Meeting Nazionale ITACARE-P 2025

La Cardiologia Riabilitativa e Preventiva come snodo fondamentale della cura della persona con cardiopatia

CENTRO CONGRESSI FRENTANI
Roma, 21-22 novembre 2025

Il fast track nel trattamento della ipercolesterolemia con PCSK9i/SIRNA dopo sindrome coronarica acuta

Verso lo studio GO TO TARGET di ITACARE-P: (vincere) l'inerzia terapeutica nel paziente ipercolesterolemico

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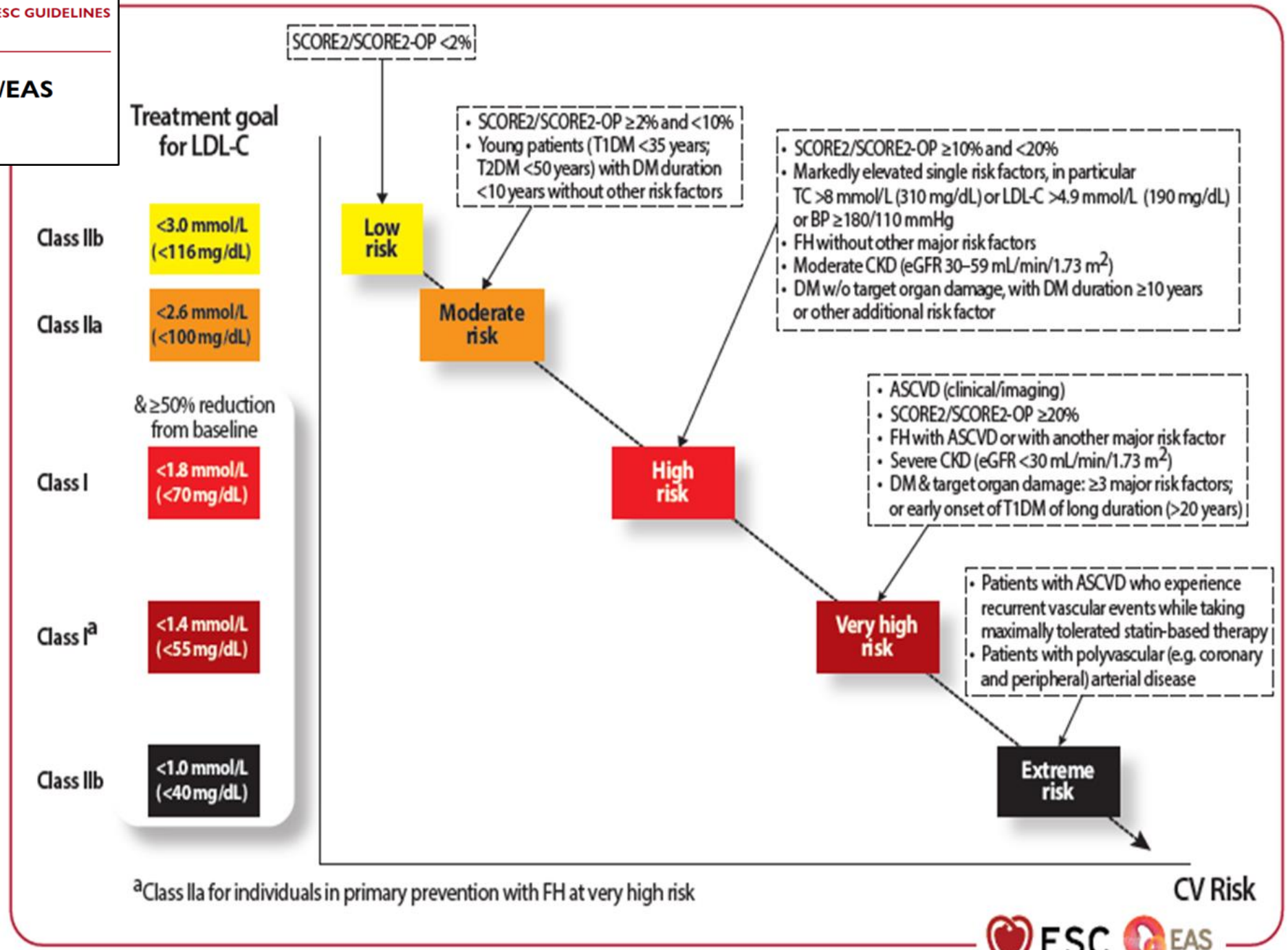
ESC European Society of Cardiology
European Heart Journal (2025) 00, 1–20
https://doi.org/10.1093/eurheartj/ehaf190
ESC GUIDELINES

2025 Focused Update of the 2019 ESC/EAS Guidelines for the management of dyslipidaemias



Combination of lipid-lowering therapies during index hospitalization for acute coronary syndromes

"Patients experiencing ACS are at particularly elevated risk of recurrent CV events, especially within the first year after hospital discharge."

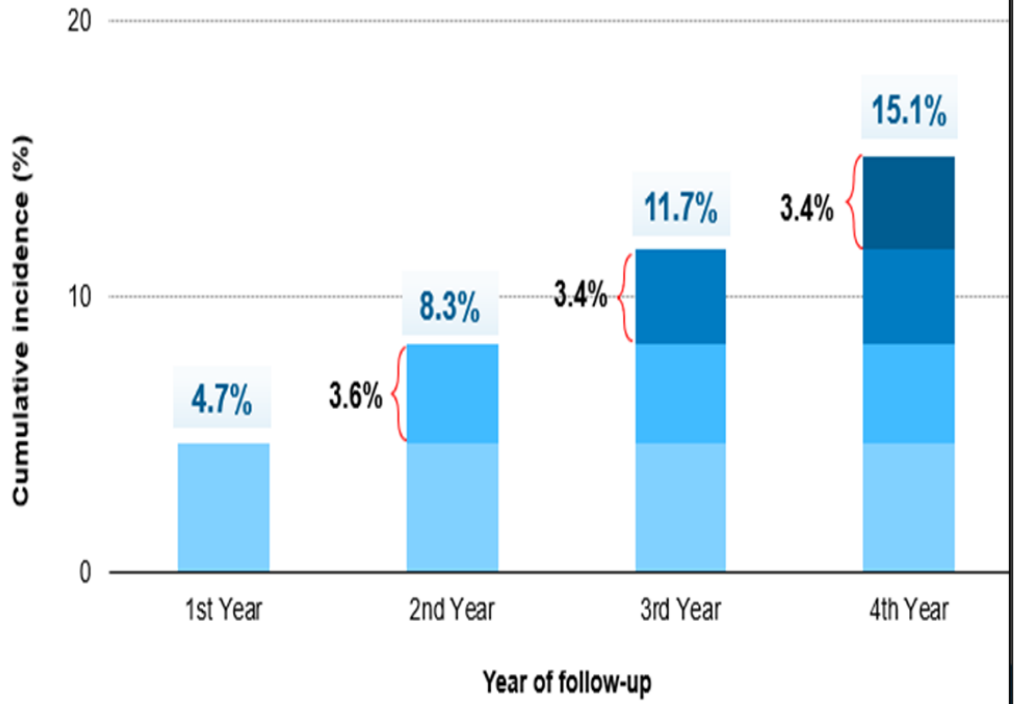
Recurrent Events are Greatest in the First Year Post-MI

Cumulative Incidence Rates of CV Events (CV Death, MI, Stroke) in Patients Post MI From the International REACH Registry

Patients:
N = 16,770 Patients with established CAD, cerebrovascular disease, PAD, or with > 3 atherothrombotic risk factors

Mean age: 67 years

Follow-up: Initially, 2 years + centers invited to participate in a 2-year extension



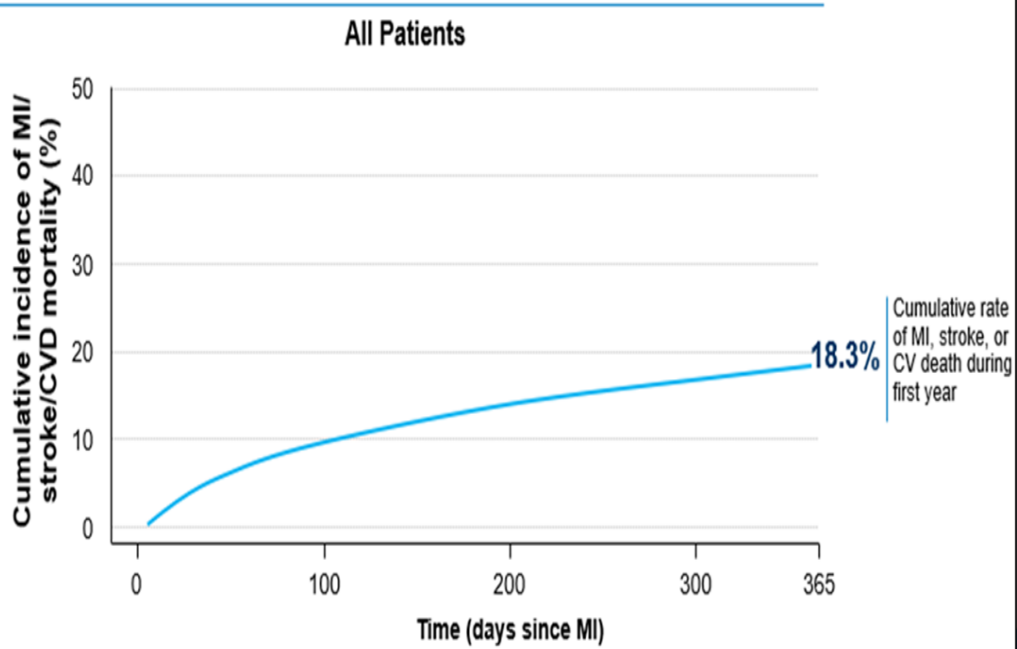
Nearly 1 in 5 of Patients Will Have a Recurrent CV Event During First Year Post MI

Observational, Retrospective, Cohort Study From Swedish National Registries of All Patients With a Prior MI

Patients:
N = 97,254 hospitalized with acute MI*

Median age: 74 years in MI population and 72 years in stable post-MI population

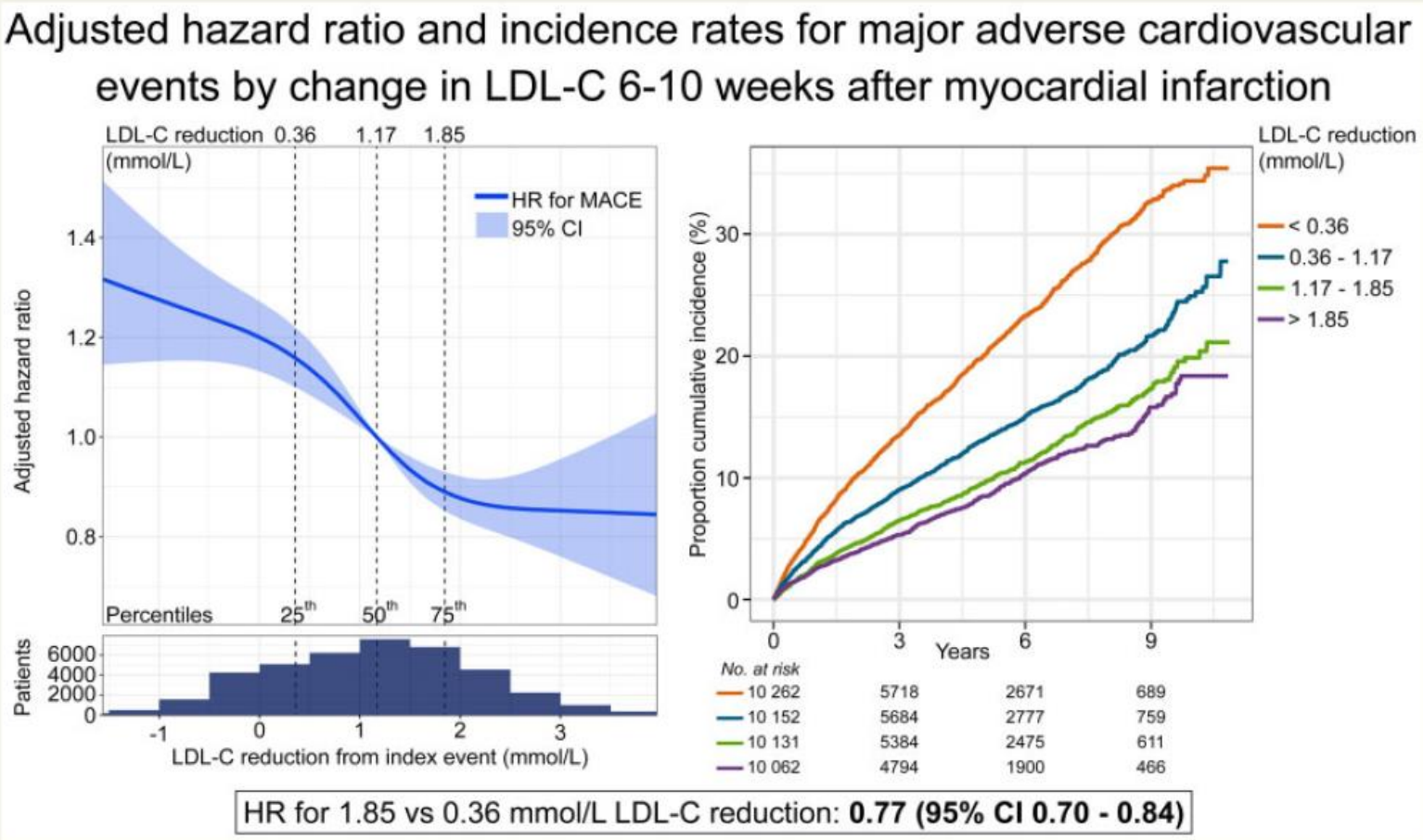
Mean duration of follow-up: 2.54 years in stable post-MI population and maximum follow-up time was 5.5 years



ESC European Society of Cardiology
European Heart Journal (2021) 42, 243–252
doi:10.1093/eurheartj/ehaa1011

CLINICAL RESEARCH
Ischaemic heart disease

Low-density lipoprotein cholesterol reduction and statin intensity in myocardial infarction patients and major adverse outcomes: a Swedish nationwide cohort study

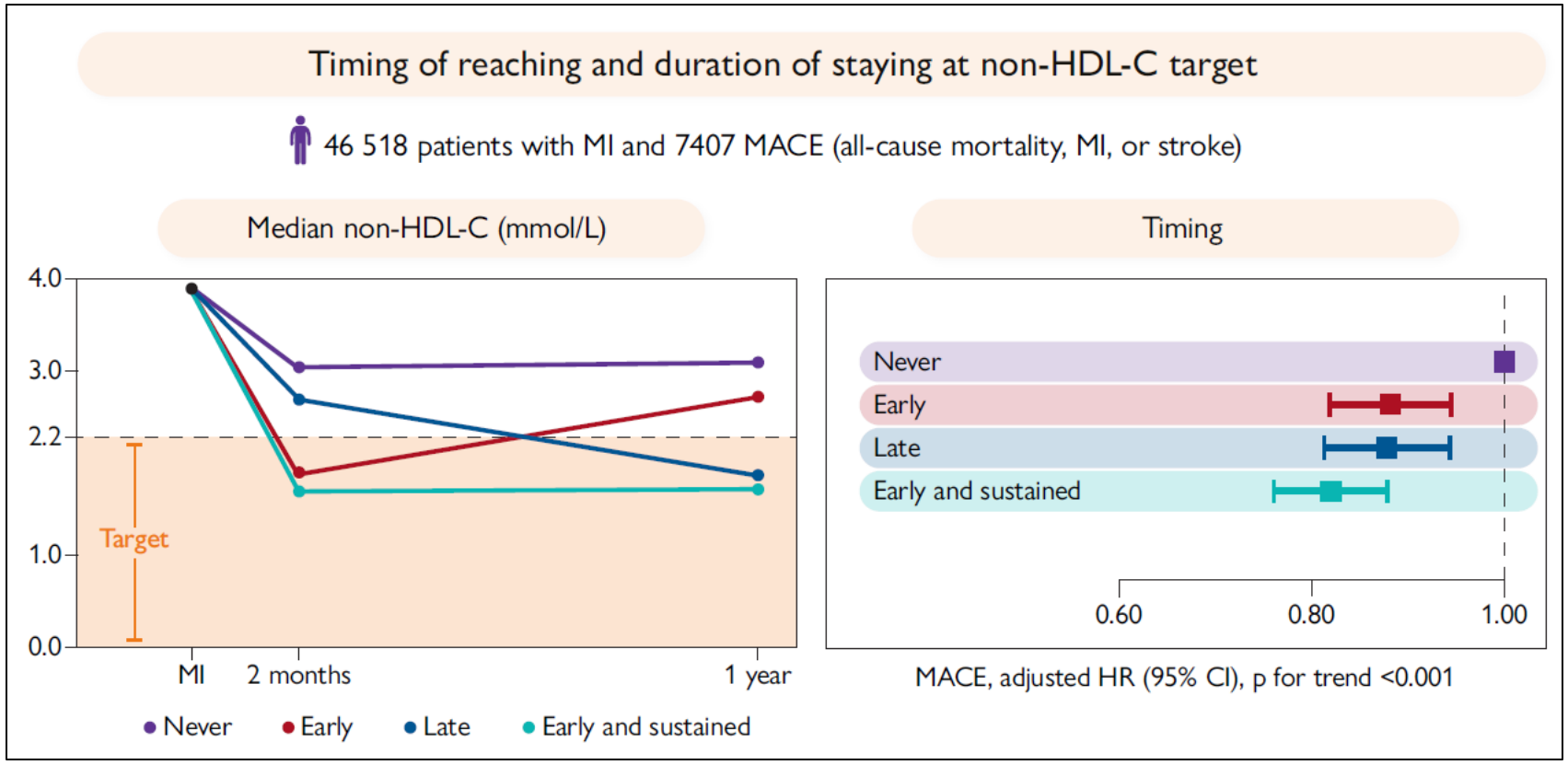


Conclusions

Larger early LDL-C reduction and more intensive statin therapy after MI were associated with a reduced hazard of all CV outcomes and all-cause mortality. This supports clinical trial data suggesting that earlier lowering of LDL-C after an MI confers the greatest benefit.

ESC European Society of Cardiology
European Heart Journal (2024) **45**, 4204–4215
https://doi.org/10.1093/eurheartj/ehae576

Intensive early and sustained lowering of non–high-density lipoprotein cholesterol after myocardial infarction and prognosis: the SWEDEHEART registry



Conclusions

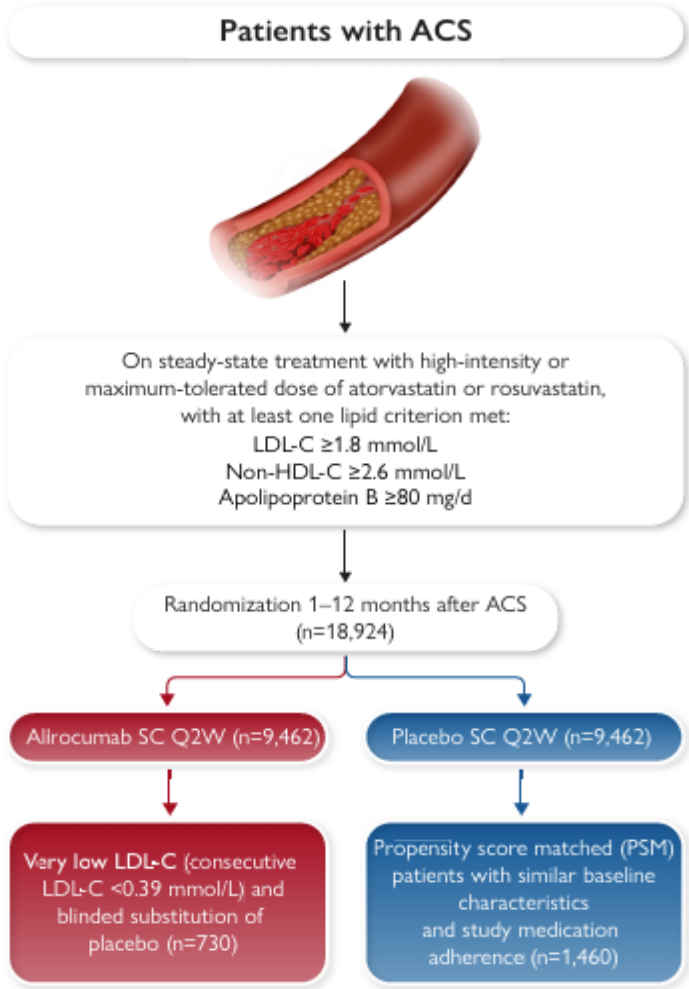
The lowest achieved levels both at 2 months and at 1 year of non–HDL-C were associated with better outcome. The lowest risk was observed when target was achieved within 2 months of MI and sustained thereafter. These findings challenge the current stepwise approach for cholesterol lowering after MI, which inevitably results in delaying goal attainment and possible harm.

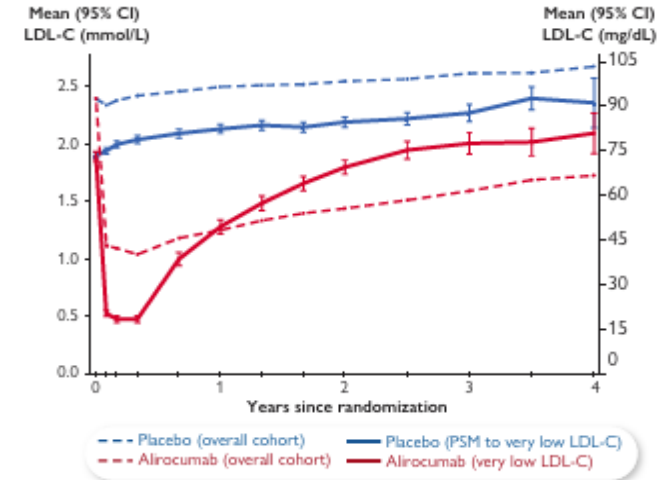
ESC European Society of Cardiology
European Heart Journal (2023) **44**, 1408–1417
https://doi.org/10.1093/eurheartj/ehad144

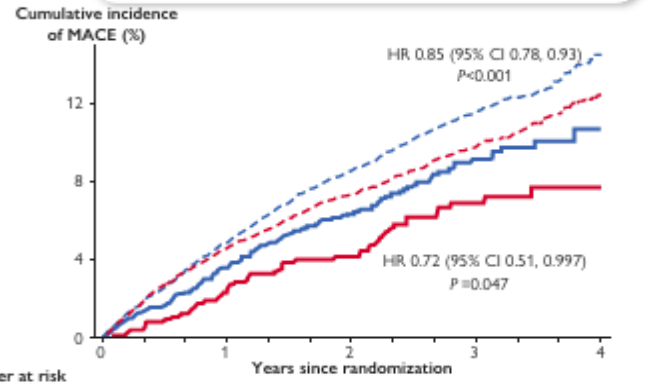
Transiently achieved very low low-density lipoprotein cholesterol levels by s and alirocumab after acute corona are associated with cardiovascula reduction: the ODYSSEY OUTCO

Take Home Message

A short period of very low LDL-C levels (<0.39 mmol/L) may result in prolonged cardiovascular risk reduction.





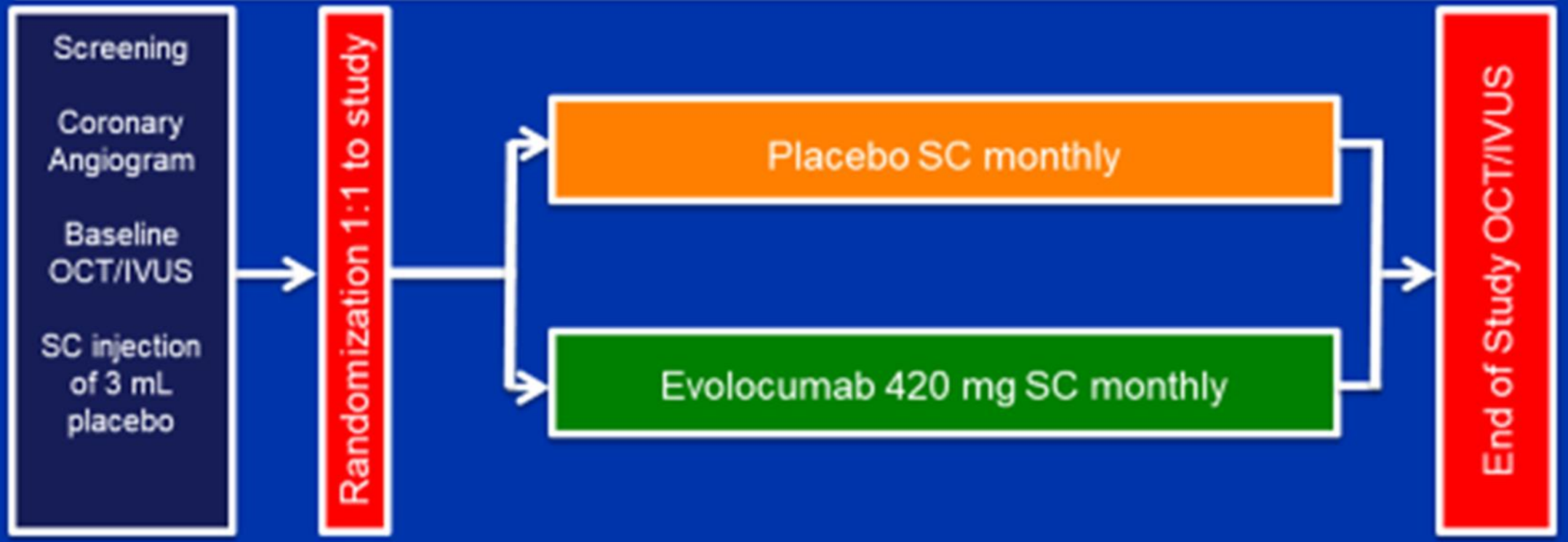


Number at risk

Placebo (overall)	9,462	8,805	8,201	3,471	629
Alirocumab (overall)	9,462	8,846	8,345	3,574	653
Placebo (PSM)	1,460	1,359	1,244	494	89
Alirocumab (very low LDL-C)	730	702	669	309	78

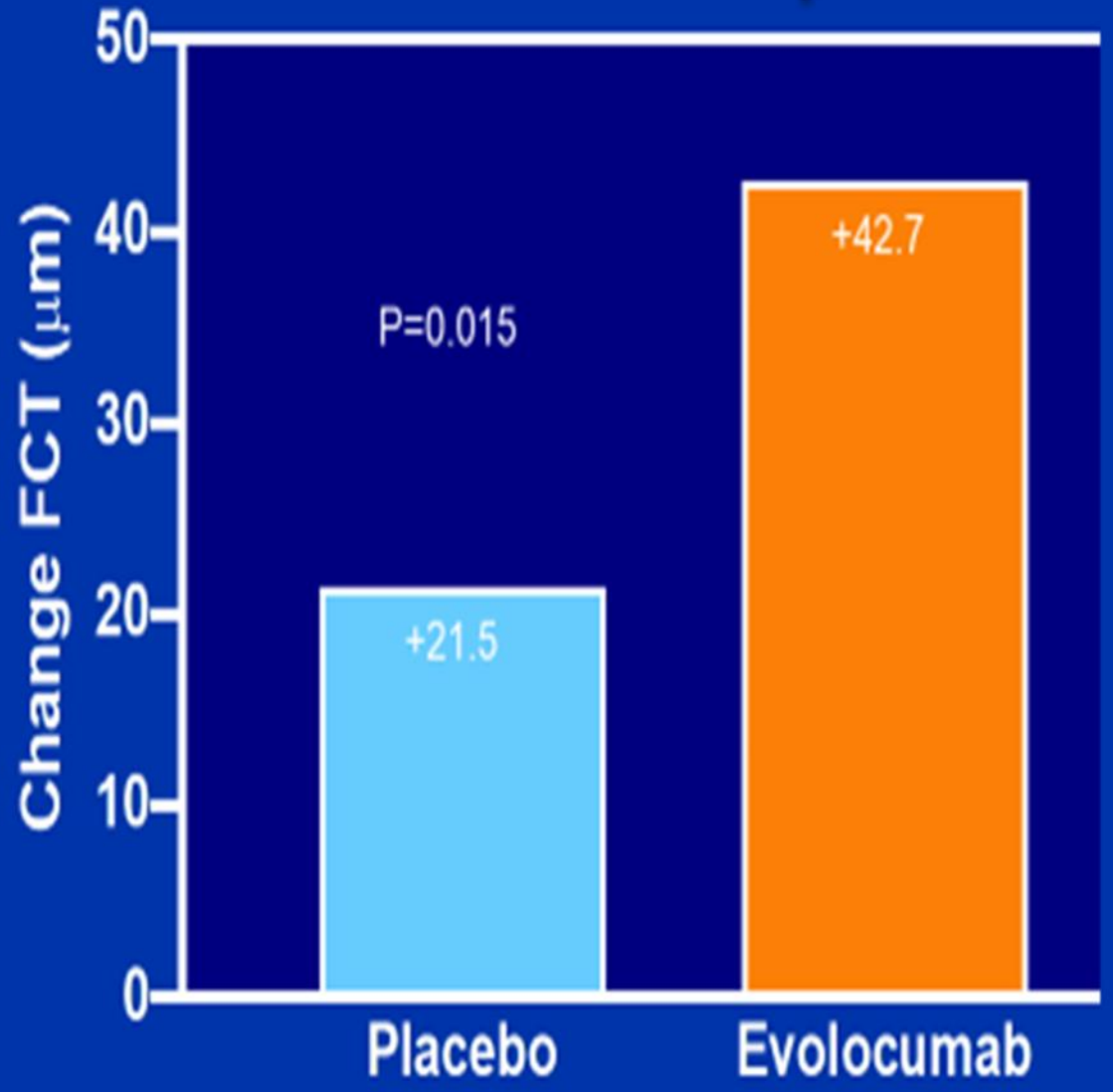
HUYGENS Study Design

161 patients with (i) NSTEMI, (ii) angiographic CAD, (iii) LDL-C ≥60 mg/dL on high-intensity, ≥80 mg/dL on low/moderate-intensity or ≥130 mg/dL on no statin at screening, (iv) subsequently treated with maximally tolerated statin and (v) target segment on OCT containing at least one image with a FCT ≤120 μm and one image with lipid arc >90°

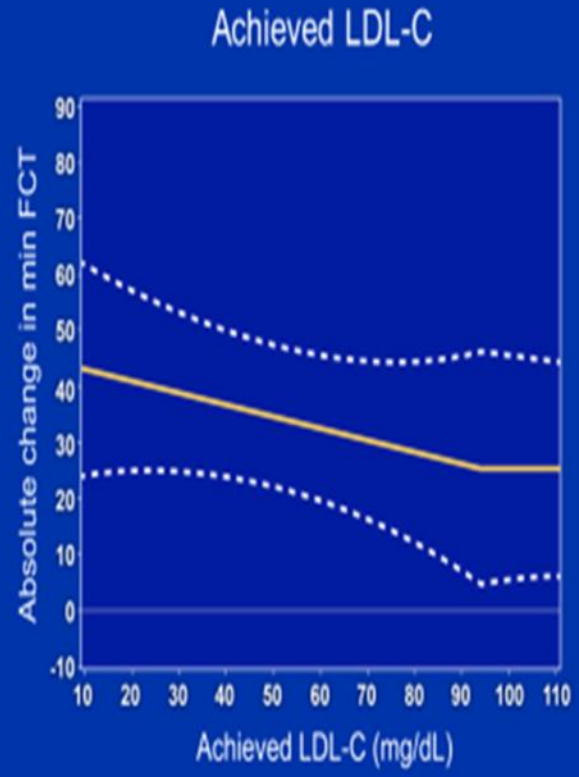


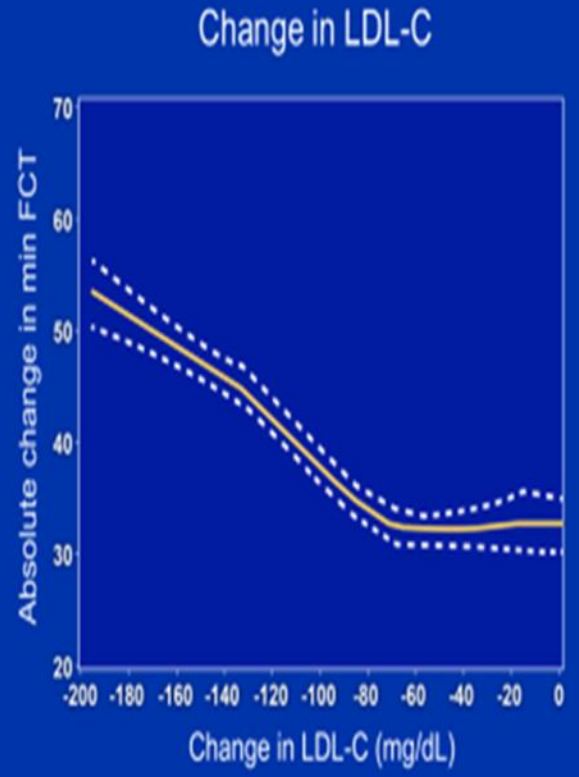
Nicholls *Cardiovasc Diag Ther* 2021

HUYGENS Primary Endpoint: Minimum Fibrous Cap Thickness



Relationship Between LDL-C and Changes in Fibrous Cap Thickness





Patients with AMI (N-STEMI/STEMI) undergoing coronary angiography & successful PCI of the infarct vessel & 2 non-infarct related arteries with angiographic evidence of atherosclerosis (20-50% DS)

PACMANAMI Alirocumab

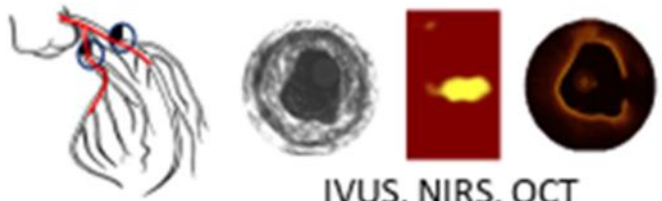
POC

No statin, LDL >125 mg/dL (>3.2 mmol/L)

On Statin, LDL >70 mg/dL (>1.8 mmol/L)

Enrollment of 300 Patients

Baseline



IVUS, NIRS, OCT

Baseline blood sampling

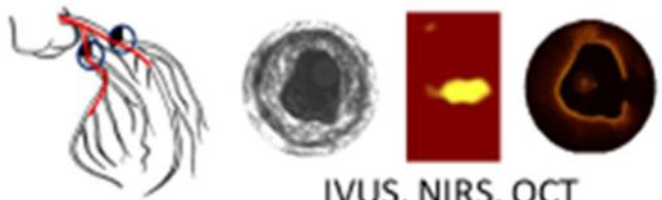
Alirocumab s.c. 150 mg / 2 weeks + Rosuvastatin 20 mg

R 1:1

Placebo s.c. / 2 weeks + Rosuvastatin 20 mg

Initiated <24 hrs after PCI

52 weeks



IVUS, NIRS, OCT

Blood sampling 4 weeks
3 visits, 4 phone calls
Blood sampling 52 weeks

Am Heart J 2021;238:33-44.

Change in LDL-C, mean (SD)

154.8 (31) mg/dL
4.00 (0.8) mmol/L

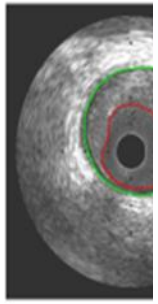
150.9 (36) mg/dL
3.9 (0.9) mmol/L

Alirocumab Placebo

* Week 52 vs. Bas

Primary

Change

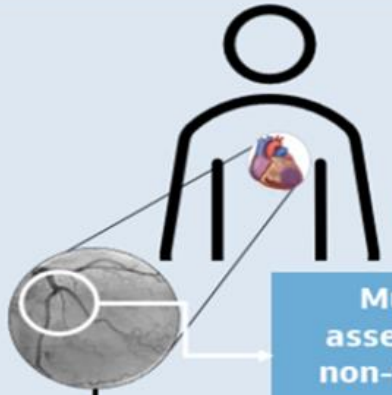


CENTRAL ILLUSTRATION: Triple regression in patients with acute MI treated with alirocumab or placebo in addition to high-intensity statin therapy.

Baseline

300 patients with acute MI randomized

265 patients analyzed



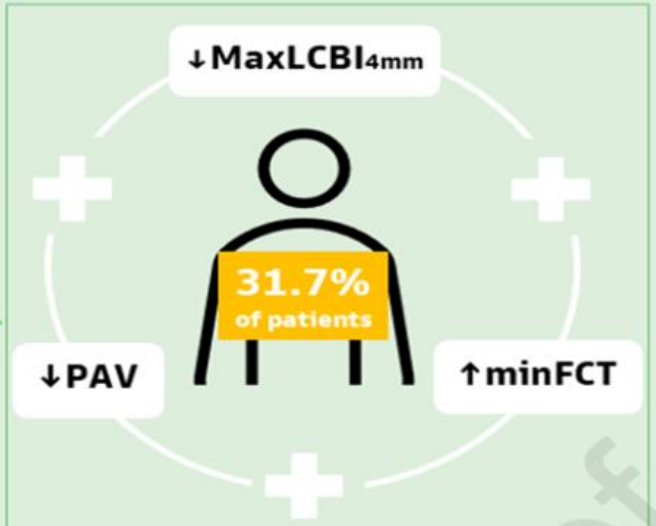
Multimodality assessment of two non-infarct related arteries

- PAV
- maxLCBI$_{4mm}$
- minFCT

130 Alirocumab

135 Placebo

52-week follow-up

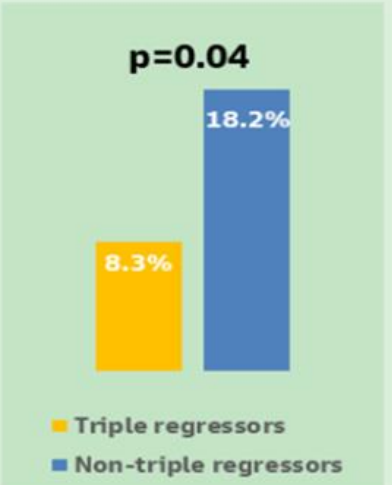


Triple Regression

Alirocumab*

Lipid-rich plaque at baseline*

*independent predictors of triple regression at follow-up



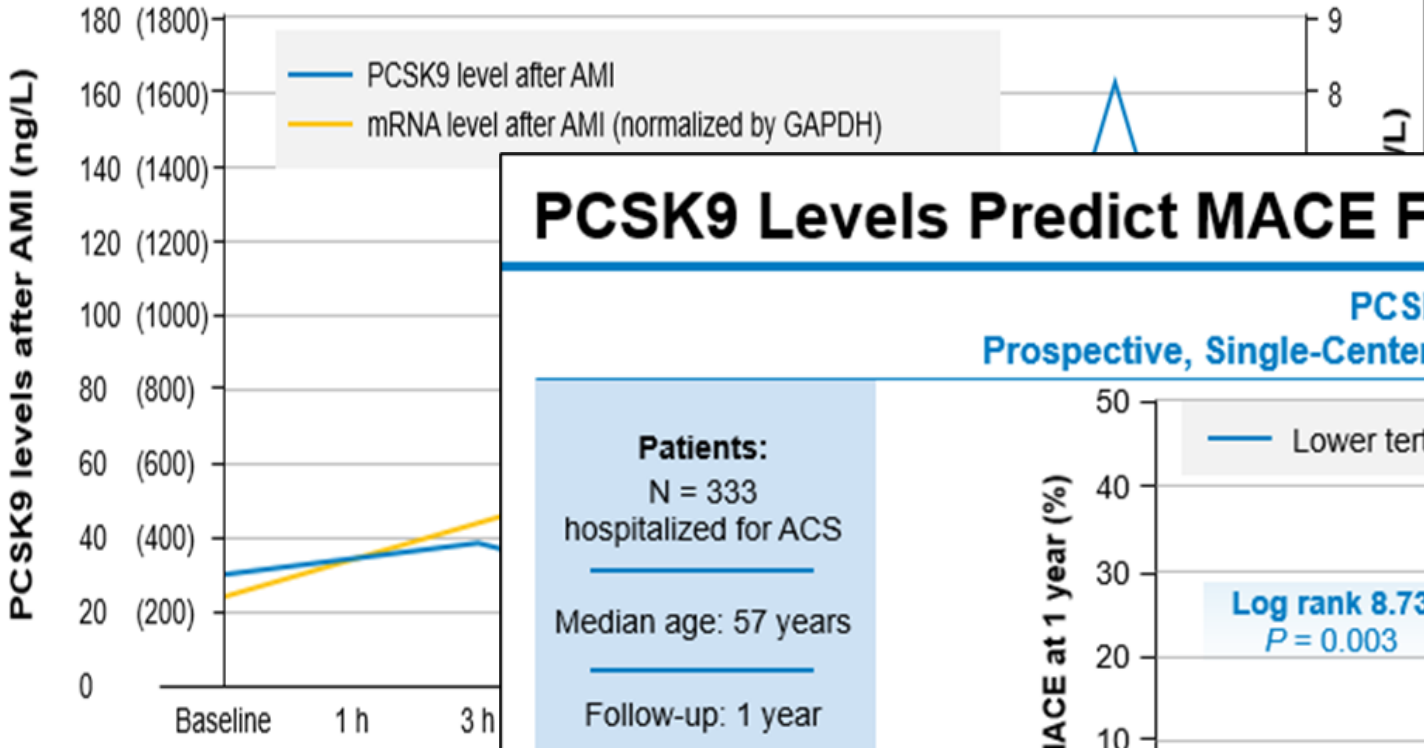
↓ Death, MI, ischemia-driven revascularization

OR$_{adj}$[1] 0.41
(95%CI 0.17-0.97)

[1] with age, sex, diabetes, prior MI

Alirocumab Placebo Alirocumab Placebo

PCSK9 Peak Levels Rise up to 48 Hours in ACS



PCSK9 Levels Predict MACE Following ACS

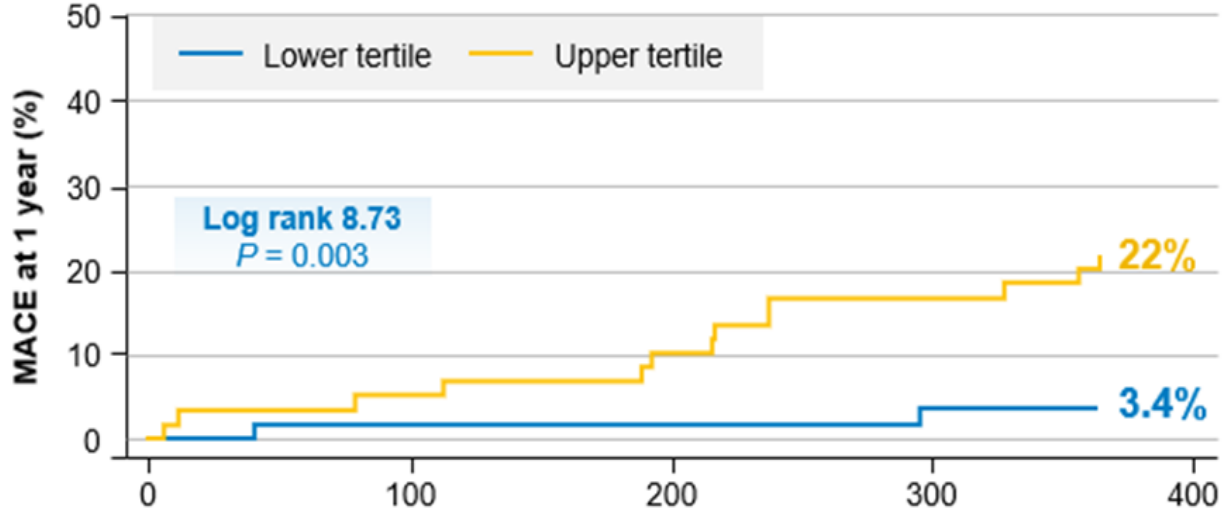
PCSK9-REACT
Prospective, Single-Center, Observational Study in Austria

Patients:
N = 333
hospitalized for ACS

Median age: 57 years

Follow-up: 1 year

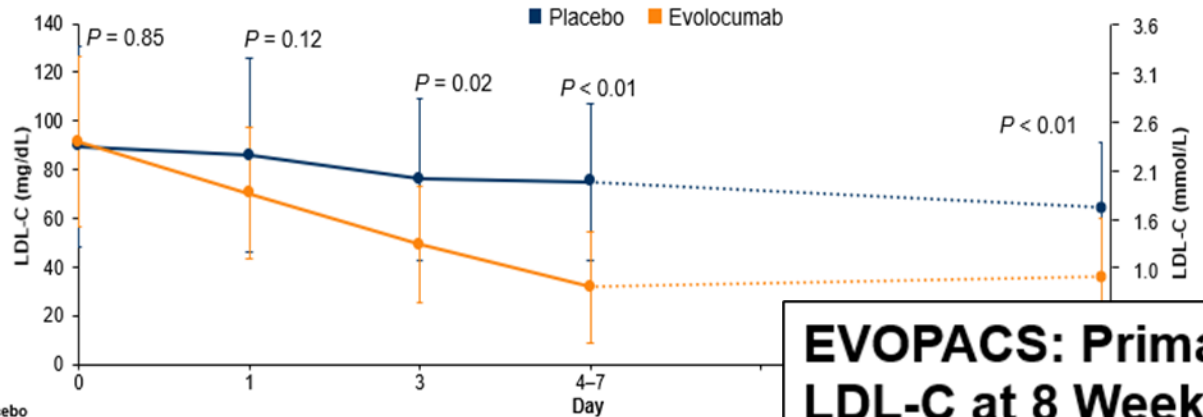
MACE = CV death, MI, UA, stent thrombosis, repeat revascularization, and ischemic stroke



No. at risk					
Lower tertile	59	57	57	52	0
Upper tertile	59	56	53	49	0

Upper tertile = higher PCSK9 concentration
Lower tertile = lower PCSK9 concentration

EVACS: LDL-C Levels Declined as Early as Day 1 After Administration of Evolocumab and Were Significantly Reduced Compared with Placebo by Day 3



Placebo				
mg/dL	89.6 ± 41	86.0 ± 40	76.1 ± 33	75.0 ± 32
mmol/L	2.3 ± 1.1	2.2 ± 1.0	2.0 ± 0.9	1.9 ± 0.8
Evolocumab				
mg/dL	91.5 ± 35	70.4 ± 27	49.2 ± 24	31.9 ± 23
mmol/L	2.4 ± 0.9	1.8 ± 0.7	1.3 ± 0.6	0.8 ± 0.6

Evolocumab, added to statin therapy, significantly reduced LDL-C levels th follow-up in comparison with the placebo group (statin alone) (35.9 ± 24 vs 64.5 ± 27 mg/dL [1.7 ± 0.7 mmol/L] placeb

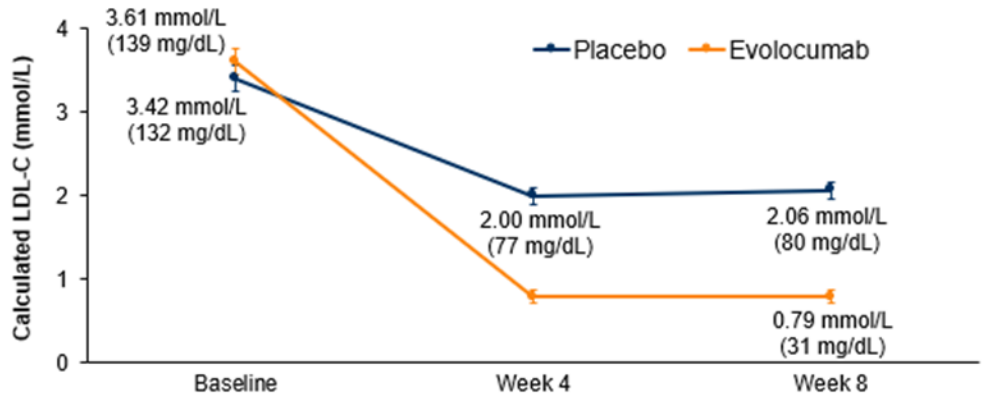
EVOPACS: Primary Endpoint Showed Significant Reduction in LDL-C at 8 Weeks

Optional Module 3: Baseline Statin Therapy

Mean Values

The reduction in LDL-C levels was evident at 4 weeks and maintained at 8 weeks

There were no differences observed for any of the exploratory endpoints



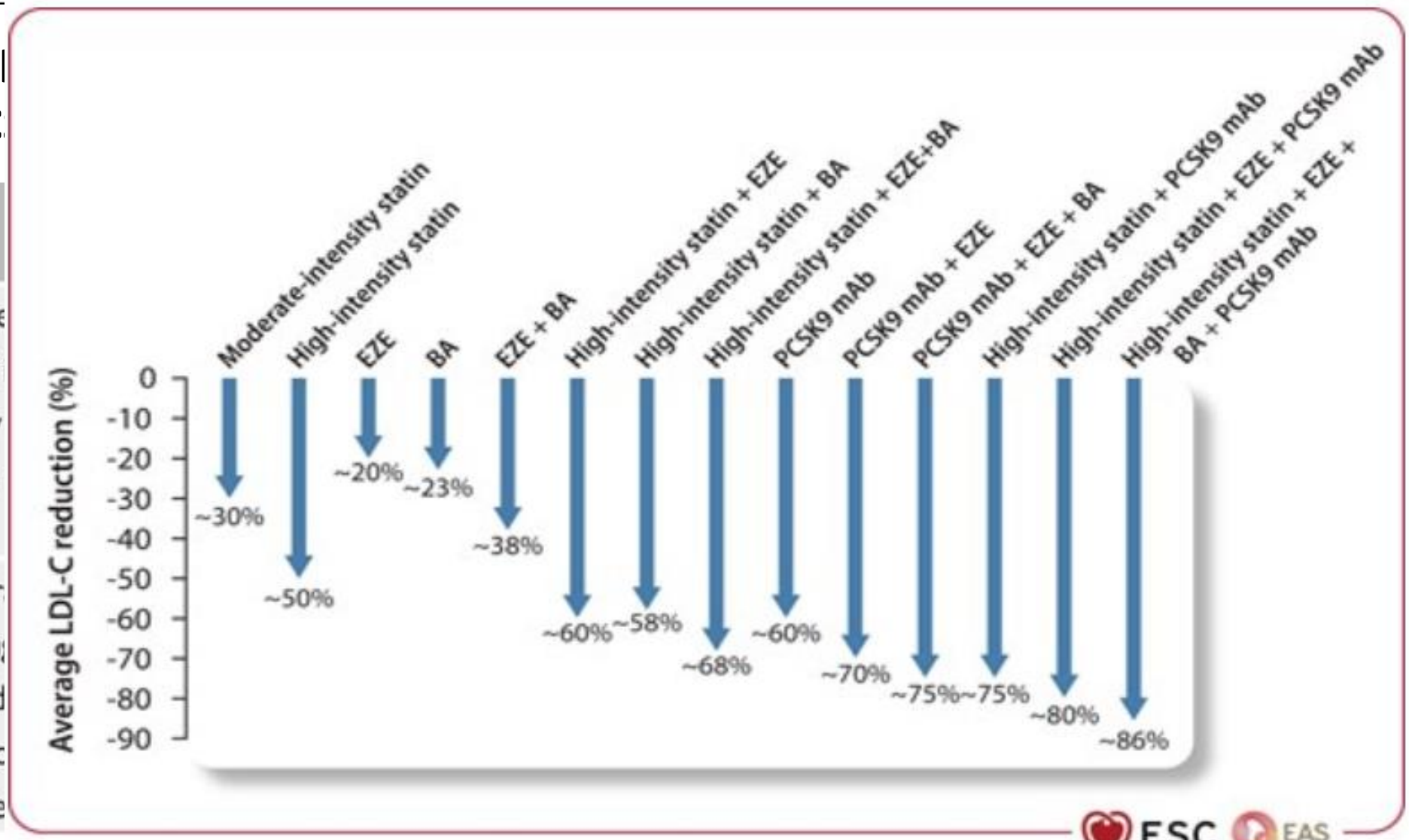
No. of patients			
Placebo	148	144	149
Evolocumab	146	136	141
Absolute difference, LS means (mmol/L)		**1.34**	**1.43**
Percentage difference		38.4%	40.7%
P value		< 0.001	< 0.001

ESC European Society of Cardiology
European Heart Journal (2025) 00, 1–20
https://doi.org/10.1093/eurheartj/ehaf190
ESC GUIDELINES

2025 Focused Update of the 2019 ESC/EAS Guidelines for the management of dyslipidaemias

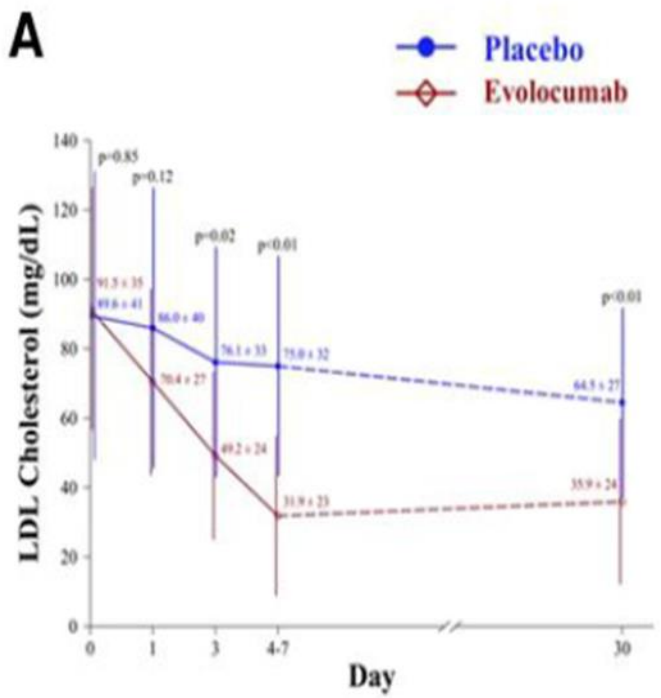
'the sooner, the
patients with AC

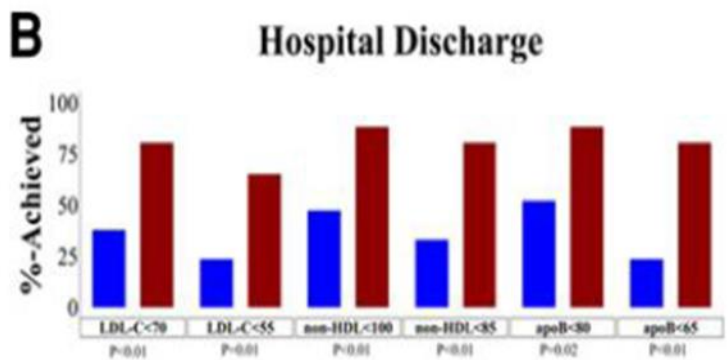
Recommendations
Intensification of lipid-lowe index ACS hospitalization patients who were on any before admission in order levels.
Initiating combination ther statin plus ezetimibe durin ACS should be considered treatment-naïve and are nc LDL-C goal with statin the

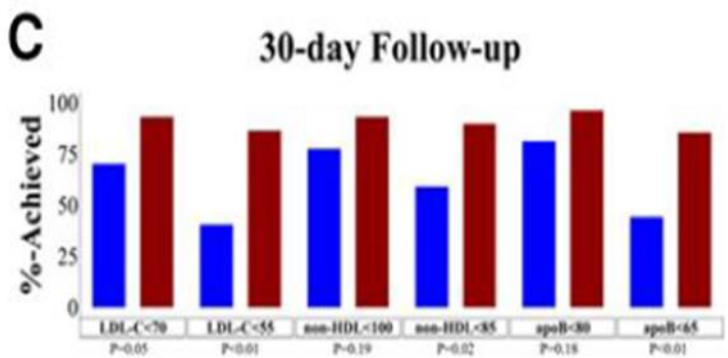


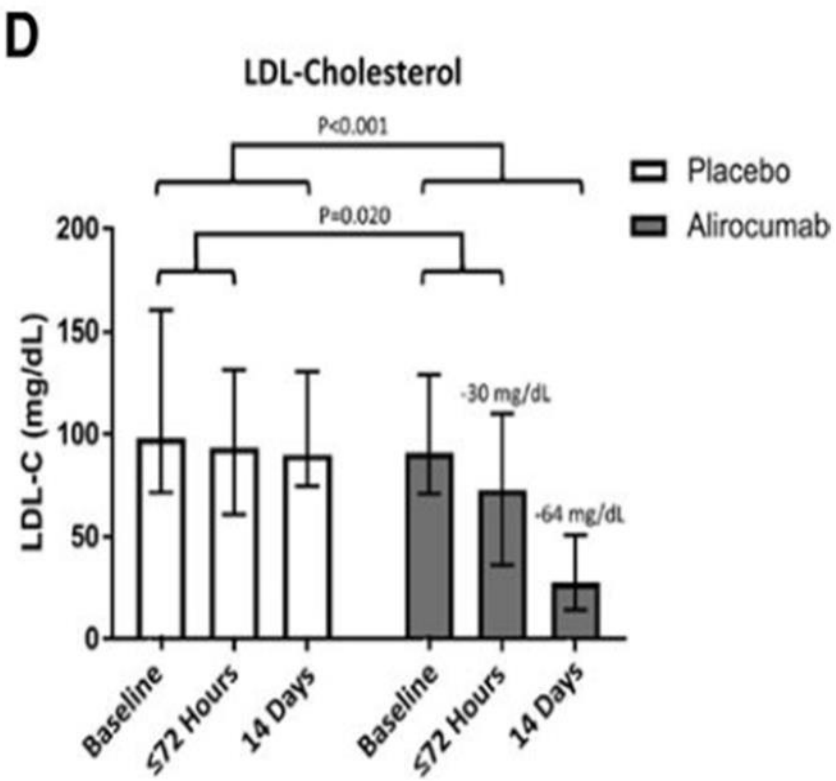
Acute LDL-C reduction post ACS: strike early and strike strong: from evidence to clinical practice. A clinical consensus statement of the Association for Acute CardioVascular Care (ACVC), in collaboration with the European Association of Preventive Cardiology (EAPC) and the European Society of Cardiology Working Group on Cardiovascular Pharmacotherapy

European Heart Journal: Acute Cardiovascular Care (2022) 11, 939–949





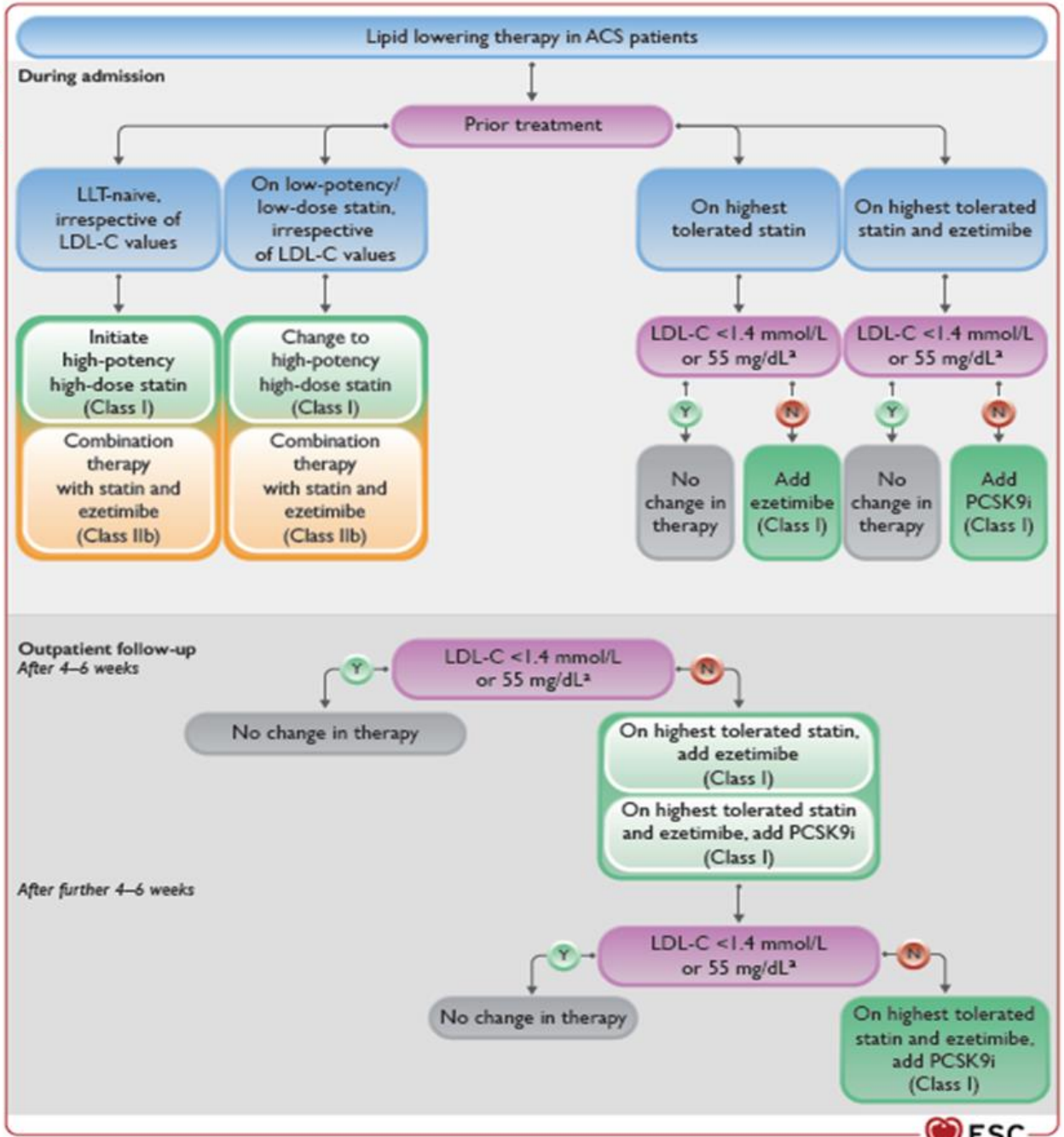




ESC European Society of Cardiology
European Heart Journal (2023) 00, 1–107
https://doi.org/10.1093/eurheartj/ehad191

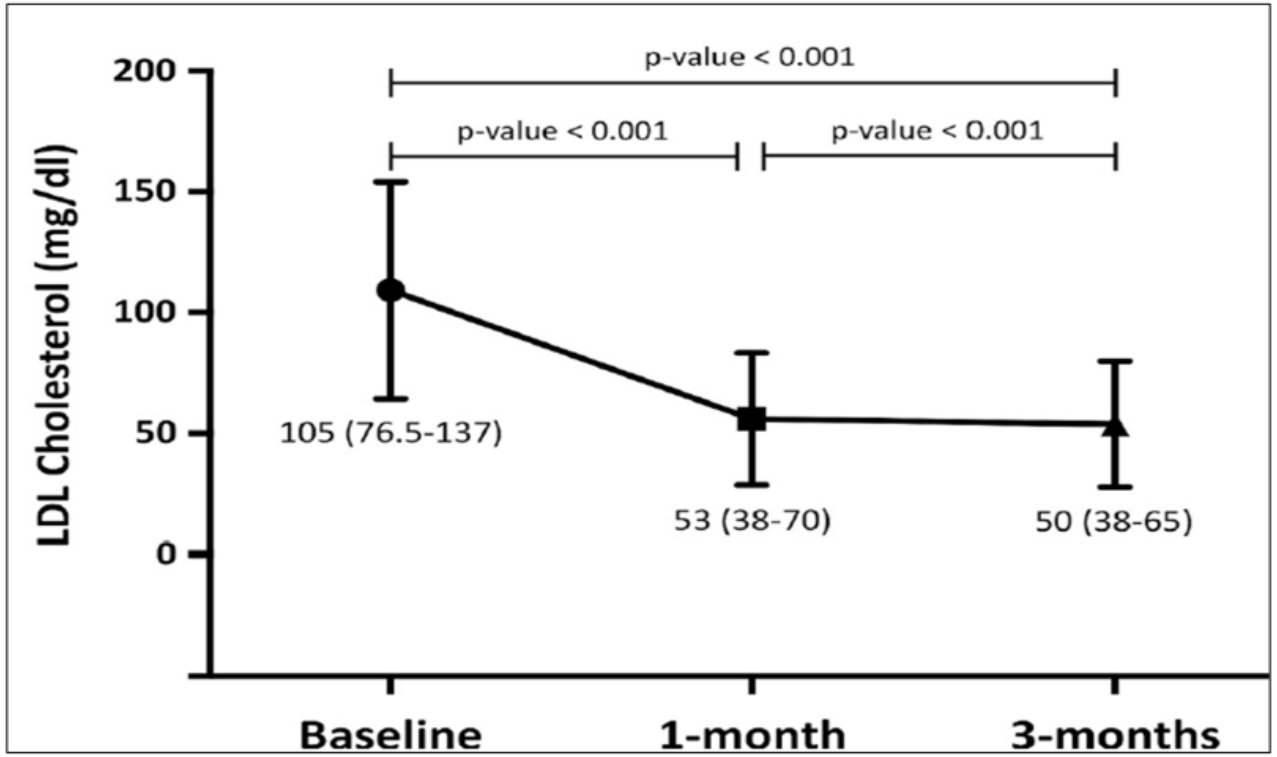
ESC GUIDELIN

2023 ESC Guidelines for the management of acute coronary syndromes



Achievement of target LDL-cholesterol level in patients with acute coronary syndrome undergoing percutaneous coronary intervention: The JET-LDL registry

Results: A total of 1095 patients were included: 33.7% were already on LLT.
Baseline LDL-C levels was 105 mg/dL.
At *hospital discharge* all patients were on LLT: 98.1% received statins (as mono or combination therapy), ezetimibe and PCSK9i were used in 60.1% and 8.5% of cases, respectively.
At *1-month* LDL-C levels dropped to 53 (38–70) mg/dL ($p < 0.001$ vs baseline) and it was **<55 mg/dL in 53%** (95% CI 49–57) of patients; however, PCSK9i were added to 7 further cases.
At *3-months* **58% of patients achieved the target level**, but PCSK9i was added to only 11 new patients.



International Journal of Cardiology 397 (2024) 131659

PCSK9i Outcome Trials: Main Results at a Glance

Outcomes relative reduction	fourier	ODYSSEY OUTCOMES
Primary endpoint	15%	15%
MI	27%	14%
Stroke	21%	27%
Unstable angina	1%	39%
CV death	+5% increase (NS)	12% (NS)
All cause death	+4% increase (NS)	15% (p=0.026*)

* Nominal p value

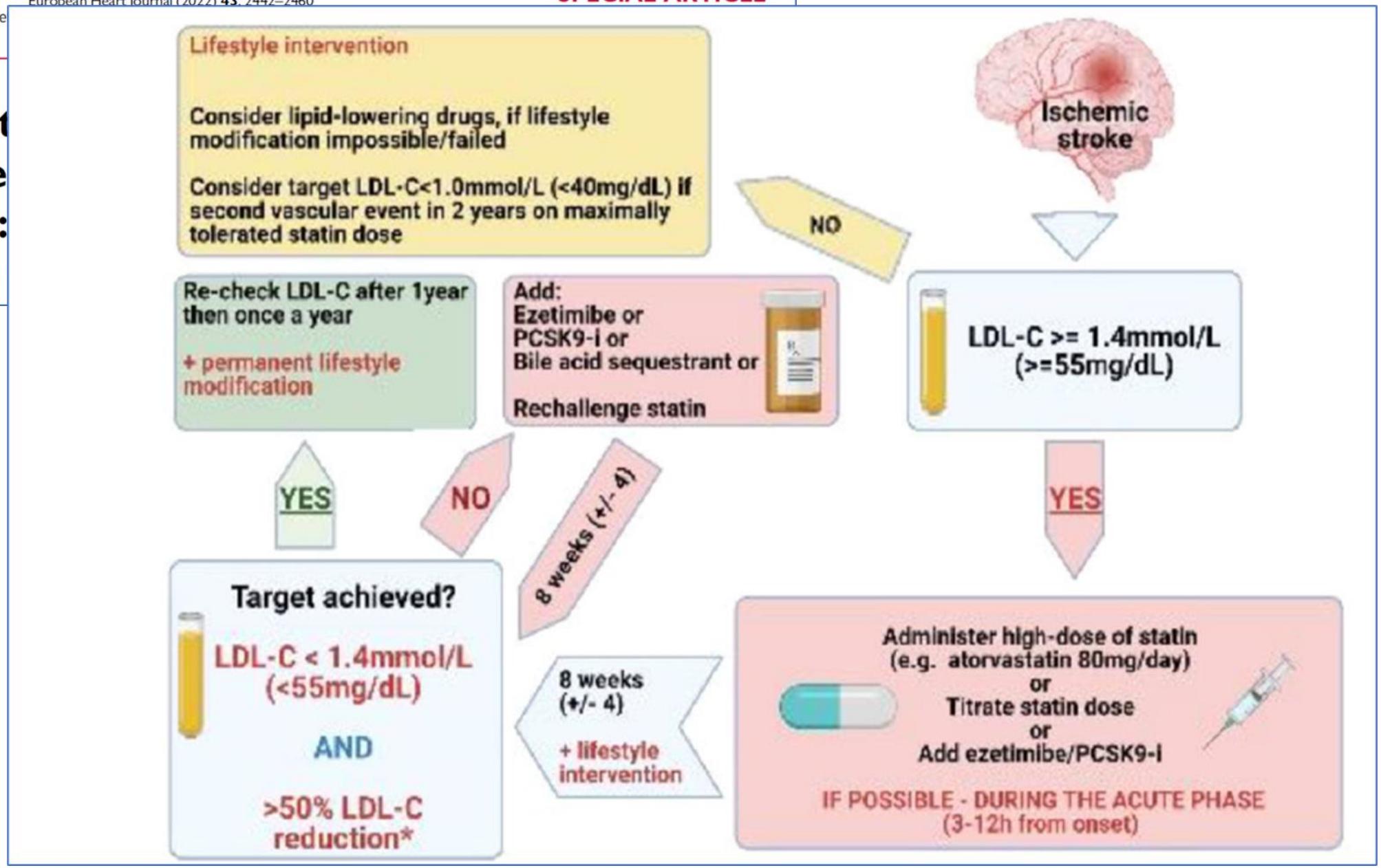
Sabatine MS, et al. N Engl J Med 2017;376:1713
Schwartz GG et al. N Engl J Med 2018 [Epub ahead of print]

ESC European Society of Cardiology

European Heart Journal (2022) 43, 2442–2460

SPECIAL ARTICLE

Integrat
manage
disease:
Society



Studio SANTORINI

SANTORINI

Solamente il 20.7% dei pazienti arruolati ha raggiunto il target LDL previsto.
Solo il 15% dei pazienti con ASCVD a sede cerebrale ha raggiunto il goal LDL previsto.

	All patients (N=6954)	Coronary ASCVD (N=4857)	Cerebral ASCVD (N=400)	Peripheral/other ASCVD (N=150)	Polyvascular ASCVD (N=1547)
Achieving LDL-C goals, n (%)	1438 (20.7)	980 (20.2)	60 (15.0)	28 (18.7)	370 (23.9)

Nonostante fossero a rischio molto alto, per **il 21,4%** dei pazienti è stata documentata **una totale assenza di terapia ipolipidemizzante**.

LDL-C goal achievement and lipid-lowering therapy in patients by atherosclerotic cardiovascular disease subtype: The SANTORINI study

Catapano et al. ESC 2022

Medical News & Perspectives

It Takes an Average of 17 Years for Evidence to Change Practice—the Burgeoning Field of Implementation Science Seeks to Speed Things Up

Rita Rubin, MA

Therapeutic inertia

refers to the failure to initiate or intensify therapy when treatment goals are not met.

This phenomenon significantly impacts lipid management, leaving patients at higher risk for cardiovascular events.

Studio SANTORINI

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ESC European Society of Cardiology

European Heart Journal (2024) **45**, 4184–4196
https://doi.org/10.1093/eurheartj/ehae558

FASTTRACK – CLINICAL RESEARCH
Epidemiology, prevention, and health care policies

International Journal of Cardiology 433 (2025) 133290

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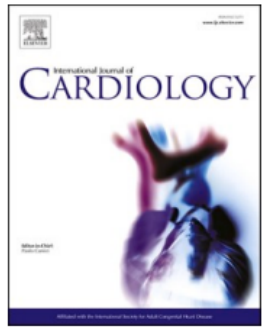

LDL-cholesterol levels and lipid lowering therapy in secondary prevention. Baseline data from the BRING-UP prospective registry

33%

- ✓ Inerzia medico-relata
- ✓ Difficolta logistico-gestionali (burocrazia, spesa economica, piani terapeutici)
- ✓ Resistenza del paziente alla modifica terapeutica
- ✓ NON-ADERENZA

Article

Therapeutic Inertia in Dyslipidemia Management for Secondary Cardiovascular Prevention: Results from the Italian ITACARE-P Network

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- **CRITERI DI INCLUSIONE:**

✓ Una storia pregressa di malattia cardiovascolare aterosclerotica (ASCVD)

✓ Disponibilità di valori di colesterolo LDL nel siero al momento della valutazione clinica nel periodo 01.01.2023 - 30.06.2024.

✓ La valutazione del colesterolo LDL avvenuta almeno 4 settimane dopo sia il primo evento ASCVD che l'inizio della terapia ipolipemizzante

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- **OBBIETTIVI DELLO STUDIO:**

Ci atteniamo alle linee guida ESC 2019??

1. Valutare il numero di pazienti con LDL a target in prevenzione secondaria in un setting di real world
2. Valutare il numero di pazienti non a target LDL a cui è stata effettuata una modifica terapeutica
3. Valutare l'efficacia delle modifiche terapeutiche proposte

Abbiamo il problema dell'inerzia terapeutica?

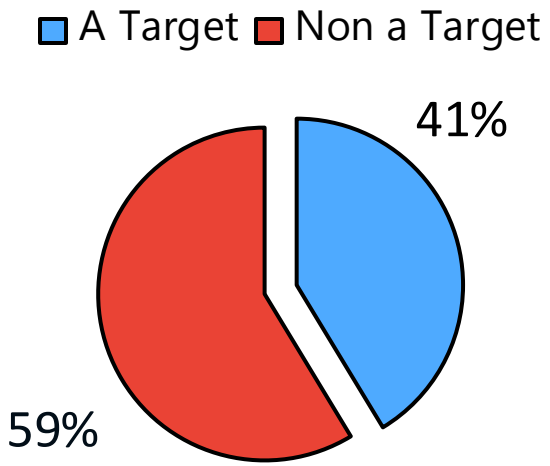
ESEMPIO: Un paziente con LDL = 67mg/dl, ossia una distanza % dal target (55mg/dl) pari al **17%** in terapia con rosuvatatina 10mg

Scelta A) Raddoppio dosaggio rosuvastatina→ attesa una riduzione del circa 6%→ ragionevolmente NON efficace

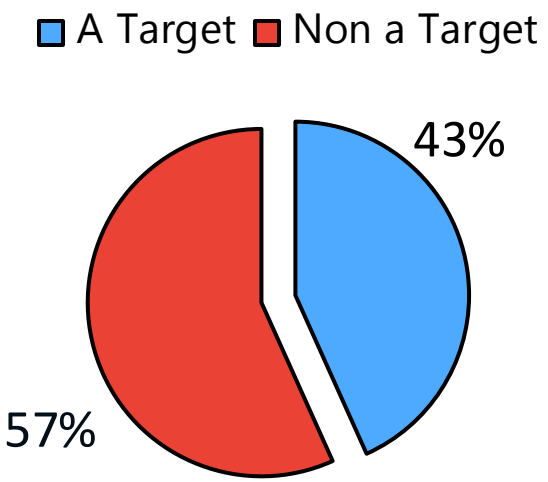
Scelta B) Aggiungo Ezetimibe → attesa riduzione del circa 20%→ ragionevolmente EFFICACE

Demographic and Clinical Characteristics	
Number of Patients	1909
Age ± SD	68 ± 11.4
- more than 75 years (%)	- 517 (27.1)
Female Gender (%)	402 (21.1)
Clinical Event (%)	1909 (100)
- CCS	- 392 (20.5)
- Post-ACS	- 1451 (76.0)
- Stroke/TIA	- 99 (5.2)
- PAD	- 268 (14.0)
- Combination (at least 2)	- 285 (14.9)
Multiple Events < 2 years (%)	170 (8.9)
Multivessel Coronary Artery Disease (%)	1018 (55.2)
Time Since first Event (months ± SD)	77 ± 87
Event < 1 year (%)	485 (26.6)
Hypertension (%)	1414 (74.1)
Diabetes (%)	506 (26.6)
Dyslipidaemia (%)	1604 (84.0)
Chronic Renal Disease (%)	329 (17.2)
Obesity (%),(data available in N = 968)	184 (19.0)
Smoking Status (%)	
- Never	- 920 (48.2)
- Former	- 732 (38.3)
- Active	- 257 (13.5)
Symptoms (%), N= 1604	239 (14.9)
- Angina	- 54 (3.4)
- Dyspnea	- 190 (12.0)
- Claudicatio	- 31 (2.0)
Atrial Fibrillation (%)	237 (12.4)
Cardiac Rehabilitation (%), N= 1209	589 (48.7%)

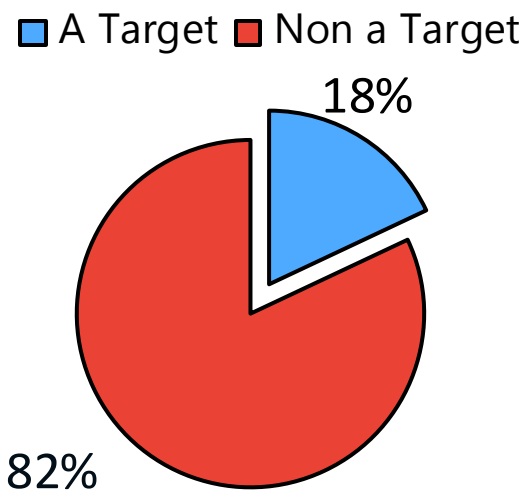
Lipid Data	
Number of Patients	1909
Total Cholesterol (mg/dl) ± SD, N= 1487	137.6 ± 41
LDL-c (mg/dl) ± SD	66.5 ± 33.6
HDL-c (mg/dl) ± SD, N= 1417	47.9 ± 12.8
Non HDL-c (mg/dl) ± SD, N= 1412	89.5 ± 38.7
Triglycerides (mg/dl) ± SD, N= 1439	118.6 ± 57.3
Patients with LDL-c target < 55 mg/dl (%): - Achieving Target	1739 (91.1) 758 (43.6)
Patients with LDL-c target < 40 mg/dl (%): - Achieving Target	170 (8.9) 31 (18.2)
Lipid-Lowering Data	
No Therapy (%)	59 (3.1)
Statin Only (%)	510 (26.7)
Ezetimibe Only (%)	24 (1.3)
PCSK9-i Only (%)	26 (1.3)
Bempedoic Acid Only (%)	0 (0)
Inclisiran Only (%)	2 (0.1)
Statin + Ezetimibe (%): - Single Pill	1046 (54.8) - 826 (79.0)
Bempedoic Acid + Ezetimibe (%) - Single Pill	8 (0.4) - 6 (75.0)
PCSK9-i + Ezetimibe (%)	39 (2.0)
Statin + Ezetimibe + PCSK9-i (%)	93 (4.9)
Bempedoic Acid + PCSK9-i (%)	2 (0.1)
Fibrates (%)	20 (1.0)
PUFA (%)	125 (6.5)



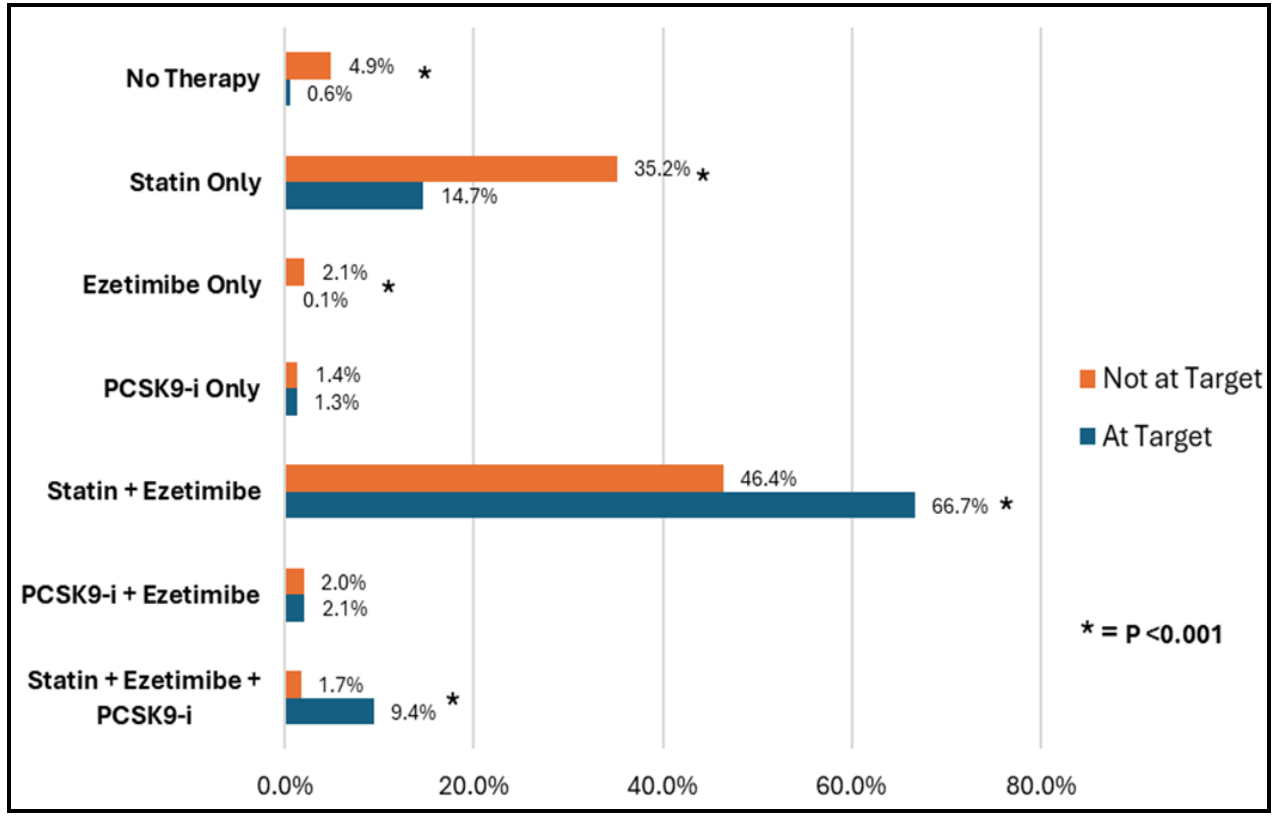
Target < 55mg/dl



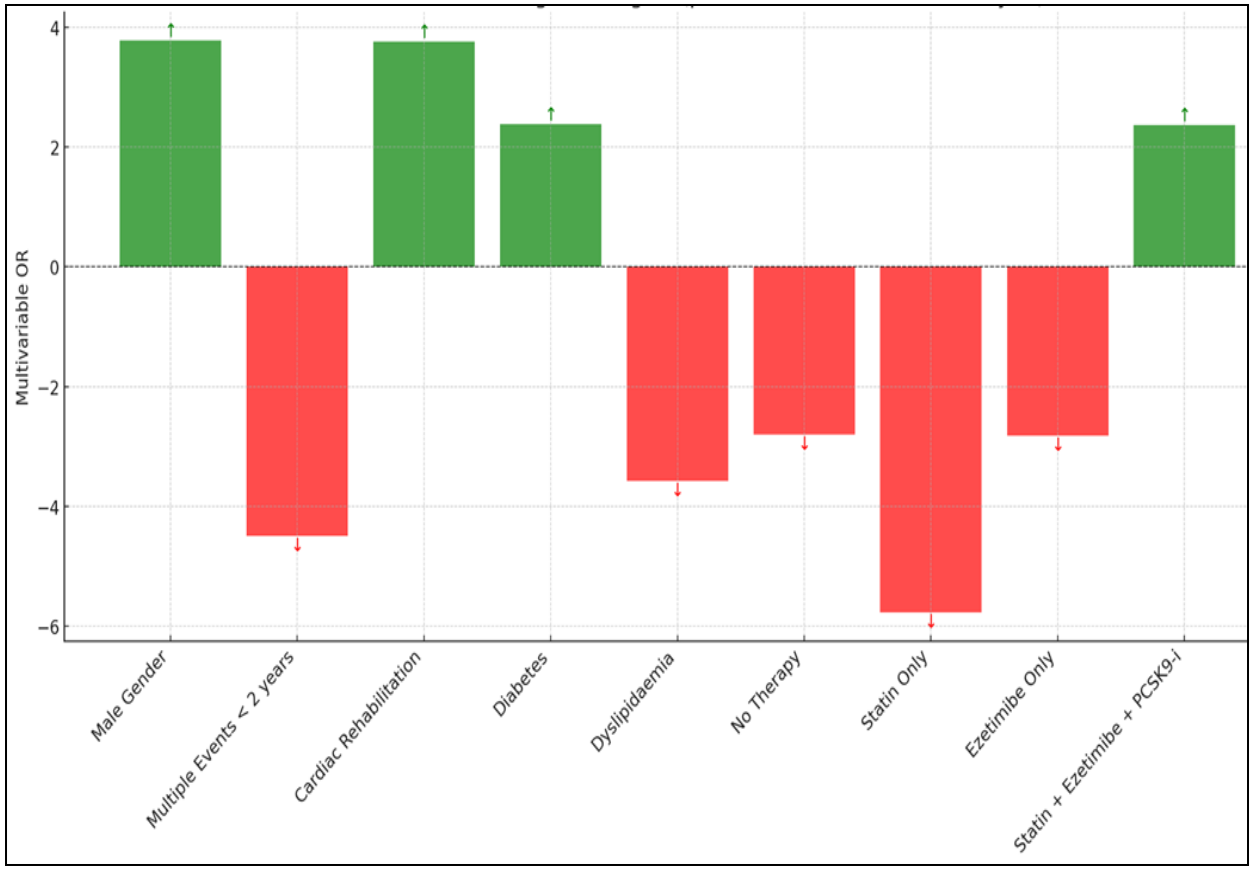
Target < 40mg/dl



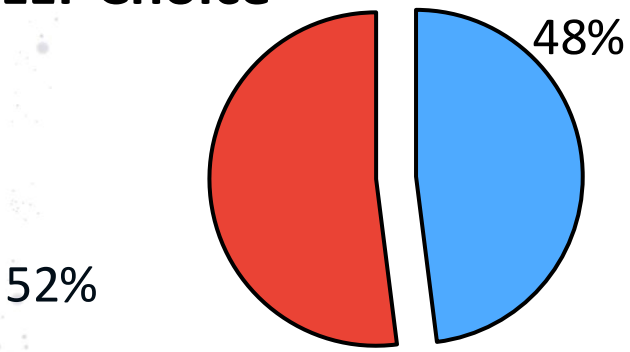
	Achieving LDL-C Target	Not Achieving LDL-C Target	P. value
Number of Patients (%)	789 (41.3)	1120 (58.7)	-
Age ± SD	66.9± 10.9	68.9± 11.7	**<0.001**
Female Gender (%)	107 (13.6)	295 (26.3)	**<0.001**
Multiple Events < 2 Years (%)	31 (3.9)	139 (12.4)	**<0.001**
Multivessel Disease (%)	447 (57.3)	571 (53.7)	**0.014**
Time Since Event (months) ± SD	70 ± 84	72 ± 86	**0.005**
Event < 1 year (%)	234 (31.0)	251(23.4)	**<0.001**
Hypertension (%)	577 (73.1)	837 (74.7)	0.432
Diabetes (%)	244 (30.9)	262 (23.4)	**<0.001**
Chronic Renal Disease (%)	122 (15.5)	207 (18.5)	0.085
Obesity (%),(N = 968)	68 (19.3)	116 (28.2)	**0.004**
Symptoms (%), N= 1604	92 (14.3)	147 (15.3)	0.180
Cardiac Rehabilitation (%), N= 1209	317 (66.3)	272 (37.2)	**<0.001**
Total Cholesterol (mg/dl) ± SD, N= 1487	108.2 ± 19	158.9 ± 39	**<0.001**
LDL-c (mg/dl) ± SD	40.8 ± 10.8	84.6 ± 32.3	**<0.001**
Absolute Distance from LDL-C Target (mg/dl) ± SD	-13.6 ±10.5	31.5 ± 31.9	**<0.001**
Percentage Distance from LDL-C Target (%) ± SD	-53.2 ± 98.9	31.5 ± 18.5	**<0.001**
HDL-c (mg/dl) ± SD, N= 1417	45.8 ± 12.1	49.4 ± 13.1	**<0.001**
Not HDL-c (mg/dl) ± SD, N= 1412	62.2 ± 16.6	110.2 ± 37.9	**<0.001**
Triglycerides (mg/dl) ± SD, N= 1439	114.1 ± 58.1	122.0 ± 56.4	**0.009**
No Therapy (%)	5 (0.6)	55 (4.9)	**<0.001**
Statin Only (%)	116 (14.7)	394 (35.2)	**<0.001**
Ezetimibe Only (%)	1 (0.1)	23 (2.1)	**0.001**
PCSK9-i Only (%)	10 (1.3)	16 (1.4)	0.853
Statin + Ezetimibe (%): - Single Pill	526 (66.7) - 434 (82.5)	520 (46.4) - 392 (75.4)	**<0.001** - **0.005**
PCSK9-i + Ezetimibe (%)	17 (2.1)	22 (2.0)	0.879
Statin + Ezetimibe + PCSK9-i (%)	74 (9.4)	19 (1.7)	**<0.001**
PUFA (%)	40 (5.1)	85 (7.6)	**0.03**

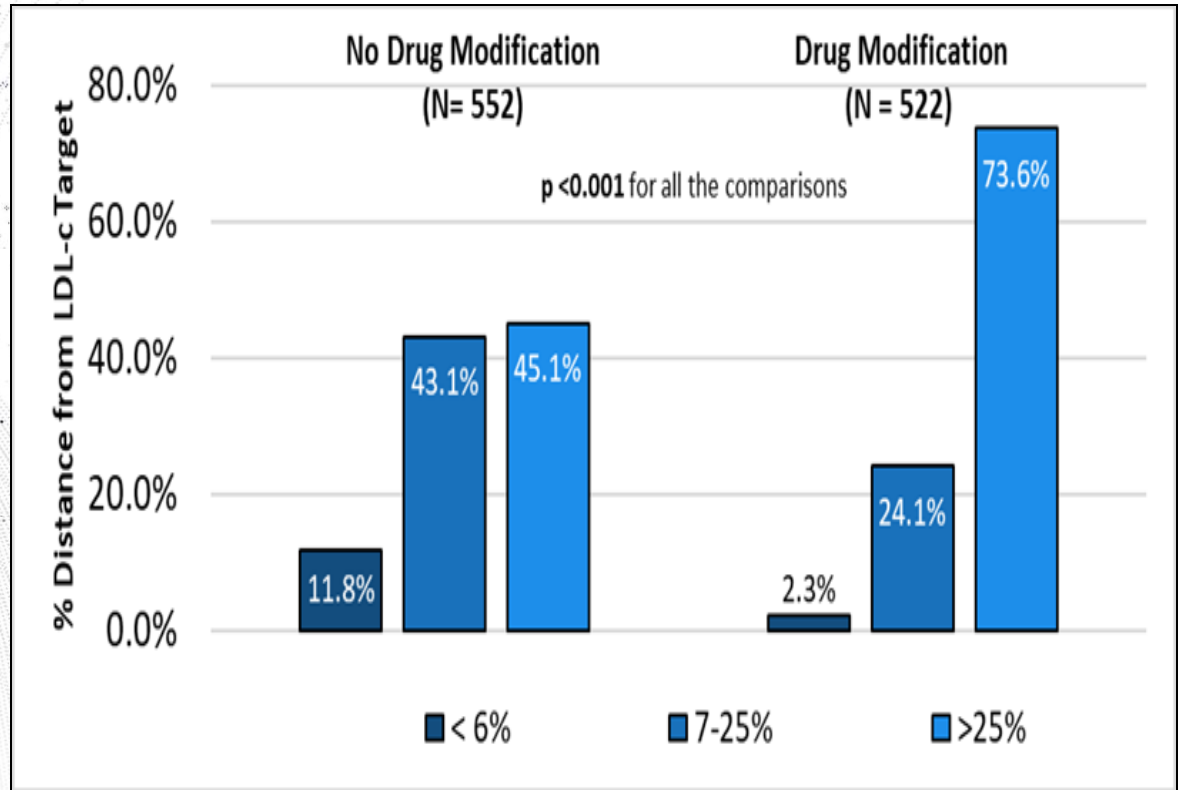


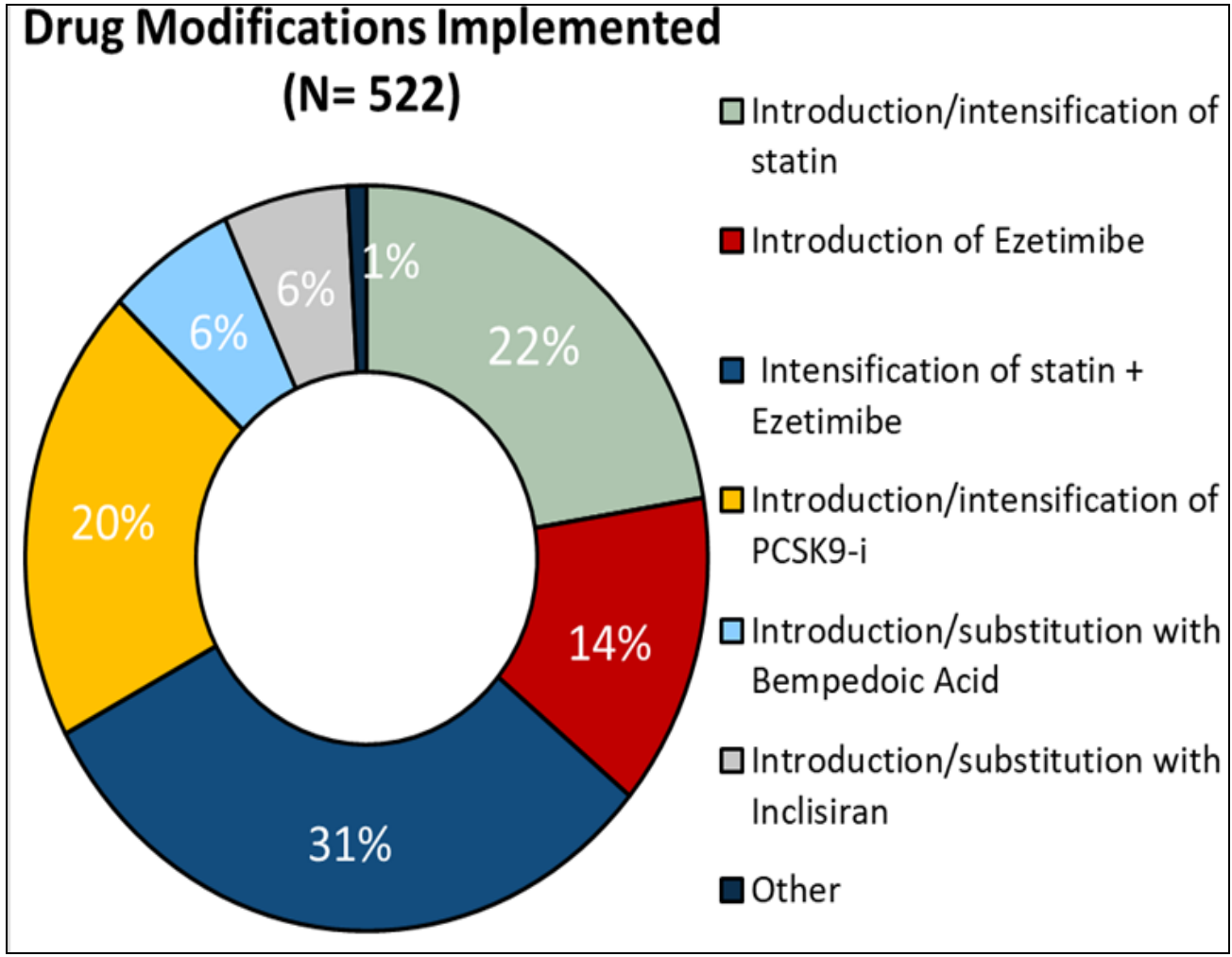
Predictors of achieving LDL targets	Univariable		Multivariable	
	OR	P value	OR	P value
Male Gender	6.82	**<0.001**	3.78	**<0.001**
Acute Coronary Syndrome	4.85	**<0.001**	1.96	**0.05**
ASCVD event < 1 year	3.61	**<0.001**	-1.41	0.158
Multiple Events < 2 years	-6.47	**<0.001**	-4.49	**<0.001**
Cardiac Rehabilitation	10.3	**<0.001**	3.76	**<0.001**
Diabetes	3.72	**<0.001**	2.38	**0.018**
Dyslipidaemia	-3.55	**<0.001**	-3.57	**<0.001**
Obesity	-2.88	**0.004**	-1.37	0.170
No Therapy	-5.24	**<0.001**	-2.80	**0.005**
Statin Only	-10.8	**<0.001**	-5.77	**<0.001**
Ezetimibe Only	-4.19	**<0.001**	-2.82	**<0.001**
Statin + Ezetimibe	8.51	**<0.001**	-0.90	0.371
Statin + Ezetimibe + PCSK9-i	7.80	**<0.001**	2.37	**0.018**



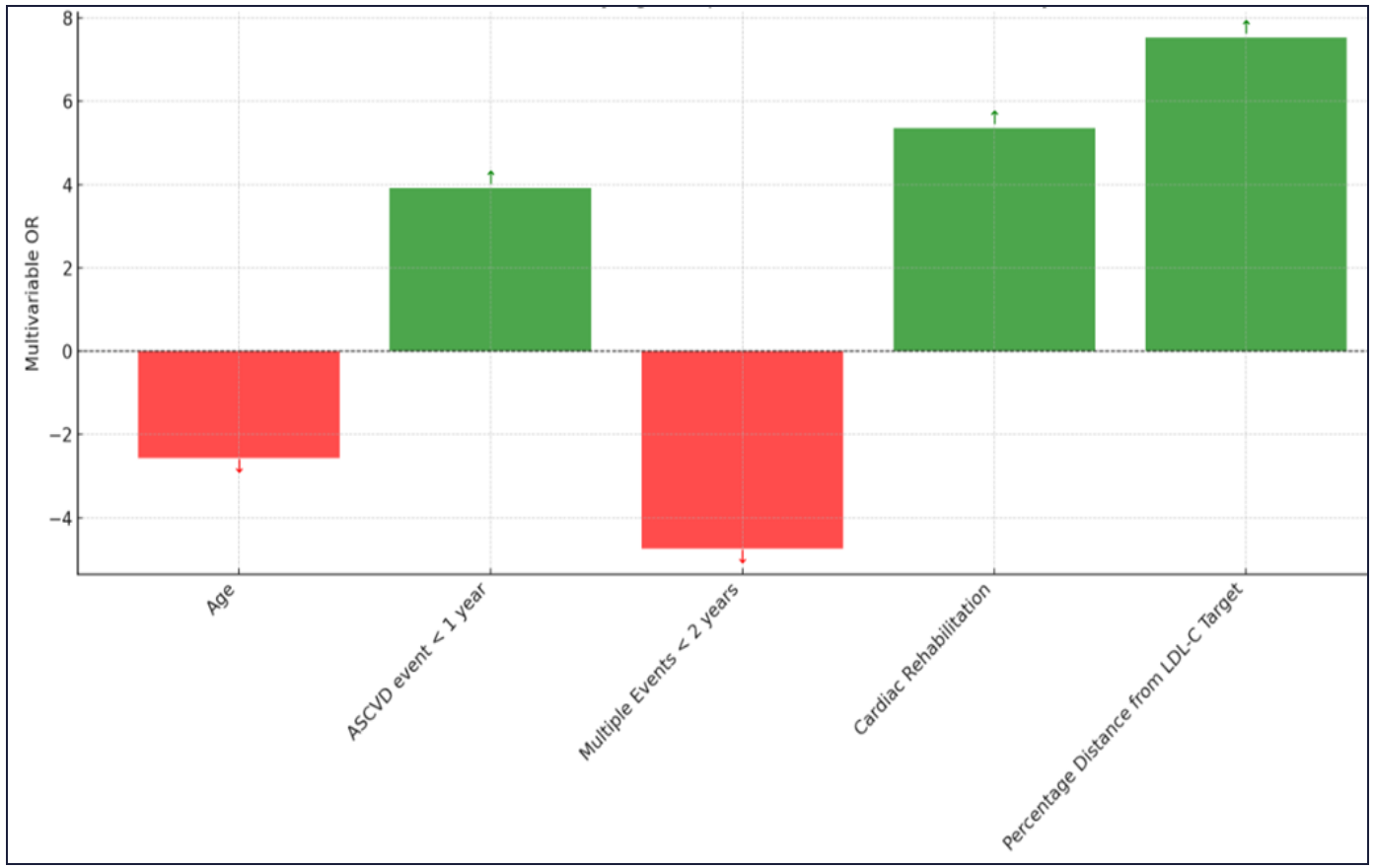
LLT Choice

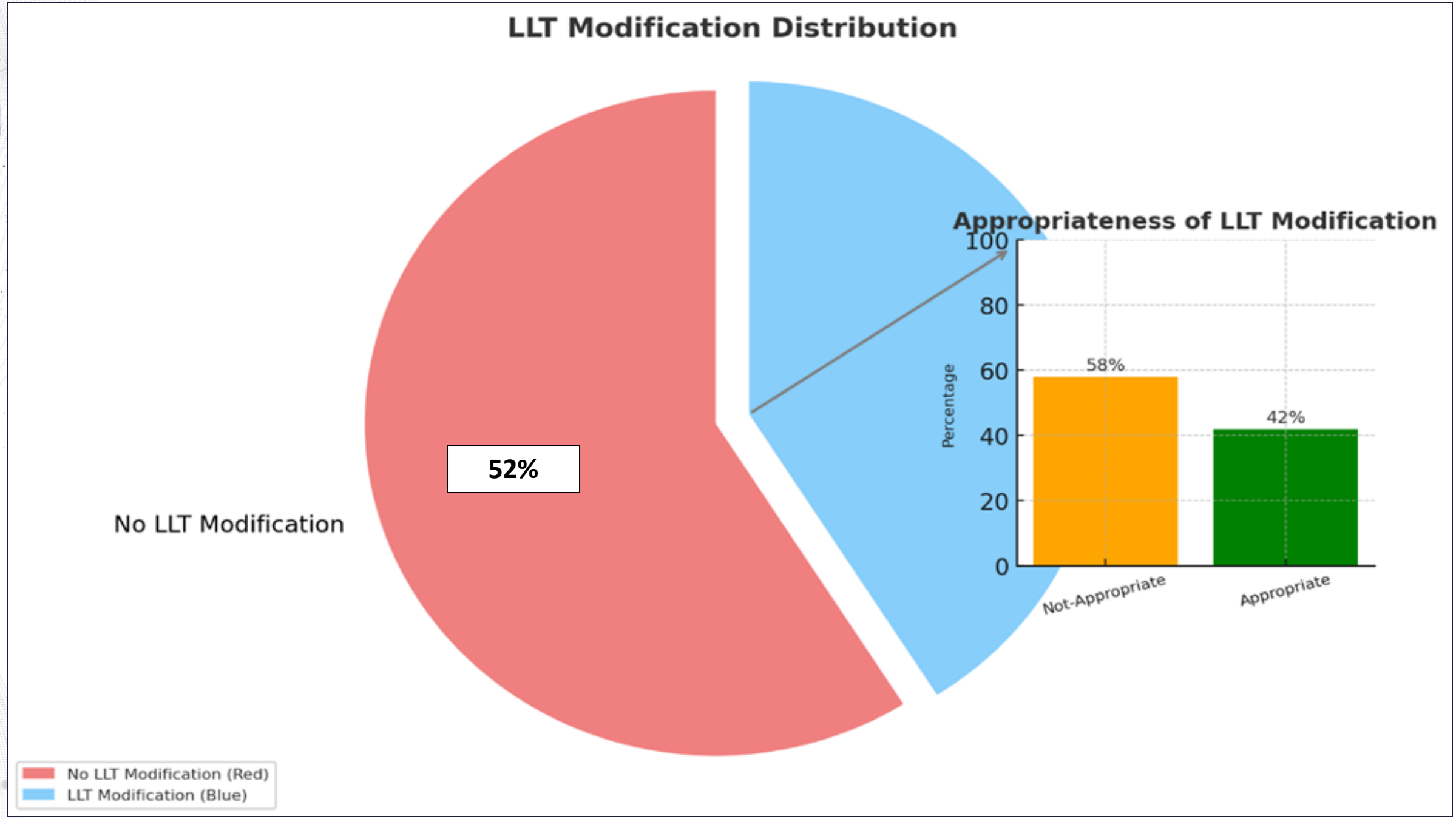

48%
52%
Drug modification
No drug modification


No Drug Modification
(N= 552)
Drug Modification
(N = 522)
p <0.001 for all the comparisons
% Distance from LDL-c Target
80.0%
60.0%
40.0%
20.0%
0.0%
11.8%
43.1%
45.1%
2.3%
24.1%
73.6%
< 6%
7-25%
>25%


Drug Modifications Implemented
(N= 522)
1%
22%
6%
6%
20%
14%
31%
Introduction/intensification of statin
Introduction of Ezetimibe
Intensification of statin + Ezetimibe
Introduction/intensification of PCSK9-i
Introduction/substitution with Bempedoic Acid
Introduction/substitution with Inclisiran
Other

Predictors of modifying LLT	Univariable		Multivariable	
	OR	P value	OR	P value
Age	-3.36	**<0.001**	-2.56	**0.011**
Multivessel Disease	-2.49	**0.013**	0.89	0.370
ASCVD event < 1 year	5.51	**<0.001**	3.91	**<0.001**
Multiple Events < 2 years	-5.19	**<0.001**	-4.74	**<0.001**
Time Since Event	-2.48	**0.013**	0.51	0.610
Cardiac Rehabilitation	3.66	**<0.001**	5.35	**<0.001**
Dyslipidaemia	2.33	**0.020**	-1.21	0.229
Chronic Renal Disease	-2.83	**0.005**	-0.75	0.452
LDL-c	11.5	**<0.001**	1.99	0.146
Percentage Distance from LDL-C Target	12.26	**<0.001**	7.53	**<0.001**
No Therapy	2.69	**0.007**	1.38	0.169
Statin Only	5.12	**<0.001**	1.18	0.239
Ezetimibe Only	3.62	**<0.001**	0.29	0.771
Statin + Ezetimibe	-6.64	**<0.001**	-0.68	0.497
Statin + Ezetimibe + PCSK9-i	-2.26	**0.024**	-1.05	0.296




LLT Modification Distribution
No LLT Modification
52%
No LLT Modification (Red)
LLT Modification (Blue)
Appropriateness of LLT Modification
Percentage
100
80
60
40
20
0
58%
42%
Not-Appropriate
Appropriate

From Clinical Inertia to Therapeutic Optimization in Patients with Atherosclerotic Cardiovascular Disease: A Monte Carlo Simulation within the ITACARE-P Registry

Articolo in stampa: Testo accettato

Andrea Faggiano MD, Alessandro Maloberti MDPhD, Marco Ambrosetti MD, Francesco Giallauria MDPhD, Gianfrancesco Mureddu MD, Elio Venturini MD, Matteo Ruzzolini MD, Francesco Maranta MD, Marco Vatri MD, Lana Zadre BSc, Stefano Carugo MD, Massimiliano Ruscica BScPhD, Francesco Fattirolli MDPhD e Pompilio Faggiano MD

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SIMULAZIONE MONTE CARLO (J Clinical Lipidology, in press)

ITACARE-P
N =1909

At target
= 789 (41.3%)

At target = 156

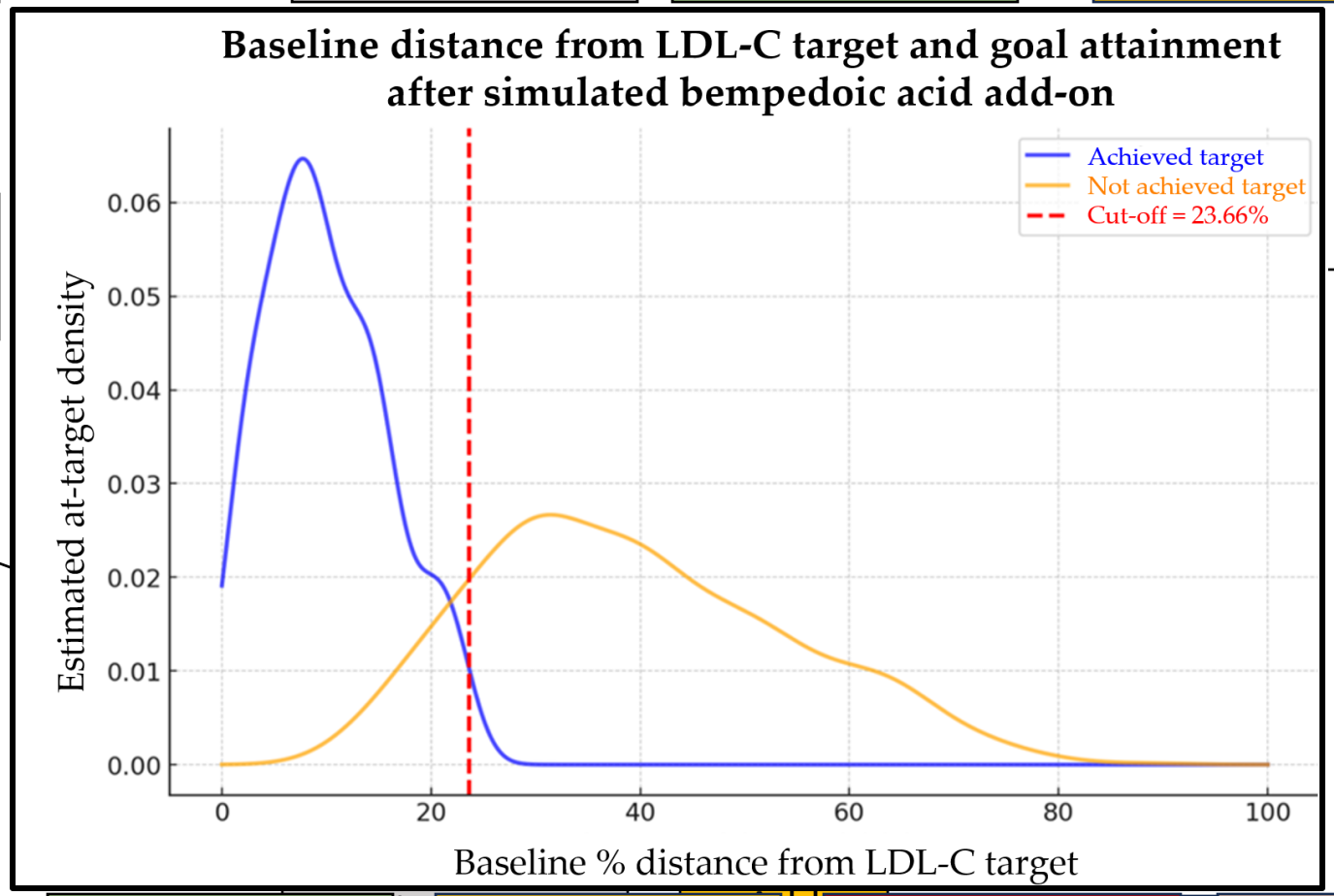
At target = 238

At target = 605

Add
PCSK9i

Efficacy as per
Fourier

Not at target
= 1120 (58.7%)



Add
BEMPE

Efficacy as per
Wisdom/Harmony

Statins + EZE +
BEMPE or EZE +
BEMPE =605

Efficacy as per
Orion 10-11

Add
Inclisiran

At target = 516

At target adding
EZE = 945 (50%)

At target adding
EZE+ BEMPE
= 1201 (63

Efficacy as per
Wisdom/Harmony

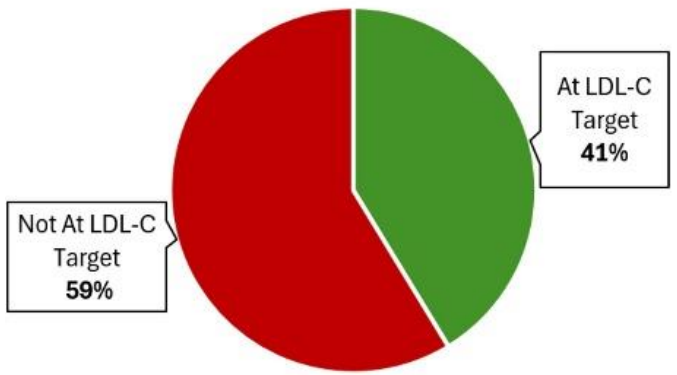
At target adding
EZE+BEMPE+ PCSK9i
=1806 (95%)

At target adding
EZE+BEMPE+
Inclisiran =1717(90%)

From 41% to >90% LDL-C Target Attainment with Monte Carlo Simulated Guideline-Based Stepwise LLT Intensification within the ITACARE-P Registry

ITACARE-P
ITALIAN ALLIANCE FOR CARDIOVASCULAR REHABILITATION AND PREVENTION

N= 1909 patients with established **ASCVD** referred to REHAB or secondary prevention clinics



Monte Carlo Simulation in Not at LDL-C target Patients (**N =1120**, 59%)

1) Add Ezetimibe

50% At target

2) Add Bempedoic Acid

63% At target

>23.6% from target → skip Bempedoic Acid, go injectables

3a) Add PCSK9i

95% At target

3b) Add Inclisiran

90% At target

- **CONCLUSIONI:**

✓ **Difficoltà concrete** nel raggiungere i target di colesterolo LDL nei pazienti in prevenzione secondaria
✓ **Inerzia terapeutica:** Ruolo critico nell'insuccesso terapeutico.
✓ **Approcci strutturati:** Calcolo della distanza percentuale dal target LDL per decisioni più efficaci e tempestive.
✓ **Terapie adeguate:** Necessità di modifiche terapeutiche aggressive per riduzioni significative del colesterolo LDL.

QUESTIONI APERTE

Inerzia terapeutica: fattori correlati al medico, al paziente, al sistema e possibili strategie di intervento

Marco Vatri[1], Elisabetta Angelino[2], Marco Ambrosetti[3], Andrea Faggiano[4], Pompilio Faggiano[5], Francesco Fattirolli[1]

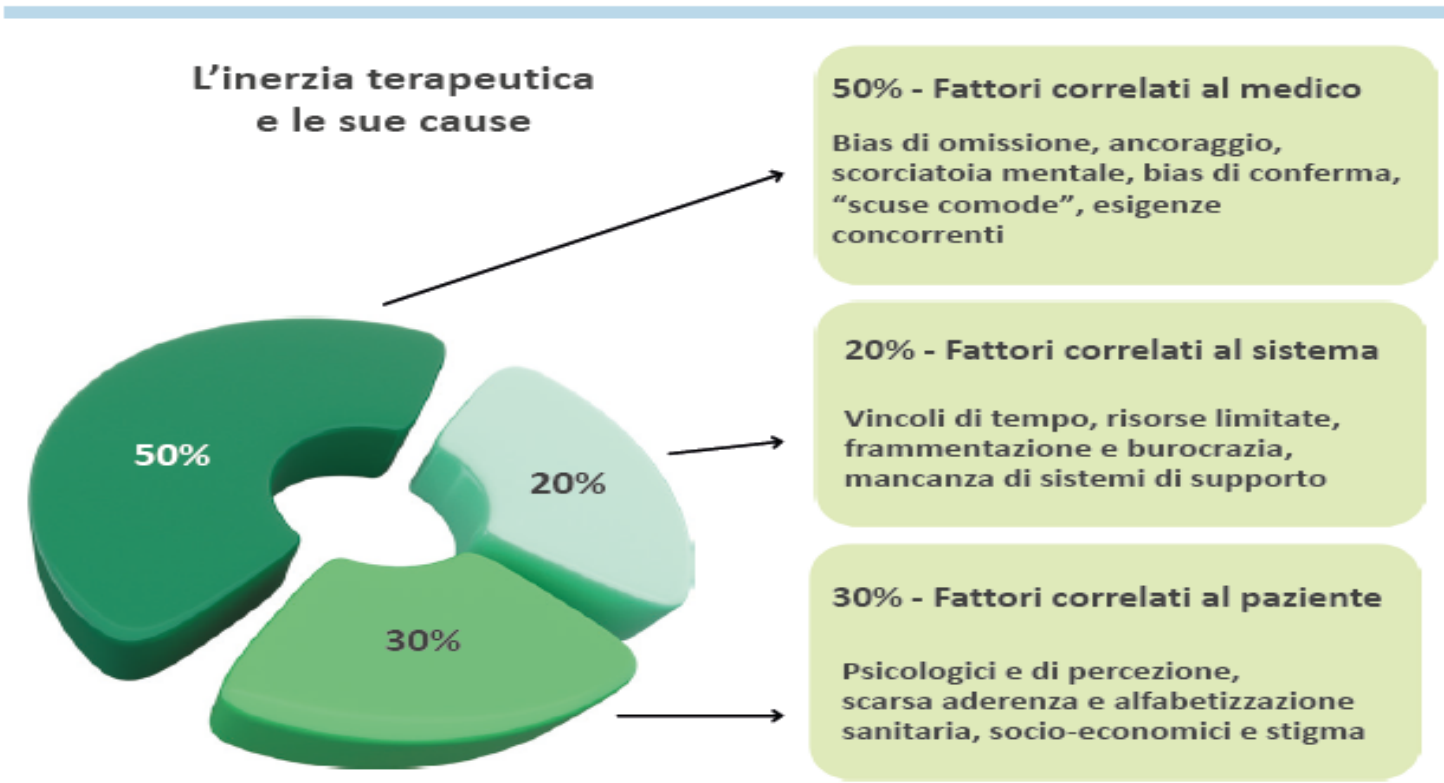


Figura 1. Ripartizione delle responsabilità dell'inerzia terapeutica e possibili cause.

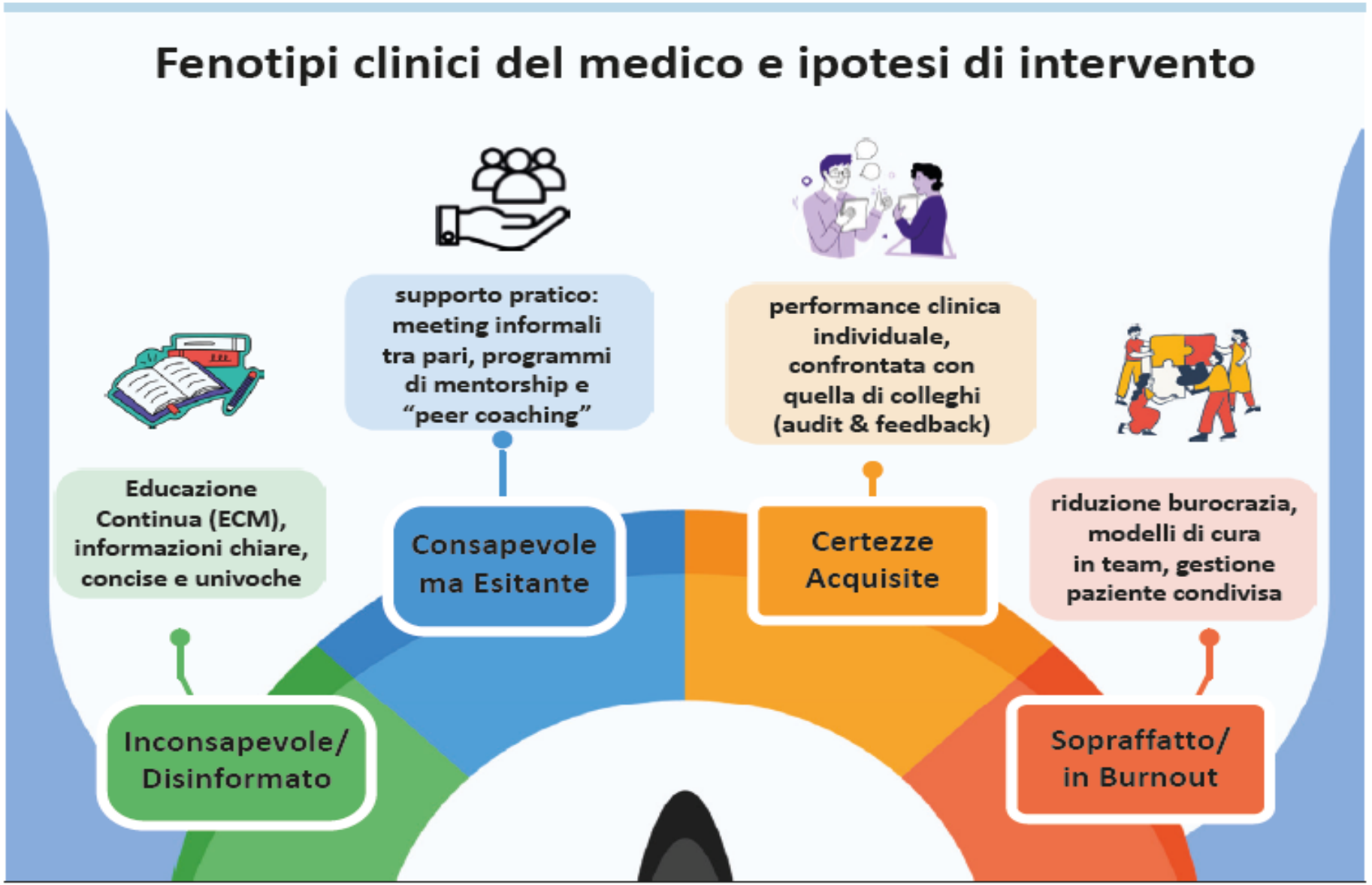


Figura 2. Fenotipi clinici del medico e possibili interventi mirati a ridurre l'inerzia.

Guidance Of better lipid profile achievemenT amOng paTients Admitted to pRoGrammes of sEcondary prevenTion and cardiac rehabilitation

GO-TO-TARGET

Study objectives	*Primary:* Assess the change in the proportion of secondary prevention patients achieving LDL-C targets before and after the educational intervention. *Secondary:* - Identify characteristics of patients achieving or not achieving LDL-C targets. - Stratify LDL-C target achievement by patient categories (e.g., post-ACS, CCS). - Analyze lipid-lowering therapies used and deviation from LDL-C targets in non-achieving patients.
Study endpoints	*Primary:* Change in the proportion of patients achieving guideline-recommended LDL-C levels. *Secondary:* - LDL-C distribution at follow-up. - Proportion achieving targets by subgroup. - Lipid-lowering therapy types and dosages.

Grazie per l’attenzione

Determinants of Therapeutic Inertia

Clinician-Related

- Lack of knowledge or guideline awareness

Patient-Related

- Poor adherence
- Misconceptions

System–and Context–Related

- Lack of follow-up
- Time constraints

Relative Contribution

50%	30%	20%

Opportunities to Address Therapeutic Inertia

Education and Awareness

Improve knowledge of guidelines and targets

Decision Support Tools

Utilize reminders and treatment algorithms

Patient Engagement

Shared decision-making and education

Audit and Feedback

Provide performance measures to clinicians