



American
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Association.

Top Take-Home Messages for Geriatric Clinicians

Adapted from: 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA
Guideline on the Management of Dyslipidemia

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1. Use the PREVENT-ASCVD equations to estimate 10-year risk

Use the American Heart Association Predicting Risk of Cardiovascular Disease EVENTS (PREVENT™) equations instead of the prior Pooled Cohort Equations (PCE) for 10-year risk assessment to guide lipid-lowering therapy (LLT) in primary prevention in adults aged 30–79 years, including older adults aged 65–79 years (*Section 4.2.3.2*).

2. Primary prevention decisions about discontinuing LLT should be based on more than age

In older adults, the benefit-risk discussion should include patient priorities, functional status, multimorbidity, frailty, polypharmacy, and life expectancy and should not be based solely on chronological age (*Section 4.2.8.3*).

3. Consider lipid-lowering therapy for intermediate and high-risk adults ages 65–79 years

LLT for primary prevention of atherosclerotic cardiovascular disease (ASCVD) should be considered after a clinician–patient discussion for adults ages 65–79 years with a 10-year PREVENT-ASCVD risk estimate of between 5% and 10% (intermediate risk) and $\geq 10\%$ (high risk). In adults ages 75 years and older with an estimated life expectancy of at least 2.5 years, it may be reasonable to initiate moderate-intensity statin therapy after a clinician–patient discussion of potential benefits and risks to reduce ASCVD risk (*Sections 4.2.3.7 and 4.2.8.3*).

4. Coronary artery calcium scores of 10 or less may help reclassify older adults as lower risk

In adults ages older than age 75 with an estimated life expectancy of at least 2.5 years and for whom the decision regarding LLT is uncertain, it may be reasonable to measure coronary artery calcium (CAC). For those with a CAC score of 1–10 or no CAC, it may be reasonable to reclassify these patients as lower risk, which would avoid LLT (*Section 4.2.8.3*).

5. In secondary prevention, a goal of LDL-C <55 mg/dL is recommended for those at very high risk of ASCVD events

The majority of those with a history of clinical ASCVD events are likely to be at very high risk and qualify for an LDL-C goal of <55 mg/dL (*Section 4.2.6*).

6. Deprescribing LLT in patients with a life expectancy of <1 year is reasonable

In patients with a life expectancy of <1 year, it may be reasonable to discontinue LLT to avoid unnecessary medication use or adverse medication effects (*Section 4.2.8.3*).