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# Top Take-Home Messages for Women's Health 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. Reproductive history

Ask about adverse pregnancy outcomes, early menopause (<45 years of age), polycystic ovarian syndrome (PCOS), and other reproductive risk markers, because these are associated with higher ASCVD risk and they can be incorporated into cardiovascular risk assessment (*Section 4.2.3.4*).

## 2. Hypertriglyceridemia: Pregnancy and medications

Some medications, including oral estrogens (e.g., certain contraceptives and hormone therapies) and pregnancy (especially the third trimester), can increase triglyceride levels. In patients with persistently elevated triglycerides ( $\geq 150$  mg/dL), assess for secondary causes, monitor levels closely, and consider medication alternatives when clinically appropriate (*Section 4.2.9*).

## 3. Statins and pregnancy

For most patients planning pregnancy and not at high ASCVD risk, statins should be stopped 1–2 months before conception or as soon as pregnancy is recognized and discontinued for the duration of the pregnancy or while lactating. In pregnant patients with familial hypercholesterolemia (FH) or clinical ASCVD, continuing statin therapy may be reasonable after individualized clinician-patient discussion of risks and benefits, with preference for a hydrophilic statin (e.g., pravastatin) based on available clinical trial data (*Section 4.2.8.4*).

### 4. **Pregnancy-safe therapy**

Bile acid sequestrants are reasonable for lowering LDL-C in pregnancy, however, they should be avoided if triglycerides are  $\geq 300$  mg/dL due to risk of worsening hypertriglyceridemia. Severe hypertriglyceridemia ( $\geq 500$  mg/dL) may be treated with fibrates (after the first trimester) or high-dose omega-3 ethyl esters to reduce the risk of pancreatitis (*Section 4.2.8.4*).

### 5. **FH: Consider apheresis**

In pregnant or lactating patients with homozygous FH (HoFH), lipoprotein apheresis is reasonable to lower LDL-C and reduce ASCVD risk (*Section 4.2.8.4*).

### 6. **Lactation and lipid-lowering medications**

Most lipid-lowering therapies (including statins, ezetimibe, PCSK9 inhibitors, and fibrates) should be avoided while lactating, with bile acid sequestrants as a potential option, in consultation with the patient and including discussion about the benefits and possible risks (*Section 4.2.8.4*).

### 7. **Use clear patient messaging**

Counsel patients that pregnancy and reproductive history affect long-term cardiovascular risk and that medication and overall treatment plans should be adjusted before, during, and after pregnancy to protect both maternal and infant health (*Sections 4.2.3.4 and 4.2.8.4*).