Table 3. Primary and secondary prevention approaches worldwide [MED ED: This table is very long – can it be online only?]

Guidelines by country	Primary prevention	Secondary prevention
Australia[6,7]	No previous CVD event Use of absolute CVD risk calculator is key approach Most age <45 years at low risk unless HeFH or atrial fibrillation www.cvdcheck.org.au: Based on Framingham studies and validated for age 30–74 years in Australia Be wary of potential very high relative risk in some patients (eg HeFH, diabetic >60 years, CKD) Risk stratification High >15% risk over next five years (angina, acute myocardial infarction, CVA, transient ischaemic attack, peripheral vascular disease, heart failure) Intermediate 10–15% risk (treat if persists posts lifestyle changes, FH premature CVD, blood pressure above 160/100, Aboriginal or Torres Strait Islander, Maori, Pacific, South Sea Islander, South Asian, Mid-Eastern ethnicity) Low <10% (start meds if high risk or if risk factors present, Aboriginal or Torres Strait islander or FH CVD) Coronary artery calcium may help if in intermediate risk group Healthy lifestyle Assess five-year CVD risk Family history premature CVD, ethnic groups Consider lipid lowering treatment	Which patients? All patients with prior significant ASCVD event Previous acute myocardial infarction Angina pectoris Coronary artery bypass grafting or stenting CVA or transient ischaemic attack Symptomatic peripheral vascular disease High >15% absolute CVD risk Key interventions Diet and lifestyle changes especially stopping smoking Increasing exercise and cardiac rehabilitation (up to 25% reduction in mortality) Lipid lowering medications especially statins (Aspirin and blood pressure meds) Treat type 2 diabetes >40 years CKD stage 3–5
Canada[26]	No previous CVD Risk <10%: encourage lifestyle changes Re-test after five years with risk assessment	Previous ASCVD Risk ≥20%: lifestyle changes Encourage high intensity statin Consider aspirin Encourage compliance
Joint British Societies[31,32]	Assess 10-year risk Healthy lifestyle	Established CVD Statins: lower is better approach Target <1.8 mmol/L aspirin Type 2 diabetes >40 [AUTHOR: Please clrify unit?] CKD stage 3–5
UK NICE[31,32]	Healthy lifestyle Option to re-asses after lifestyle change attempt If 10-year risk CVD >10, offer atorvastatin 20 mg daily; same if type 2 diabetes and CKD present May need review and up-titration depending on response	Healthy lifestyle Start treatment with atorvastatin 80 mg daily. Can lower dose to 40 mg if interactions, adverse effects or patient preference Treat all type 1 diabetes with statin therapy High risk groups – maximum tolerated atorvastatin Consider annual cholesterol review
New Zealand[27]	Healthy lifestyle Assess five-year CVD risk If 5–15% consider medication treatment of modifiable risk factors: discuss with patient – informed decision Target LDL-C reduction of 40% if medication commenced Annual reviews once stabilised Avoid aspirin in over 70s or if five-year risk <15%	Five-year CVD risk of 15% considered equivalent to prior ASCVD Asymptomatic carotid disease, coronary disease (CAC score >400) or plaque on computed tomography angiography – risk regarded as ≥15% Lipid-lowering treatment strongly recommended Consider aspirin LDL-C target should be <1.8 mmol/L
European Atherosclerosis Society/ European Society of Cardiology[15]	Healthy lifestyle If not FH and very high risk, aim for LDL-C reduction of 50% and goal of <1.4 mmol/L If FH and very high risk, aim for LDL-C reduction of 50% and consider goal of <1.4 mmol/L All patients at high risk, aim for LDL-C reduction of 50% from baseline and LDL-C goal of <1.8 mmol/L All patients at mod risk, LDL-C goal of <2.6 mmol/L should be considered All patients at low risk, LDL-C goal of <3.0 mmol/L may be considered	All high-risk patients, LDL-C reduction of 50% and goal of <1.4 mmol/L Patients with second vascular event <2 years on maximum statins, LDL-C goal of <1.0 mmol/L may be considered Same as for primary prevention
American Heart Association/ACA [AUTHOR: Is this the ACC? American College of Cardiology?] [9,16]	Healthy lifestyle Assess CVD in each age group Low risk <5%: discuss lifestyle Borderline 5–7.5%: consider risk enhancers to assess Intermediate risk 7.5% to <20%: if risk enhancers positive, consider moderate potency statin High >20%: add statin to lower LDL-C by 50% If LDL-C still >4.9 mmol/L or type 2 diabetes 40–75 years: add moderate-intensity statin If type 2 diabetes age 40–75 years, consider moderate-intensity statin	Patients have ASCVD Healthy lifestyle High intensity maximum tolerated statin Aim to reduce LDL-C by 50% from baseline If remains>1.8mmol/L, add ezetimibe Option of PCSK9i if level still >1.8 mmol/L

ASCVD, atherosclerotic cardiovascular disease; CAC, coronary artery calcium; CHD, coronary heart disease; CKD, chronic kidney disease; CVA, cerebrovascular accident; FH, familial hypercholesterolaemia; HDL, high-density lipoprotein; HeFH, heterozygous familial hypercholesterolaemia; LDL-C, low-density lipoprotein cholesterol; NICE, National Institute for Health and Care Excellence; PCSK9i, PCSK9, proprotein convertase subtilisin/kexin type 9 inhibitor