American Heart Association.

Top Take-Home Messages for Pediatric 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. Promote lifelong heart-healthy behaviors starting in early childhood to lower cholesterol and improve cardiovascular health

Support your patients in consuming a healthy diet (emphasizing fruits, vegetables, nuts, legumes, whole grains, fiber, and monounsaturated or polyunsaturated fats), getting regular physical activity, achieving a healthy weight, avoiding nicotine exposure, getting the right amount of good quality sleep, and managing stress from early childhood through adulthood to reduce dyslipidemia and atherosclerotic cardiovascular disease (ASCVD) risk *(Section 4.1.1)*.

2. Screen all children and adolescents to identify lipid disorders such as familial hypercholesterolemia

Children aged 9–11 years not previously screened should have a lipid profile to identify familial hypercholesterolemia (FH) and other significant lipid disorders. Screening is recommended again at age 19 years and then at least every 5 years thereafter *(Section 3.1)*.

3. Children with a concerning family history can be screened for FH as early as age 2 years

It is reasonable for children with a first- or second-degree relative with premature ASCVD, severe hypercholesterolemia, or FH to be screened for lipid disorders starting at age ≥2 years (cascade screening) *(Section 3.1)*.

4. Nonfasting lipid levels are generally sufficient for lipid screening

Children and adolescents can be screened nonfasting; fasting is reserved for elevated triglycerides (TG ≥400 mg/dL), suspected disorders of triglyceride metabolism, or strong family history of hyperlipidemia. Non–high-density lipoprotein-cholesterol, or non-HDL-C (calculated as total cholesterol minus HDL-C) is reliable, whether fasting or not, and is a good reflection of lipid-related ASCVD risk. Routine advanced lipoprotein testing is not recommended in childhood *(Section 3.2)*.

5. Consider genetic testing for FH

Testing children with suspected FH using an FH genetic panel can be useful to confirm the diagnosis, guide cascade screening, and inform treatment *(Section 4.2.8.1)*.

6. The foundational treatment for pediatric dyslipidemias is lifestyle management

Lifestyle management is recommended for all children and adolescents with lipid abnormalities to improve low-density lipoprotein-cholesterol (LDL-C), TG, and non–HDL-C *(Section 4.2.8.1)*.

7. Lipid-lowering therapy is recommended for children and adolescents with familial hypercholesterolemia

Randomized controlled trials of statin use in children show significant LDL-C lowering with good short- and medium-term safety. In children aged ≥8 years with LDL-C ≥160 mg/dL and a presentation consistent with FH, statin therapy is recommended if 3–6 months of lifestyle therapy does not sufficiently lower LDL-C *(Sections 4.2.8.1 and 4.2.4.4)*.

8. Refer to a pediatric lipid specialist if homozygous FH (HoFH) is suspected, as there may be coronary obstruction in childhood

Most children with lipid disorders can be treated with lifestyle modification, and sometimes statins. However, individuals with HoFH can have significant heart disease in early childhood and require evaluation by a pediatric cardiologist and an experienced lipid specialist for aggressive lipid-lowering therapy at diagnosis. Individuals with severe or monogenic lipid disorders may similarly benefit from expert input *(Sections 4.2.3 [Table 9], 4.2.8.1, and 4.2.4.4)*.