

Potential implications of the 2026 ACC/AHA dyslipidemia guideline for family medicine practice in Türkiye

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Dear Editor,

The 2026 American College of Cardiology/American Heart Association (ACC/AHA) Dyslipidemia Management Guideline offers a more comprehensive, lifelong, risk-focused approach than previous guidelines. Key changes include earlier intervention to reduce lifelong exposure to atherogenic lipoproteins, replacing the Pooled Cohort Equations (PCE) with the Predicting Risk of Cardiovascular Disease Events—Atherosclerotic Cardiovascular Disease (PREVENT-ASCVD) equation, setting explicit LDL and non-HDL cholesterol targets, measuring Lipoprotein(a) (Lp(a)) once in adulthood, and selectively using Apolipoprotein B (Apo B) and coronary artery calcium (CAC) scores for risk assessment.^[1] The most significant feature of this guideline for family medicine in Türkiye is its potential to accelerate the transition from a focus on periodic risk assessment in middle age to a lifelong approach to risk accumulation. Dyslipidemia is a major public health issue affecting approximately one in every two people in Türkiye.^[2] However, in primary care, adults aged ≥40 years undergo cardiovascular risk

assessment through the Disease Management Platform (HYP) rather than disease-specific dyslipidemia assessment screening.^[3]

Transition from periodic risk assessment to lifetime risk assessment

The most significant implication of this guideline for family medicine in Turkey is the shift from risk assessment conducted after age 40 to a lifelong risk assessment. The new guideline recommends screening individuals with a family history of familial hypercholesterolemia, severe hypercholesterolemia, or a first/second-degree relative with early-onset ASCVD starting from age 2. If not previously evaluated, lipid profile screening between ages 9 and 11 is also suggested. In adults, screening begins at age 19.^[4] Current HYP cardiovascular risk assessment begins at age 40, potentially delaying identification of younger individuals with elevated lifetime lipid-related cardiovascular risk. Conducting opportunistic lipid screening prior to routine HYP eligibility assessments could help identify younger individuals at high risk.

Integration of biomarkers into family medicine

Another significant issue pertains to the integration of biomarkers into family medicine. The guideline recommends a single Lp(a) measurement in adulthood, ApoB-guided treatment, and CAC scoring for selected high-risk patients.^[5,6] In family medicine practice in Turkey, the use of CAC scores recommended by the guideline may be limited due to access to testing centers. In high-risk cases, gradually adopting Lp(a) and ApoB measurements in family medicine could be a more realistic starting point. National primary care guidelines, such as the 2026 Primary Care Diagnostic and Treatment Guidelines, may play an important role in adapting international recommendations to local clinical workflows.^[7]

LDL/Non-HDL target-oriented monitoring

Explicit targets for LDL and non-HDL cholesterol provide a clear framework for monitoring within primary care settings. The guideline recommends LDL targets of <100 mg/dL for borderline/moderate-risk individuals, <70 mg/dL for high-risk individuals, and <55 mg/dL (non-HDL <85 mg/dL) for very high-risk secondary prevention.^[1] Family medicine follow-ups can be made more structured, especially regarding statin adherence, dose titration, target-based stepwise intensification of lipid-lowering therapy, and timely referral of high-risk patients to higher levels of care. Considering our country's reimbursement policies for dyslipidemia treatments at the primary care level, the focus is expected to be on follow-up rather than on treatment itself.^[8]

Conclusion

In conclusion, the main contributions of the new dyslipidemia guideline to family medicine practice in Turkey include earlier assessment of dyslipidemia, the use of biomarkers in selected

patients, and more systematic follow-up based on LDL/non-HDL targets. The recommendations of this new guide should be evaluated in the context of national risk assessment strategies, health infrastructure, reimbursement policies, and local evidence.

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Conflict of interest

The author declare that there is no conflict of interest to disclose.

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