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## SHORT COMMUNICATION

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# The Role of Ldl-C Levels in secondary prevention lower is better and faster

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The main cause of death worldwide is still ischemic heart disease. LDL-c (Low-Density Lipoprotein Cholesterol) is the primary underlying pathophysiologic cause. Despite the significant advancements in pharmaceutical lipid-lowering therapies Most of our patients in secondary prevention have LDL-c levels that are above normal (inhibitors and those that are still to come, bempedoic acid and inclisiran). Over what the Clinical Practice Guidelines advise. Due to this, we created a particular programme in an effort to accomplish the objective of the sooner and lower LDL-c levels are reduced, the better.

We are reminded by the WHO that ischemic heart disease still exists.to be the main cause of death on the planet. Over the recent in recent years, a pertinent scientific movement aimed at examining its pathogenesis and identifying various causes that, in varying degrees, are accountable for it. Along with the adage "the lower, the better," it is required to lower LDL-c levels and the earlier the better. This obviously necessitates tighter monitoring of patients, with more consistent analytical checks and a deeper commitment to than what is typically employed in a conventional procedure for attaining the cholesterol threshold consultation in cardiology [1].

Atherosclerotic Cardiovascular Disease (ASCVD) is extremely common and contributes significantly to morbidity and mortality on a global scale. Elevated blood cholesterol is a major factor in the risk of atherosclerotic events, and patients with established ASCVD are among the high-risk groups that benefit most from LDL-C medication, which is strongly recommended by numerous guidelines. In clinical practice today, a growing number of drugs from many pharmacologic classifications are available. In order to manage residual atherosclerotic risk cost-effectively, guidance on the proper

use of these therapies is required. LDL-c and cardiovascular risk: a more thorough approach to lowering LDLc should aid in lowering the, and the sooner the better, rate of fresh ischemic hospitalizations following ACS (Acute Coronary Syndrome) [2].

The clinical benefit of altering each type of lipid sub fraction has been examined in numerous big cardiovascular outcomes trials, although with variable degrees of success. Reducing LDL-C lowers the incidence of cardiovascular events in both primary and secondary preventive cohorts, as shown repeatedly by randomized controlled trials. Low density lipoprotein (LDL) cholesterol levels are strongly connected with the risk of Coronary Heart Disease (CHD), according to studies. The risk of Cardiovascular Disease (CVD) decreases with decreasing LDL cholesterol, although it is unclear how much LDL cholesterol reduction is necessary and what evidence there is to support this. With reference to updated recommendations from the Adult Treatment Panel III of the National Cholesterol Education Program, this article analyses recent research supporting the idea that "lower LDL cholesterol is better" [3].

We will have two novel molecules in a few months: bempedoic acid for those who are unable to take statins or as a supplement in those patients who are almost achieving their goals, as well as Inclisiran RNA interference-based medication with promising results outcomes to alter the lipid-lowering therapy regimen, using alternating dosage. Considering this remarkable advancement in cardiovascular considering that clinical practice has contributed to have digested the fact that a decrease in LDL-c, the better, the lower. Therefore, it should have led to a greater effectiveness in meeting the lipid targets advised by based on the patient's risk, the Clinical Practice Guidelines (CPGs) score.

It entails regular monitoring and analyses of patients who have experienced an ACS These Patients are released from the

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hospital using powerful statins. In addition to a demand for a lipid profile within one month after ACS and are comprised of a certain database. Evaluation and Every month, phone consultations are conducted. These are during the course of the treatment, which includes monthly telephone consultations; LDL-c target of 55 mg/dL is met for lipids. Currently, the "time" until the lipid target" is calculated, which is the primary of this software; variable. Our present task is to complete the follow-up with the previous patients. Included, but, in an early stage, we may predict that the vast majority of them had LDL-c levels under 55 mg/dL. This took about three months on average. Despite this results are still early, but we think that this more serious method under LDL-control c's will enable the accomplishment of the specifically, the European CPG's suggested goals percentage of patients, particularly in a shorter amount of time than usual [4].

Physicians who already find it challenging to treat and accomplish the objective will confront even greater hurdles as treatment guidelines, such as those from the NCEP, start to reflect the need to strive for substantially lower LDL cholesterol levels in clinical practice. To stop the development of the atherosclerotic plaque, LDL cholesterol levels must be reduced by close to 50%. Ezetimibe / simvastatin can achieve this degree of reduction at the recommended starting dose, whereas conventional statin therapy often cannot. In this regard, statin monotherapy with a single inhibitor may no longer be the best option. Dual inhibition with

ezetimibe/simvastatin addresses two sources of cholesterol and enables more patients to reach their treatment objectives. As a result, this strategy may be more beneficial for the management of LDL cholesterol [5].

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