



For people with extremely high triglycerides despite standard of care
**WHAT COULD ACHIEVING EXPERT
 GUIDELINE-RECOMMENDED
 TRIGLYCERIDES <500 mg/dL
 MEAN FOR YOUR PATIENTS?^{1,2}**

AIM LOWER

Not an actual patient.

What the expert guidelines say about extremely high triglycerides and acute pancreatitis



People with extremely high triglyceride levels (>880 mg/dL) despite standard of care may have **Familial Chylomicronemia Syndrome (FCS)**, a rare form of severe hypertriglyceridemia characterized by impaired triglyceride metabolism that can be genetically or clinically diagnosed.³

Clinical practice consensus from the American Association of Clinical Endocrinology/American College of Endocrinology (ACE/ACE) and the American College of Cardiology/American Heart Association/National Lipid Association (ACC/AHA/NLA) clinical guidelines establish **triglycerides <500 mg/dL** as the goal to reduce acute pancreatitis risk.^{1,2}



People with fasting triglyceride levels >880 mg/dL are at a **high risk for acute pancreatitis** that rises as triglycerides rise. Accumulation of chylomicrons from dietary fat can dramatically spike acute pancreatitis risk after just one meal.^{1,3,4-6}



Additionally, people with extremely high triglyceride levels (hypertriglyceridemia) have a **significantly increased risk of acute pancreatitis and subsequent hospitalizations** compared to the general population.^{1,2,7-9}



Consider a diagnosis of FCS in people who consistently have extremely high triglycerides despite treatment. Diagnosis can be confirmed with the presence of any of the following: prior history of acute pancreatitis, hospitalizations for unexplained severe abdominal pain, family history of hypertriglyceridemia-induced pancreatitis, childhood pancreatitis, or genetic testing (if possible).^{3,9,10}

Just one episode of acute pancreatitis can heighten the risk of another.

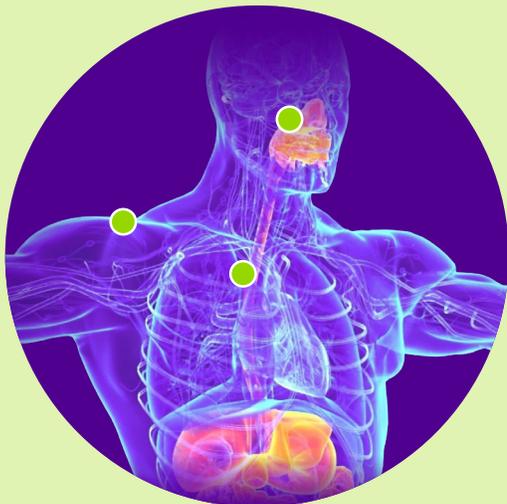
As compared to the risk for those with triglycerides <200 mg/dL, the risk of acute pancreatitis is higher by¹¹:



Retrospective cohort study annualized incidence rate of acute pancreatitis.
 Data were obtained from IQVIA's US ambulatory electronic medical records database (N=7,119,195).

Visit lowertriglycerides.com to learn more about FCS and guideline-directed care, or scan this QR code.





Burdens of extremely high triglycerides

People living with FCS face frequent physical, emotional, and social burdens.^{9,12}



Common systemic consequences include asthenia, eating disorders, and fatigue.⁹



Some physical symptoms for these patients may include lipemia retinalis, eruptive xanthomas, abdominal pain, and **acute pancreatitis**.^{3,9}



People living with FCS can also experience psychological impacts and stigmas that can negatively **influence their mental health**.^{9,12}

“ I felt like I was dealing with something that nobody really understood. ”

— Patient living with FCS

Visit [lowertriglycerides.com/patientstories](https://www.lowertriglycerides.com/patientstories) to see stories from diagnosed patients about living with FCS.

Guidelines suggest checking triglyceride levels every 3 months¹



Getting your patients to the guideline-recommended level of <500 mg/dL is the goal to reduce the risk for acute pancreatitis. Testing triglyceride levels every 3 months or more frequently as necessary helps you track their progress.^{1,2}

According to the American Association of Clinical Endocrinology and the American College of Endocrinology consensus statement that complements the guidelines, it is recommended that patients with extremely high triglycerides, such as those with FCS, should get their lipids checked **every 3 months** or more frequently as necessary. Regular testing helps you evaluate a treatment's success and disease progression by keeping you informed of triglyceride levels and acute pancreatitis risk if those levels are **>500 mg/dL**.^{1,2}

AIM LOWER

For people living with extremely high triglycerides, like those with FCS, lower is better.

- Aim to reach guideline-recommended triglyceride levels of **<500 mg/dL** to help patients reduce their risk of acute pancreatitis^{1,2}
- Test triglyceride levels **every 3 months** or more frequently as necessary to stay updated on treatment progress¹

To learn more about FCS and guideline-directed care, visit [lowertriglycerides.com](https://www.lowertriglycerides.com).

References: **1.** Handelsman Y, Jellinger PS, Guerin CK, et al. Consensus statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the management of dyslipidemia and prevention of cardiovascular disease algorithm - 2020 executive summary. *Endocr Pract.* 2020;26(10):1196-1224. **2.** Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *J Am Coll Cardiol.* 2019;73(24):e285-e350. **3.** Falko JM. Familial chylomicronemia syndrome: a clinical guide for endocrinologists. *Endocr Pract.* 2018;24(8):756-763. **4.** de Pretis N, Amodio A, Frulloni L. Hypertriglyceridemic pancreatitis: epidemiology, pathophysiology and clinical management. *United Eur Gastroenterol J.* 2018;6(5):649-655. **5.** Qiu M, Zhou X, Zippi M, et al. Comprehensive review on the pathogenesis of hypertriglyceridaemia-associated acute pancreatitis. *Ann Med.* 2023;55(2):2265939. **6.** Goldberg RB, Chait A. A comprehensive update on the chylomicronemia syndrome. *Front Endocrinol (Lausanne).* 2020;11:593931. **7.** Mszar R, Bart S, Sakers A, Soffer D, Karalis DG. Current and emerging therapies for atherosclerotic cardiovascular disease risk reduction in hypertriglyceridemia. *J Clin Med.* 2023;12(4):1382. **8.** Shamsudeen I, Hegele RA. Safety and efficacy of therapies for chylomicronemia. *Expert Rev Clin Pharmacol.* 2022;15(4):395-405. **9.** Davidson M, Stevenson M, Hsieh A, et al. The burden of familial chylomicronemia syndrome: results from the global IN-FOCUS study. *J Clin Lipidol.* 2018;12(4):898-907.e2. **10.** Paquette M, Bernard S, Hegele RA, Baass A. Chylomicronemia: differences between familial chylomicronemia syndrome and multifactorial chylomicronemia. *Atherosclerosis.* 2019;283:137-142. **11.** Sanchez RJ, Ge W, Wei W, Ponda MP, Rosenson RS. The association of triglyceride levels with the incidence of initial and recurrent acute pancreatitis. *Lipids Health Dis.* 2021;20(1):72. **12.** Williams L, Rhodes KS, Karmally W, et al. Familial chylomicronemia syndrome: bringing to life dietary recommendations throughout the life span. *J Clin Lipidol.* 2018;12(4):908-919.