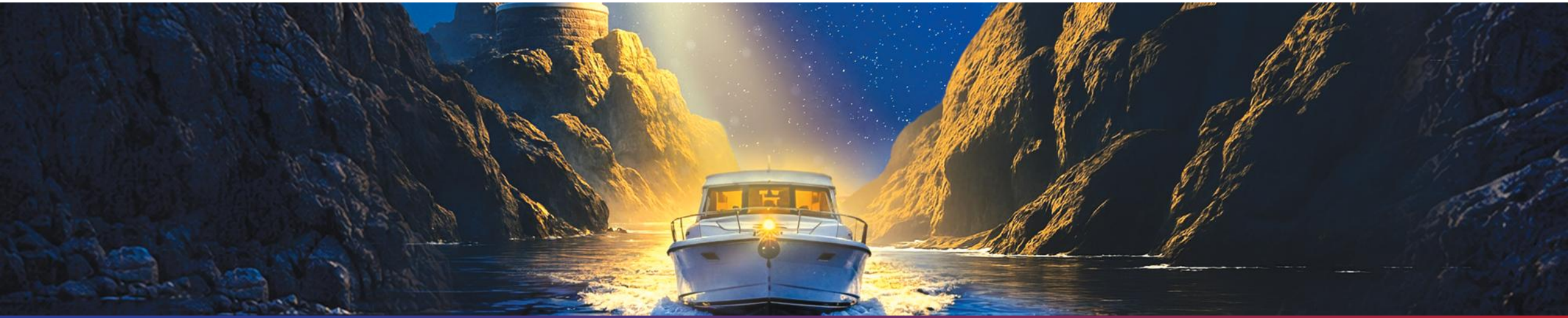
- 1 ASCVD
- 2 Premature coronary events
- 3 Recurrent coronary events

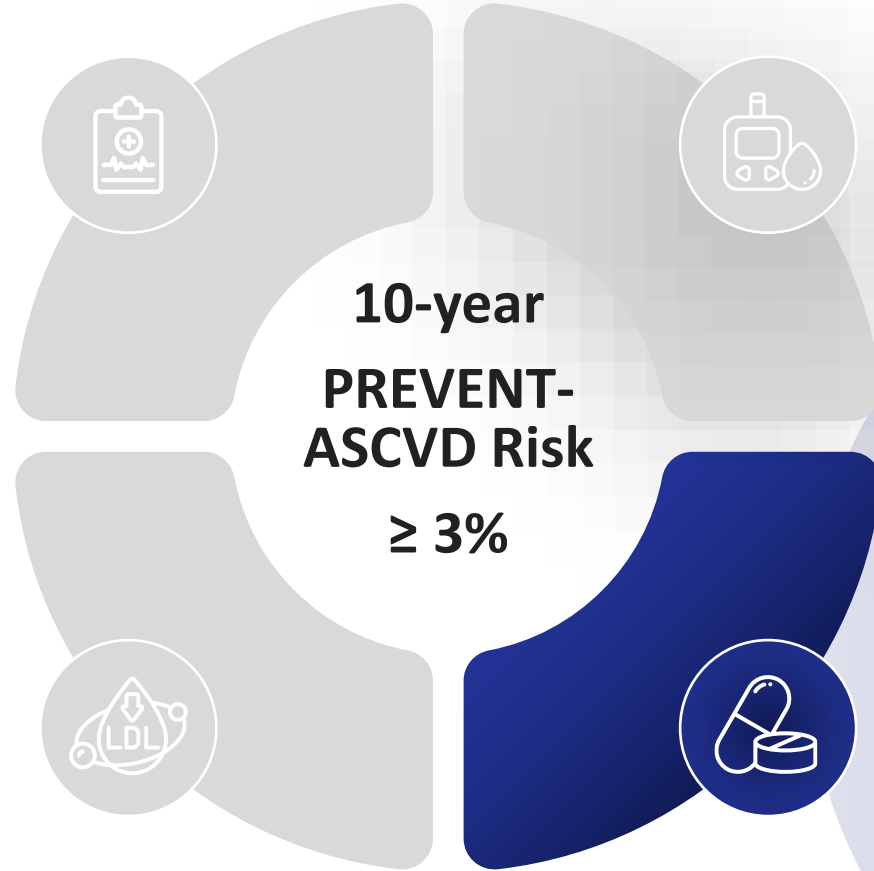
# Immediate statin initiation in severe hypercholesterolemia is critical



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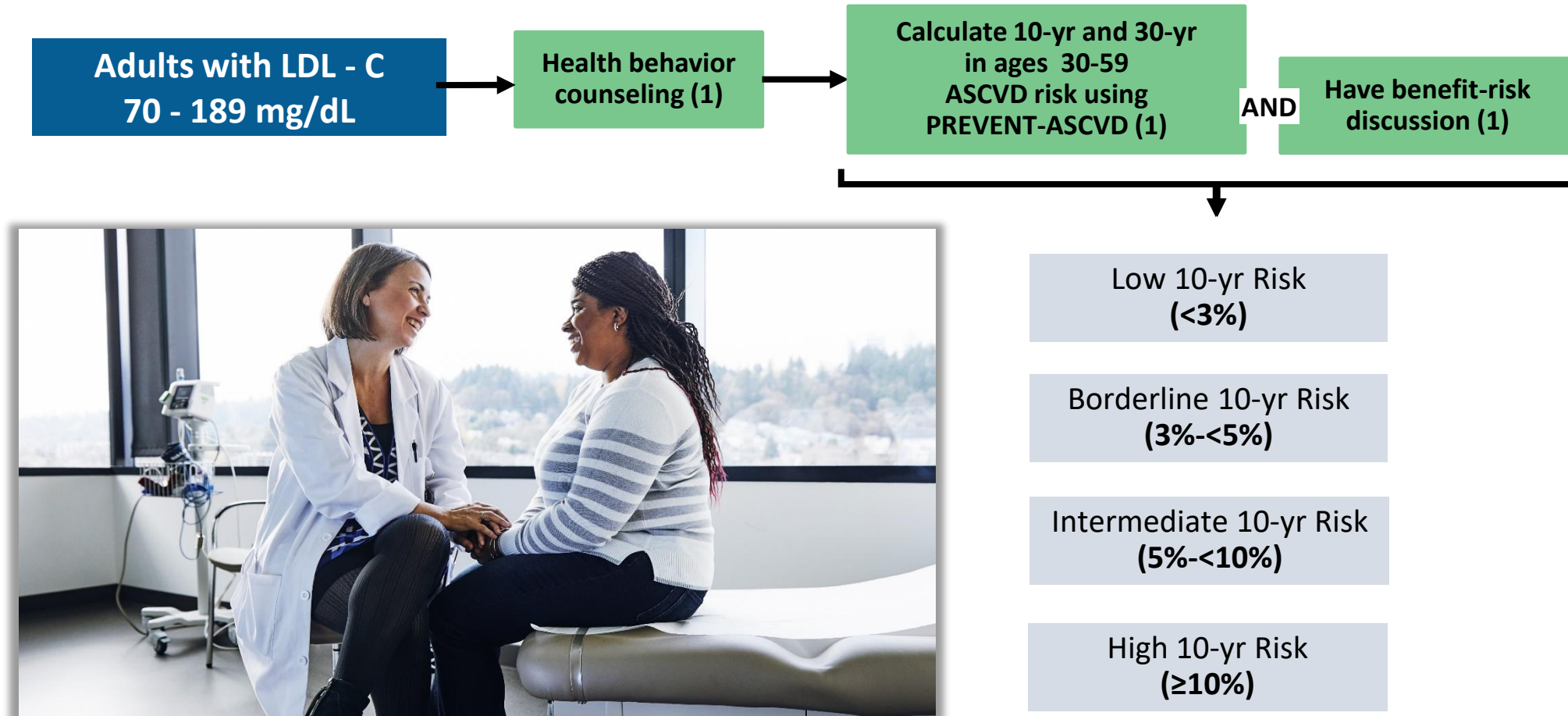
## 4. 10-year PREVENT-ASCVD Risk $\geq 3\%$





**Adults in 30-79 yrs.:  
Without Clinical  
ASCVD,  
Without Diabetes,  
LDL-C level between  
70 to 189 mg/dL  
Benefit from Statin**

# Primary Prevention 30–79 Years Without ASCVD



Circulation. 2026;153:e11154–e1276.

# PREVENT-ASCVD Risk Calculator

CVD

ASCVD

Heart Failure

Sex\*

☒ Male ☐ Female

Total Cholesterol (mg/dL)\*

130-320

BMI (kg/m<sup>2</sup>)\*

18.5-39.9

Lipid-lowering medication

Current use of statin medication to lower cholesterol

☒ No ☐ Yes

Age (years)\*

30-79

HDL Cholesterol (mg/dL)\*

20-100

Diabetes

Any history of diabetes.

☒ No ☐ Yes

Anti-hypertensive medication

Current use of any medication for hypertension

☒ No ☐ Yes

SBP (mmHg)\*

90-200

eGFR (mL/min/1.73m<sup>2</sup>)\*

15-140

Current Smoking

Any cigarette use within the last 30 days

☒ No ☐ Yes

The following three predictors are optional for further personalization of risk assessment. When they are clinically indicated or available,

If available or indicated, select "Yes" and enter the value.

UACR (mg/g)

UACR is clinically indicated for individuals with chronic kidney disease, diabetes, or hypertension

☒ No ☐ Yes

HbA1c

HbA1c is clinically indicated for individuals with diabetes, prediabetes, overweight, or obesity, or those with history of gestational diabetes

☒ No ☐ Yes

Zip Code

valid 5-digit zip code is needed to estimate social deprivation index [SDI]

☒ No ☐ Yes

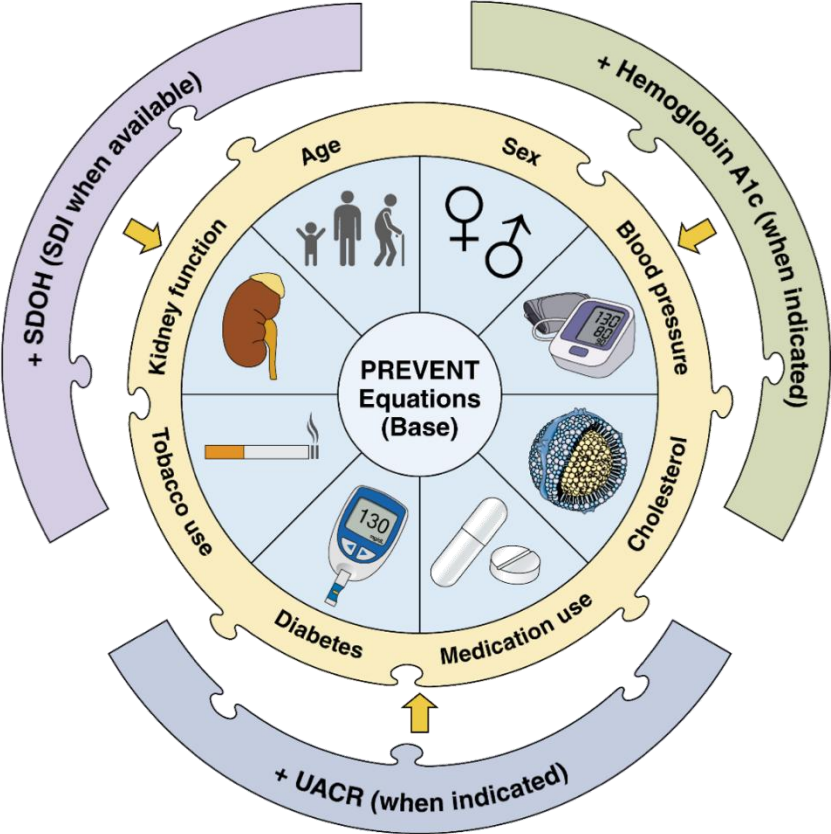
Calculate

Reset

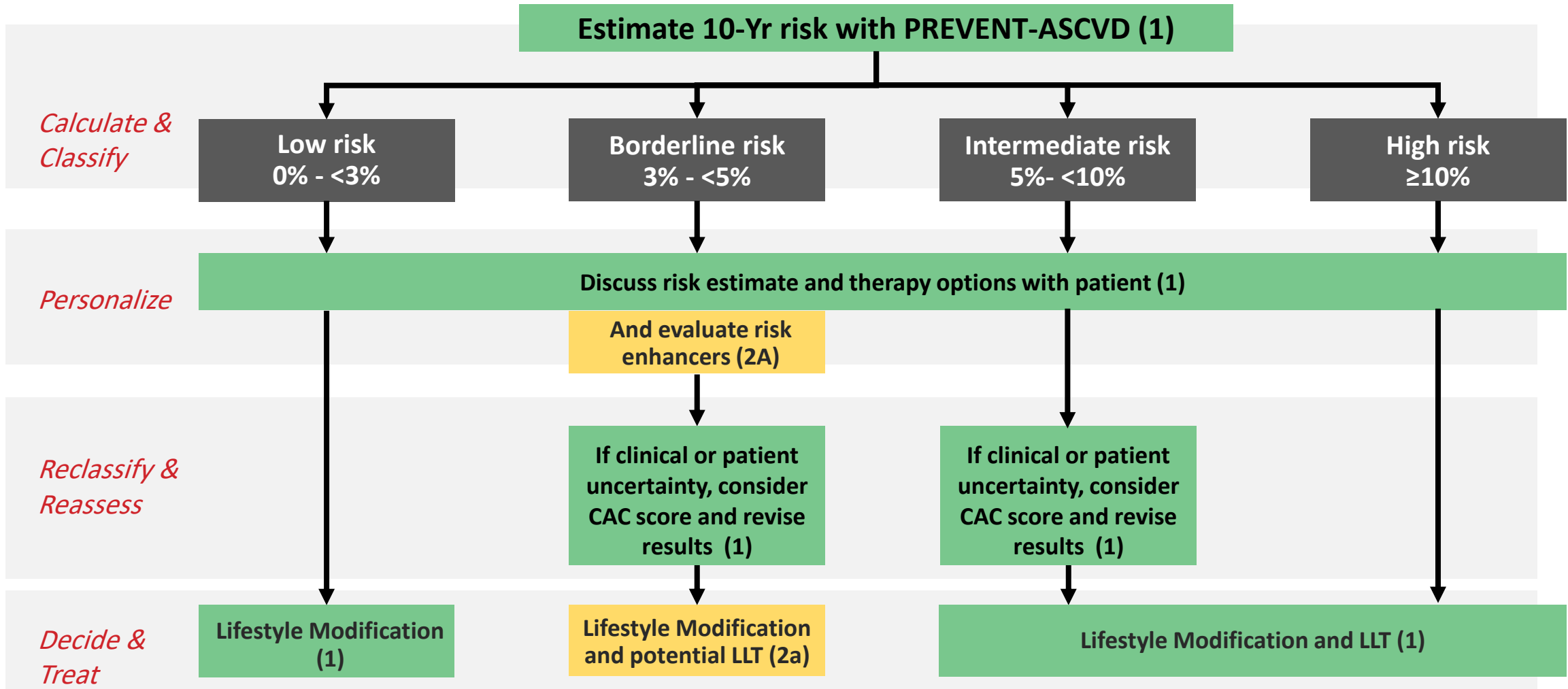
# PREVENT-ASCVD Risk Calculator

| COR | RECOMMENDATIONS                                                                                                                                              |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1   | PREVENT-ASCVD equations should be used for risk assessment in adults aged 30-79 years without ASCVD or subclinical atherosclerosis, with LDL-C 70-189 mg/dL. |

| Approximate Equivalent Ranges of 10-yr ASCVD Risk Estimates |                         |               |
|-------------------------------------------------------------|-------------------------|---------------|
| RISK                                                        | POOLED COHORT EQUATIONS | PREVENT-ASCVD |
| Low                                                         | <5%                     | <3%           |
| Borderline                                                  | 5 - <7.5%               | 3 to <5%      |
| Intermediate                                                | 7.5 - <20%              | 5 to <10%     |
| High                                                        | ≥20%                    | ≥10%          |

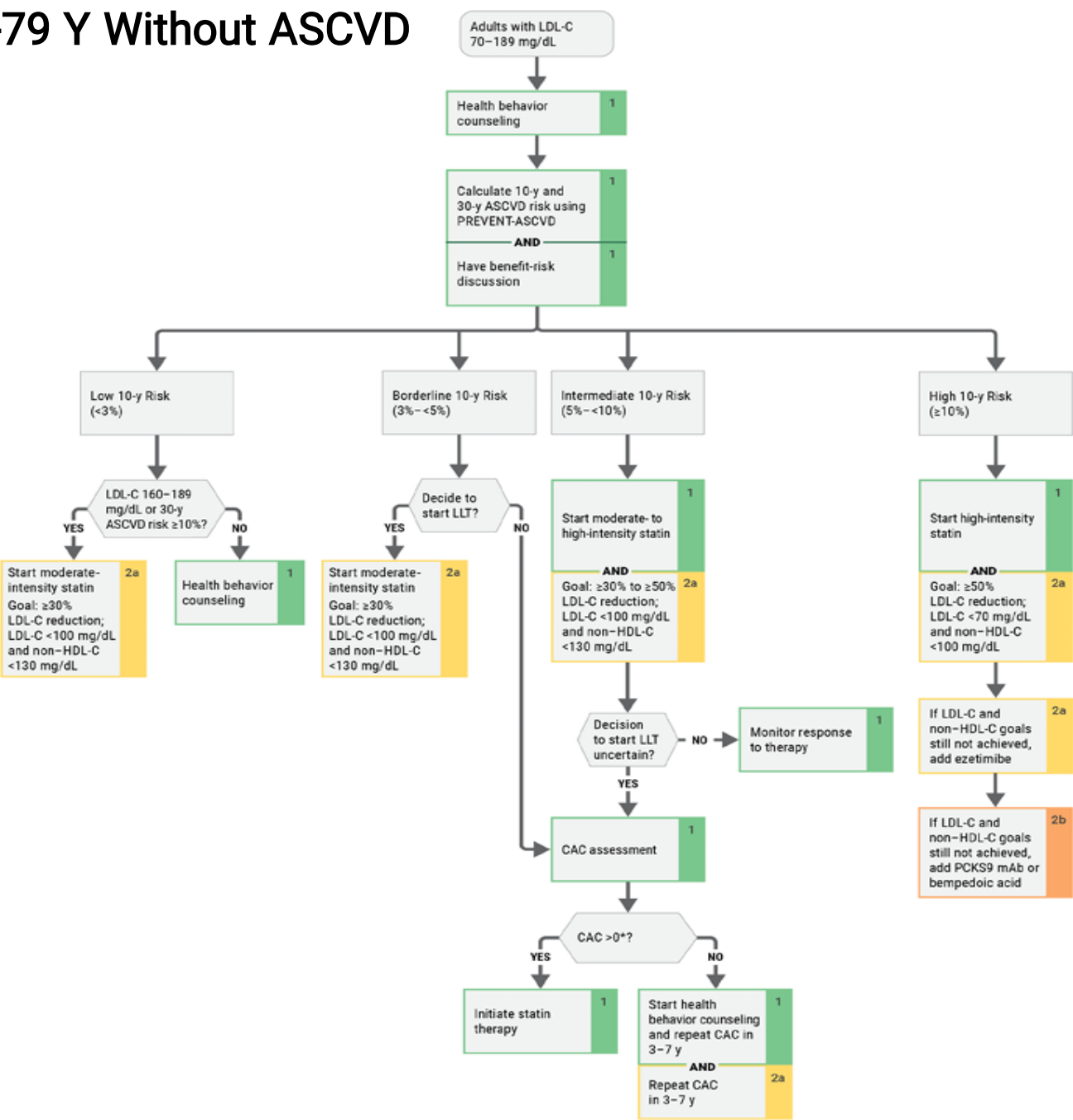


# Calculate, Personalize, Reclassify (CPR) Framework



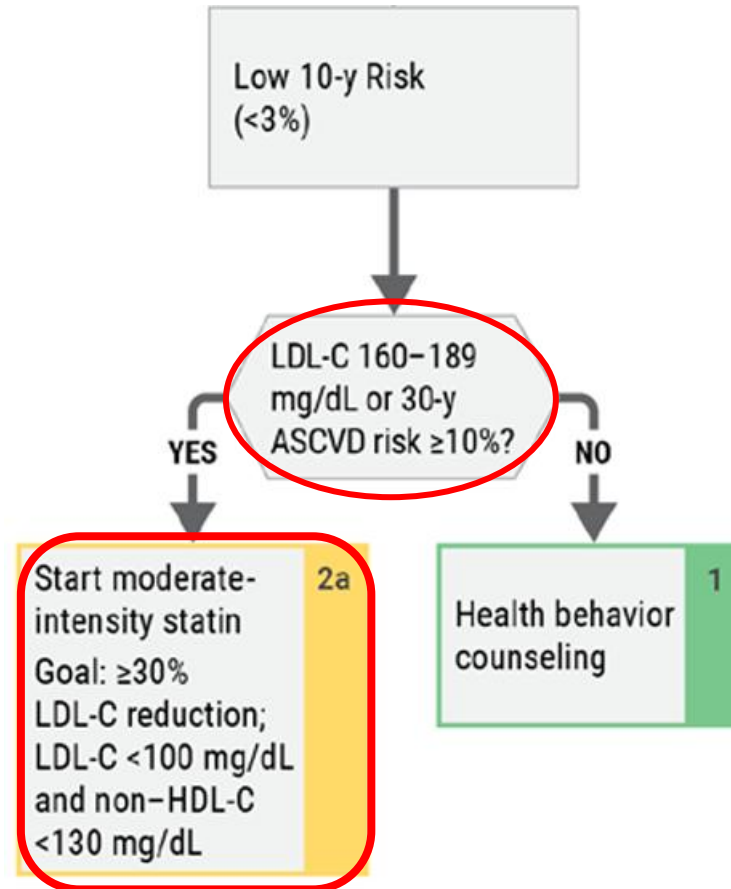
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# Primary Prevention in Adults 30-79 Y Without ASCVD



Circulation. 2026;153:e

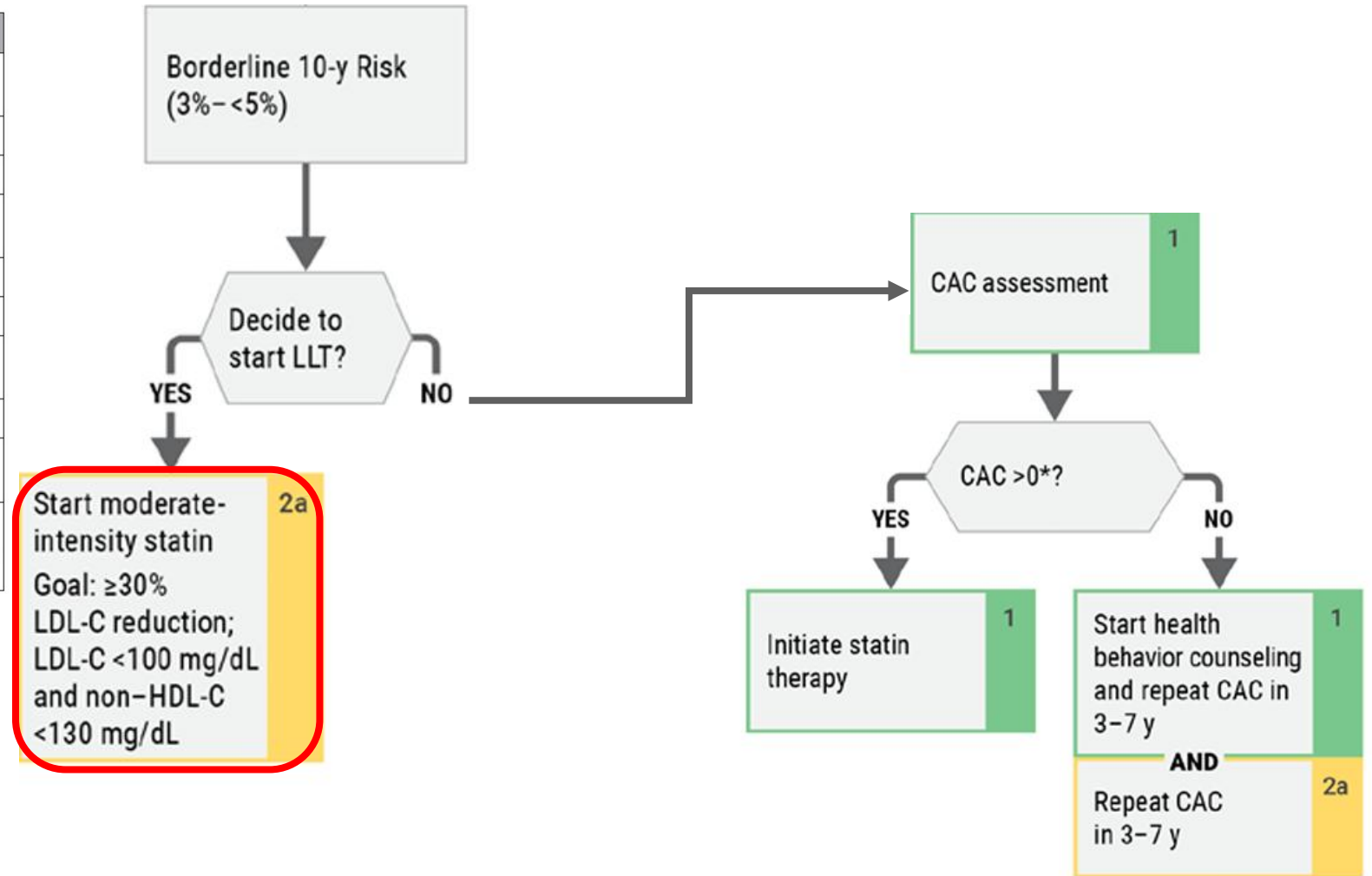
# Primary Prevention in Adults 30-79 Y Without ASCVD at Low 10-y Risk (<3%)



Circulation. 2026;153:e1154–e1276.

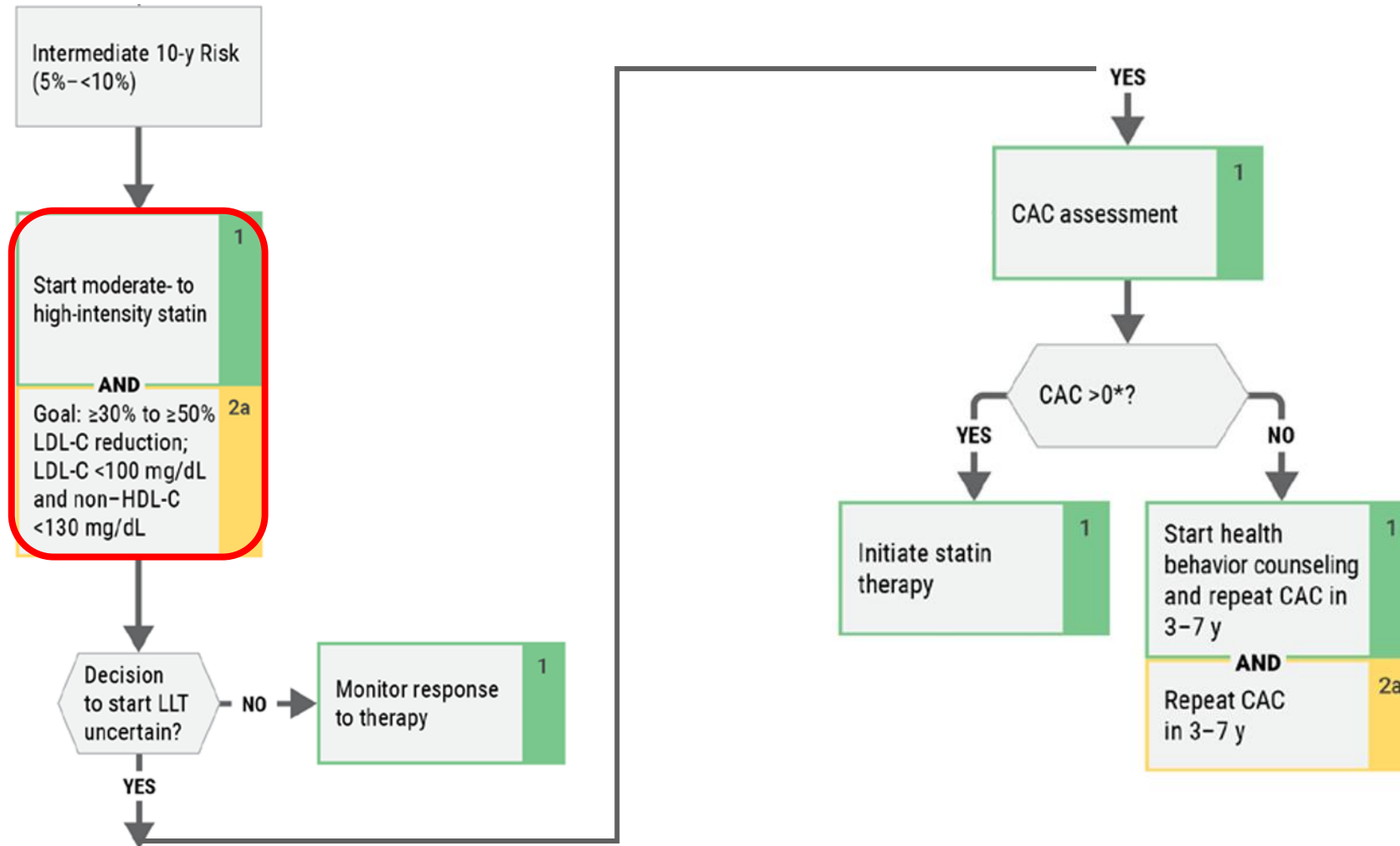
# Primary Prevention in Adults 30-79 Y Without ASCVD at **Borderline 10-y Risk (3% - <5%)**

| Risk Enhancers                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| History of premature ASCVD in a parent or sibling (onset age <55 y for men, <65 y for women)                                                                                 |
| Higher risk ancestry (eg, South Asian, Filipino)                                                                                                                             |
| High polygenic risk (if measured) (Section 4.2.3.5, "Polygenic Risk Scores")                                                                                                 |
| Chronic inflammatory diseases (eg, systemic lupus, rheumatoid arthritis, advanced psoriasis, inflammatory arthritis)                                                         |
| Lp(a) $\geq 125$ nmol/L or $\geq 50$ mg/dL                                                                                                                                   |
| hsCRP $\geq 2$ mg/L on $>1$ occasion (if measured)                                                                                                                           |
| TG persistently $\geq 175$ mg/dL (2 mmol/L) (if nonfasting) and $\geq 150$ mg/dL (1.7 mmol/L) (if fasting)                                                                   |
| CKM syndrome                                                                                                                                                                 |
| LDL-C persistently $\geq 160$ – $189$ mg/dL (4.1–4.9 mmol/L), non-HDL-C $\geq 190$ – $219$ mg/dL or apoB $\geq 120$ mg/dL*                                                   |
| Reproductive risk markers (premature menopause, preeclampsia, gestational diabetes, gestational hypertension, preterm delivery; Section 4.2.3.4, "Reproductive Risk Marker") |



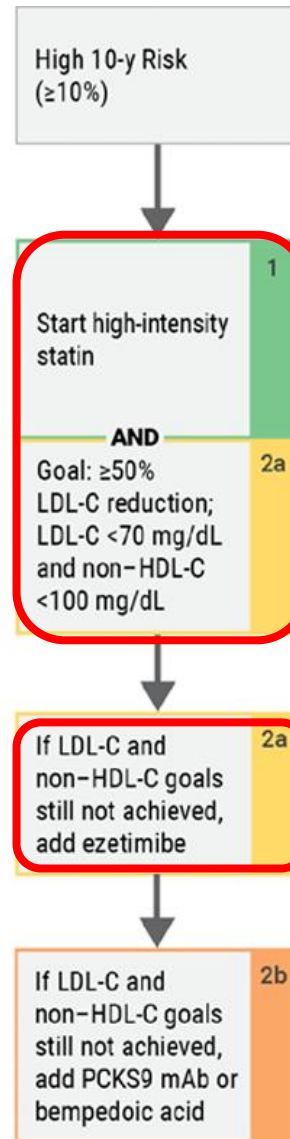
Circulation. 2026;153:e1154–e1276.

# Primary Prevention in Adults 30-79 Y Without ASCVD at Intermediate 10-y Risk (5% - <10%)



Circulation. 2026;153:e11154-e1276.

# Primary Prevention in Adults 30-79 Y Without ASCVD at High 10-y Risk ( $\geq 10\%$ )



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# Lipoprotein Goals for ASCVD Risk Reduction

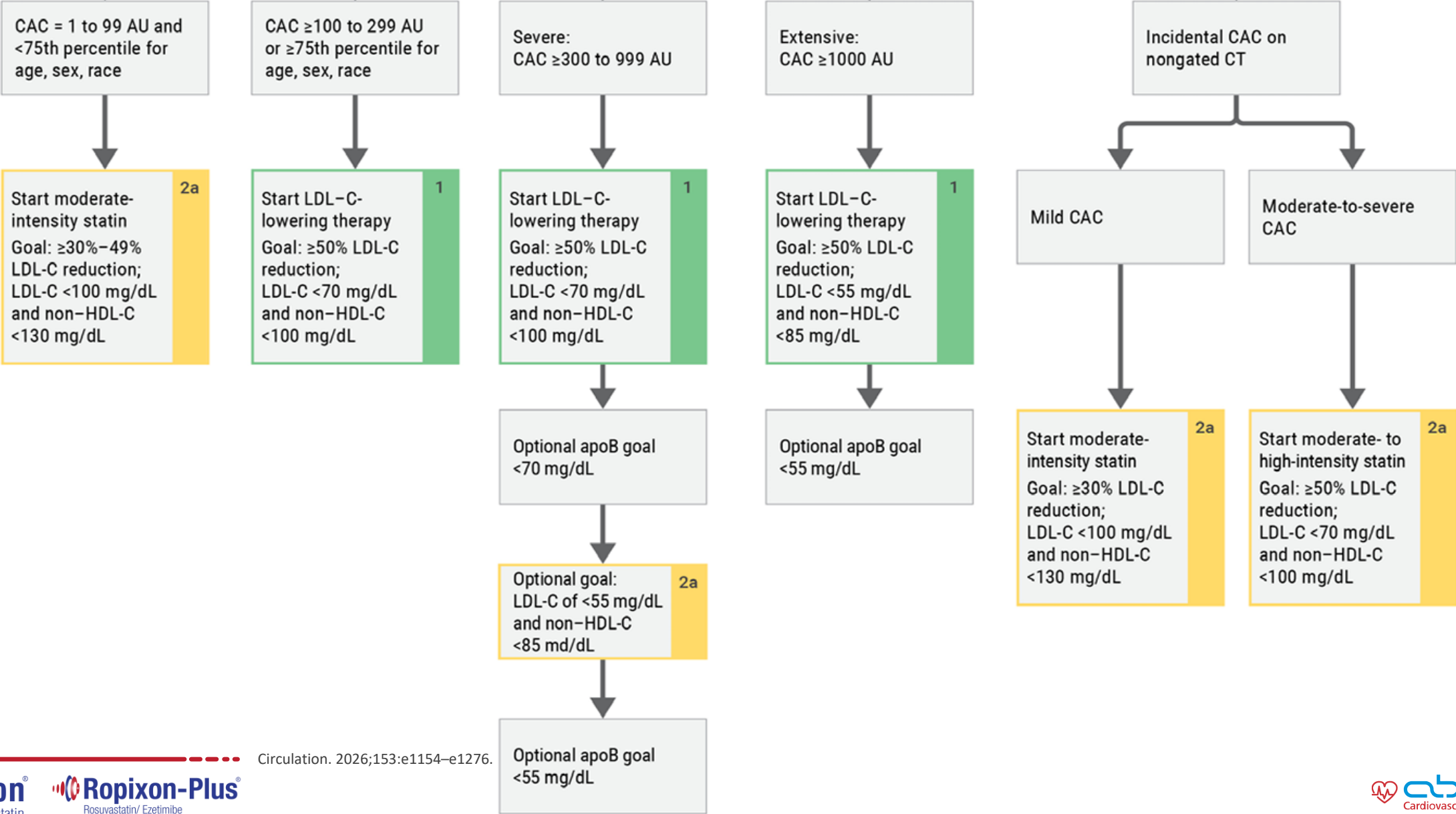
|                    |                                                                                                                             |                                                                                                                             |                                               |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| Patient population | LDL-C <100 mg/dL<br>AND<br>Non-HDL-C <130 mg/dL                                                                             | LDL-C <70 mg/dL<br>AND<br>Non-HDL-C <100 mg/dL                                                                              | LDL-C <55 mg/dL<br>AND<br>Non-HDL-C <85 mg/dL |
| Primary prevention | PREVENT-ASCVD < 10% <ul style="list-style-type: none"><li>If TG ≥ 150 mg/dL to 499 mg/dL, apoB goal: &lt;90 mg/dL</li></ul> | PREVENT-ASCVD ≥ 10% <ul style="list-style-type: none"><li>If TG ≥ 150 mg/dL to 499 mg/dL, apoB goal: &lt;70 mg/dL</li></ul> | N/A                                           |

Circulation. 2026;153:e1154–e1276.



**Patients with Subclinical  
Coronary Atherosclerosis  
(Men  $\geq 40$  or Women  $\geq 45$   
Years), Benefit from  
Ropixon®**

# Managing Adults with Subclinical Atherosclerosis

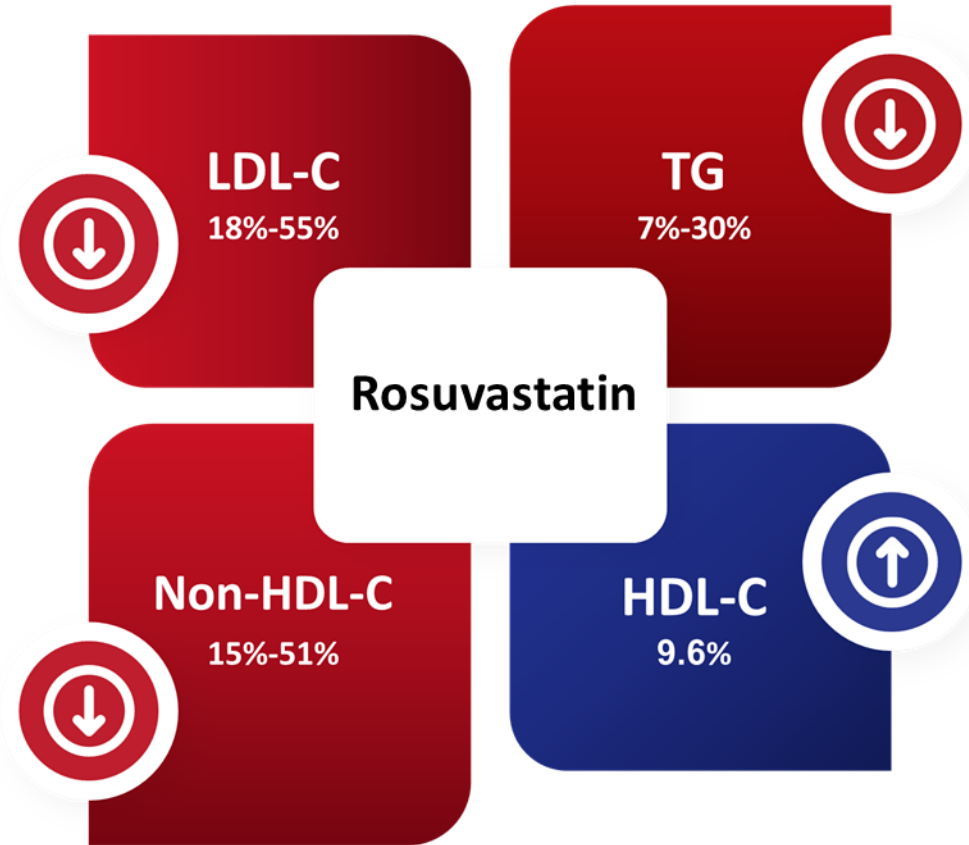


Circulation. 2026;153:e1154–e1276.

# Lipoprotein Goals for ASCVD Risk Reduction

| Patient population          | LDL-C <100 mg/dL<br>AND<br>Non-HDL-C <130 mg/dL                       | LDL-C <70 mg/dL<br>AND<br>Non-HDL-C <100 mg/dL                                                                                                                                                                                                                    | LDL-C <55 mg/dL<br>AND<br>Non-HDL-C <85 mg/dL |
|-----------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| Subclinical atherosclerosis | CAC = 1-99 AU and <75 <sup>th</sup> percentile for age, sex, and race | <ul style="list-style-type: none"> <li>• CAC ≥ 100 to 299 AU or ≥75<sup>th</sup> percentile for age, sex, and race</li> <li>• CAC ≥ 300 to 999 AU<br/>– Optional goal: LDL-C &lt;55 mg/dL, non-HDL-C &lt;85 mg/dL, and consider apoB goal &lt;55 mg/dL</li> </ul> | CAC ≥ 1000 AU                                 |

# Statins as cornerstone drugs due to the comprehensive effects on lipid profile

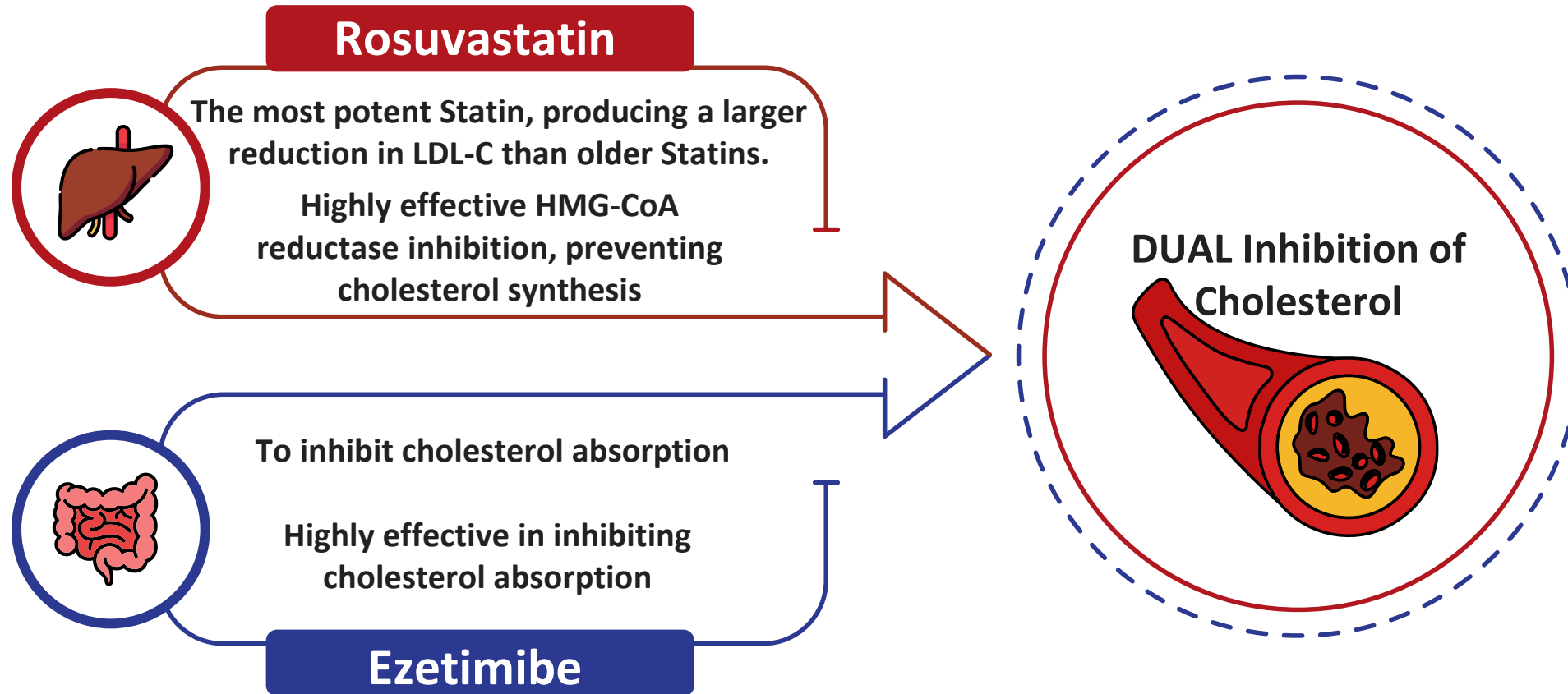


Rosuvastatin significantly improve blood lipid profile by lowering LDL-C, Non-HDL-C and TG levels and increasing HDL-C levels.



**Ropixon-Plus**  
(Rosuvastatin/Ezetimibe)  
**Single Pill Combination**

# Dual Inhibition, Providing Complementary Action Against Cholesterol



# Ropixon-Plus: One Pill, Dual Mechanisms for More Effective LDL-C Goal Achievement

## Effects on Lipids

**Rosuvastatin**

**Ezetimibe**

High-intensity therapy: LDL-C reduction  $\geq 50\%$

Moderate-intensity therapy: LDL-C reduction 30–50%

LDL-C reduction (monotherapy): 15–22%

LDL-C reduction (added to statin therapy): 21–27%

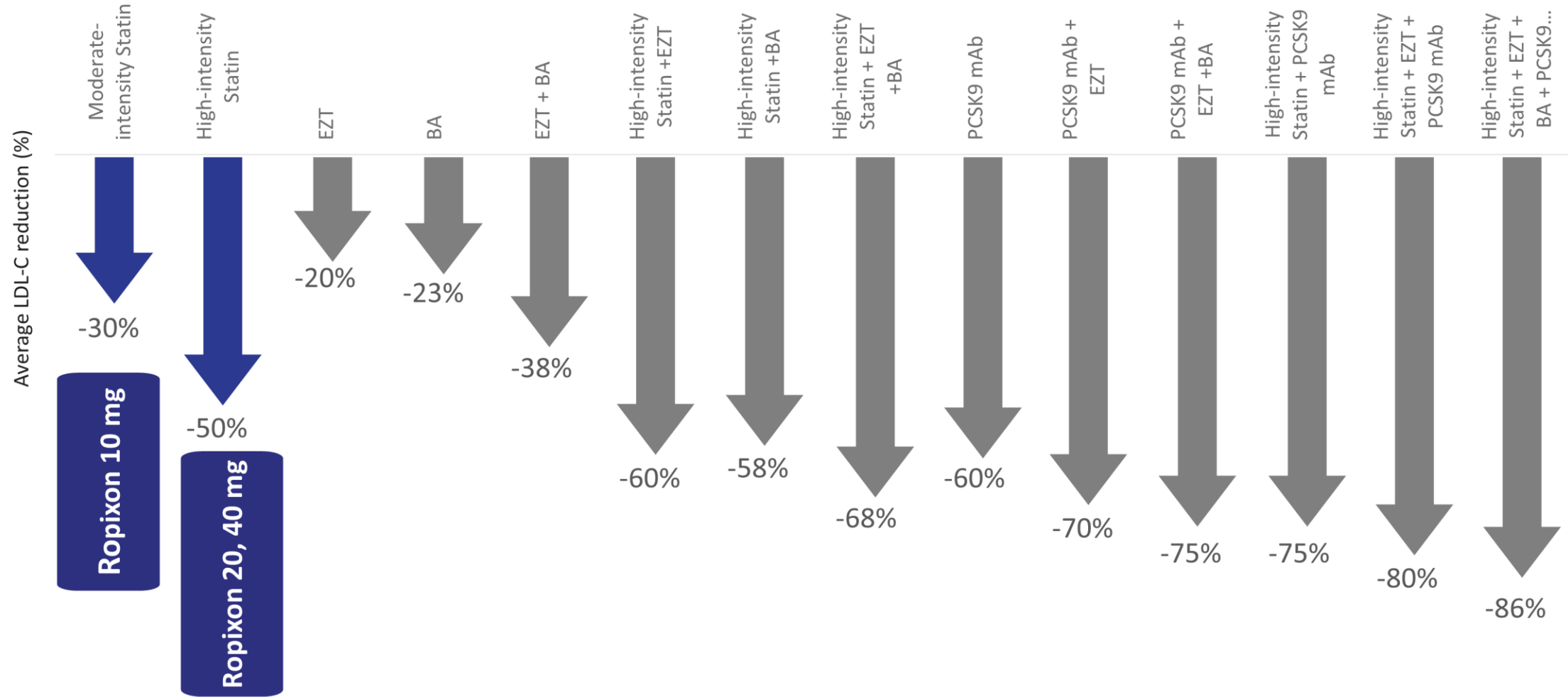
# When to choose Ropixon-Plus?

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## Prevention of cardiovascular diseases in adults with hyperlipidemia:

- Adults who have **not achieved LDL-C treatment** goals with the maximum tolerated dose of Rosuvastatin or Atorvastatin<sup>1</sup>
- Replacement therapy for those on **separate Atorvastatin or Rosuvastatin plus Ezetimibe**<sup>1</sup>
- Initiation in patients with **acute coronary syndrome**<sup>1</sup>
- Initiation in patients with **familial hypercholesterolemia**<sup>2</sup>

# Average LDL-C lowering of proven cardiovascular benefit

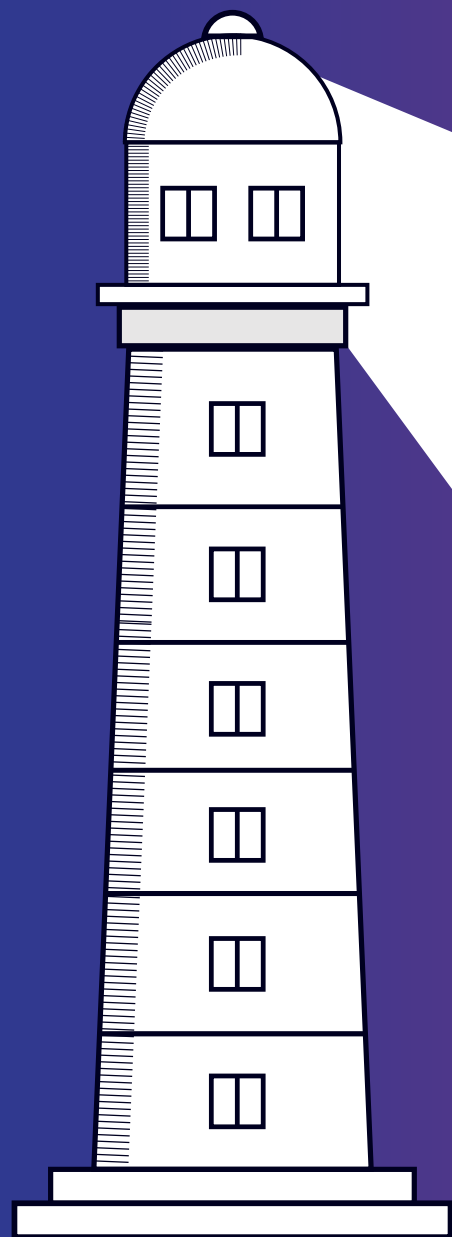


Eur Heart J. 2026 Feb 11;47:697.

# Lipoprotein Goals for ASCVD Risk Reduction

| Patient population          | LDL-C <100 mg/dL (2.6 mmol/L)<br>Non-HDL-C <130 mg/dL (3.4 mmol/L)                       | LDL-C <70 mg/dL (1.8 mmol/L)<br>Non-HDL-C <100 mg/dL (2.6 mmol/L)                                                                                                             | LDL-C <55 mg/dL (1.4 mmol/L)<br>Non-HDL-C <85 mg/dL (2.2 mmol/L) |
|-----------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| Primary prevention          | PREVENT-ASCVD <10%<br>• If TG ≥150 mg/dL to 499 mg/dL,<br>apoB goal: <90 mg/dL           | PREVENT-ASCVD ≥10%<br>• If TG ≥150 mg/dL to 499 mg/dL,<br>apoB goal: <70 mg/dL                                                                                                | N/A                                                              |
| Severe hypercholesterolemia | Without FH, ASCVD risk factors, and subclinical atherosclerosis                          | With FH, ASCVD risk factors, or subclinical atherosclerosis                                                                                                                   | Severe hypercholesterolemia or HeFH with clinical ASCVD          |
| Diabetes                    | Without ASCVD risk factors or diabetes-specific risk modifiers<br>• apoB goal: <90 mg/dL | With ASCVD risk factors or diabetes-specific risk factors<br>• apoB goal: <70 mg/dL                                                                                           | N/A                                                              |
| Subclinical atherosclerosis | CAC = 1–99 AU and <75th percentile for age, sex, and race                                | • CAC ≥100 to 299 AU or ≥75th percentile for age, sex, race<br>• CAC ≥300 to 999 AU<br>◦ Optional goal: LDL-C <55 mg/dL, non-HDL-C <85 mg/dL and consider apoB goal <55 mg/dL | CAC ≥1000 AU                                                     |
| Hypertriglyceridemia        | <50 y old with no additional risk enhancers                                              | • With clinical ASCVD not at very high risk<br>◦ apoB goal: <70 mg/dL<br>• Age 40–75 y with ≥1 ASCVD risk factor<br>◦ apoB goal: <70 mg/dL                                    | With clinical ASCVD at very high risk<br>• apoB goal: <55 mg/dL  |
| Clinical ASCVD              | N/A                                                                                      | Not at very high risk<br>• Optional goal: LDL-C <55 mg/dL, non-HDL-C <85 mg/dL and consider apoB goal <55 mg/dL                                                               | • At very high risk<br>◦ apoB goal: <55 mg/dL<br>• With CKD      |

Circulation. 2026;153:e1154–e1276.



# Let's Have a Case

# Case Presentation 1

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A 57-year-old gentleman with hypertension history came for his concern about his Cholesterol number. He had MI 5 weeks ago and discharged with Atorvastatin 80 mg. His current LDL-C is 100 mg/dL.

- What is the next plan for his LDL-C management?
  - a. Switch to Ropixon 40, once daily
  - b. Switch to Ropixon-Plus 20/10, once daily
  - c. Switch to Ropixon-Plus 40/10, once daily
  - d. Option b, with follow-up visit after 8 weeks

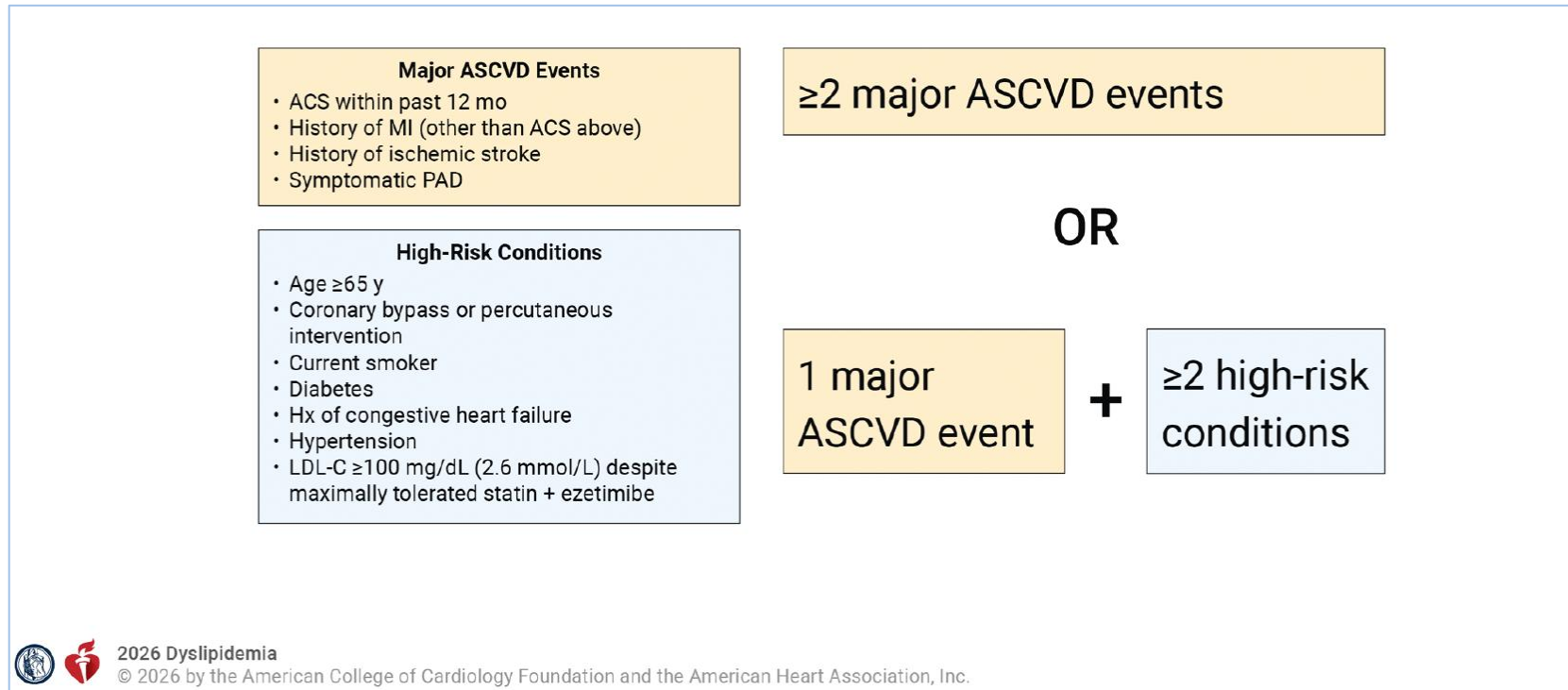
# Lipoprotein Goals for ASCVD Risk Reduction

| Patient population          | LDL-C <100 mg/dL (2.6 mmol/L)<br>Non-HDL-C <130 mg/dL (3.4 mmol/L)                       | LDL-C <70 mg/dL (1.8 mmol/L)<br>Non-HDL-C <100 mg/dL (2.6 mmol/L)                                                                                                             | LDL-C <55 mg/dL (1.4 mmol/L)<br>Non-HDL-C <85 mg/dL (2.2 mmol/L) |
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| Clinical ASCVD              | N/A                                                                                      | Not at very high risk<br>• Optional goal: LDL-C <55 mg/dL, non-HDL-C <85 mg/dL and consider apoB goal <55 mg/dL                                                               | • At very high risk<br>◦ apoB goal: <55 mg/dL<br>• With CKD      |

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# The majority of patients with clinical ASCVD are likely to be at very high risk

## Clinical ASCVD: Criteria for Defining “At Very High Risk” in Adults



ACS indicates acute coronary syndrome; ASCVD, atherosclerotic cardiovascular disease; Hx, history; LDL-C, low-density lipoprotein cholesterol; MI, myocardial infarction; and PAD, peripheral artery disease.

# Clinical ASCVD is an indication for Ropixon®

## Treatment approach:

Initiate Ropixon® 20–40 mg for most patients with ASCVD.

| Clinical ASCVD     | Goal                                           |
|--------------------|------------------------------------------------|
| At very high risk  | LDL-C <55 mg/dL<br>and<br>non-HDL-C <85 mg/dL  |
| Not very high risk | LDL-C <70 mg/dL<br>and<br>non-HDL-C <100 mg/dL |

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# Clinical ASCVD is an indication for Ropixon®

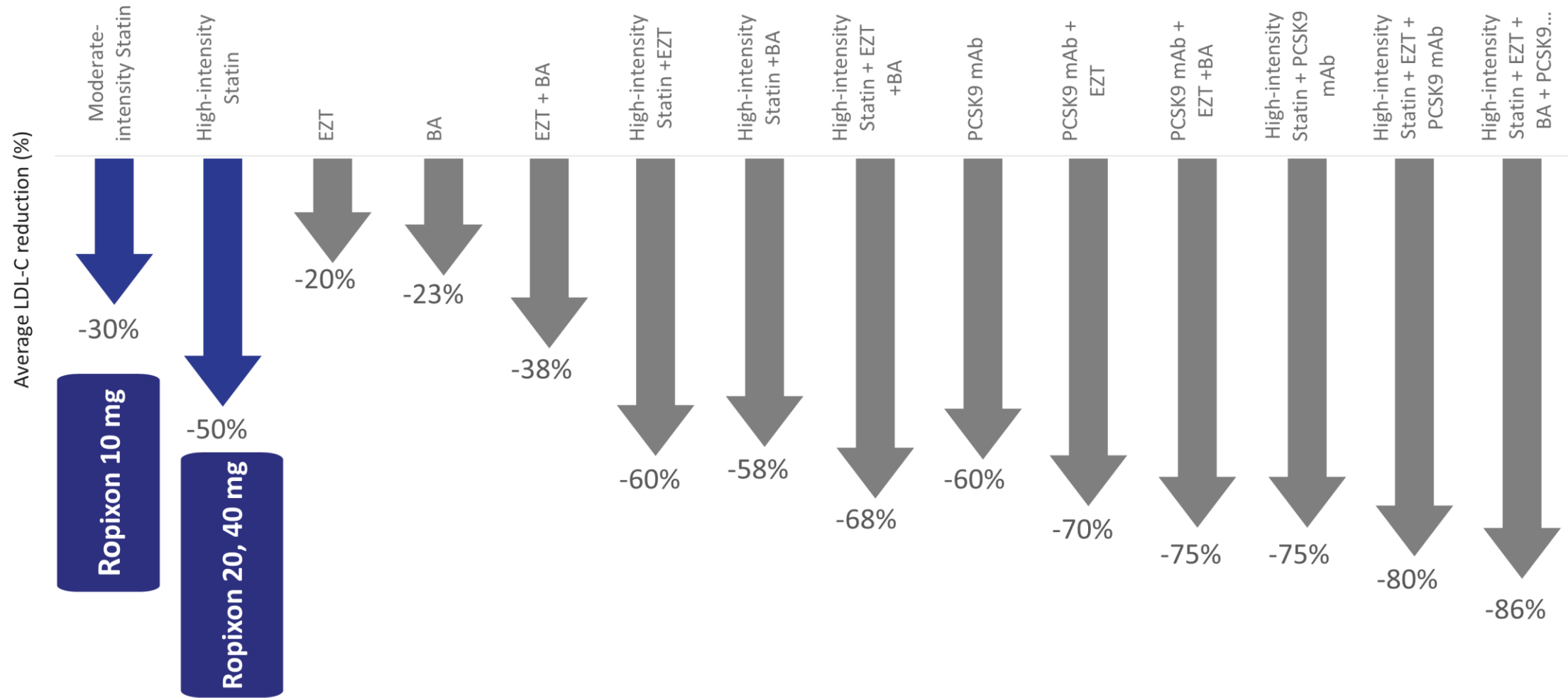
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# Average LDL-C lowering of proven cardiovascular benefit



Eur Heart J. 2026 Feb 11;47:697.

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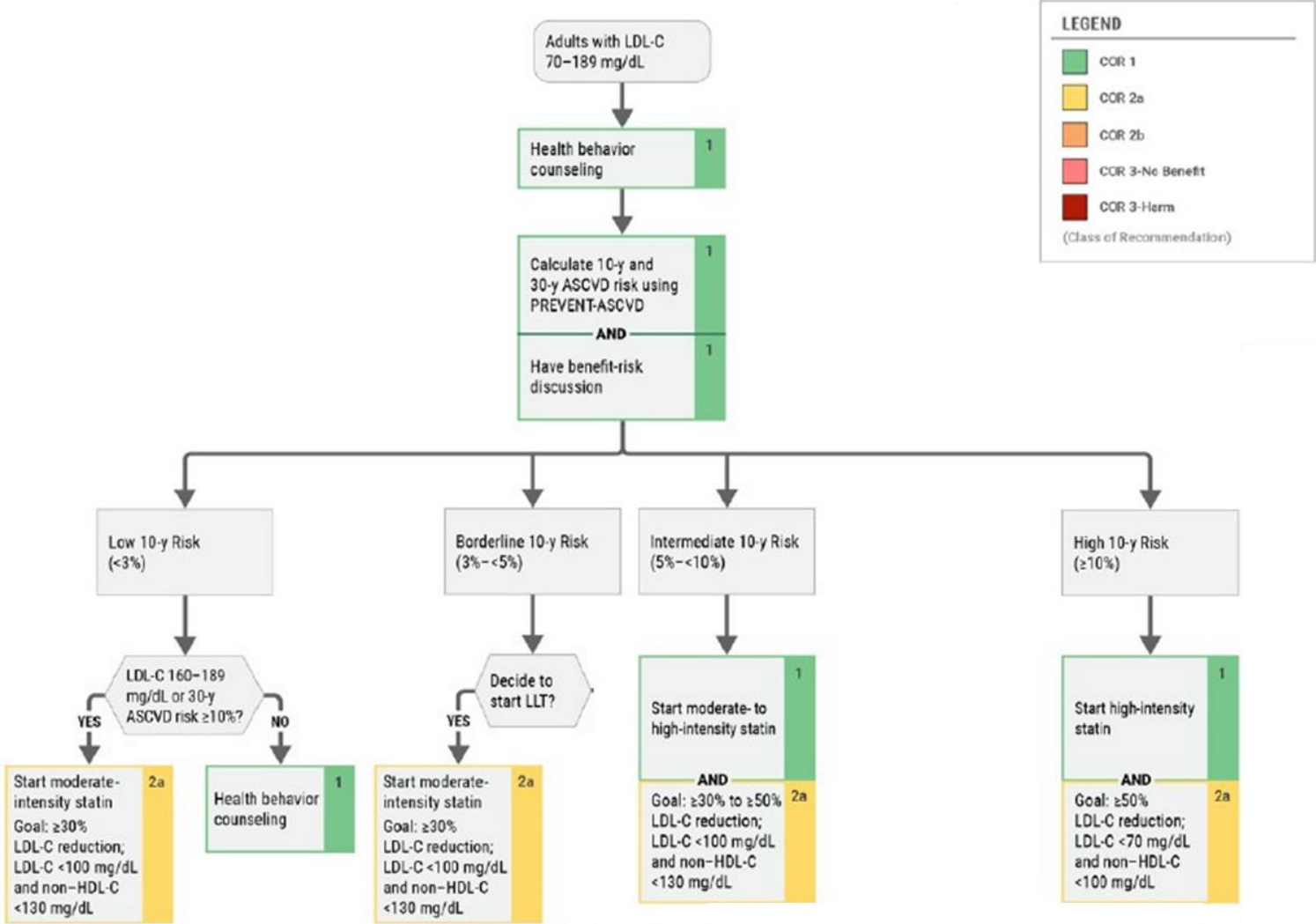
## Case Presentation 2

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A 49-year-old male, current smoker, presented for an annual occupational health screening. He has no history of atherosclerotic cardiovascular disease (ASCVD), diabetes mellitus (DM), or hypertension (HTN). Laboratory findings are as follows: total cholesterol 238 mg/dL, LDL-C 125 mg/dL, HDL-C 30 mg/dL, and eGFR 93 mL/min/1.73m<sup>2</sup>. His BMI is 34.5 kg/m<sup>2</sup>.

- What is the recommended management plan for his dyslipidemia?
  - a. No treatment is needed because LDL-C is below 130 mg/dL
  - b. Start life style modification
  - c. Start high-intensity Statin therapy immediately
  - d. Perform 10-year ASCVD risk assessment based on PREVENT calculator

# Primary prevention in adults 30-79 Y without ASCVD



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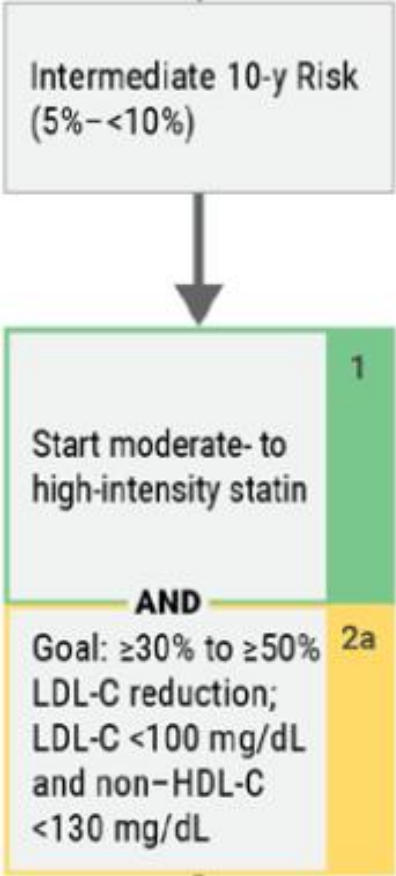
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- After risk calculation (10-year ASCVD= 5.9%) which of the following should be considered?
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# Ropixon-Plus<sup>®</sup>

Rosuvastatin/ Ezetimibe



Endeavor to an Atherosclerosis-Free Life

# **Ropixon**<sup>®</sup>

Rosuvastatin

*Endeavor to  
ASCVD-Free Life*



A dramatic night scene featuring a white lighthouse with a black top, perched on a dark, jagged rock formation. A powerful beam of light from the lighthouse's lantern room illuminates a white motorboat as it moves through the dark water towards the viewer. The surrounding cliffs are also rugged and dark, with some areas catching the light from the lighthouse. The sky is a deep blue, filled with numerous stars, creating a serene yet powerful atmosphere.

Thank You for  
Your Attention