Korean Guidelines for the Management of Dyslipidemia 2026

Committee of Clinical Practice Guideline of
the Korean Society of Lipid and Atherosclerosis

KSoLA
The Korean Society of Lipid and Atherosclerosis

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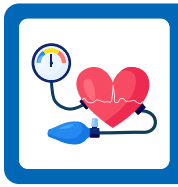
Major risk factors of atherosclerotic cardiovascular disease other than LDL-C

Age

Men ≥ 45; Women ≥ 55 years

Family history of premature coronary artery disease

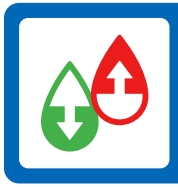
If either parent or sibling (men < 55; women < 65 years) has coronary artery disease



Hypertension

Blood pressure ≥ 140/90 mmHg or on antihypertensive medication

Smoking



Low HDL cholesterol level

< 40 mg/dL[1)]

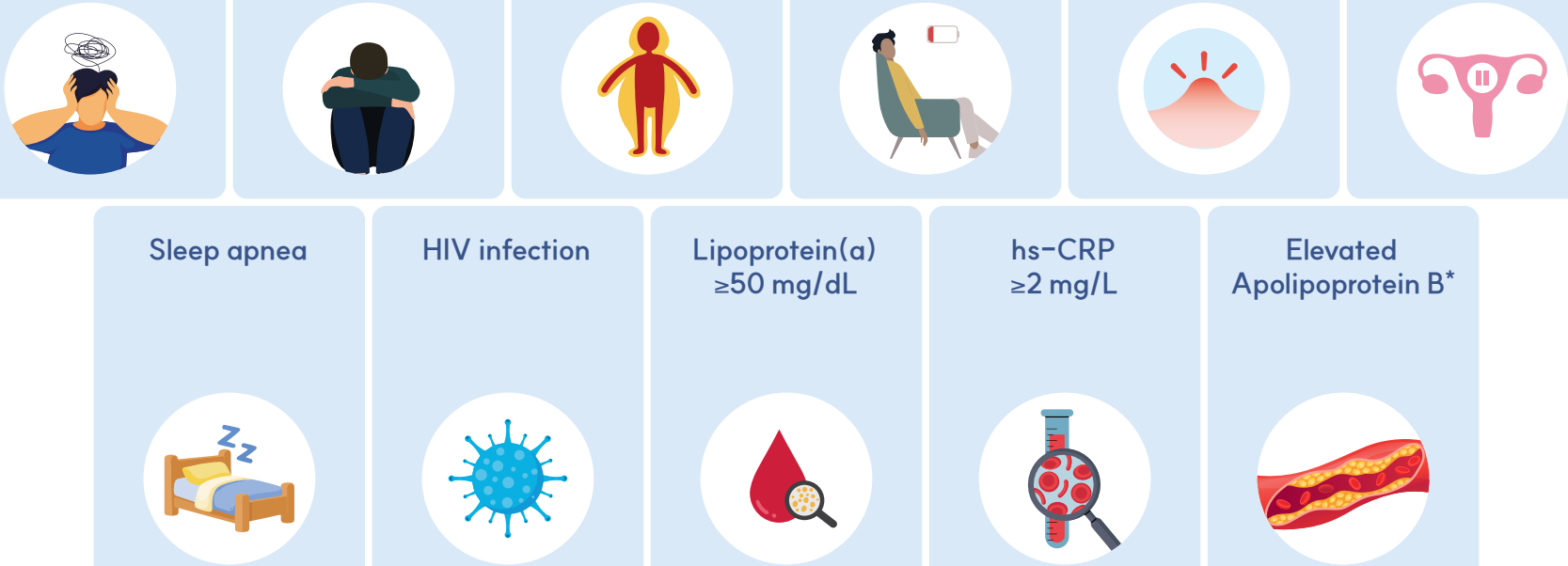
Diabetes mellitus is not included in the count of major risk factors and is classified separately according to disease duration, accompanying risk factors, and target-organ damage.

1) HDL-C is considered a protective factor only within the range of 60-100 mg/dL, and one is subtracted from the total count of major risk factors.
LDL-C, low-density lipoprotein cholesterol ; HDL, high-density lipoprotein cholesterol

Risk-enhancing factors

Risk-enhancing factors

- Stress
- Major psychiatric disorders, such as depression
- Obesity
- Physical inactivity
- Chronic inflammatory diseases
- History of premature menopause, preeclampsia, or gestational hypertension
- Sleep apnea
- HIV infection
- Lipoprotein(a) ≥50 mg/dL
- hs-CRP ≥2 mg/L
- Elevated Apolipoprotein B*



Risk enhancing factors should be used to refine clinical judgment and tailor treatment intensity after baseline risk assessment using traditional major risk factors.
*Used as an additional risk factor when elevated despite achieving LDL-C/non-HDL-C targets
hs-CRP, High-sensitivity C-reactive protein

Recommendations for treatment goals of LDL-C and non-HDL-C

Risk category*	LDL-C (mg/dL)	Non-HDL-C (mg/dL)
Coronary artery disease[1)†] **High risk of recurrent atherosclerotic ischemic stroke** **(Optional) Diabetes**† (with ≥3 major risk factors* or target organ damage‡)	< 55	< 85
Atherosclerotic stroke and transient ischemic attack† **/ Carotid artery disease**† **/ Peripheral artery disease**† **/ Abdominal aortic aneurysm**† **/ Diabetes mellitus**† (duration ≥ 10 years or with major risk factor* or target organ damage‡)	< 70	< 100
Diabetes mellitus (duration < 10 years and no major risk factors*)	< 100	< 130
Moderate risk (major risk factors* ≥ 2)	< 130	< 160
Low risk (major risk factors* ≤ 1)	< 160	< 190

In primary prevention including low and moderate risk groups, more intensive treatment goals may be considered in the presence of risk-enhancing factors.
* Major risk factors: age (men ≥45 years, women ≥55 years), family history of premature coronary artery disease (in a parent or sibling before age 55 years in men or 65 years in women), hypertension, smoking, and low HDL-C (<40 mg/dL).
† It is also recommended to reduce LDL-C by ≥ 50% from the baseline level.
‡ Albuminuria, eGFR < 60 mL/min/1.73 m^2, retinopathy, neuropathy, or left ventricular hypertrophy
1) For acute myocardial infarction, statin therapy should be initiated regardless of baseline LDL-C levels.

Treatment strategies by risk categories and LDL-C

Risk category	LDL-C (mg/dL)					
	< 55	55-69	70-99	100-129	130-159	≥ 160
Coronary artery disease[1)†] **High risk of recurrent atherosclerotic ischemic stroke (Optional) Diabetes**[†] (with ≥3 major risk factors[*] or target organ damage[‡])	Lifestyle modification and consider pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy
Atherosclerotic stroke and transient ischemic attack[†] **/ Carotid artery disease**[†] **/ Peripheral artery disease**[†] **/ Abdominal aortic aneurysm**[†] **/ Diabetes mellitus**[†] (duration ≥ 10 years or with major risk factor[*] or target organ damage[‡])	Lifestyle modification	Lifestyle modification and consider pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy
Diabetes mellitus (duration < 10 years and no major risk factors[*])	Lifestyle modification	Lifestyle modification	Lifestyle modification and consider pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy
Moderate risk[2)] (major risk factors[*] ≥ 2)	Lifestyle modification	Lifestyle modification	Lifestyle modification	Lifestyle modification and consider pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy
Low risk[2)] (major risk factors[*] ≤ 1)	Lifestyle modification	Lifestyle modification	Lifestyle modification	Lifestyle modification	Lifestyle modification and consider pharmacotherapy	Lifestyle modification and concomitant pharmacotherapy

In primary prevention including low and moderate risk groups, more proactive pharmacological therapy may be considered to achieve intensified treatment goals in the presence of risk enhancing factors.

* Major risk factors: age (men ≥45 years, women ≥55 years), family history of premature coronary artery disease (in a parent or sibling before age 55 years in men or 65 years in women), hypertension, smoking, and low HDL-C (<40 mg/dL).

† It is also recommended to reduce LDL-C by≥ 50% from the baseline level.

‡ Albuminuria, eGFR < 60 mL/min/1.73 m^2, retinopathy, neuropathy, or left ventricular hypertrophy

1) For acute myocardial infarction, statin therapy should be initiated regardless of baseline LDL-C levels.

2) For moderate and low-risk patients, consider statin initiation if LDL-C goals are not met despite several weeks to months of intensive lifestyle intervention

Dietary recommendation

Category	Recommendation	Practical Considerations
Energy and body weight	Maintain an appropriate body weight	Avoid excessive energy intake
Carbohydrates and sugars	Carbohydrates: 50–65% of total energy intake; total sugars: ≤20% of total energy intake	Prefer whole grains and mixed grains; limit sugar-sweetened beverages and processed foods
Dietary fiber and whole grains	≥ 25 g/day	Adequate intake of whole grains, vegetables, and fruits
Protein	Focus on legumes and fish	Limit red and processed meat
Total fat and saturated fatty acids	Total fat: ≤30% of total energy intake; saturated fat: ≤7% of total energy intake	Replace saturated fatty acids with unsaturated fatty acids
Trans fat	Avoid trans fat intake	Unsaturated fatty acids
Cholesterol	(In case of hypercholesterolemia) Avoid dietary cholesterol intake	Limit cholesterol-rich foods
Dietary patterns	Recommend plant-forward dietary patterns	Mediterranean, DASH, and balanced Korean diet

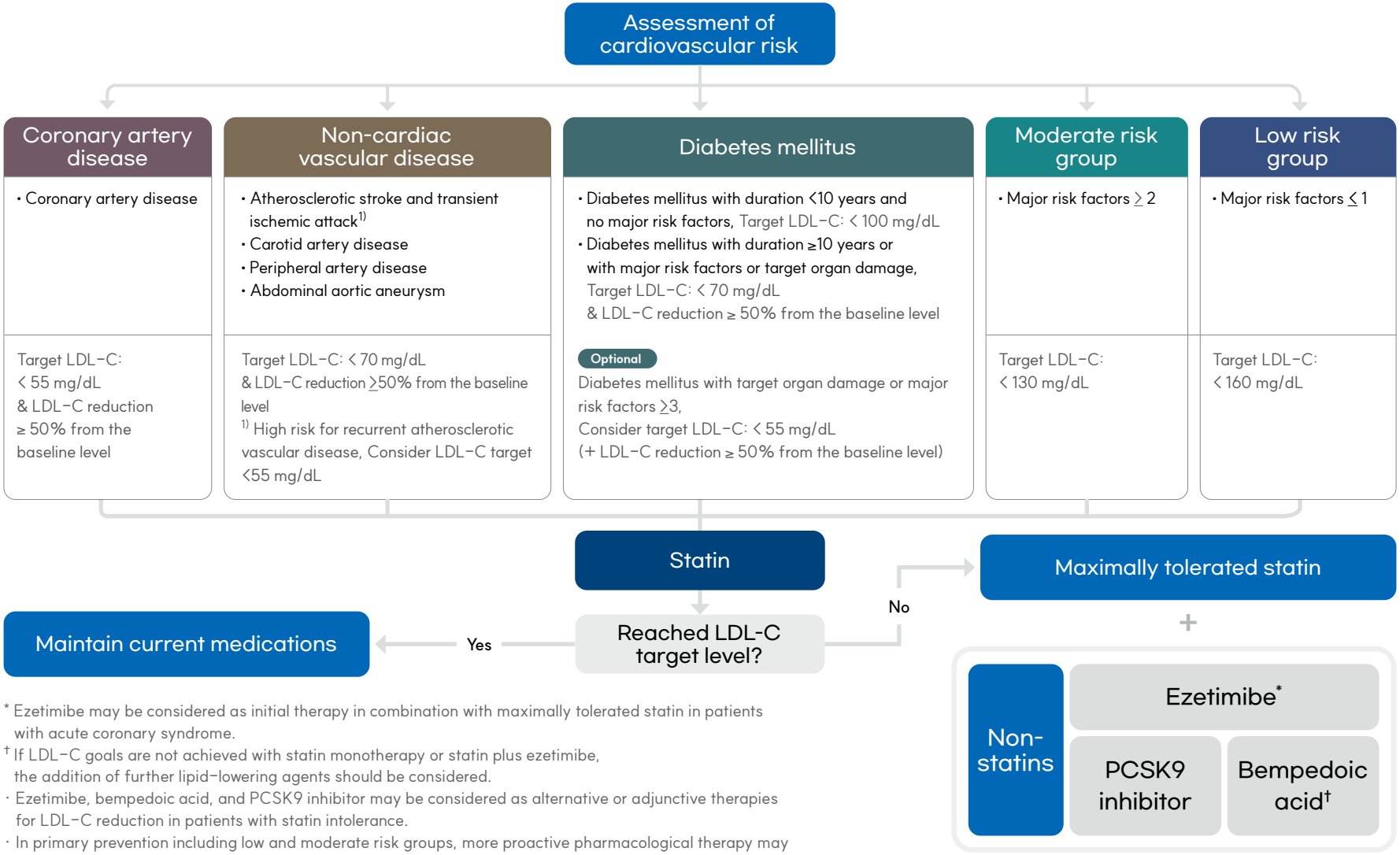
Category	Mediterranean Diet	DASH Diet	Plant-based Diet
Key foods	Olive oil, nuts, vegetables, fruits, whole grains, legumes, fish	Vegetables, fruits, whole grains, low-fat dairy products, legumes	Whole grains, vegetables, fruits, legumes, nuts, and plant-based foods
Fat	Focus on unsaturated fatty acids	Restriction of saturated fatty acids	Replace saturated fatty acids with unsaturated fatty acids
Protein	Focus on fish and legumes	Focus on lean protein sources	Focus on plant-based protein sources
Foods to be limited	Red meat, processed meat, butter, cream, fried foods	Sodium, processed meats, foods high in saturated fatty acids	Red meat, processed meat, and animal-derived fats

Exercise Prescribtion

Type	Recommendation	Practical points
Aerobic physical activity	150–300 min/week of moderate-intensity or 75–150 min/week of vigorous-intensity aerobic physical activity.	Start with walking, cycling, or swimming.
Combined exercise	Combine aerobic and resistance exercise.	Add resistance exercise 2–3 times/week.
Reducing sedentary time	Break up prolonged sitting with more frequent movement.	Stand up every 30–60 min and take short walking breaks.
Pre-exercise evaluation	High-risk patients should undergo a medical evaluation before starting exercise.	Assess symptoms, comorbidities, and plans for vigorous exercise.
Lifestyle intervention	Behavioral strategies and use of wearable devices should be considered.	Use goal setting, self-monitoring, and activity tracking.

Type	Implementation strategy	Key point for clinical practice
Physically inactive patients	Start with low-burden activities such as walking and encourage daily movement, even for short periods.	Emphasize that "any activity is better than none."
Patients with limited time for exercise	Break exercise into several short bouts during the day rather than one long session.	Increase lifestyle activity as a practical alternative.
Patients requiring weight reduction	Increase aerobic exercise and combine it with resistance exercise.	Include resistance exercise to help prevent muscle loss during weight reduction.
Older adults or patients with low fitness	Start at low intensity and increase gradually.	Individualize the exercise program based on fall risk and fatigue.
High-risk patients or those with comorbidities	Begin exercise after medical evaluation and within a safe range.	Evaluate before exercise if chest pain, dyspnea, dizziness, or syncope is present.
Patients with prolonged sedentary behavior	Frequently interrupt sitting time and encourage brief bouts of movement.	Sedentary behavior itself should be addressed separately from structured exercise.
Patients with low motivation	Set specific, achievable goals and encourage self-monitoring.	Apps and wearable devices may improve adherence.

Treatment Algorithm for Dyslipidemia



* Ezetimibe may be considered as initial therapy in combination with maximally tolerated statin in patients with acute coronary syndrome.

† If LDL-C goals are not achieved with statin monotherapy or statin plus ezetimibe, the addition of further lipid-lowering agents should be considered.

· Ezetimibe, bempedoic acid, and PCSK9 inhibitor may be considered as alternative or adjunctive therapies for LDL-C reduction in patients with statin intolerance.

· In primary prevention including low and moderate risk groups, more proactive pharmacological therapy may be considered to achieve more intensive treatment goals in the presence of risk enhancing factors.

Secondary causes of hypercholesterolemia or hypertriglyceridemia

	Elevated LDL cholesterol	Elevated Triglycerides
Diet	• Intake of saturated fatty acid • Intake of trans fatty acid • High caloric intake	• Alcohol intake • High caloric intake • High carbohydrate intake
Drugs	• Diuretics • Glucocorticoid • Amiodarone • Cyclosporine	• Oral estrogen • Bile acid sequestrant • Retinoic acid • Sirolimus • Tamoxifen • Thiazide diuretics • Glucocorticoid • Protease inhibitor • Anabolic steroids • Raloxifene • Beta-blocker
Disease	• Obstructive liver disease • Nephrotic syndrome • Anorexia nervosa	• Chronic kidney disease • Nephrotic syndrome • Sepsis
Abnormal metabolism	• Obesity • Pregnancy • Hypothyroidism	• Obesity • Pregnancy • Uncontrolled diabetes

Lipid-lowering efficacy and pharmacologic characteristics of statins

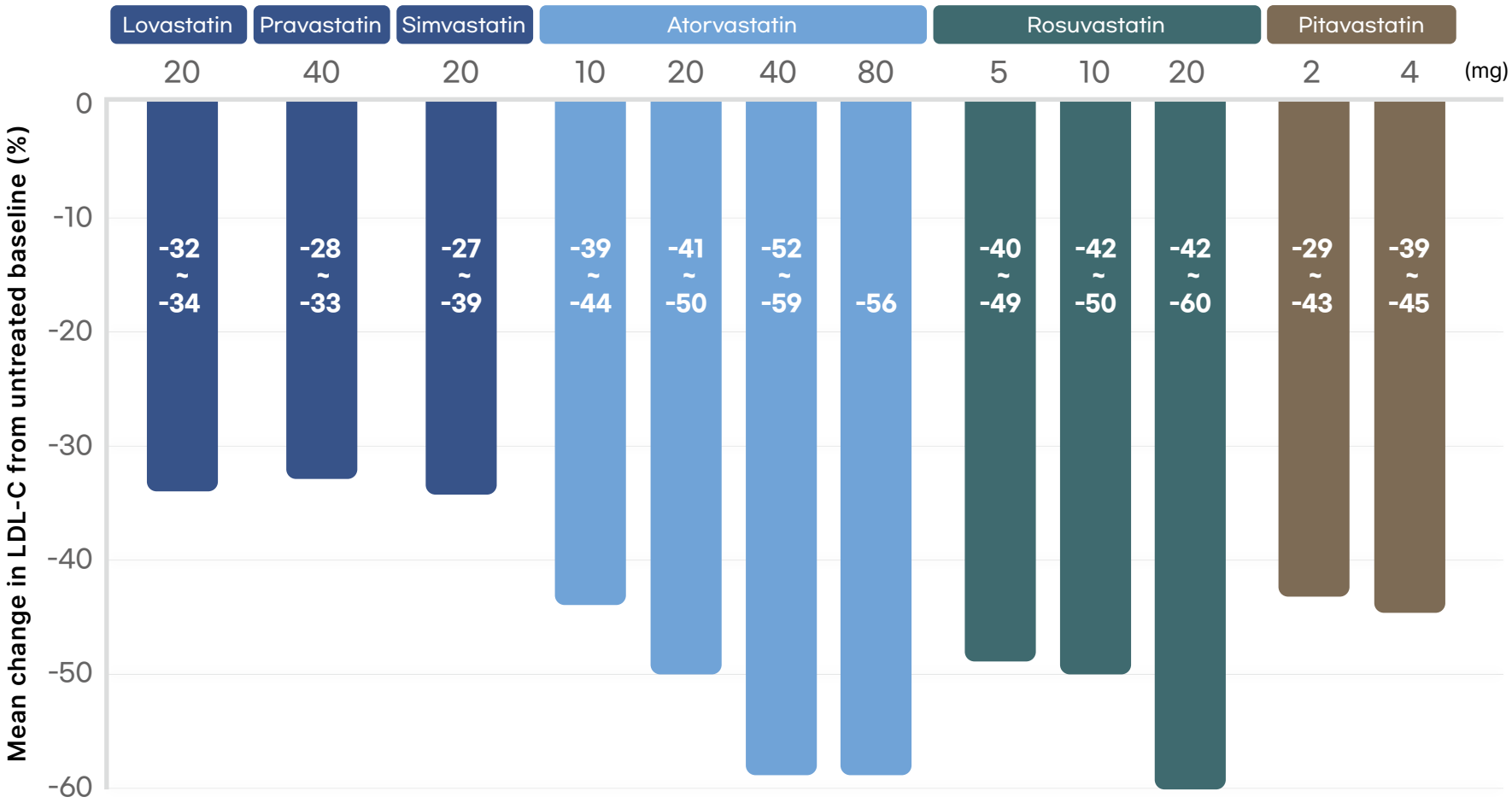
		Lovastatin	Pravastatin	Simvastatin	Atorvastatin	Fluvastatin	Rosuvastatin	Pitavastatin
Daily dose (mg)		20-80	10-40[1)]	20-40	5-80	20-80	2.5-20	1-4
LDL-C reduction (%)	24-28	20	20			40		1
	30-36	40	40	20	10	80		2
	39-45	80		40	20		5-10	4
	46-52				40-80		20	
Metabolism		CYP3A4	Sulfonation	CYP3A4	CYP3A4	CYP2C9	CYP2C9	Glucuronidation (Partial CYP2C9)
Protein binding (%)		>95	43-67	95-98	98	98	88	> 99
Half-life (h)		2-4	2-3	1-3	13-30	0.5-3	19	12
Hydrophilicity		-	+	-	-	-	+	-
Elimination		Hepatobiliary	Hepatobiliary	Hepatobiliary	Hepatobiliary	Hepatobiliary	Hepatobiliary	Hepatobiliary
Renal elimination fraction (%)		10	20	13	< 2	< 6	28	15

1) 40~80 mg in Caucasian countries
2) 5~40 mg in Caucasian countries

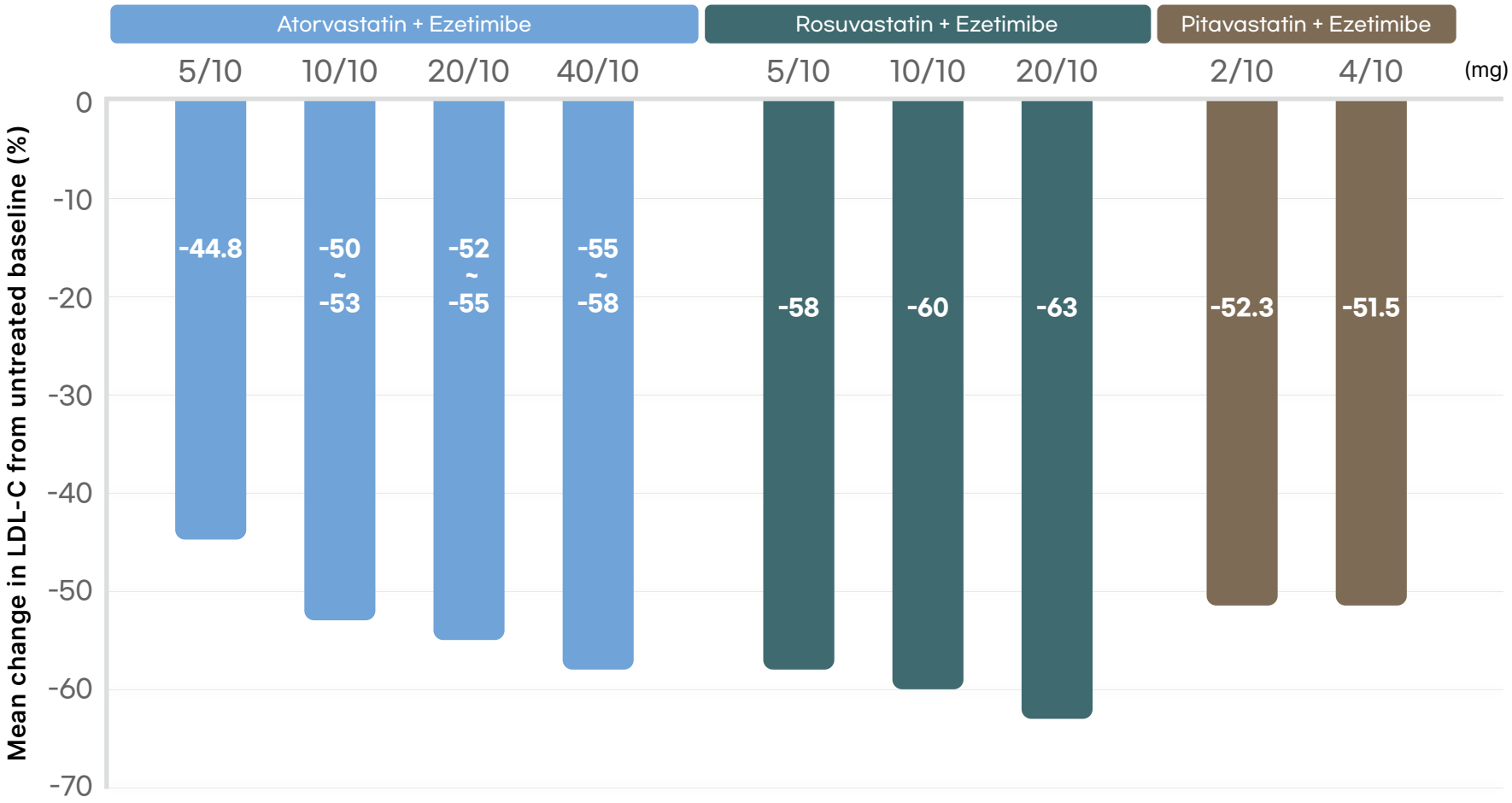
Summary of statin use

Statin: HMG-CoA reductase inhibitor		
Dosing	Lovastatin	20-80 mg once daily, take with dinner
	Pravastatin	10-40 mg once daily, more effective to take it in the evening
	Simvastatin	20-40 mg once daily, more effective to take it in the evening
	Atorvastatin	5-80 mg once daily, not significantly affected by the time taken
	Fluvastatin	20-80 mg once daily, more effective to take it in the evening
	Rosuvastatin	2.5-20 mg once daily, not significantly affected by the time taken
	Pitavastatin	1-4 mg once daily, not significantly affected by the time taken
Monitoring		Lipid profiles, liver function test and muscle enzymes (in case of unexplained myalgia or muscle weakness)
Adverse effects		Dyspepsia, epigastric soreness, abdominal pain, hepatotoxicity, myopathy and diabetes mellitus
Contraindications		It is absolutely contraindicated in patients with active liver disease. Relative contraindications and caution are required during concomitant use with cyclosporin, macrolide antibiotics, systemic antifungals, or strong cytochrome P-450 inhibitors. Statins should be discontinued immediately upon confirmation of pregnancy. However, continuation may be considered in very high-risk cardiovascular conditions (e.g., homozygous familial hypercholesterolemia) after a thorough risk-benefit discussion with the patient.

LDL-C lowering effect of statins in Koreans



LDL-C lowering effect of statin/ezetimibe combination in Koreans



Dyslipidemia in Coronary Artery Disease

Recommendations	Class/Level
In patients with coronary artery disease, an LDL cholesterol level <55 mg/dL together with a ≥50% reduction from baseline is recommended for secondary prevention.	I A
When acute myocardial infarction occurs, statin therapy is recommended immediately, regardless of the baseline LDL cholesterol level.	I A
In patients with acute coronary syndrome already receiving lipid-lowering therapy, intensification of the existing treatment during hospitalization should be considered.	I C
In patients with coronary artery disease who do not reach the LDL cholesterol goal with statin therapy alone, or when early goal attainment is needed, adding a non-statin agent such as ezetimibe or a PCSK9 inhibitor is recommended.	I B
In patients with coronary artery disease and statin intolerance, bempedoic acid should be considered to achieve the LDL cholesterol goal.	IIa B
In patients with acute coronary syndrome, upfront combination of a maximally tolerated statin and ezetimibe should be considered to reach the LDL cholesterol goal early.	IIa B

Dyslipidemia in Stroke (Cerebrovascular Disease)

Recommendations	Class/Level
High-intensity statin therapy is recommended for secondary stroke prevention in patients with an LDL cholesterol level ≥100 mg/dL in the absence of coronary artery disease or a cardioembolic source.	I A
In patients with ischemic stroke or transient ischemic attack who have intracranial or extracranial cerebral artery stenosis, aortic atherosclerotic plaque, or a history of coronary artery disease, statin therapy is recommended first, adding ezetimibe if needed, to lower LDL cholesterol to <70 mg/dL.	I B
In patients with ischemic stroke who have atherosclerotic disease and cardiovascular risk factors, a PCSK9 inhibitor should be considered if LDL cholesterol does not fall below 70 mg/dL despite a maximally tolerated statin combined with ezetimibe.	IIa B
In patients with atherosclerotic ischemic stroke, or transient ischemic attack presumed to be of atherosclerotic origin, who are considered at high risk of recurrent atherosclerotic vascular disease, lowering LDL cholesterol to <55 mg/dL should be considered.	IIa B

Dyslipidemia in Diabetes Mellitus

Recommendations	Class/Level
In patients with diabetes and cardiovascular disease, lowering LDL cholesterol to <55 mg/dL together with a ≥50% reduction from baseline is recommended.	I A
In patients with diabetes who have target-organ damage (albuminuria, eGFR <60 mL/min/1.73 m^2, retinopathy, neuropathy, or left ventricular hypertrophy) or major cardiovascular risk factors, or type 2 diabetes of ≥10 years' duration, lowering LDL cholesterol to <70 mg/dL together with a ≥50% reduction from baseline is recommended.	I A
In patients with diabetes who have target-organ damage (albuminuria, eGFR <60 mL/min/1.73 m^2, retinopathy, neuropathy, or left ventricular hypertrophy) or ≥3 major cardiovascular risk factors, lowering LDL cholesterol to <55 mg/dL together with a ≥ 50% reduction from baseline should be selectively considered for additional prevention of cardiovascular events.	IIa B
In patients with diabetes of <10 years' duration and without major cardiovascular risk factors, drug therapy is recommended for primary prevention when LDL cholesterol is ≥100 mg/dL.	I A

Dyslipidemia in Chronic Kidney Disease

Recommendations	Class/Level
In patients with chronic kidney disease (non-dialysis/non-transplant) who are ≥50 years of age or have an eGFR <60 mL/min/1.73 m^2, statin or statin plus ezetimibe therapy is recommended to reduce the risk of cardio-cerebrovascular disease.	I A
In patients ≥50 years of age with CKD stage 1–2 and an eGFR ≥60 mL/min/1.73 m^2, statin therapy is recommended.	I B
In patients with chronic kidney disease (non-dialysis/non-transplant) aged 18–49 years, statin therapy should be considered according to cardiovascular risk.	II A
In adult patients with chronic kidney disease and hypertriglyceridemia, therapeutic lifestyle changes should be considered first.	II A

Dyslipidemia in Children and Adolescents

Recommendations	Class/Level
In children with dyslipidemia, the Cardiovascular Health Integrated Lifestyle Diet 1 (CHILD 1) is recommended for 3–6 months. If not controlled with CHILD 1, CHILD 2-LDL or CHILD 2-TG is recommended.	I A
In obese children with high triglycerides, reducing caloric intake and increasing physical activity are recommended first.	I B
Exclusive breastfeeding is recommended during the first 6 months of life.	I B
In children ≥10 years of age, a statin is recommended when after 6 months of lifestyle modification and diet (CHILD 1 → CHILD 2-LDL), LDL cholesterol remains ≥190 mg/dL; or is 160–189 mg/dL with a family history of premature cardiovascular disease and at least one high-risk factor/condition or two or more moderate-risk factors; or is 130–159 mg/dL with two or more high-level risk factors, or one high-level risk factor plus two or more moderate-risk factors.	I A

Dyslipidemia in Older Adults

Recommendations	Class/Level
In older adults with cardio-cerebrovascular disease, statin therapy is recommended.	I A
In older adults ≤75 years of age, a statin is recommended for primary prevention according to cardiovascular risk.	I A
In older adults >75 years of age, statin therapy for primary prevention may be considered in high-risk individuals.	IIb B
In older adults with renal impairment, potential drug interactions, or frailty, it is recommended to start with a low-dose statin and individualize treatment intensity and the LDL cholesterol goal, considering cardiovascular risk, functional status, degree of frailty, comorbidities, polypharmacy, life expectancy, and patient preferences.	I C

Dyslipidemia during Pregnancy

Recommendations	Class/Level
Women who experienced complications of a hypertensive disorder of pregnancy (preeclampsia) have an increased risk of cardiovascular disease or stroke 10–15 years later. Therefore, follow-up with a blood lipid test during the postpartum period is recommended.	I A
High maternal triglycerides are associated with increased neonatal weight gain and an increased risk of macrosomia.	IIa A
Statins are not thought to increase the risk of fetal malformation during pregnancy. However, there is no evidence that treating hypercholesterolemia during pregnancy benefits maternal health, and because cholesterol is required for embryonic development, statin use during pregnancy and lactation is not recommended.	III A

Familial Hypercholesterolemia (FH)

Recommendations	Class/Level
Screening for FH is performed when coronary artery disease develops in a man <55 years or a woman <60 years of age, when the patient or a family member has an LDL cholesterol level >190 mg/dL (>150 mg/dL in children), when there is a family history of premature cardiovascular disease; or when tendon xanthomas are present.	I C
Once the first patient in a family is diagnosed, cascade screening within blood relatives is performed to identify additional patients early.	I C
In adult FH patients with atherosclerotic cardiovascular disease or major risk factors for it, the LDL cholesterol treatment goal is <55 mg/dL.	IIa C
In adult FH patients without either atherosclerotic cardiovascular disease or major risk factors, the LDL cholesterol treatment goal is <70 mg/dL.	IIa C

Dyslipidemia in Other Special Populations

	Recommendations
Chronic inflammatory disease	Considered a risk-enhancing factor that increases atherosclerotic cardiovascular disease risk. The indication for lipid-lowering therapy and the LDL cholesterol goal are determined by the individual's overall cardiovascular risk.
Human immunodeficiency virus (HIV) infection	In HIV-infected individuals ≥40 years of age, statin therapy for primary prevention should be considered regardless of the LDL cholesterol level or baseline cardiovascular risk (with attention to interactions with antiretroviral therapy).
Cancer chemotherapy	In patients receiving anthracycline-based chemotherapy who are at high risk (older age or cardiovascular risk factors), statin therapy may be considered to prevent cardiac dysfunction.
Vaccination	As an adjunctive cardiovascular prevention strategy that reduces the triggering of cardiovascular events by preventing infection, appropriate vaccination should be considered according to age and baseline risk.

Future Research Agenda

- Development and validation of a cardiovascular disease risk assessment tool
- Validation of the ≥60 mg/dL HDL cholesterol risk-subtraction criterion
- Establishing Korean-specific evidence on whether to adjust the LDL cholesterol goal in the low-risk group (130 vs 160 mg/dL)
- Establishing Korean-specific evidence for the use of coronary artery calcium score in risk assessment
- Establishing Korean-specific evidence for the use of Lp(a) in cardiovascular risk prediction
- Establishing Korean-specific evidence for the use of genetic markers in risk assessment

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