Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/heart-matters/treating-what-we-can-a-practical-approach-to-high-lipoproteina/57045/

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Treating What We Can: A Practical Approach to High Lipoprotein(a)

Announcer:
Welcome to *Heart Matters* on ReachMD. On this episode, we'll hear from Dr. Nishant Shah, who's an Associate Professor of Medicine at Duke University School of Medicine in Durham, as well as a Member of the Duke Clinical Research Institute. He'll be discussing the barriers to lipoprotein(a) testing in clinical practice. Here's Dr. Shah now.

Dr. Shah:
The biggest reasons for low lipoprotein(a) testing in practice largely is multifactorial, in my opinion. There are a lot of providers that are not familiar with the test. There are a lot of providers that are also not familiar with what to do with the test result. There are common thoughts in practice that, because we don't have Lp(a)-lowering agents or directly targeting Lp(a)-lowering therapies, we can't really do anything with the number.

However, I would argue that is not necessarily true. Whether or not Lp(a) is modifiable or not remains in question, as there are many drugs in clinical trials right now testing the impact of lowering Lp(a). But what we do know is that Lp(a) is a marker of risk. And when you have a high marker of risk, you know that at least you need to modify what you can modify. That means modifying the LDL cholesterol, modifying the blood pressure, or being more aggressive with blood pressure management or LDL cholesterol management, obesity management, and, if they have diabetes, diabetes management. I think that practice is starting to become a little bit more understood across different practices, but there's a lot of work to be done. So we need to do a lot in the education space.

There are a lot of issues as well with insurance coverage of Lp(a) testing that may lead to low amounts of testing. Fortunately, especially with the release of the new 2026 dyslipidemia guidelines that are recommending universal screening for Lp(a), many payers are starting to cover at least once-in-a-lifetime testing, which will help.

The other issue becomes assay variability. Sometimes, the test for lipoprotein(a) may not be available in a current practice. They need to do a send-out study, which adds some administrative barriers. The other thing is that the assay may be very variable at the institution and may not be consistent with what's universally recommended as a standard assay to measure Lp(a). That might lead to more confusion.

But I think that, as more people become aware of what lipoprotein(a) is, more people become aware of lipoprotein(a) being a marker of risk. I think you'll start seeing more trends in testing. I think the biggest momentum forward, however, for testing is going to be if we discover a directly lowering Lp(a) therapy that actually improves cardiovascular outcomes. I would suspect that more people are going to test when there's a therapy that directly targets it. However, I would argue that until we actually have something like that, we should view Lp(a) as a marker of risk, just like we view premature family history of coronary disease as a marker of risk, and just as we view coronary calcium as a marker of risk. You can't necessarily make someone's coronary calcium go away. You can't necessarily make somebody's family history go away, and you may not be able to make somebody's Lp(a) away. But you can treat the risk factors that can be treated today.

Announcer:
That was Dr. Nishant Shah talking about how we can close the gap in lipoprotein(a) testing. To access this and other episodes in our series, visit *Heart Matters* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!

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