Spring 2026

GP Connect

Supporting best practice in cardio-metabolic health



Sydney Cardiology



From the editor – Dr Gunjan Aggarwal

Specialising in general adult cardiology and non-invasive cardiac imaging, particularly echocardiography and cardiac computed tomography (CT).

Welcome to the spring edition of GP Connect 2026.

This issue provides recent trial and guideline updates on renal denervation and lipid management.

There is also an excellent article by Dr Bill Petrellis summarising the current state of play regarding consumer health wearables like smartwatches and fitness bands. They have rapidly transitioned from lifestyle gadgets to common clinical touchpoints, offering continuous data collection that can help detect conditions like atrial fibrillation. However, these devices present significant challenges, including high rates of false positives, uncertain clinical outcomes for brief subclinical episodes, and a risk of triggering patient anxiety or "somatic preoccupation."

For general practitioners, managing this influx of patient-generated health data requires a balanced approach that avoids both uncritical acceptance and outright dismissal. Clinicians must use wearable alerts as conversation starters rather than diagnostic tools, confirming any irregularities with medical-grade ECG monitoring, assessing individual stroke risk factors, and helping patients contextualize normal physiological variations to prevent data overload and unnecessary healthcare utilization.

I hope you enjoy this edition of GP Connect. We remain available as always to provide continued care to you and your patients in any way possible.

Thank you for your continued support,
Dr Gunjan Aggarwal

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Smartwatches, heartbeats and the GP:

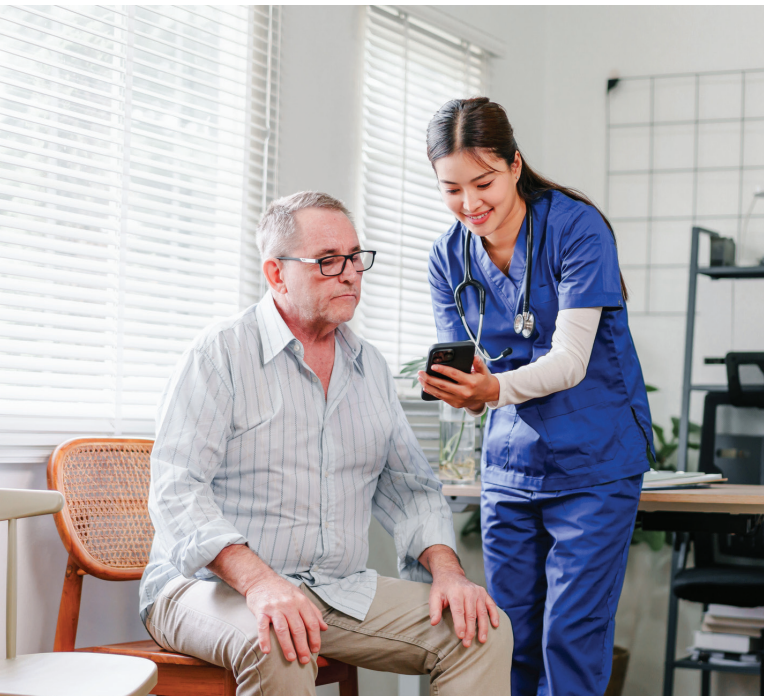


Dr Bill Petrellis

Specialising in general adult cardiology and electrophysiology, including atrial fibrillation and device implantation.

Walk into almost any waiting room and you will see them: patients glancing at their wrists or smartphones, scrolling through heart rates, step counts and sleep scores. Consumer wearable devices – smartwatches, fitness bands and health apps – have quietly embedded themselves into everyday life. Increasingly, they are also walking through the consulting room door.

A recent scientific statement published in the Journal of the American College of Cardiology takes a sober look at what this trend means for cardiovascular care. Its conclusion is neither breathless enthusiasm nor outright scepticism. For GPs, who sit at the frontline of cardiovascular risk detection and long-term management, the message is clear: wearables are here to stay, but they need to be handled thoughtfully.



From Novelty to Normality

Consumer mobile health technologies were initially marketed as lifestyle gadgets - tools for fitness enthusiasts or early adopters. That has changed rapidly. Modern devices can track heart rate continuously, estimate sleep quality, detect physical activity and, in some cases, record single-lead ECGs or flag possible arrhythmias.

Crucially, these data are collected outside the clinic, often continuously. This *patient-generated health data* has the potential to fill gaps left by episodic clinic visits. For cardiovascular disease, where symptoms can be intermittent and risk evolves silently over years, this is an appealing proposition.



The Promise: Earlier Signals and Engaged Patients

One of the strongest arguments in favour of wearables is their ability to capture physiological data in real-world settings. Unlike blood pressure measured once in a consulting room, wearable data reflect daily life - movement, stress, sleep and recovery.

For some patients, this information is empowering. Seeing step counts increase or resting heart rate fall can reinforce healthy behaviours. Wearables can improve physical activity levels and engagement with cardiovascular health, particularly when aligned with clinical goals rather than used in isolation.

The most talked-about application of wearables is atrial fibrillation (AF) detection. Many devices use photoplethysmography (PPG) to detect pulse irregularities, while some allow users to record a brief

ECG tracing. Large studies have demonstrated that wearables can identify previously undiagnosed AF, including asymptomatic episodes that would otherwise go unnoticed.



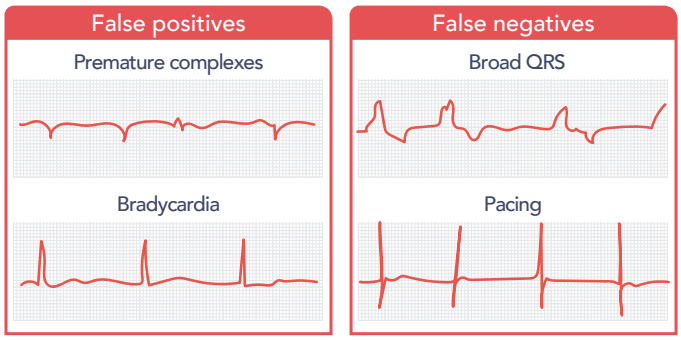
AF detection: Opportunity with Caveats

Atrial fibrillation is an ideal as a case study to illustrate the potential and the pitfalls of wearable technology.

On the positive side, wearables may identify irregular rhythms that prompt patients to seek medical review. They can capture events that occur outside clinic hours and provide a time-stamped record linked to symptoms. For patients with known AF, these captured events may help track recurrence or response to treatment.

However, the limitations are substantial. Wearables do not diagnose AF; they flag possible irregularity. False positives are common, particularly with motion artefact, high heart rates or ectopic beats. Conversely, false negatives can occur, especially with brief or intermittent episodes.

Challenges in automatic diagnosis of atrial fibrillation by a smartwatch ECG



Screening for AF: How Much Really Matters?



One of the most challenging questions raised by wearable technology is not whether atrial fibrillation can be detected more often, but whether detecting more AF actually improves outcomes. Direct-to-consumer wearables are likely to uncover far more short, asymptomatic AF episodes than traditional, clinician-prescribed monitoring. The clinical importance of these subclinical events, however, remains uncertain.

Evidence from studies using cardiac implantable electronic devices highlights this dilemma. In the ASSERT trial , brief episodes of subclinical AF lasting less than 24 hours were associated with no greater thromboembolic risk than in individuals without AF. Similarly, the LOOP study demonstrated that intensive continuous ECG monitoring led to a three-fold increase in AF detection and anticoagulation for episodes as short as 6 minutes, yet this did not translate into a reduction in stroke or systemic embolism.

Smartwatches, heartbeats and the GP (continued)

Population screening data offer mixed reassurance. In Europe, analyses from the STROKESTOP study suggest that AF screening in older adults may be cost-effective. Whether this ultimately results in a meaningful reduction in cardioembolic stroke, the central goal of screening, remains unclear.

Reflecting this uncertainty, current European Society of Cardiology guidelines recommend opportunistic AF screening and device interrogation in individuals aged 75 years or older, or in those at high risk of stroke.

For general practitioners, the message is one of caution: detecting AF is only the first step, and not all AF detected, particularly short, subclinical episodes, carries the same clinical weight. Confirmation with medical-grade ECG monitoring and consideration of patient specific risk (i.e. CHA_2DS_1-VASc score) remains essential. Wearable data should never be used in isolation to make treatment decisions such as anticoagulation (figure 1).

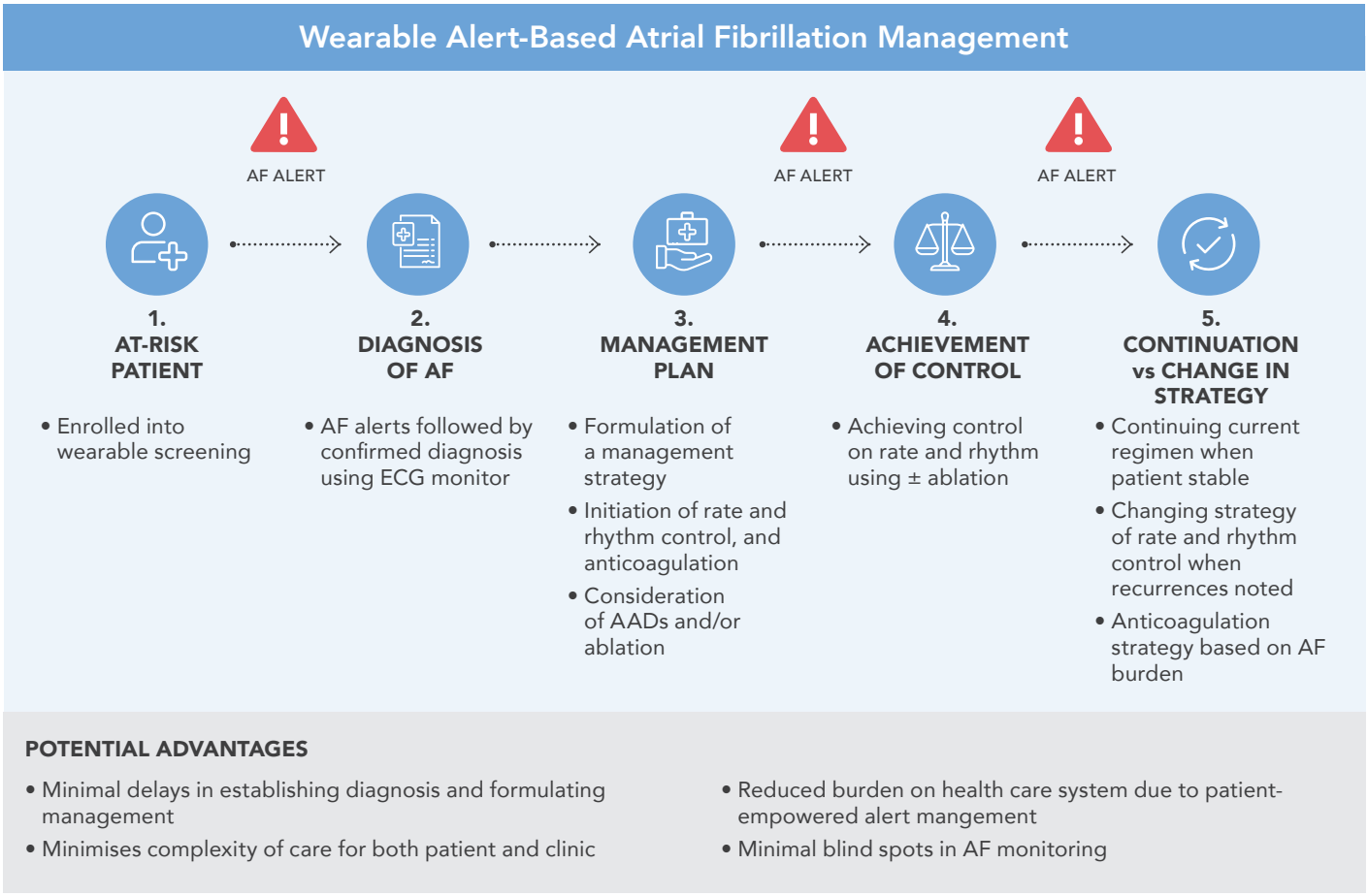


figure 1

Are Wearables for Everybody? Behavioural Heterogeneity Matters

Not all patients respond to wearable technology in the same way. While some are motivated to adopt healthier behaviours and engage more actively in cardiovascular self-management, others may experience unintended psychological effects (figure 2).

For certain individuals, often the "worried well", constant monitoring can lead to obsessive symptom checking. Notifications meant to prompt healthy habits may instead become reminders of disease, or cause anxiety when results are inconclusive. These negative responses can erode satisfaction with care, strain the doctor-patient relationship and reduce trust.

Wearables are not one-size-fits-all. Their benefits depend as much on patient behaviour and mindset as on the technology itself.

Psychosocial Impacts | Wearable Health Technologies

PATIENT ENGAGEMENT

- Gamification to encourage and incentivise healthy behaviours
- Provides individualised risk scores
- Delivers personalised patient education and support

PERCEIVED CONNECTEDNESS

- Connection to health care providers may enhance the patient-provider relationship
- May promote a sense of safety and satisfaction with care

REAL-TIME FEEDBACK

- Feedback from wearable devices and biosensors
- May improve adherence and facilitate CV self-management



SOMATIC PREOCCUPATION

- "Worried well" phenomenon
- Excessive focus on CV symptoms
- Pathological anxiety

UNNECESSARY AND FREQUENT CONTACT WITH THE MEDICAL SYSTEM

- Phone calls, messages, and unscheduled visits due to wearable alerts/normal fluctuations in HR
- Adverse relationship with health care providers
- Discrepancies between data from wearable device vs medical grade diagnostic tests

FALSE REASSURANCE

- Insufficient education about the limitations
- False sense of security/safety

The psychsocial effects of wearable health devices is multifaceted, with positive and negative attributes. CV = cardiovascular, HR = heart rate.

figure 2

The Hidden Burden: Data Overload

While patients may see wearable data as helpful, clinicians often experience it differently.

GPs are increasingly presented with screenshots, app summaries and weeks of heart-rate graphs. A key concern is that much wearable data is non-standardised, unvalidated, and clinically ambiguous. Clear thresholds for action are lacking, leaving interpretation to already time-pressured clinicians.



Without proper integration into clinical systems, wearable data can disrupt workflows rather than enhance them. Reviewing large volumes of raw data is rarely feasible in routine consultations and medico-legal uncertainty about responsibility for acting on patient-generated data adds further complexity.

Anxiety at the Wrist

Another unintended consequence of wearables is patient anxiety. Alerts about "irregular rhythms" or "abnormal heart rates" may prompt worry, repeated checking and increased healthcare utilisation, even when findings are benign.

Many physiological variations flagged by wearables are normal or clinically insignificant. For some patients, particularly those with health anxiety, constant monitoring may do more harm than good.

This places GPs in a crucial interpretive role: helping patients contextualise alerts, understand uncertainty and avoid over-medicalisation of normal bodily variation.

Smartwatches, heartbeats and the GP (continued)

What does this mean for everyday general practice?

In clinical practice, the goal is not to reject wearable technology. The key is to incorporate them thoughtfully into practice in a way that complements clinical judgment.

Wearables may be helpful:

- As adjuncts for patients already engaged in lifestyle modification
- To prompt clinical assessment when symptoms or alerts align with risk factors
- For selected patients with known cardiovascular disease who understand the limits of the technology

They are not a substitute for:

- Clinical history and examination
- Validated diagnostic tests
- Evidence-based risk stratification and management

Consumer wearables are powerful tools for engagement and observation. Their greatest value lies in supporting informed conversations between patients and their doctors.

Wearables: Promise, Perils, and the Road Ahead

Direct-to-consumer wearables hold genuine promise for cardiovascular care. By giving patients greater insight into their health and enabling more continuous monitoring, these devices could improve outcomes, support personalised medicine and even streamline aspects of care delivery. They open the door to new approaches for disease screening, diagnosis and management, widening the toolkit for clinicians and patients alike.

Yet, the potential benefits come with caveats. Reliability and accuracy remain variable, the predictive value of many data streams is uncertain, and patient adherence is often inconsistent. Unguided use can trigger unintended psychological effects, raise privacy concerns and add to clinic workload.

Wearables sit at the intersection of technology and clinical care. Better validation studies, clearer guidelines and improved integration with electronic medical records could enhance their clinical usefulness. Realising their full potential requires collaboration among clinicians, regulators, device manufacturers and patients. Only then can these devices be effectively integrated into cardiovascular practice, balancing innovation with clinical prudence.



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Atrial Fibrillation Detection: What Wearables Can and Can't Do

What Wearables **CAN Do**	What Wearables **CANNOT Do**
• Detect pulse irregularity • Capture intermittent episodes • Prompt clinical review	• Confirm AF diagnosis • Assess stroke risk • Determine need for anticoagulation

GP Tips: When a Patient Brings Smartwatch Data

Do	**Don't**
• Ask why the patient checked the data • Link alerts to symptoms and risk factors • Use wearables as a conversation starter, not a diagnosis	• Make treatment decisions from wearable alerts alone • Feel obliged to review weeks of raw data • Dismiss concerns without explanation

GP Tips: Managing AF Alerts

- Confirm rhythm with ECG or ambulatory monitoring
- Assess CHA_2DS_1-VASc stroke risk
- Reassure patients about false positives
- Avoid "alert-driven" prescribing

GP Tips: Avoiding Data Overload

- Ask patients to summarise concerns, not show entire apps
- Focus on trends, not individual readings
- Set expectations: "Bring alerts, not raw data"
- Document advice about limitations of wearables

GP Tips: Reducing Wearable-Driven Anxiety

- Normalise physiological variability
- Explain false positives early
- Encourage symptom-led monitoring
- Consider advising less frequent checking

Sometimes the best intervention is switching notifications off.



Our team

We have experienced cardiologists in all major sub-specialties to provide the highest quality of patient care. We also have specialists in related fields including endocrinology and respiratory medicine. Our Sydney Cardiology team includes:

Cardiology



Dr James Wong

Specialising in general cardiology, prevention of coronary artery disease and hypertension.



Dr Abhinav Luhach

Specialising in general adult cardiology, cardiac CT, and preventive cardiology.



Dr Gunjan Aggarwal

Specialising in general adult cardiology and non-invasive cardiac imaging, particularly echocardiography and cardiac CT.



Dr Andrew Terluk

Specialising in general cardiology with an interest in cardiomyopathy in the setting of cancer.



Dr Ru-Dee Ting

Specialising in general and interventional cardiology, including cardiac haemodynamic studies and complex coronary intervention.



Dr Fiona Foo

Specialising in general and interventional cardiology with an interest in heart disease affecting women and sports cardiology.



Dr Bill Petrellis

Specialising in general adult cardiology and electrophysiology, including atrial fibrillation and device implantation.



A/Prof Martin Brown

Specialising in advanced heart failure, pulmonary hypertension, and transplant cardiology.

Endocrinology



Dr Suja Padmanabhan

Specialising in diabetes and general endocrinology with a special interest in diabetes in pregnancy and women's health.

Respiratory Medicine



Dr Tracy Smith

Respiratory and sleep physician specialising in respiratory disease with a special interest in respiratory failure due to lung or heart disease.

Update on renal denervation

Hypertension remains one of the leading modifiable risk factors for cardiovascular disease worldwide. Although lifestyle modification and multiple effective antihypertensive drug classes are available, blood pressure remains uncontrolled in a substantial proportion of patients. Medication non-adherence remains one of the major barriers to effective blood pressure control, affecting up to 50% of treated patients[1]. These limitations have renewed interest in device-based therapies that provide sustained blood pressure reduction independent of daily medication adherence.



Renal denervation premise

The concept of device-based treatments for hypertension has been around for decades, with a focus on interrupting renal signalling through the ablation of renal afferent and efferent nerves. Activation of renal efferent sympathetic nerves increases sodium and water reabsorption, renin release, and decreased renal blood flow. These changes lead to increased intravascular volume, peripheral vasoconstriction and higher BP. Activation of the afferent nerves also increases central sympathetic outflow, which translates into increased renal vascular resistance and higher sympathetic flow to the heart and peripheral vessels.

Thus, minimally invasive catheter-based approaches to achieve renal sympathetic denervation were developed (Fig 1). Most renal sympathetic nerves lie within 6 mm of the arterial lumen in the periadventitial tissue surrounding the renal arteries[2]. Their proximity to the vessel lumen allows an intravascular device to apply an energy source to create heat (via radiofrequency or ultrasound energy) to ablate the renal nerves. Treatment with catheter-based renal denervation (RDN) with sufficient ablation of a majority of nerves leads to substantially reduced noradrenaline levels[3].

Initial Trials of RDN

In the SYMPLICITY HTN-2 trial[4] in 2010, 106 patients with resistant hypertension were randomly assigned to RDN plus drug therapy or drug therapy only. Office BP was reduced by 32/12 mmHg in the RDN group compared with 1/0 mmHg in the control group. However, the FDA mandated the completion of a randomized, sham-controlled trial where control group patients underwent a sham procedure to maintain blinding. The SYMPLICITY HTN-3 trial[5] unexpectedly did not demonstrate a significant difference in blood pressure reduction between RDN and the sham procedure. Several postulated reasons why this study did not demonstrate a treatment effect included inadequate screening, non-adherence to medication and operator inexperience.

Nevertheless, the trial results nearly caused the demise of RDN, and research and commercial development stalled. The entire field underwent a reset. What followed was an entirely revamped approach, supported by technological advances and refinements to trial design. This included better patient selection, sham controls, ambulatory BP as primary endpoint, improved medication monitoring, more complete circumferential ablation and improved operator training.

Update on renal denervation (continued)

Newer trials

In the last 8 years, updated trials have demonstrated efficacy and renewed interest in the field. The SPYRAL HTN trial programme consisted of a series of sham-controlled, randomised trials studying the Spyral device, with off-medication and on-medication trials[6-8]. In these trials of radiofrequency RDN, ambulatory systolic BP measurements were the primary end points for the efficacy of BP lowering. The reductions in office systolic BP were 9–10 mmHg from baseline and 5–7 mmHg compared with the sham procedure.

The RADIANCE-HTN programme studied ultrasound-based RDN in three independently powered, sham-controlled trials using the Paradise device: two off-medication trials and one on-medication trial conducted among patients with truly resistant hypertension[9-11]. The decreases in daytime ambulatory systolic BP were 8–9 mmHg from baseline and 5–6 mmHg compared with sham.

Overall, the magnitude of blood pressure reduction achieved with RDN is broadly comparable to that expected from the addition of a single antihypertensive agent, although individual responses vary.

Both the SPYRAL radiofrequency device and the PARADISE ultrasound system have demonstrated a strong safety profile for up to 3 years in sham-controlled trials and for longer in observational cohorts. These studies demonstrate the efficacy and safety of RDN in patients across the spectrum of hypertension, including patients with mild disease, as well as those with truly resistant hypertension[12-14].

Whether cardiovascular endpoints are reduced by RDN remains to be shown. Observational data from the Global Symplicity Registry indicates RDN is associated with a lower risk of subsequent cardiovascular events[15]. Nonetheless, clinical outcomes trials are needed.

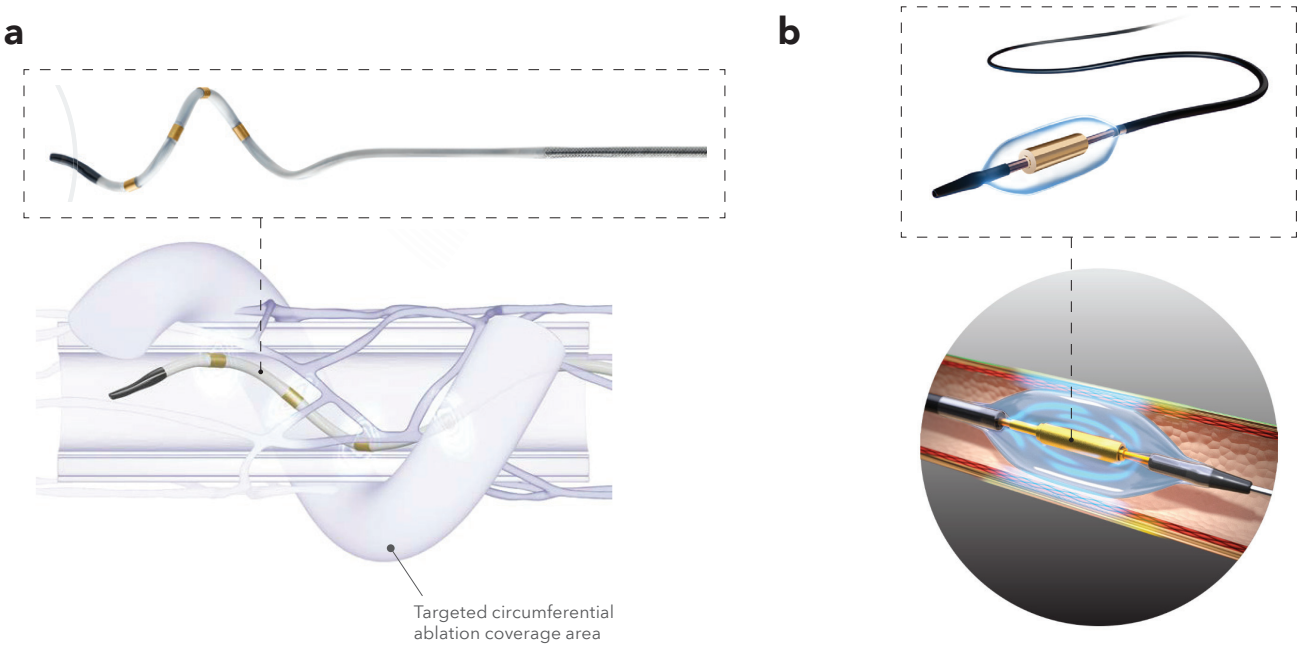


Fig 1. Devices for renal denervation. **a, The Symplicity Spyral renal denervation system.** This catheter has four monopolar radiofrequency electrodes arranged in a flexible helical pattern to deliver radiofrequency energy covering four quadrants to ablate the renal nerves. **b, The Paradise ultrasound renal denervation system.** This catheter uses a balloon-based catheter to centre the cylindrical transducer that delivers a ring of ultrasound energy from inside the main renal artery. *Panel a courtesy of Medtronic. Panel b courtesy of Recor Medical*[20].

Safety considerations

To date, RDN has shown an excellent safety profile. Potential procedural complications include vascular access and bleeding complications and renal artery dissection or perforation. In the trials to date, the incidence of these complications has been low. Over the intermediate to longer term, potential complications include renal artery stenosis and worsening of renal function.

At this time, limited data is available to support the use of RDN in patients with eGFR <40 ml/min/1.73 m2. Caution should also be taken in patients with end stage renal disease[16], patients with a renal stent, renal tumour or renal artery aneurysm.

Patient selection

Across the trials of RDN, the best predictor of the magnitude of BP response is baseline BP, with the largest reductions seen among those with higher starting BP[17]. As standard of care, patients with newly diagnosed hypertension should first optimize lifestyle measures. Failing this, antihypertensive medication should be prescribed, with attention to optimizing adherence.

Patients at high cardiovascular risk frequently require 3 or more antihypertensive agents to achieve contemporary blood pressure targets[18]. In the RADIANCE-HTN TRIO trial (8), of all the patients screened and enrolled with an office BP that was consistent with hypertension (>140/90 mmHg), 43% were excluded because subsequent daytime ambulatory BP was controlled (<135/85 mmHg) after taking a fixed-dose triple pill. This suggests that reducing pill burden with combination pills can help achieve a high rate of adherence (approximately 80%).

For these patients whose hypertension is readily controlled with one or two medications, RDN is not indicated. Patients with truly resistant hypertension are at increased cardiovascular risk and are likely to derive substantial benefit from better control and RDN should be discussed. RDN should also be considered in patients with uncontrolled hypertension who are unable or unwilling to escalate antihypertensive therapy because of medication intolerance or adherence difficulties.

Preprocedural work-up and exclusion of secondary causes of hypertension are imperative. Patients with secondary treatable causes of hypertension, such as primary aldosteronism, should not be treated with RDN before appropriate evaluation is undertaken. Other comorbid contributing factors, such as sleep apnoea and obesity, should not preclude referral to RDN.

The decision to proceed with RDN should follow informed shared decision-making that considers patient preference, medication tolerance, expected blood pressure reduction and procedural risks.

The 2024 European Society of Cardiology hypertension guidelines give RDN a Class IIb recommendation for patients with truly resistant hypertension and a Class IIa recommendation for patients with uncontrolled hypertension at increased cardiovascular risk despite treatment with one or two antihypertensive medications[19].

The guideline authors emphasize that RDN is not recommended as a first-line BP-lowering intervention and urge caution with the use of RDN in patients with moderately-to-severely impaired renal function.

Conclusion

Renal denervation has re-emerged as an evidence-based adjunctive treatment for selected patients with uncontrolled hypertension. It should be viewed as a complementary therapy rather than a replacement for lifestyle modification and antihypertensive medication. Following the negative SYMPLICITY HTN-3 trial, improvements in device technology, procedural technique and trial design have demonstrated consistent reductions in blood pressure with an excellent safety profile. Although definitive cardiovascular outcome trials are still awaited, current evidence supports RDN as an important addition to the therapeutic armamentarium for appropriately selected patients.

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Our services

Sydney Cardiology is a world class comprehensive cardiology service, delivered with expertise and experience. Using state of the art diagnostic equipment in all five clinic locations, Sydney Cardiology strives to provide exemplary outcomes for long term patient care.

Non-invasive testing

Including stress-echocardiography, echocardiography, holter monitor studies, ambulatory blood pressure studies, coronary calcium score, dobutamine stress echo, electrocardiogram and event monitor recording.

Echo, ABP, and holter monitor-only referral services

We provide echo-only, ABP-only, and holter monitor-only referral services, with a summary report on any adverse findings.

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Including diagnostic electrophysiology studies, ablation of cardiac arrhythmias, cardiac device implantation, pacemakers and defibrillators, and follow up of implanted cardiac devices.

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Including renal and lower limb angioplasty, ankle brachial index and SphygmoCorR central blood pressure testing.





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All patients with appropriate private health coverage undergoing hospital procedures, do not incur any out-of-pocket costs. Sydney Cardiology has access to leading private hospitals, including:

Sydney Adventist Hospital
Wahroonga

Norwest Private Hospital
Bella Vista

Macquarie University Hospital
North Ryde

Northern Beach Hospital
Frenchs Forest

Patient fees

Sydney Cardiology is a private clinic however there are no out of pocket costs for Department of Veterans Affairs patients.

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What's new in lipid management in 2026?



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Specialising in general adult cardiology, cardiac CT, and preventive cardiology.



Earlier this year, the American College of Cardiology (ACC) published updated guidelines on lipid management. At present in Australia there are no contemporary lipid guidelines. Rather clinicians are encouraged to use the Aus-CVD risk calculator, published in 2023.

The Aus-CVD risk calculator has been developed specifically for use in primary prevention to assess and manage CV risk in the general population. The risk calculator is derived from PREDICT-1o equation, which was initially developed from New Zealand population data, but for the purposes of the Aus-CVD risk calculator, has been modified to reflect local population characteristics. It remains a useful tool that allows clinicians to stratify CV risk and, on that basis, comes up with recommendations on lifestyle management and pharmacotherapy. The ACC guidelines also use a (different) risk calculator to stratify risk, but also provides recommendations on lipid targets, when to escalate therapy beyond statins, use of other lipid markers and also guidance on specific clinical situations clinicians' encounter in clinical practice

If we put aside the differences in the actual risk calculators, there are still important points of difference in risk stratification and management between the two guidelines. The ACC guidelines emphasise the importance of early treatment of lipids. This is because there is increasing recognition that cumulative lifetime exposure to raised lipids increases CV risk. As such, it recommends beginning risk assessment at the age of 30. In contrast, the Australian CV risk calculator is to be used from the age of 45, although it recommends earlier risk assessment in diabetics (age 35 onwards) and First Nations people. The ACC guidelines classifies patients into one of 4 risk groups based on the calculator as opposed to 3 in Aus-CVD, but more significantly, leans toward more aggressive recommendations for initiating lipid lowering therapy. Whilst the risk calculators are not directly interchangeable, pharmacotherapy is to be considered at lower risk levels in the ACC guidelines.

Both risk guidelines allow for the use of clinical risk enhancers that are not incorporated into the actual calculators. These are particularly of value when applied to the intermediate (or borderline) CV risk group. This allows the clinician to account for other risk markers such as ethnicity, family history, renal disease & mental illness. Other considerations are the presence of chronic inflammatory disease and reproductive risk factors in women. Both guidelines also mention use the of calcium scoring, with the Australian guidelines more selective, recommending considering its use when treatment decisions are uncertain, particularly in low-intermediate risk groups where other CV risk markers are present. ACC guidelines provide a stronger recommendation (Class 1) for the use of calcium scoring in the equivalent patient group.

There are also differences in recommendations for the use of other risk markers. Australian guidelines recommend NOT using ABI and hs-CRP as they are thought to provide little additional value beyond the risk calculator. ACC guidelines specifically recommend testing Lp(a) levels in all patients once, recognising it association with increased CV risk. Recommendations are also made for testing ApoB levels, especially in patients with diabetes, raised TG levels and cardiorenal metabolic disease. This is because ApoB directly quantifies the number of atherogenic particles,

making it a better marker of CV risk than traditional LDL calculations in these groups and can identify residual risk when LDL targets have been met. Whilst both ApoB and Lp(a) are readily available via pathology they entail out-of-pocket costs for patients.

The Australian guidelines do not specify lipid lowering drugs or any associated targets. It is likely these will be incorporated in future, lipid specific local guidelines. The ACC guidelines have made detailed recommendations on initiating statins and LDL targets across different risk groups. Whilst older guidelines did for a whilst omit specific LDL targets, they have always been considered an important part of clinical practice and have reincorporated in these guidelines. In borderline (defined as 3 to <5% risk over 10 years) and intermediate (5 to <10% risk over 10 years) a LDL treatment goal of <2.6mmol/L and non-HDL <3.4mmol/L is deemed reasonable. For high-risk primary prevention groups the recommended LDL target is <1.8mmol/L and non-HDL <2.6mmol/L. In these groups use a high-intensity statin is recommended to achieve a >50% LDL reduction. These LDL targets are broadly consistent with local practice.

The above targets are for primary prevention only. In secondary prevention, where patients have established clinical ASCVD, targets are more aggressive. For many of these patients, a LDL target of <1.4mmol/L and non-HDL <2.2mmol/L is appropriate. The Australian CVD-risk calculator and subsequent recommendations are strictly focused on primary prevention. However, more recent Australian ACS guidelines are consistent with this, recommending a LDL <1.4mmol/L with at least 50% LDL baseline reduction, whilst also mentioning that further benefit is obtained by treating to the lowest achievable level.

ACC guidelines also provide recommendations about when to escalate therapy beyond statins, covering the use of ezetimibe, bempedoic acid, PCSK9 inhibitors and inclisiran. In Australia, whilst ezetimibe no longer requires authority prescription, bempedoic acid is not yet available and use more advanced therapies are restricted as per PBS criteria, unless patients are willing to pay privately. The ACC also recommends that in patients with no history of ASCVD if incidental CAC is noted on a non-cardiac CT, then this should be considered when making decisions about lipid treatment. A common example of this is when a low-dose CT chest is done as part of a lung screening programme and the report comments on the presence of coronary artery calcification. The extent of calcification, in turn can guide LDL treatment targets.

Whilst, both the Australian and ACC guidelines emphasise the importance of a good diet, the ACC guidelines also state the use of dietary supplements is not recommended to lower LDL. Interestingly there is no recommendation for the use of plant sterols as an adjunct to either dietary modification or pharmacotherapy.

Finally, the ACC provides guidance on how to manage patients reporting statin related muscle symptoms. Much of this is not new, but it is worthwhile remembering that routine use of CoQ10 is not recommended. Similarly routine testing of CK levels and LFTs are not indicated in the absence of associated symptoms.

Key take home messages from the 2026 ACC/AHA lipid guidelines

- Consider screening and treating earlier in life recognising the concept of cumulative lifetime lipid exposure
- More aggressive treatment recommendations with LDL targets. Escalating therapy beyond statins when necessary.
- Recommendations for the use of Lp(a) and ApoB biomarkers
- Recommendations for the use of CT calcium scoring
- Note some of these recommendations differ from the 2023 Australian CV risk assessment guidelines

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Clinic locations

All clinics have emergency appointment timeslots available for same-day referrals. Contact any of our clinics directly for more assistance.

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