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Unmasking Hidden Risk: The Role of Lp(a) in Cardiovascular Risk Assessment

Announcer:
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Dr. Gluckman:
Welcome to CME on ReachMD. I'm Dr. Ty Gluckman.

Dr. Wadhera:
And I'm Dr. Rishi Wadhera.

Dr. Gluckman:
In this episode, we're going to talk about the role of lipoprotein(a) in cardiovascular risk assessment. So I suspect that for all of you listening, you're hearing more and more about lipoprotein(a) than maybe you ever have before, despite the fact that we've known that it's been a risk factor for thrombosis, clotting, cardiovascular events, the development of atherosclerosis, and even the development of calcific aortic stenosis for decades. Lipoprotein(a) is distinct from LDL cholesterol, but nonetheless enriches the risk for individuals having premature events or cardiovascular disease. It is important to realize that lipoprotein(a) is genetically predetermined, and therefore individuals who have been found to have elevated lipoprotein(a) levels do warrant communicating that to their relatives to appropriately get cascade testing as a result.

We know that there are varying levels of elevation of lipoprotein(a), the higher the level, the higher the cardiovascular risk. And it's estimated that in the US, as many as 20 to 25% of individuals have elevated lipoprotein(a) levels.

Now, part of the challenge in getting people tested for lipoprotein(a) is that there is not uniformity across professional societies as to who should get tested. Historically, we've consolidated a lot of our testing in individuals that have premature atherosclerosis or a family history of atherosclerotic cardiovascular disease. But I think globally, there is an increased push to have all individuals undergo testing once in their lifetime. And for most individuals, at least as of today, there shouldn't be the necessity to do repeat testing. We may have to revisit that as we have new drug therapy to lower LP(a) in the future.

Despite the increased push to test more individuals, we see in large observational recent analyses that most at-risk individuals have not had a lipoprotein(a) level tested. And even in some recent data amongst those with established atherosclerotic cardiovascular disease, we'll see LP(a) testing of fewer than 5% of individuals. And so a challenge as we have new therapies in development is identifying eligible individuals potentially for those therapies, if they've never actually been tested.

It is important to realize that there are some therapies that we use today that can actually lower LP(a). Statins, you might find surprising, actually modestly increase LP(a) levels. Nonetheless, you should still be using it in your patients with atherosclerotic cardiovascular disease. And the one therapy to call out are, in particular, the PCSK9 inhibitors that can lower LP(a) levels by about 20 to 25%, and at least with the monoclonal antibodies are felt to contribute to the cardiovascular risk reduction that's been associated with this drug class.

There is a lot of excitement about an array of largely injectable agents that are in development to lower LP(a). We know that for many of these drugs, they've been shown to very meaningfully lower LP(a), and we're awaiting the cardiovascular outcomes trial data to help us better understand whether the meaningful reduction in LP(a) translates into cardiovascular risk reduction.

And so Rishi, as we think about adding yet another complimentary cardiovascular potentially risk-reducing therapy to our armamentarium, we don't have that data yet, how do you think about the challenges in rural settings, given the fact that a majority of these drugs are injectable?

Dr. Wadhera:
Yeah, thanks, Ty. It's a great point. And I think we just need to remember that people living in rural communities face barriers accessing lab testing and longitudinal outpatient care, which creates barriers when it comes to a new test like LP(a). So if a patient is in your office and lives in a rural community, and you're sending off a lipid panel, it's probably worth thinking about whether they are someone that you should send an LP(a) level off on too.

I'll also just building on your point about the upcoming trials, outcomes trials, as it pertains to reducing LP(a) levels with novel therapeutics, the intervals in which some of those newer therapeutics are administered vary anywhere from every month to every 3 months, which, of course, has important implications for how we think about, potentially depending on the outcomes trials, delivering these therapeutics to people in rural settings.

Dr. Gluckman:
I couldn't agree with you more. Those are great points, and it's been a great discussion, but unfortunately, our time is up. Thanks so much for listening.

Announcer:
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