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<https://reachmd.com/programs/cme/extra-innings-sustaining-victory-beyond-the-first-game/56439/>

Released: 06/08/2026

Valid until: 06/08/2027

Time needed to complete: 48m

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Extra Innings – Sustaining Victory Beyond the First Game

Announcer:

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Dr. Malachowski:

Hello, I'm Dr. Malachowski. Here with me today is Dr. Randy Englert. Today, we're talking about long-term management strategies for ASCVD.

Randy, why is it important to plan for extra innings and to be prepared for long-term lipid management in patients with ASCVD?

Dr. Englert:

Well, our patients with very high risk for recurrent ASCVD, these are patients that have very high risk for recurrent events and therefore have the most to gain from optimal control of their cardiovascular risk factors. When you're looking at patients who are considered very high risk for recurrent events, they are 3 times more likely to have a recurrence than patients who are not considered at very high risk for recurrence.

Additionally, when you're looking within patients that are very high risk, those that have had 2 major ASCVD events were twice more likely to have a recurrence than those that are still at very high risk but have not had 2 major ASCVD events. This is a population with a substantial amount of risk that requires longitudinal care.

And so I know the focus of our discussions is going to be on lipid management, but this is a population of patients where we have to make sure we're optimizing control of all cardiovascular risk factors: hypertension, diabetes, making sure they're having healthy lifestyle, so eating a healthy Mediterranean diet, they're regularly exercising, their weight is under good control, and they're not smoking.

And so in addition, the long-term management of the lipids is going to ensure that you have a structured regimen for monitoring those lipids. At 4 to 12 weeks after intensification or initiation of statin therapy, you're going to want to recheck the lipid panel. Once your patients have your LDL at target, then you can swap to 6 to 12 months for checking. And that can be individualized. If you have a patient that's routinely at goal and they're adherent to their medications, maybe once a year is enough. If you have a patient that's closer to more borderline for their target or if you're worried about adherence, you can check more often at that 6-month mark.

And so even after you have your LDL at goal, there is still a residual lipid risk that persists for non-LDL atherogenic particles. And so your non-HDL, this serves as a secondary target that represents all the atherogenic lipoproteins. And so the goal for non-HDL when your patient is considered at very high risk, is less than 85, and for patients not at very high risk is less than 100.

Apolipoprotein B identifies patients with persistent atherogenic particle burden despite LDL control. And really think about this for patients that have diabetes or metabolic syndrome or persistent triglyceridemia. In your patients who have persistent hypertriglyceridemia despite statin therapy should also consider icosapent ethyl.

And so remember, your patients with ASCVD, the risk is not static. Patients initially present with an event and then may subsequently develop more comorbidities—diabetes, heart failure, kidney disease—or experience another ischemic event, and these may reclassify them into a higher risk. And so you have to not only get your LDL at target but constantly be reassessing your patient's risk chronically.

Dr. Malachowski:

Those are some great insights, Randy. And as discussed, managing ASCVD is really a long game that sometimes can involve some extra innings. To set our organizations and our patients up for success, there are some systems-based approaches that can help ensure your team is ready for those longer games and maybe even a double-header or 2.

Some optimizations that can occur in the EMR, some of our colleagues at Yale have developed the PROMPT-Lipid EMR integration. We have PROMPT-Lipid here at Ochsner Health, and it helps standardize our identification of patients, as well as helping to ensure we're appropriately checking labs and ordering agents that are going to provide the greatest benefit to our patients.

There are also ways to create registries that identify these patients and ensure that we're able to follow them longitudinally but also see how the organization does with our long-term outcomes. How effectively are we getting their LDLs to goal, and then how is that translating into improved patient care? Are we able to drive some of those other key ASCVD outcomes with our management strategies? And where do we need better change-management operations and additional PDSA cycles to ensure we're getting the most bang for our buck?

And finally, good pharmacist follow-up can also support the team in those longer innings, being able to contact the patient, make sure that they're not having side effects, make sure that they're able to afford their medication, and make sure they really understand the why behind these care decisions. That's going to help ensure that the patients are following the strategy and that they feel engaged in the process to get you through to the bottom of the ninth.

Randy, any other insights or additions you'd like to add to that?

Dr. Englert:

I'd just like to elaborate further on the point-of-care tools. And so these tools are useful at the bedside when you're having the discussions with the patient. So not only is it the reminder to check the lipids, to intensify the regimen, but it's something that's also actionable, and so more than just an alert. So something that allows you to, within 1 or 2 clicks, recognize that the patient's LDL was above goal and take an action for it. And so tools like that are going to be the most benefit for patients, especially if you're making this easier for the docs at the bedside.

Dr. Malachowski:

Excellent. Well, that's it for us batting tonight. Thanks so much for the excellent discussion, and we'll see you again next time.

Announcer:

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