CHIẾN LƯỢC ĐIỀU TRỊ RỐI LOẠN LIPID MÁU CẬP NHẬT KHUYẾN CÁO CỦA ESC 2025

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ESC 2025: CELEBRATING 75 YEARS

"Global Health – Cardiology Beyond Borders"

ESC 2025
IFEMA Madrid, Spain
29.08.2025 – 01.09.2025

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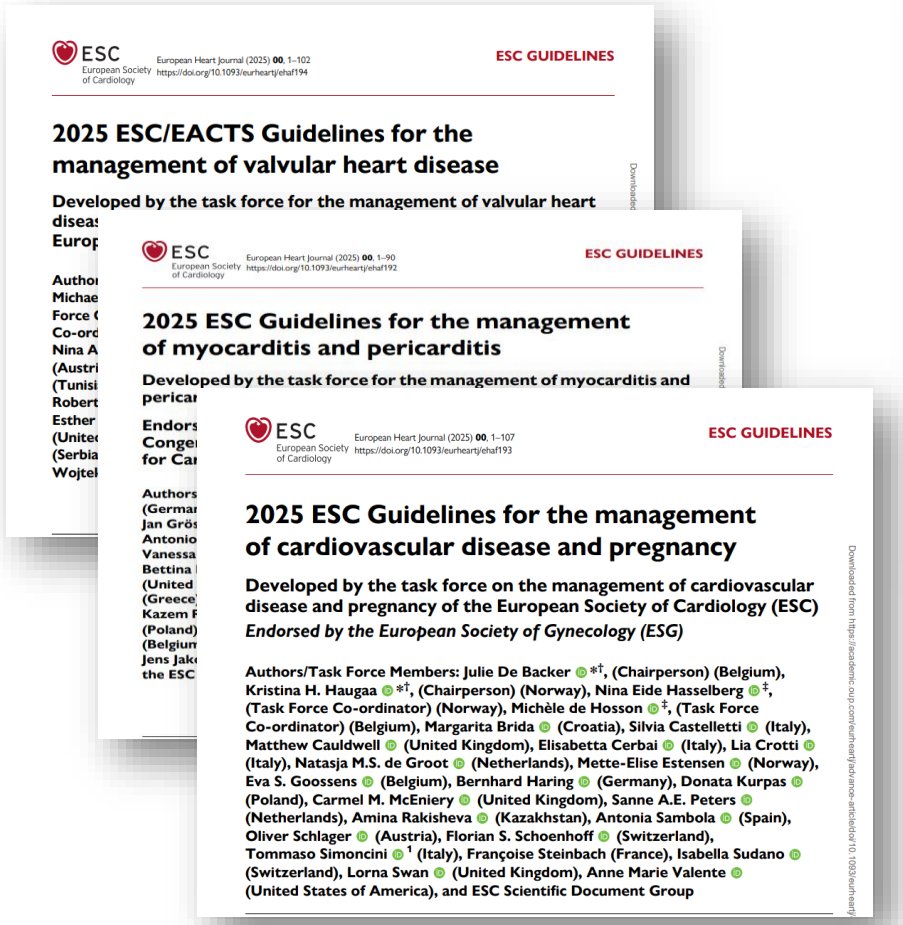
European Heart Journal (2025) **00**, 1–20 https://doi.org/10.1093/eurheartj/ehaf190

CÁC CÔNG BỐ QUAN TRỌNG

3 hướng dẫn mới



ESC European Society of Cardiology — European Heart Journal (2025) **00**, 1–102 https://doi.org/10.1093/eurheartj/ehaf194 — ESC GUIDELINES

2025 ESC/EACTS Guidelines for the management of valvular heart disease

Developed by the task force for the management of valvular heart disease

ESC European Society of Cardiology — European Heart Journal (2025) **00**, 1–90 https://doi.org/10.1093/eurheartj/ehaf192 — ESC GUIDELINES

2025 ESC Guidelines for the management of myocarditis and pericarditis

Developed by the task force for the management of myocarditis and pericar

ESC European Society of Cardiology — European Heart Journal (2025) **00**, 1–107 https://doi.org/10.1093/eurheartj/ehaf193 — ESC GUIDELINES

2025 ESC Guidelines for the management of cardiovascular disease and pregnancy

Developed by the task force on the management of cardiovascular disease and pregnancy of the European Society of Cardiology (ESC)

Endorsed by the European Society of Gynecology (ESG)

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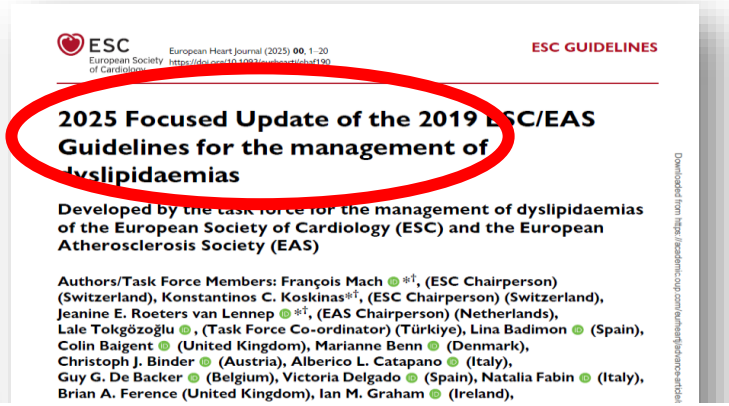
Focused Update



ESC European Society of Cardiology — European Heart Journal (2025) **00**, 1–20 — ESC GUIDELINES

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

Developed by the task force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and the European Atherosclerosis Society (EAS)

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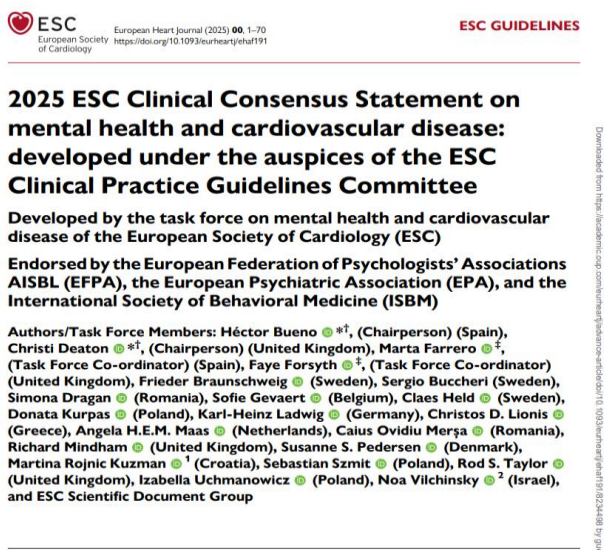
Consensus Statement



ESC European Society of Cardiology — European Heart Journal (2025) **00**, 1–70 https://doi.org/10.1093/eurheartj/ehaf191 — ESC GUIDELINES

2025 ESC Clinical Consensus Statement on mental health and cardiovascular disease: developed under the auspices of the ESC Clinical Practice Guidelines Committee

Developed by the task force on mental health and cardiovascular disease of the European Society of Cardiology (ESC)

Endorsed by the European Federation of Psychologists' Associations AISBL (EFPA), the European Psychiatric Association (EPA), and the International Society of Behavioral Medicine (ISBM)

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> 190 new trials

1. REBOOT Trial: Beta-Blockers in Post-MI with Preserv
- The REBOOT trial, presented in a Hotline session, four benefit of beta-blocker therapy on composite outcome death, reinfarction, or heart failure admission) in post-r infarction (MI) patients with left ventricular ejection fra ≥40% .
- Meta-analysis including REBOOT hinted there might b in patients with mildly reduced LVEF (40–49%), though preliminary .

2. PARACHUTE-HF Trial: Sacubitril/Valsartan in Chagas
- The PARACHUTE-HF trial showed efficacy of sacubitri treating the often-overlooked Chagas cardiomyopathy, improvements in NT-proBNP levels. Experts hope this p further targeted research .

3. POTCAST Trial: Targeting High-Normal Potassium Le
- The POTCAST trial, another late-breaking study, found plasma potassium to the high end of normal (4.5–5.0 m significantly reduced ventricular arrhythmias, ICD inter hospitalizations, and possibly mortality, without increa hyper- or hypokalaemia .
- The hazard ratio for the primary composite outcome w 0.61–0.95; p=0.015), indicating a robust benefit .

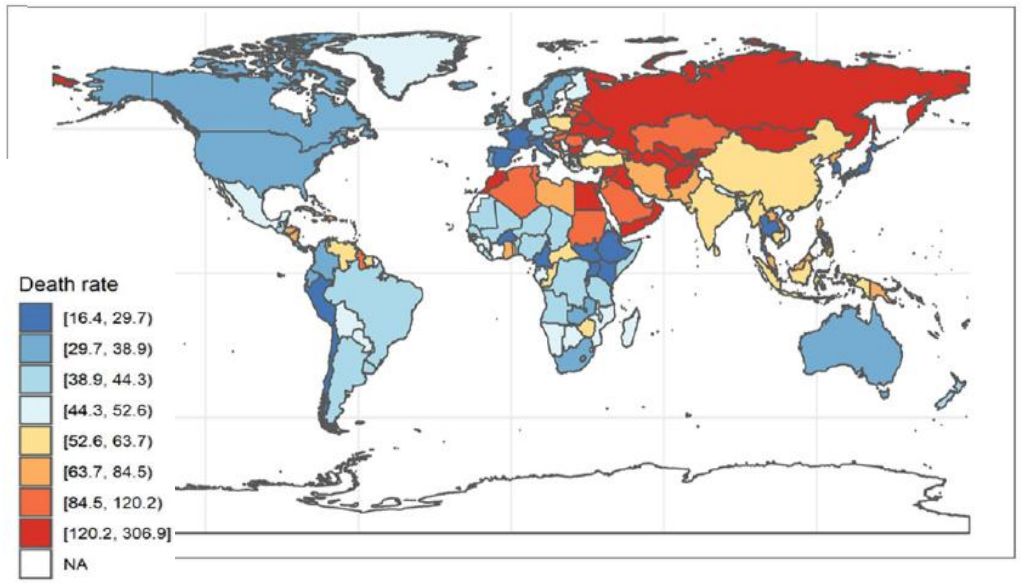
European Heart Journal (2025) **00**, 1–20 https://doi.org/10.1093/eurheartj/ehaf190

VÌ SAO CẬP NHẬT HƯỚNG DẪN XỬ TRÍ RỐI LOẠN MỠ MÁU

frontiers | Frontiers in Cardiovascular Medicine

ORIGINAL RESEARCH
published: 09 June 2022
doi: 10.3389/fcvm.2022.903126

Global Burden Attributable to High Low-Density Lipoprotein-Cholesterol



"This 2025 Focused Update addresses changes in recommendations for the treatment of dyslipidaemia based on new evidence published"

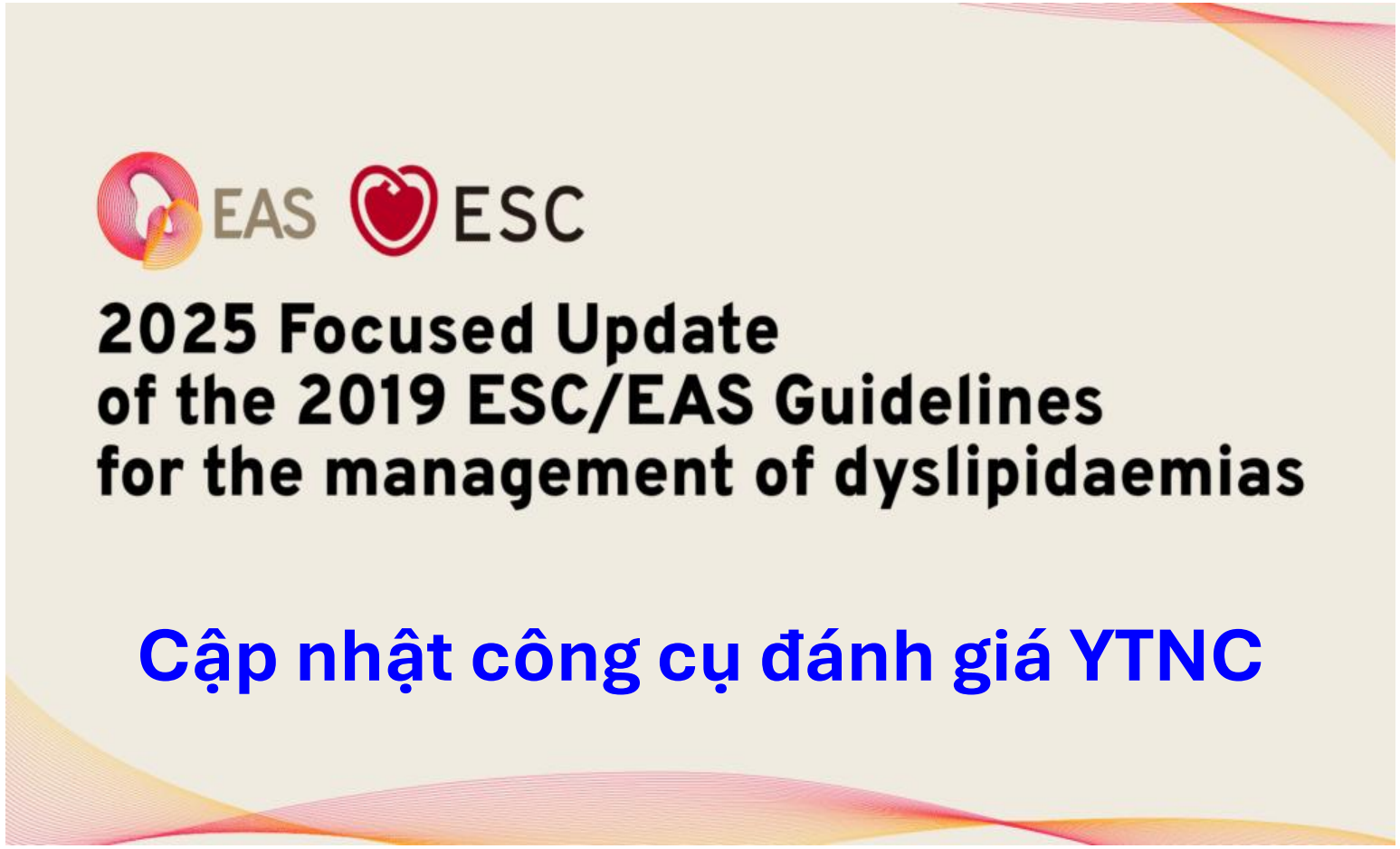
EAS ESC

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

1. Cập nhật công cụ đánh giá toàn diện YTNC
2. Thêm điều trị mới
3. Quản lý đối tượng đặc biệt (ACS, HIV,...)

doi: 10.3389/fcvm.2022.903126

European Heart Journal (2025) **00**, 1–20 https://doi.org/10.1093/eurheartj/ehaf190



European Heart Journal (2025) **00**, 1–20 https://doi.org/10.1093/eurheartj/ehaf190

1

ĐÁNH GIÁ NGUY CƠ TIM MẠCH = SCORE 2/ SCORE 2 OP

Recommendation Table 1 — Recommendations for cardiovascular risk estimation in persons without known cardiovascular disease (see also Supplementary data online, Evidence Table 1)

Recommendations	Class[a]	Level[b]
SCORE2 dùng cho người có vẻ khỏe mạnh < 70 tuổi, không có ASCVD, đái tháo đường, suy thận mạn, rối loạn lipid hoặc huyết áp di truyền/ít gặp để ước tính nguy cơ tử vong và không tử vong do CVD trong 10 năm.	I	B
SCORE2-OP dùng cho người có vẻ khỏe mạnh > 70 tuổi, không có ASCVD, đái tháo đường, suy thận mạn, rối loạn lipid hoặc huyết áp di truyền/ít gặp để ước tính nguy cơ tử vong và không tử vong do CVD trong 10 năm.	I	B
Presence of subclinical coronary atherosclerosis by imaging or increased CAC score by CT should be considered as risk modifiers in individuals at moderate risk or individuals around treatment decision thresholds to improve risk classification.[24,27,28,36 d]	IIa	B
Risk modifiers[e] should be considered in individuals at moderate risk or individuals around treatment decision thresholds to improve risk classification.[17,27,37 f]	IIa	B
In primary prevention,[g] pharmacological LDL-C-lowering therapy is recommended in persons: • at very high risk and LDL-C ≥1.8 mmol/L (70 mg/dL), or • at high risk and LDL-C ≥2.6 mmol/L (100 mg/dL) despite optimization of non-pharmacological measures, to lower CVD risk.[1,13,38,39]	I	A
In primary prevention,[g] pharmacological LDL-C-lowering therapy should be considered in persons: • at very high risk and LDL-C ≥1.4 mmol/L (55 mg/dL) but <1.8 mmol/L (70 mg/dL), or • at high risk and LDL-C ≥1.8 mmol/L (70 mg/dL) but <2.6 mmol/L (100 mg/dL), or • at moderate risk and LDL-C ≥2.6 mmol(L (100 mg/dL) but <4.9 mmol/L (190 mg/dL), or • at low risk and LDL-C ≥3.0 mmol/L (116 mg/dL) but <4.9 mmol/L (190 mg/dL) despite optimization of non-pharmacological measures, to lower CVD risk.[1,13,38,39]	IIa	A

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CÁC YẾU TỐ ĐIỀU CHỈNH NGUY CƠ NGOÀI SCORE2 VÀ SCORE2-OP

Box 1 Risk modifiers for consideration beyond the risk estimation based on the SCORE2 and SCORE2-OP algorithms

Demographic/clinical conditions

- Family history of premature CVD (men: <55 years; women: <60 years)
- High-risk ethnicity (e.g. Southern Asian)
- Stress symptoms and psychosocial stressors
- Social deprivation
- Obesity
- Physical inactivity
- Chronic immune-mediated/inflammatory disorders
- Major psychiatric disorders
- History of premature menopause
- Pre-eclampsia or other hypertensive disorders of pregnancy
- Human immunodeficiency virus infection
- Obstructive sleep apnoea syndrome

Biomarkers

- Persistently elevated hs-CRP (>2 mg/L)
- Elevated Lp(a) [>50 mg/dL (>105 nmol/L)].

CVD, cardiovascular disease; hs-CRP, high sensitivity C-reactive protein; Lp(a), lipoprotein(a).

1. Nhân khẩu học – lâm sàng

- Gia đình bệnh tim mạch sớm (nam: <55 tuổi; nữ: <60 tuổi)
- Dân tộc nguy cơ cao (ví dụ: người Nam Á)
- Các triệu chứng stress và các áp lực tâm lý xã hội
- Tình trạng thiệt thòi xã hội
- Béo phì
- Thiếu hoạt động thể chất
- Các bệnh mạn tính do rối loạn miễn dịch hoặc viêm
- Các rối loạn tâm thần nghiêm trọng
- Tiền sử mãn kinh sớm
- Tiền sản giật hoặc các rối loạn tăng huyết áp trong thai kỳ
- Nhiễm virus HIV
- Hội chứng tắc nghẽn đường thở khi ngủ

2. Dấu ấn sinh học

- ***hs-CRP tăng kéo dài (>2 mg/L)***
- **Lp(a) tăng > 50 mg/dL (> 105 nmol/L)**

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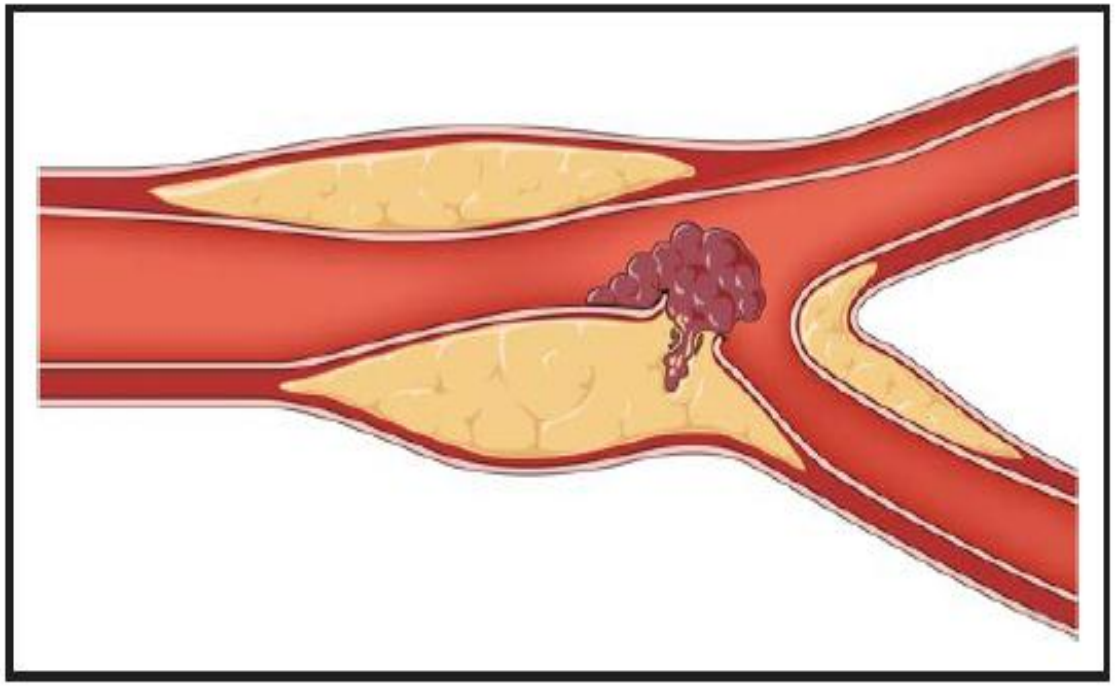
THÊM MỘT GÓC NHÌN VỀ YẾU TỐ NGUY CƠ TIM MẠCH TỒN DƯ



"Atherosclerosis is caused by the progressive deposition of ***LDL-C*** ***and other apolipoprotein-B (ApoB)****-containing lipoproteins within the artery wall, which triggers a cascade of inflammatory reactions leading to the formation and progression of atherosclerotic plaque…"*

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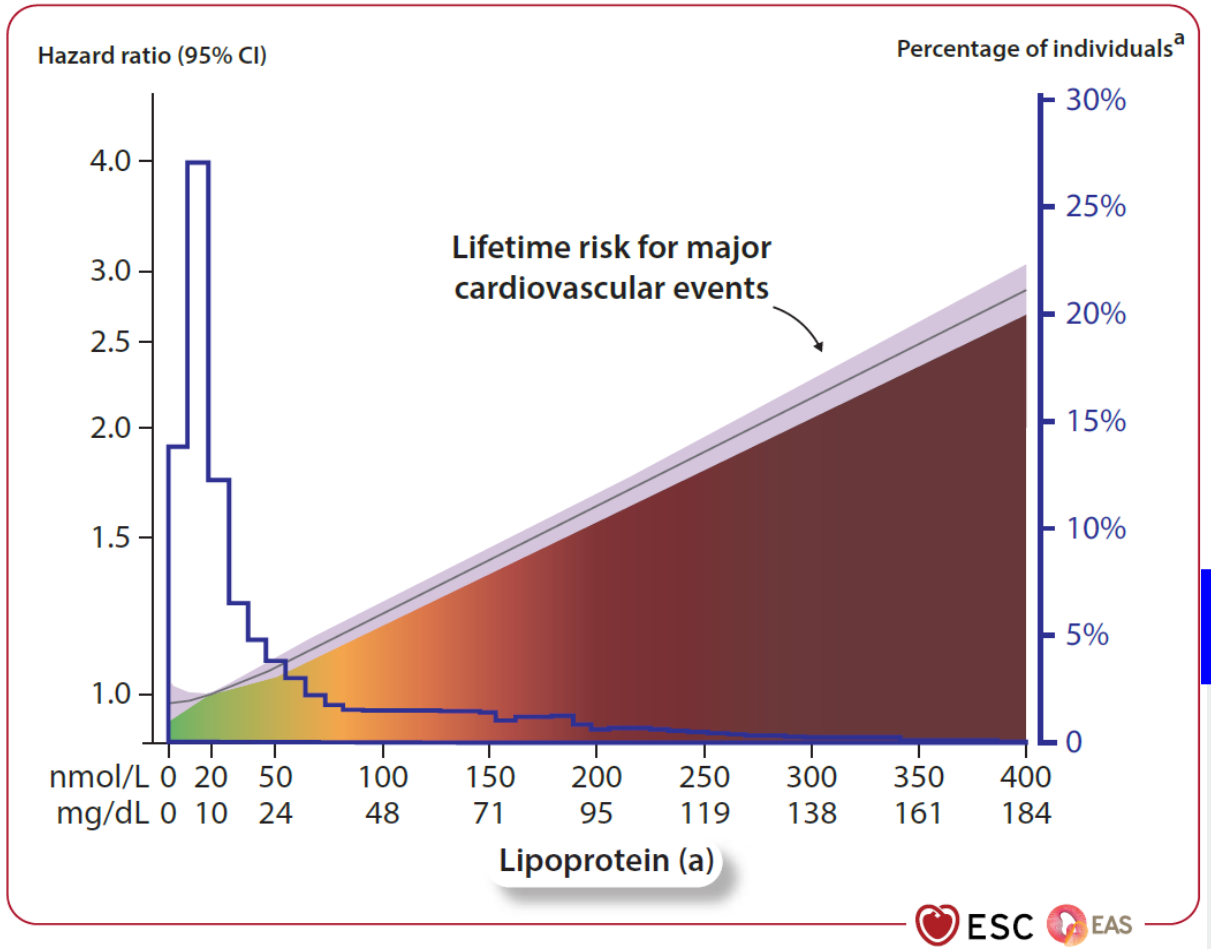
CẦN QUAN TÂM ĐÚNG MỨC LP (A)



Liên quan giữa mức Lp(a) và nguy cơ suốt đời của các biến cố tim mạch lớn

Recommendation Table 4 — Recommendations for measurement of lipoprotein(a) (see also Supplementary data online, Evidence Table 4)

Recommendations	Class[a]	Level[b]
Lp(a) > 50 mg/dL(105 nmol/L) nên xem xét ở tất cả người trưởng thành như 1 yếu tố làm tăng nguy cơ tim mạch, Lp(a) càng cao thì nguy cơ tim mạch càng tăng	IIa	B

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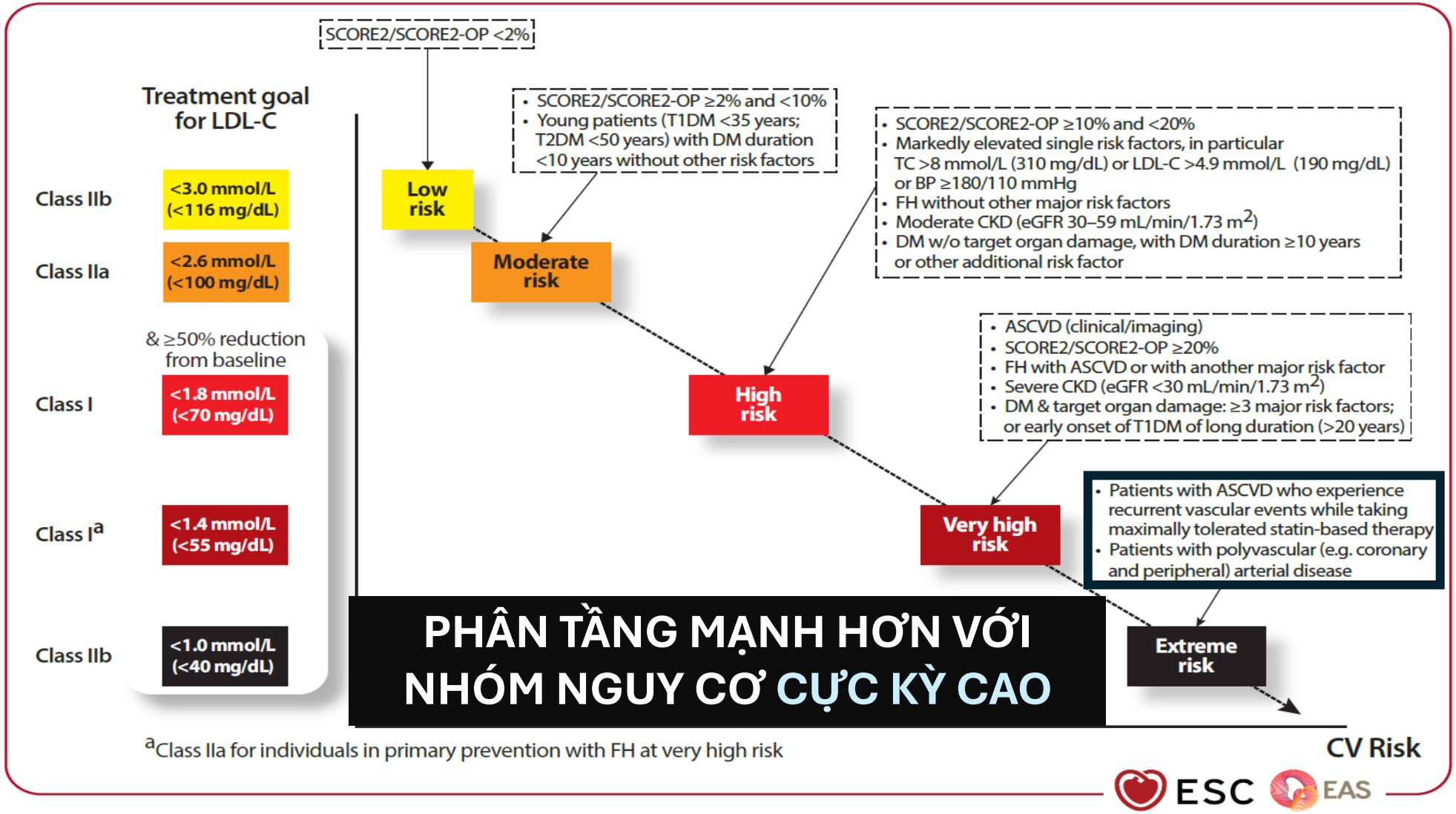
MỤC TIÊU ĐIỀU TRỊ LDL-C THEO PHÂN TẦNG NGUY CƠ TIM MẠCH



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EAS ESC

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

Thêm liệu pháp mới

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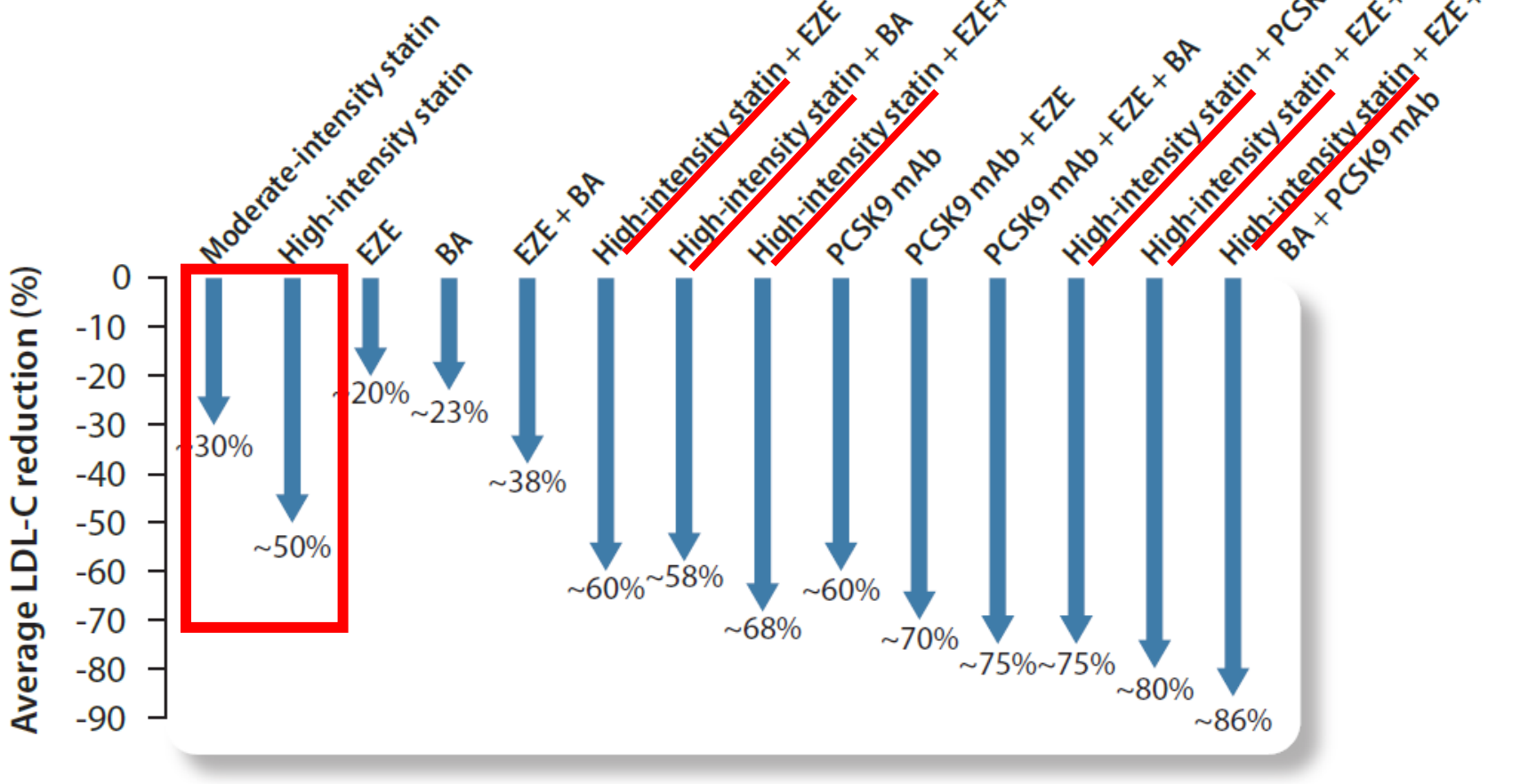
2

THÊM NHIỀU LIỆU PHÁP KIỂM SOÁT LIPID MÁU HIỆU QUẢ

STATIN VẪN LÀ NỀN TẢNG



ESC EAS

Mức giảm trung bình LDL-C với các thuốc có lợi ích tim mạch được chứng minh

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STATIN GIẢM HẦU HẾT DẤU ẤN VIÊM SO VỚI THUỐC HẠ MỠ MÁU KHÁC

Table 1. Impact of lipid-lowering drugs on selected inflammatory biomarkers.

Medication	Inflammatory Biomarkers				
	CRP or hsCRP	IL-1	IL-6	TNF	IL-10
Statins	↓	↑↓	↓	↓	/
Ezetimibe	↔	/	/	/	/
BAS	↓	/	↔	↔	/
PCSK9i	↔	↓	↓	↓	↑
Bempedoic acid	↓	/	/	/	/
Lomitapide	↓	/	/	/	/
Evinacumab	/	/	/	/	/
Fibrates	↓	↓	↓	↓	↑
Omega-3 fatty acids	/	/	/	↓	/
Icosapent ethyl	↓	↓	↓	/	/

↑—increased concentration; ↓—decreased concentration;/—no date available; ↔—no changes in the concentration; CRP—C—reactive protein; hsCRP—high-sensitivity C—reactive protein; IL-1—interleukin 1; IL-6—interleukin 6; TNF—tumor necrosis factor; IL-10—interleukin 10; BAS—bile acid sequestrants; PCSK9i—proprotein convertase subtilisin/kexin type 9 inhibitors.

Nutrients 2023, 15, 1517. https://doi.org/10.3390/nu15061517

NON-STATIN

CHỈ DÙNG KHI KHÔNG THỂ TĂNG LIỀU HOẶC KHÔNG THỂ DÙNG STATIN

Recommendations	Class[a]	Level[b]
Non-statin therapies with proven cardiovascular benefit,[c] taken alone or in combination, are recommended for patients who are unable to take statin therapy to lower LDL-C levels and reduce the risk of CV events. The choice should be based on the magnitude of additional LDL-C lowering needed.[4,53,54]	I	A

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TRONG ĐÓ, ACID BEMPEDOIC ĐƯỢC KHUYẾN CÁO MẠNH
KHI KHÔNG THỂ DÙNG STATIN

Recommendations	Class[a]	Level[b]
Bempedoic acid is recommended in patients who are unable to take statin therapy to achieve the LDL-C goal.[4]	I	B
The addition of bempedoic acid to the maximally tolerated dose of statin with or without ezetimibe should be considered in patients at high or very high risk in order to achieve the LDL-C goal.[42,55]	IIa	C
Evinacumab should be considered in patients with homozygous familial hypercholesterolaemia aged 5 years or older who are not at LDL-C goal despite receiving maximum doses of lipid-lowering therapy to lower LDL-C levels.[5,50,51]	IIa	B

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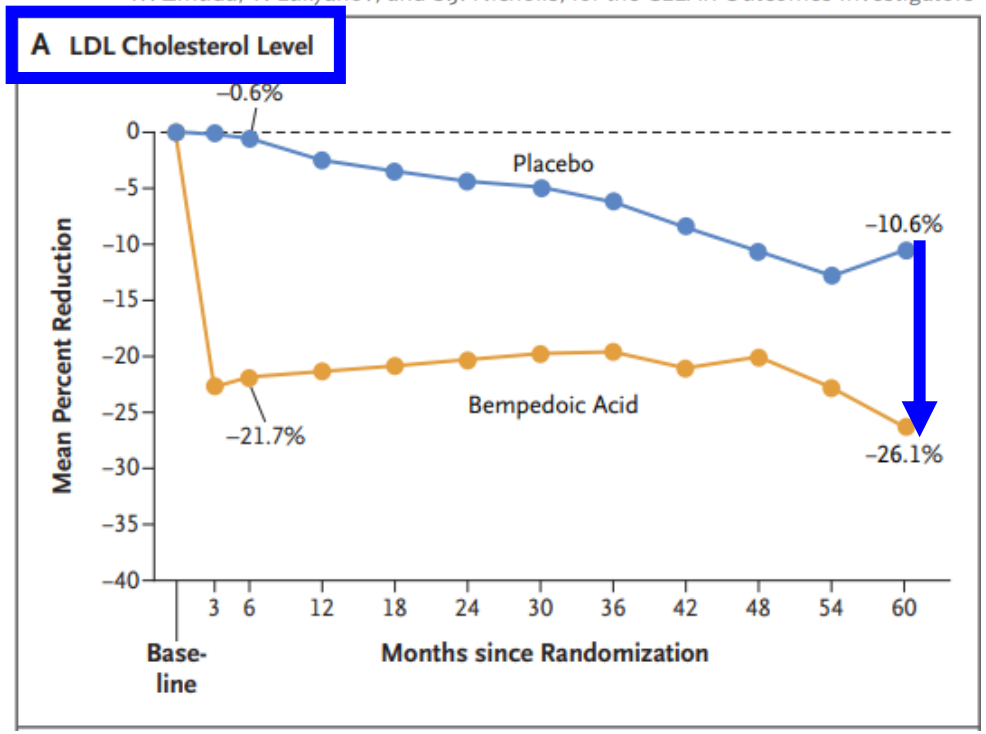
CLEAR OUTCOME TRIAL: ACID BEMPEDOIC THAY STATIN

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 APRIL 13, 2023 VOL. 388 NO. 15

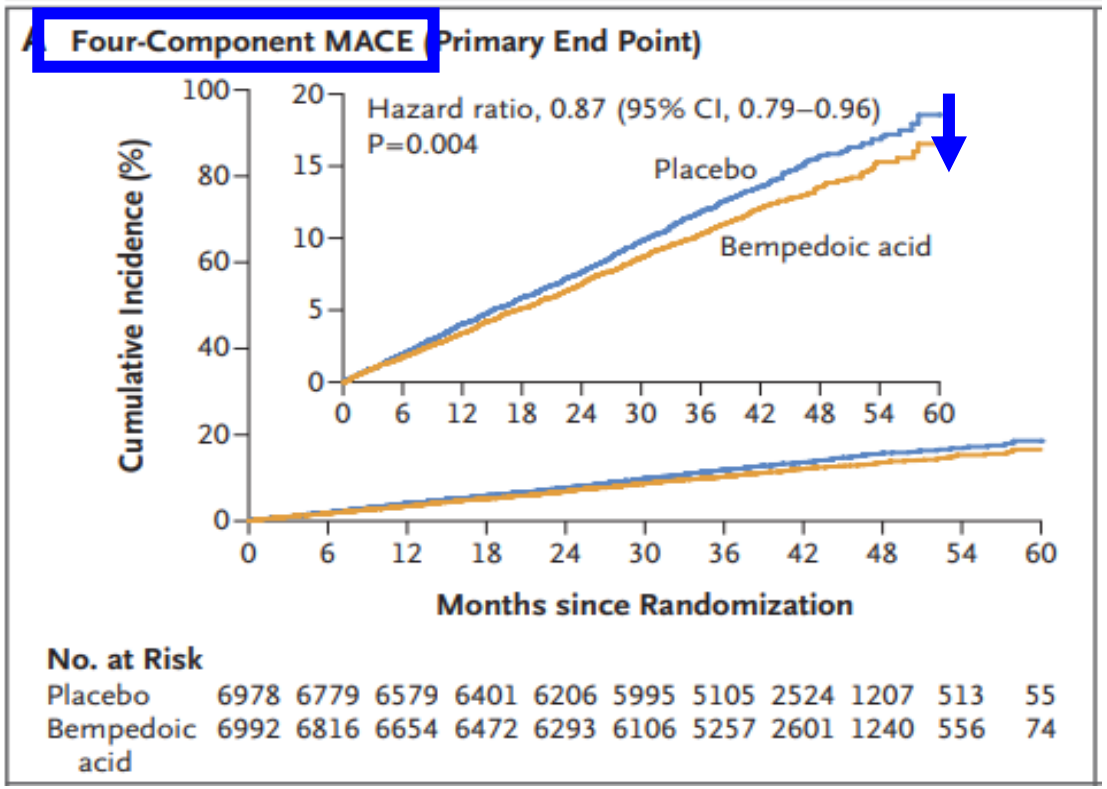
Bempedoic Acid and Cardiovascular Outcomes in Statin-Intolerant Patients

S.E. Nissen, A.M. Lincoff, D. Brennan, K.K. Ray, D. Mason, J.J.P. Kastelein, P.D. Thompson, P. Libby, L. Cho, J. Plutzky, H.E. Bays, P.M. Moriarty, V. Menon, D.E. Grobbee, M.J. Louie, C.-F. Chen, N. Li, L.A. Bloedon, P. Robinson, M. Horner, W.J. Sasiela, J. McCluskey, D. Davey, P. Fajardo-Campos, P. Petrovic, J. Fedacko, W. Zmuda, Y. Lukyanov, and S.J. Nicholls, for the CLEAR Outcomes Investigators*



13.970 BN **không dung nạp Statin**

Theo dõi trung bình **40,6 tháng**



DOI: 10.1056/NEJMoa2215024

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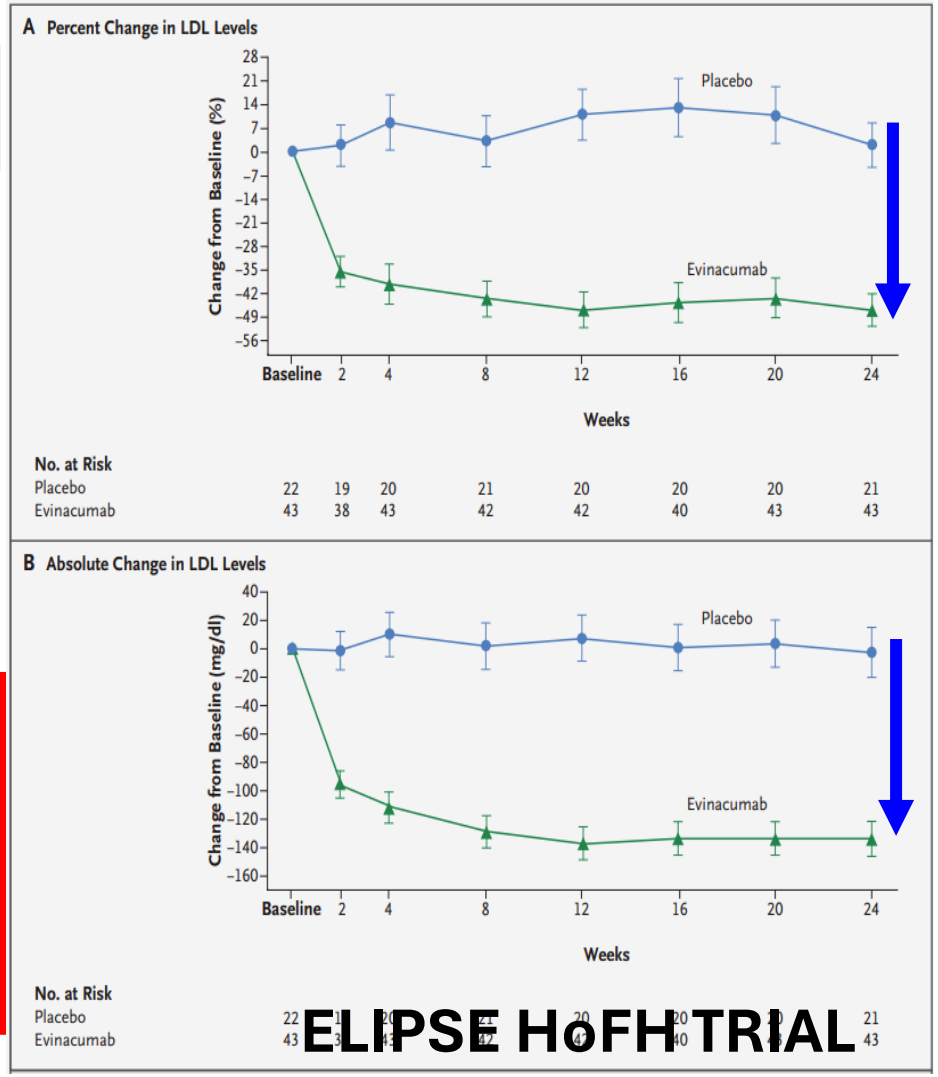
TRONG ĐÓ, EVINACUMAB
KHI TĂNG CHOLESTEROL MÁU GIA ĐÌNH

Recommendations	Class[a]	Level[b]
Bempedoic acid is recommended in patients who are unable to take statin therapy to achieve the LDL-C goal.[4]	I	B
The addition of bempedoic acid to the maximally tolerated dose of statin with or without ezetimibe should be considered in patients at high or very high risk in order to achieve the LDL-C goal.[42,55]	IIa	C
Evinacumab should be considered in patients with homozygous familial hypercholesterolaemia aged 5 years or older who are not at LDL-C goal despite receiving maximum doses of lipid-lowering therapy to lower LDL-C levels.[5,50,51]	IIa	B



ELIPSE HoFH TRIAL

European Heart Journal (2025) **00**, 1–20 https://doi.org/10.1093/eurheartj/ehaf190

ĐIỀU TRỊ TĂNG TRIGLYCERID MÁU

Recommendation Table 5 — Recommendations for drug treatment of patients with hypertriglyceridaemia (see also Supplementary data online, Evidence Table 5)

Recommendations	Class[a]	Level[b]
High-dose icosapent ethyl (2 × 2 g/day) should be considered in combination with a statin in high-risk or very high-risk patients with elevated triglyceride levels (fasting triglyceride level 135–499 mg/dL or 1.52–5.63 mmol/L) to reduce the risk of cardiovascular events.[8,111]	IIa	B
Volanesorsen (300 mg/week) should be considered in patients with severe hypertriglyceridaemia (>750 mg/dL or >8.5 mmol/L) due to familial chylomicronaemia syndrome, to lower triglyceride levels and reduce the risk of pancreatitis.[6,117]	IIa	B

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EAS ESC

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Quản lý đối tượng đặc biệt

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3

ĐIỀU TRỊ HỘI CHỨNG VÀNH CẤP TÍCH CỰC HƠN TỪ NỘI VIỆN

Recommendation Table 3 — Recommendations for lipid-lowering therapy in patients with acute coronary syndromes (see also Supplementary data online, Evidence Table 3)

Recommendations	Class[a]	Level[b]
Intensification of lipid-lowering therapy during the index ACS hospitalization is recommended for patients who were on any lipid-lowering therapy before admission in order to further lower LDL-C levels.	I	C
Initiating combination therapy with high-intensity statin plus ezetimibe during index hospitalization for ACS should be considered in patients who were treatment-naïve and are not expected to achieve the LDL-C goal with statin therapy alone.[66]	IIa	B

European Heart Journal (2025) **00**, 1–20 https://doi.org/10.1093/eurheartj/ehaf190

STATIN VẪN LÀ NỀN TẢNG Ở BỆNH NHÂN : HIV, HÓA TRỊ ANTHRACYCLINE

Recommendation	Class[a]	Level[b]
Statin therapy is recommended for people in primary prevention aged ≥40 years with HIV, irrespective of estimated cardiovascular risk and LDL-C levels, to reduce the risk of cardiovascular events; the choice of statin should be based on potential drug interactions.[7]	I	B
Statins should be considered in adult patients at high or very high risk of developing chemotherapy-related cardiovascular toxicity[c] to reduce the risk of anthracycline-induced cardiac dysfunction[9,132–134]	IIa	B

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THỰC PHẨM CHỨC NĂNG, VITAMIN KHÔNG GIẢM BTMXV

Recommendation Table 8 — Recommendations for dietary supplements (see also Supplementary data online, Evidence Table 8)

Recommendation	Class[a]	Level[b]
Dietary supplements or vitamins without documented safety and significant LDL-C-lowering efficacy are not recommended to lower the risk of ASCVD.[10,11]	III	B

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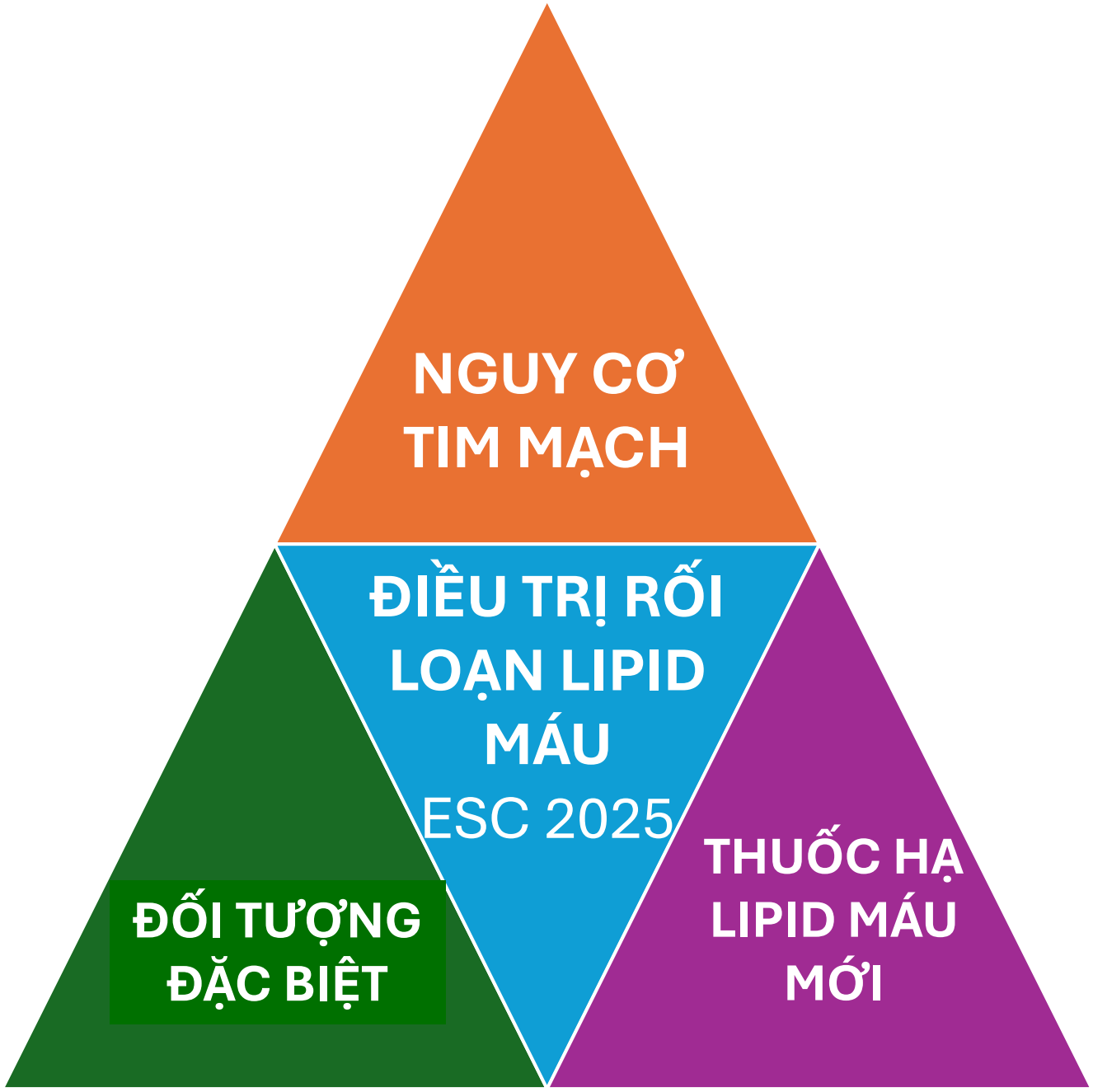

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