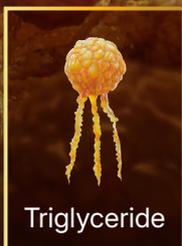


## Don't let your patients drown in the risks of dangerously high triglycerides

Severe hypertriglyceridemia (sHTG) increases the risk of potentially life-threatening outcomes, including acute pancreatitis and atherosclerotic cardiovascular disease.<sup>1-3</sup>

**Turn the tide on triglycerides now**

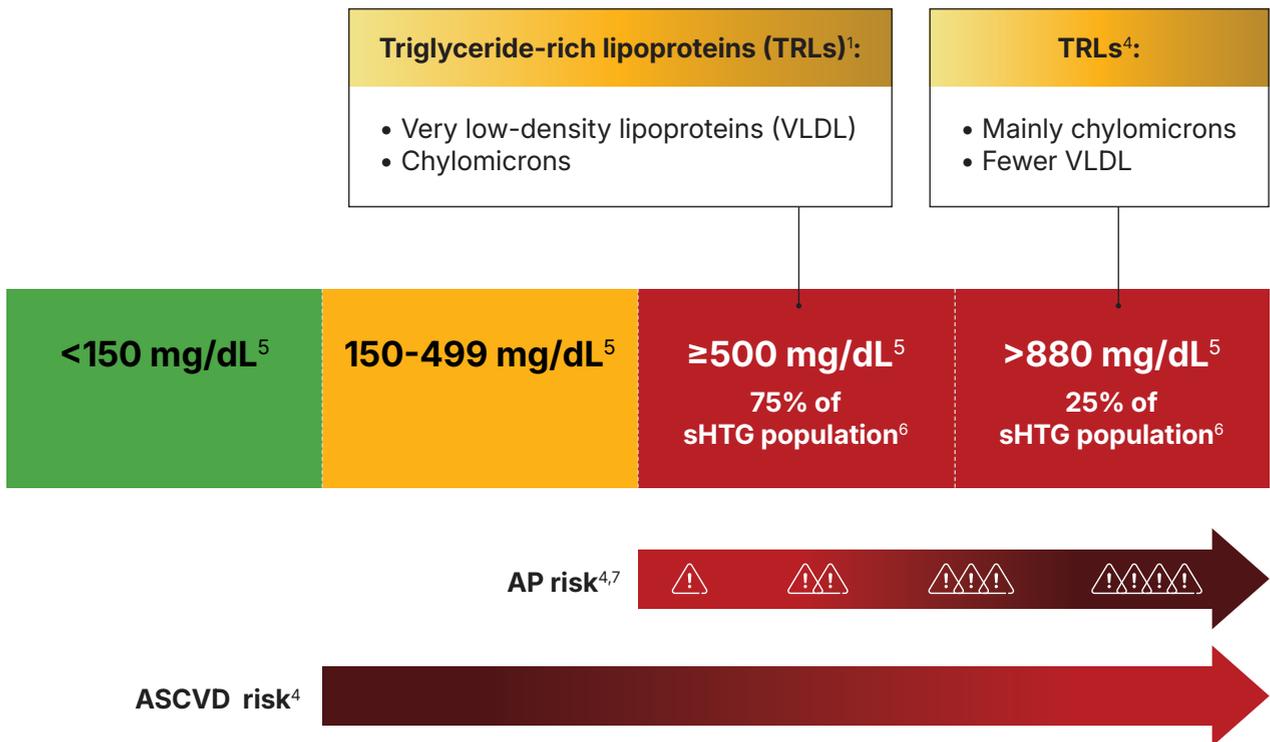
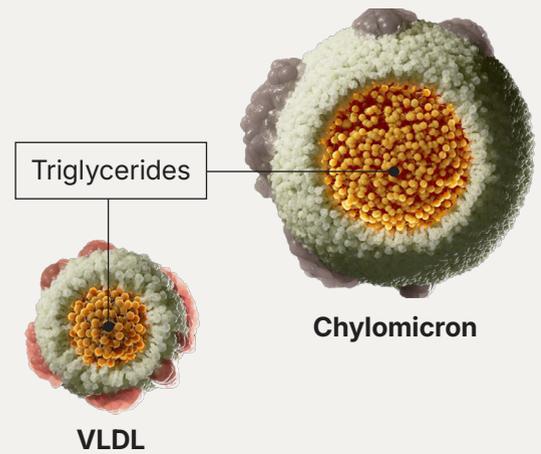


Triglyceride

sHTG is defined as fasting triglyceride levels  $\geq 500$  mg/dL.<sup>1</sup>

Actor portrayal. Not an actual patient.

sHTG is defined as fasting **triglyceride levels  $\geq 500$  mg/dL<sup>1</sup>**



**The risks associated with sHTG increase as triglyceride levels rise.<sup>1,4,7</sup>**

AP=acute pancreatitis; ASCVD=atherosclerotic cardiovascular disease; sHTG=severe hypertriglyceridemia.

More than

**3 million**

American adults are estimated to have sHTG<sup>8</sup>

**However, the true prevalence of sHTG is likely higher than current estimates due to several factors<sup>9-12</sup>**

**Guidelines call for testing of fasting triglyceride levels**



Patients are in a postprandial state most of the day, allowing severe elevations to be missed<sup>10,12,13</sup>

**Lack of ICD-10 code for sHTG**



Classification under broader hyperlipidemia terms limits understanding of true sHTG prevalence<sup>9</sup>

**Signs and symptoms may not be recognized**



sHTG as a cause of acute abdominal pain and acute pancreatitis is often overlooked<sup>14</sup>

**When prevalence of sHTG is underestimated, so is the true risk of severe complications.**<sup>9-12</sup>



# *sHTG* increases the risk of potentially **life-threatening acute pancreatitis (AP)**<sup>1,2</sup>

At triglyceride levels  $\geq 500$  mg/dL, the buildup of chylomicrons increases the risk of AP. As triglyceride levels continue to rise, the risk of AP increases.<sup>1,15,16</sup>



**apoB-48**  
the only specific marker  
of intestinal chylomicrons<sup>5,17</sup>



**Chylomicron**

## **sHTG-induced AP by the numbers**

**Mortality**  
rate as  
high as

**8%**<sup>2</sup>

**Prolonged**  
**hospitalization**  
of around

**17** days<sup>2</sup>

**Healthcare**  
**costs** averaging

**~\$100k**

including hospital  
costs and the  
12 months following  
an AP event<sup>18</sup>

# Preventing the first episode of AP is **critical**<sup>19</sup>

Once a patient with sHTG has had an episode of AP, their risk for a second can be as

**high as 24%**<sup>19\*</sup>

After 2 or more episodes, the risk for another can

**increase to nearly 49%**<sup>19\*</sup>

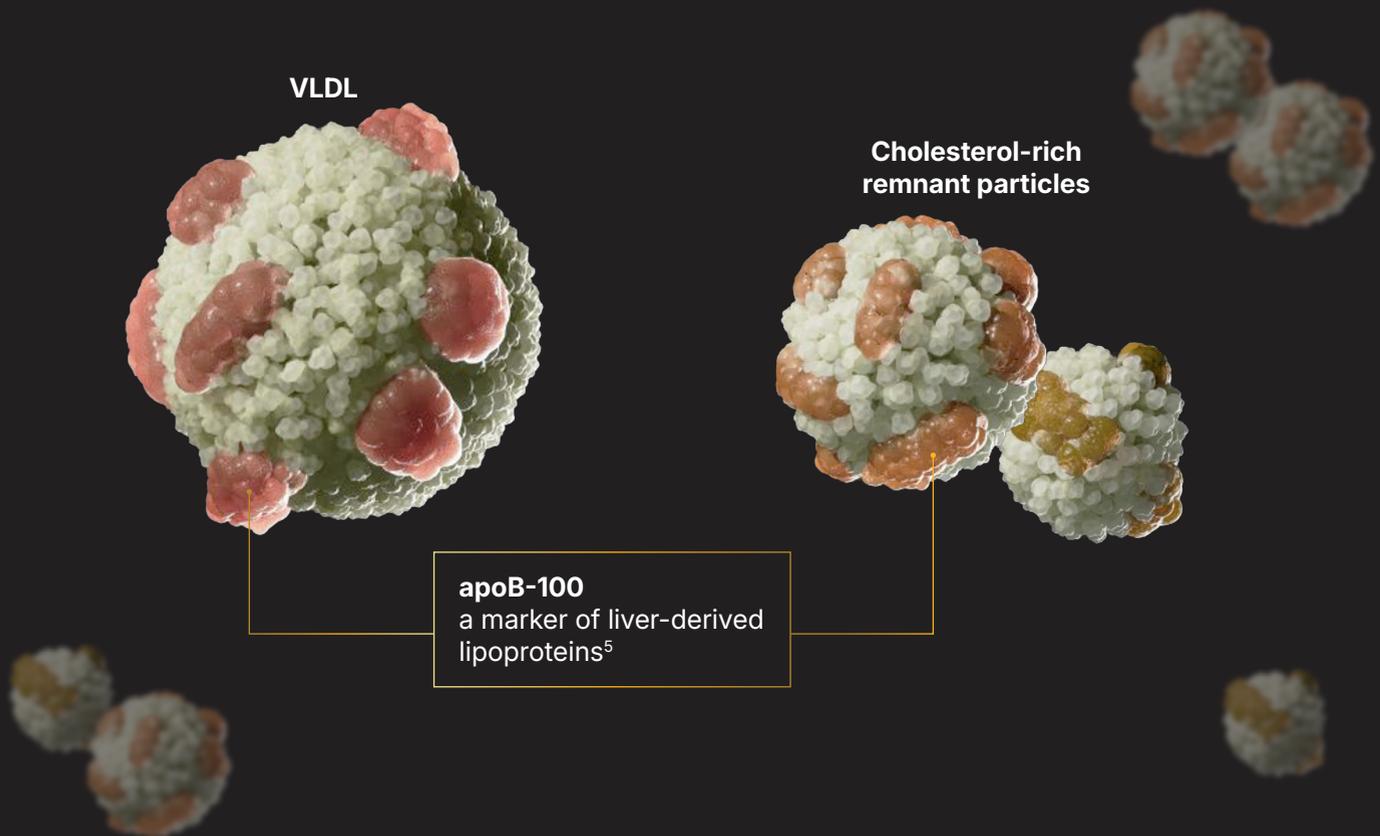
\*In patients with triglyceride levels >1000 mg/dL.

**Each subsequent event of AP after the first episode increases the risk of a future attack.**<sup>19</sup>



*sHTG* substantially increases a person's risk of  
**atherosclerotic cardiovascular  
disease (ASCVD)<sup>1,3</sup>**

At triglyceride levels  $\geq 500$  mg/dL, accumulation of non-HDL-containing atherogenic lipoproteins, such as VLDL and cholesterol-rich remnant particles, increases the risk of ASCVD.<sup>1,5</sup>



**VLDL and cholesterol-rich remnant particles contain apoB-100, a marker of liver-derived lipoproteins that may represent a strong predictor of ASCVD risk.<sup>5,17</sup>**



*sHTG is independently associated with*

# coronary heart disease (CHD)<sup>20</sup>

In a real-world study,\* the rate of CHD events was significantly higher in patients with sHTG compared with those who had normal triglyceride levels at baseline, respectively:

## 16.2% vs 9.5%

95% CI, 1.32-2.58;  $P < 0.001$

**sHTG requires immediate attention to reduce the risk of ASCVD.**



\*Adults with primary isolated hypertriglyceridemia and at least 1 triglyceride level  $\geq 500$  mg/dL (n=517) between 1998 and 2015 in Olmsted County, Minnesota, were identified and matched with 766 controls with triglyceride levels  $< 150$  mg/dL. CHD was defined as myocardial infarction, surgical or percutaneous coronary revascularization, cardiac angina, high-grade stenosis on coronary angiography, or an abnormal stress test.<sup>20</sup>

# Available treatment approaches rarely meet the challenge of sHTG

Lifestyle modifications (ie, diet and exercise) and commonly used therapies, such as fibrates, omega-3 fatty acids, statins, and GLP-1 receptor agonists, can provide some triglyceride reduction but are limited in their ability to sufficiently lower triglyceride levels in all patients with sHTG.<sup>21-24</sup>



**Expert guidelines and recommendations underscore the urgent need to lower triglyceride levels that are  $\geq 500$  mg/dL<sup>1,22,25,26</sup>**

GLP-1=glucagon-like peptide 1; sHTG=severe hypertriglyceridemia.

**sHTG demands prompt identification and urgent intervention.**



Visit [TGAware.com](https://www.tgaware.com) to take action against sHTG.

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