Healthcare trends
by PwC

In what ways can we elevate action around Lp(a) as new risk factor for Cardiovascular Disease?

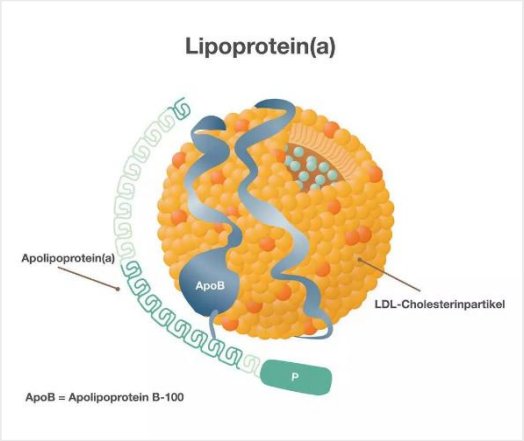
Whitepaper | December 2025

www.pwc.be

Introduction

Cardiovascular diseases (CVDs) represent the **leading cause of death** globally, claiming millions of lives each year. In 2019, the World Health Organization reported that CVDs accounted for 32% of all deaths worldwide [1]. In Belgium, CVD mortality was equally alarming, with cardiovascular conditions responsible for **23% of deaths** in 2021 making them the second most common cause of mortality, just behind cancer [2]. Beyond these statistics, CVDs carry a **tremendous economic burden**, costing the Belgian healthcare system nearly €5 billion annually, with individual patients often facing high out-of-pocket expenses that average around €7,000 each year [3].

The **growing prevalence** of Atherosclerotic Cardiovascular Disease (ASCVD), the most common form of CVD, presents an urgent challenge. Currently, up to **750,000 patients in Belgium are diagnosed** with ASCVD, while many **remain undiagnosed** [3]. Despite a recent decline in cardiovascular-related mortality due to advances in prevention and treatment, this positive trend may soon reverse [4]. Therefore, it is crucial to **rethink our approach** to understanding cardiovascular risk factors to effectively curb this pandemic.



Simply put,
From momentum to mandate, from declaration to determination, from a plan to prevention.

One of the most important yet often overlooked risk factors is **lipoprotein(a)**, known as Lp(a). This macromolecule, composed of cholesterol and proteins, plays a **pivotal role** in cardiovascular health. Elevated levels of Lp(a) are **an independent risk factor for ASCVD** [5], heightening risk significantly for about 20% of the population [6]. What makes Lp(a) particularly concerning is its **genetic underpinning**; approximately 90% of an individual's Lp(a) levels are determined by their genetic composition, rendering traditional risk factor modifications, such as changes in diet or exercise, less effective for those with high levels [7].

Studies have established a **direct link between elevated Lp(a) and** the incidence of **ASCVD**. For instance, routine testing has shown that 20% of middle-aged individuals in the UK are **categorized as high-risk** due to elevated Lp(a) levels [8]. These findings highlight an urgent need for increased awareness and action regarding Lp(a), as was recently emphasized in the Brussels International Declaration on Lp(a) testing and management [9].

Understanding Lp(a) is essential. Research indicates that individuals with markedly high Lp(a) concentrations face a **2.7-fold increased risk of ASCVD** compared to those with lower levels [10]. Lp(a) particles are about 6 times more atherogenic than LDL particles, making them a significant risk factor, a risk that is often not tested in standard cholesterol testing [10].

The call to action is clear: We must **prioritize Lp(a) screening** within healthcare practices to enhance **cardiovascular health outcomes** and mitigate the impact of ASCVD. By doing so, we can work toward a healthier future for Belgians, ultimately reducing the burden of cardiovascular diseases and saving lives.

Where the journey started…

To tackle the pressing issue of Lp(a) awareness in cardiovascular health, we initiated a **collaborative effort** to gather critical insights and develop an effective strategy. Our journey began with a pivotal **advisory board** event held on June 18, 2024, where we convened a distinguished **group of scientific experts** to explore the role of Lp(a) in the future of cardiovascular risk prevention, all united by a shared goal of advancing cardiovascular care.

Facilitated by our dedicated task force, this gathering culminated in the creation of **five actionable calls to action**.

Following the advisory board meeting in June 2024, we saw the necessity to bridge the gap between the scientific community and **broader society**. Thus, we organized an Lp(a) event on March 12, 2025, to integrate more diverse perspectives from the political world and healthcare payers, expanding our insights. The panels involved a **diverse pool of experts** like policymakers, scientific experts, general practitioners, health insurance and a patient with elevated levels of Lp(a). The information gathered from this event is set to provide a comprehensive, **pragmatic roadmap** to combat the current lack of awareness surrounding Lp(a).

In parallel, between these two significant events, the **ASCVD plan** was officially requested by Belgian experts to the federal government and signed on January 23, 2025. The plan urged the development of an **action plan aiming to reduce ASCVD events.**

Finally, in September 2025, we conducted an **interactive event** aiming to refine the calls to action and addressing the remaining open questions. This encouraged dynamic discussions among participants, allowing us to delve deeper into the **complexities of Lp(a)** and its **implications for cardiovascular strategy**.

To ensure a thorough understanding, we also conducted a **series of interviews**, broadening our knowledge and capturing a range of viewpoints.

5 calls to action

A diverse pool of experts gave their validation on the five calls to action:

1. Recognize Lp(a) as **independent**, **genetic** risk factor.
2. Use Lp(a) as a new asset for **driving efficiency** in CV prevention.
3. Implement **accessible testing** for Lp(a).
4. Leverage the potential of **e-health** in managing Lp(a).
5. Build a broad, evidence-based **educational campaign** to promote health equality.

Where we are now

Throughout the process, it became clear that the five calls to action can not be addressed in isolation; they are **interconnected** and require a **holistic approach**. Consequently, we formulated **several questions** aiming to cover the expansive scope defined by these five calls to action:

1	Which steps can be taken to integrate Lp(a) in the Belgian government's CVH plan?
2	How can we gather epidemiological data for Belgium?
3	How to enhance the acceptance of Lp(a) testing as a tool to improve CV prevention in the population?
4	What must be done to reduce the costs of unnecessary tests to finance Lp(a) testing?
5	How can we generalize the insights from local initiatives to create CVH passports at the Belgian level?
6	How to ensure clear reporting and interpretation of laboratory results to improve patient understanding and willingness to act?

The task force behind the success:

Ernst Rietzschel
UGhent

Jan Bertels
Vooruit

Antoine Bondue
Hôpital Erasme

Mickaël Daubie
INAMI-RIZIV

Bart Demyttenaere
Solidaris

Peter de Jaeger
AZ Delta

Kathleen Depoorter
N-VA

Hendrik De Rocker
APB

Damien Gruson
UCL Saint-Luc

Michel Langlois
AZ Sint-Jan Brugge

Noémie Ligot
Hôpital Erasme

Sam Proesmans
ZAS

Arthur Rodenbach
ReaniMate

Stefan Teughels
Domus Medica

1 | Focus point

Which steps can be taken to integrate Lp(a) into the Belgian government's CVH plan?

The Belgian government's **CVH plan** serves as a strategic framework aimed at **reducing the incidence and mortality** associated with CVDs through **preventive** measures, early **detection**, and targeted **treatment** pathways. While the plan already addresses established risk factors, such as cholesterol and hypertension, Lp(a) remains largely absent.

Integrating Lp(a) into this plan is crucial due to its status as an **important risk factor** for ASCVD. Elevated Lp(a) levels significantly increase cardiovascular risk for a substantial portion of the population, yet many individuals remain unaware of their status [6] [11] .

Focusing on integrating Lp(a)

Integrating Lp(a) testing into Belgium's CVH plan is essential for **improving public health** and **achieving long-term healthcare savings**. Lp(a) is and should be recognized as an **independent** and **causal risk factor** for cardiovascular events, highlighting the need for routine testing within the CVD risk assessment protocols [6]. Lp(a) should stand **alongside established markers** such as LDL cholesterol [10].

Studies indicate that the **health benefits** of routine Lp(a) testing are considerable. For every 10,000 individuals tested, aged between 40 and 69 years without CVD, it could potentially prevent 60 heart attacks, 13 strokes, and 26 premature deaths. Furthermore, the **economic benefits** are substantial: in primary prevention, Lp(a) testing is not only cost-effective, but potentially cost-saving from both healthcare and societal perspectives, with net savings estimated at AU$85 in Australia and £263 in the UK per person tested, in the primary prevention population from a healthcare perspective, largely due to reductions in hospitalizations and improved productivity [12].

Addressing budget constraints

Engaging with RIZIV to **explore reimbursement options** for Lp(a) testing is crucial for its integration into the CVH plan. The recent **guidelines** from the European Society of Cardiology (ESC) emphasize the need for reimbursement in line with European standards [11]. Showcasing cost-effectiveness and potential savings from relevant studies can strengthen arguments for its inclusion in the CVH plan.

Preparing for a 2026 CVD resolution to include Lp(a) testing in the European plan requires a strategic focus on how it can lead to **significant budget savings**. Addressing **financial constraints within laboratory settings** will also be important to ensure access to the relevant individuals.

Strong European collaboration

The upcoming announcement regarding the inclusion of Lp(a) testing in the EU CVH plan provides a crucial opportunity for collaborative engagement [11]. **Partnerships** with **organizations** such as the ESC will be key to tackle reimbursement challenges and integrating Lp(a) testing into the broader cardiovascular health strategies.

Coordinated discussions are crucial to align resources and strategies, facilitating the systematic integration of Lp(a) testing into routine cardiovascular risk assessments. By optimizing collaboration and **sharing best practices** across European countries, Belgium can not only enhance the integration of Lp(a) in its national CVH plan but also **align with European health initiatives**, greatly improving the prevention and management of cardiovascular diseases.

> Incorporate Lp(a) testing into the government's broader strategy for preventing atherosclerotic and cardiovascular diseases, focusing on high-risk groups, including individuals with genetic predispositions and those with a history of premature CVD.
>
> **Kathleen Depoorter**

2 | Focus point

How can we gather epidemiological data for Belgium?

Epidemiological Lp(a) data gathering is essential for understanding its **prevalence, risk factors,** and **impact** on CVD. This process involves systematically collecting and analyzing data on Lp(a) levels in various populations, and clinical settings. The importance of this data lies in its ability to **inform** public health strategies and clinical guidelines. By establishing a **clearer picture** of how prevalent elevated Lp(a) is among different groups, healthcare experts can develop **targeted interventions** and **screening programs**.

A centralized data approach

An impactful method for gathering epidemiological data on Lp(a) in Belgium is to implement a centralized data management strategy. This approach **minimizes fragmentation** across existing healthcare platforms and enables effective data integration. By consolidating systems into a **single centralized data hub**, we can streamline access to crucial epidemiological and clinical information related to Lp(a).

A core component of this unified approach is the establishment of a national **CVD registry** on systematic data collection regarding Lp(a) and its implications for cardiovascular health. This registry should utilize integrated systems to **automate the aggregation of laboratory results**, providing a comprehensive overview of cardiovascular trends across the population.

In addition, creating a **federated data network among hospitals** can facilitate the secure sharing of relevant health information while safeguarding patient privacy. This network will allow for the sharing of, for example, Lp(a) and lipid test results across various healthcare settings, supporting the identification of geographic disparities in testing and enabling **targeted community interventions**.

Furthermore, the introduction of a unified health passport for patients will offer a holistic view of individual health data, optimizing **care coordination** and ensuring that healthcare providers have **timely access** to essential information.

Improving data availabilty

Building partnerships with organizations such as **Sciensano** and the **Health Data Agency (HDA)** is critical to systematically collect comprehensive epidemiological data on Lp(a). This can be achieved **through regular health surveys** or **standardized data collection methods** that assess Lp(a) levels and their relationship to cardiovascular outcomes, providing essential insights for public health policymaking.

Existing mechanisms should be leveraged to improve data accessibility, ensuring timely public health responses. Drawing inspiration from successful models like the **UK Biobank** will help **improve data availability** in Belgium. By fostering strong partnerships and ensuring robust political support, Belgium can **strengthen its data infrastructure**, to overcome cardiovascular health challenges related to Lp(a).

> By working together and sharing insights, we can increase our understanding of Lp(a) and effectively improve cardiovascular health outcomes for our population.
>
> **Sam Proesmans**

3 | Focus point

How to enhance the acceptance of Lp(a) testing as a tool to improve CV prevention in the population?

Lp(a) is increasingly recognized as a critical risk factor for CVD [6] [11]. However, there are varying opinions on the **communication of Lp(a) testing within the broader population**. Some stakeholders believe that screening should primarily **target individuals** with elevated risk factors or a strong genetic predisposition to CVD. They argue that widespread communication regarding Lp(a) testing is premature, as effective treatments are not yet available, which could induce unnecessary fear among the public. However, guidelines clearly advocate that knowledge of Lp(a) levels should drive better targeting of addressable risk factors, thereby effectively driving down an individuals' risk. Therefore, others advocate for **proactive communication** to raise awareness about Lp(a) levels, empowering individuals with knowledge about their risks.

Shift communication focus

To effectively increase awareness regarding Lp(a) testing, the communication strategy must evolve from generic messaging about cardiovascular risk factors to a targeted focus on the **specific risks associated with elevated Lp(a) levels.** Clear, concise information will help individuals understand the significance of Lp(a) testing and its relevance to their overall health.

Initiatives should be strategically designed to reach specific communities in Flanders, Wallonia, and Brussels. By **tailoring messaging** to reflect local contexts and concerns, campaigns can enhance relevance and engagement. Besides that, the messaging also trigger a sense of responsibility that values the **emotional aspect**, particularly underscoring a **sense of responsibility** that values the protection of not just their own health, but also that of their families.

Unifying the message

Acceptance cannot be achieved without the active **involvement** of the **medical community**. Empowering HCPs with knowledge makes them trusted advocates for educating patients on their risks. **Multi-disciplinary collaboration** among healthcare professionals, such as general practitioners, pharmacists, dietitians, and specialists, will ensure a unified messaging strategy that prioritizes **early detection and proactive health** management centred around Lp(a).

3 | Focus point

How to enhance the acceptance of Lp(a) testing as a tool to improve CV prevention in the population?

Utilizing various channels

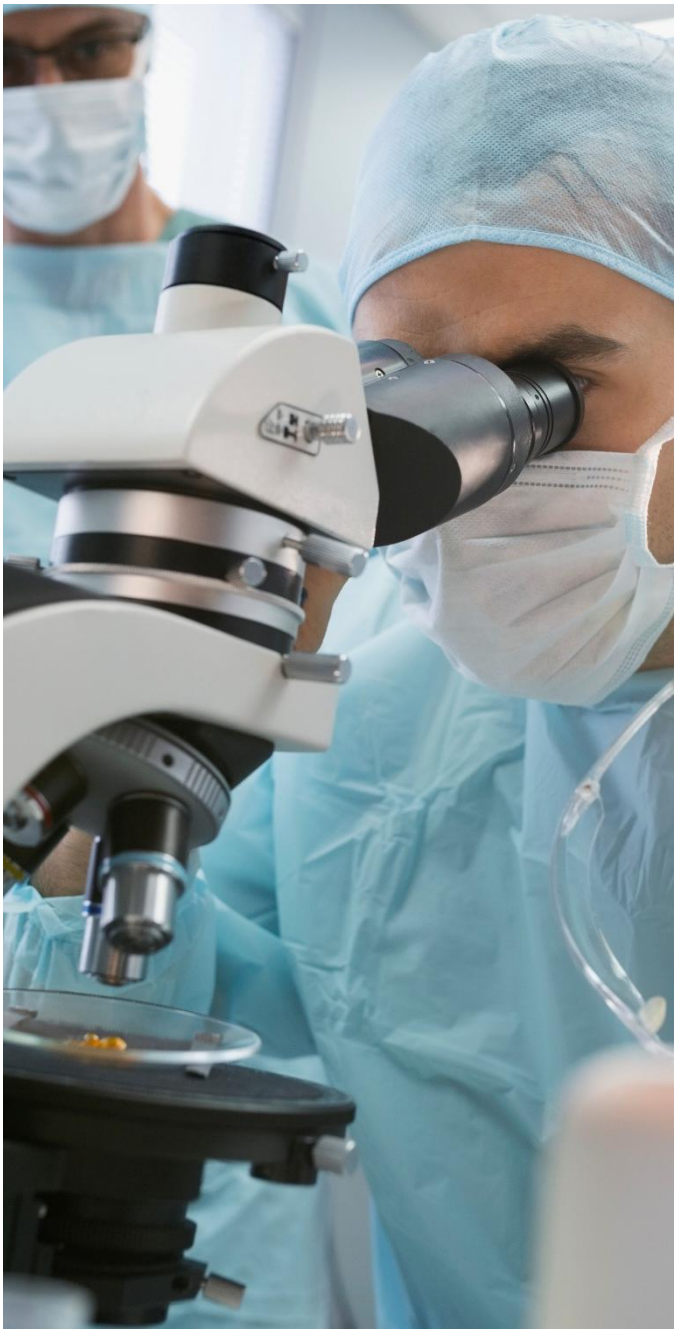
To maximize the reach and impact of Lp(a) campaigns, it is important to utilize a **diverse set of communication channels**. Employing multiple platforms ensures that the message is accessible to a **broader audience**. Partnering with various **media outlets**, including television, radio, and online platforms, can amplify the reach of Lp(a) messaging. **Collaborations** with influencers and health advocates can further enhance visibility and credibility.

Developing **community outreach programs** that facilitate direct engagement with the public, such as workshops, health fairs, and informational seminars, allows healthcare professionals to interact meaningfully with individuals. These programs can serve as forums to answer questions and provide clarity on Lp(a) testing.

Creating easily **accessible educational materials**, such as brochures, online toolkits, and infographics, is crucial for enabling informed discussions about Lp(a).

Before launching any **communication effort,** the targeted population must first be **clearly defined**. Based on this, decisions can then be made regarding the appropriate frequency, structure, and potential phasing of this communication.

To ensure that outreach efforts remain effective, **ongoing feedback** from stakeholders should be an integral part of the campaign development. **Monitoring awareness levels and testing rates** will allow to refine the strategy based on real-world insights, making campaigns more responsive to community needs.



> Communication regarding Lp(a) should be strategically focused on high-risk patients to avoid unnecessary fear among the wider population, especially considering that no effective treatments are currently available.
>
> **Stefan Teughels**

4 | Focus point

What must be done to reduce the costs of unnecessary tests to finance Lp(a) testing?

To foster wider acceptance and **implementation of Lp(a) testing** within the healthcare system, it is crucial to address the cost of **unnecessary tests**. Reducing costs associated with superfluous testing can lead to more **efficient allocation of resources**. By reducing unnecessary tests, we can minimize financial waste and ensure that available funds are efficiently deployed.

Better resource allocation

To enhance the efficiency and effectiveness of testing practices within the healthcare system, it is essential to streamline multiple facets of the testing process. Diagnostic tests that are not indicated or supported by applicable guidelines, should be avoided, or at least reduced. Nevertheless, according to the guidelines, every adult should at least be tested once in their lifetime [11].

A targeted approach to imaging reimbursements is critical; reimbursement should be limited to specific imaging requests that are **clearly justified** and address **clinically relevant questions**.

Safeguarding data storage across the healthcare system will enable all stakeholders to access relevant patient information. This accessibility encourages **targeted prescriptions** and reduces the incidence of unnecessary tests. Implementing **decision support tools** can greatly assist healthcare providers in determining the appropriateness of various tests, particularly among prescribers who might usually order extensive laboratory tests. By **refining the testing process**, we can allocate resources more effectively and ensure that finances that would have gone to unnecessary tests can instead fund essential procedures like Lp(a) testing.

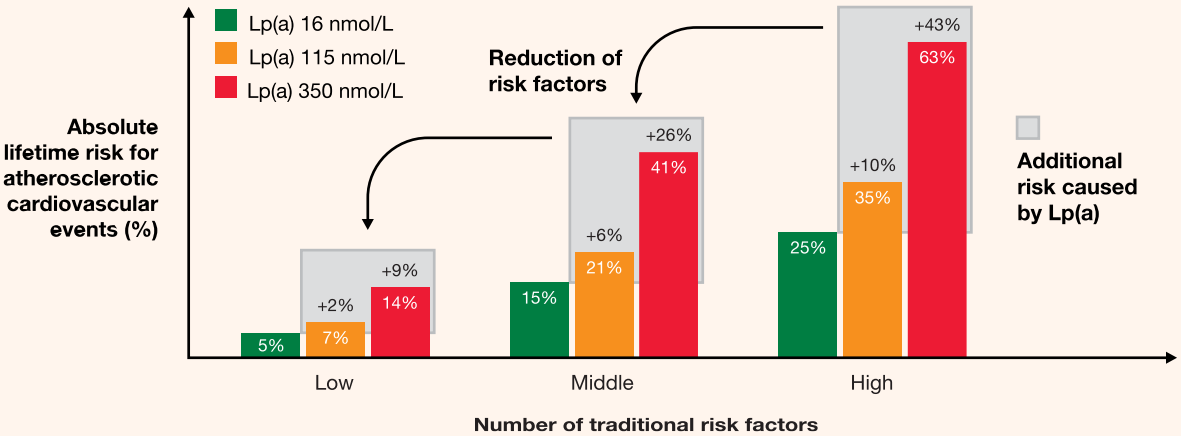


Figure 1. Relationship between Lipoprotein(a) and Atherosclerotic Risk.

Adapted from Kronenberg (2024), Current Atherosclerosis Reports, 26(3), 75–82.

4 | Focus point

What must be done to reduce the costs of unnecessary tests to finance Lp(a) testing?

Discover the risk calculator

Reassess the target group of testing

A pragmatic first step is to focus on populations at **moderate and elevated risk,** such as individuals with diabetes, hypertension, kidney disease, or a strong family history of premature CVD. By embedding Lp(a) into **existing risk calculators** and targeting these groups, Belgium can generate compelling early evidence of health and economic benefits, making the case for broader reimbursement and systematic testing.

Addressing medical shopping

Finally, it is important to address the **issue of medical shopping**, where patients seek multiple tests from various providers. To counteract this behavior, strategies should be developed to **reduce reimbursement for unnecessary tests** resulting from medical shopping, ensuring appropriate and necessary care. This approach will also reinforce the understanding that the healthcare system is not free, further promoting responsible usage among patients.

> Creating a responsible healthcare landscape means addressing the root causes of unnecessary testing and reinforcing the principle that every decision should be rooted in clinical relevance.
>
> **Ernst Rietzschel**

5 | Focus point

How can we generalize the insights from local initiatives to create CVH passports at the Belgian level?

To generalize insights from other local initiatives in creating CV health passports for Belgium, we can draw valuable lessons from the CoZo pilot project. This CoZo project provides a **concrete foundation** for reflecting on how CV health passports could be developed nationally. CoZo functions as a **secure digital platform** that **connects** hospitals, general practitioners, laboratories, and patients, enabling the exchange of health data across institutions.

Standardize data collection and interoperability

A unified framework for data collection is critical to ensure consistency across regions and providers. The digital infrastructure must support **interoperability** between hospitals, general practitioners, laboratories, and pharmacists, enabling seamless data sharing and integration into existing electronic health records.

Establish a centralized communication strategy

To prevent fragmented or siloed practices, Belgium needs a **coordinated national communication strategy**. This would align stakeholders across Flanders, Wallonia, and Brussels, ensuring consistent implementation, messaging, and patient engagement.

Collaboration and shared responsibility

Scaling the CoZo model nationally requires a culture of **collaboration** between stakeholders, healthcare providers, policymakers, insurers, and patient associations. **Shared responsibility** for data governance, funding, and patient engagement will ensure long-term sustainability.

> By focusing on standardization, interoperability, and centralized communication, we can bridge gaps in healthcare delivery and create a collaborative environment that empowers both patients and providers with tailored cardiovascular health information.
>
> **Bart Demyttenaere**

Empower patients and providers

CV health passports should be designed not only as repositories of information but as practical tools that **empower patients** to actively engage in their cardiovascular health. At the same time, healthcare professionals should be able to use the passports to **guide preventive care, monitor progress,** and **personalize treatment**.

Strengthen public-private collaboration

Building a national CV health passport requires **leveraging the expertise and resources** of both private and academic actors while maintaining close **alignment with public authorities**. Continuous communication with governmental bodies is essential to raise awareness on the taken initiatives. A structured **public–private partnership** framework can accelerate implementation while safeguarding equity, accessibility, and trust.

6 | Focus point

How to ensure clear reporting and interpretation of laboratory results to improve patient understanding and willingness to act?

Clear reporting of laboratory results is crucial for improving **patient understanding** and supporting informed **decision-making**. Variability in how results are presented between laboratories often creates confusion, especially for lipid-related parameters such as Lipoprotein(a). Establishing a **standardized, guideline-based reporting system** will improve coherence, transparency, and patient's willingness to act.

Clear interpretation

Interpretation must be aligned with established clinical guidelines. According to **ESC recommendations**, an Lp(a) value **above 105 mg/dL** should be considered an **independent** cardiovascular risk factor. Including a brief interpretative sentence directly in the report provides essential context without overwhelming the patient with technical complexity. For example, a clear statement such as "*According to ESC guidelines, an Lp(a) value greater than 105 mg/dL is considered an independent cardiovascular risk factor*" ensures patients understand the significance of their results [11].

To further improve coherence, Lp(a) should be positioned close to the **lipid profile in the report**, since it belongs to the same group of parameters and its interpretation is directly linked to cardiovascular risk assessment.

Consensus on minimal wording

Because not all laboratories provide interpretation in the same way, there is a need for national consensus on the **minimal wording** that should accompany results. Establishing a **standardized, concise sentence** that all laboratories must include will reduce variation in communication and guarantee that every patient receives consistent, evidence-based information. This approach also facilitates clearer dialogue between laboratories, clinicians, and patients.

Such a consensus statement could be **endorsed by expert bodies**, such as the Royal Belgian Society of Laboratory Medicine (RBSLM) board, to ensure alignment with the latest guidelines.

Transparency on test funding

Transparency is also essential in building patient trust. In countries where Lp(a) testing is **not reimbursed**, such as Belgium and several other European regions, the report should **explicitly state** that the test is **patient-funded**. Acknowledging this within the report ensures that patients are aware of the financial context of their testing and avoids misunderstandings regarding coverage and reimbursement.

> For clear and uniform reporting of Lp(a) and lipid results, we should work towards a consensus statement based on the ESC guidelines.
>
> **Damien Gruson**

Conclusion

The **urgent integration of Lp(a) testing** into Belgium's **national CVD strategy** is crucial for enhancing public health outcomes and addressing the economic burden of cardiovascular diseases, which currently accounts for a significant proportion of mortality across the EU. With an anticipated rise in CVD incidence, particularly among an aging population, **prioritizing awareness and routine assessment of Lp(a)**, a well-established independent risk factor for atherosclerotic cardiovascular disease, can facilitate targeted interventions and significantly improve cardiovascular health among approximately **20% of the population exhibiting elevated Lp(a) levels** [6].

Establishing **national guidelines**, a comprehensive **CVD registry**, **and educational initiatives** will ensure that healthcare professionals and the public are adequately informed about the risks associated with elevated Lp(a). Moreover, **collaboration** with **relevant organizations** to address **reimbursement** and integration **challenges** is crucial. By promoting a **coordinated approach** that emphasizes prevention, education, and strategic health management, we can substantially reduce the incidence of heart attacks, strokes, and premature deaths.

Ultimately, a **robust framework** that encompasses **data sharing**, **targeted outreach, and effective resource allocation** will not only facilitate the timely **identification** and **management** of cardiovascular risk factors but also foster a **healthier future for all Belgians**.

References

[1] Wilkins JT, Ning H, Berry J, Zhao L, Dyer AR, Lloyd-Jones DM. Lifetime Risk and Years Lived Free of Total Cardiovascular Disease. JAMA. 2012;308(17):1795–1801. https://doi. org/10.1001/jama.2012.14312

[2] Sciensano. (2024, April 15). Causes of death – For a Healthy Belgium. For a Healthy Belgium. https://www.healthybelgium.be/en/health-status/mortality-and-causesof-death/general-mortality-by-cause#:~:text=This%20is%20due%20to%20a,men%20and%2032%25%20for%20women

[3] Maes I., Rey S. (2022). The status of atherosclerotic cardiovascular disease in Belgium, a silent and long-term killer: The prevalence, impact and cost of atherosclerotic cardiovascular disease (ASCVD) and recommendations for stakeholders to improve ASCVD in Belgium.

[4] Mensah, G. A., Wei, G. S., Sorlie, P. D., Fine, L. J., Rosenberg, Y., Kaufmann, P. G., Mussolino, M. E., Hsu, L. L., Addou, E., Engelgau, M. M., & Gordon, D. (2017). Decline in cardiovascular mortality. Circulation Research, 120(2), 366–380. https://doi.org/10.1161/circresaha.116.309115

[5] Kronenberg, F., Mora, S., Stroes, E. S. G., et al. (2022). Lipoprotein(a) in atherosclerotic cardiovascular disease and aortic stenosis: A European Atherosclerosis Society consensus statement. European Heart Journal, 43(39), 3925–3946. https://doi.org/10.1093/eurheartj/ehac361

[6] Enas, E. A., Varkey, B., Dharmarajan, T., Pare, G., & Bahl, V. K. (2019). Lipoprotein(a): An independent, genetic, and causal factor for cardiovascular disease and acute myocardial infarction. Indian Heart Journal, 71(2), 99–112. https://doi. org/10.1016/j.ihj.2019.03.004

[7] Coassin, S., & Kronenberg, F. (2022). Lipoprotein(a) beyond the kringle IV repeat polymorphism: The complexity of genetic variation in the LPA gene. Atherosclerosis, 349, 17–35. https://doi.org/10.1016/j.atherosclerosis.2022.04.003

[8] Kronenberg, F. (2024). Lipoprotein(a): from Causality to Treatment. Current Atherosclerosis Reports, 26(3), 75–82. https://doi.org/10.1007/s11883-024-01187-6

[9] Kronenberg, F., et al. (2025). The Brussels International Declaration on Lipoprotein(a) testing and management. Atherosclerosis, 406, 119218. https://doi.org/10.1016/j.atherosclerosis.2025.119218

[10] Björnson, E, Adiels, M, Taskinen, M. et al. Lipoprotein(a) Is Markedly More Atherogenic Than LDL: An Apolipoprotein B-Based Genetic Analysis. JACC. 2024 Jan, 83 (3) 385–395. https://doi.org/10.1016/j.jacc.2023.10.039

[11] Mach, F., Koskinas, K. C., Roeters van Lennep, J. E., Tokgözoğlu, L., Badimon, L., Baigent, C., Benn, M., Binder, C. J., Catapano, A. L., De Backer, G. G., Delgado, V., Fabin, N., Ference, B. A., Graham, I. M., Landmesser, U., Laufs, U., Mihaylova, B., Nordestgaard, B. G., Richter, D. J., Sabatine, M. S., … (2025). 2025 Focused Update of the 2019 ESC/EAS Guidelines for the management of dyslipidaemias. European Heart Journal. Advance online publication. https://doi.org/10.1093/eurheartj/ehaf190

[12] Morton, J. I., et al. (2025). Atherosclerosis. https://doi.org/10.1016/j.atherosclerosis.2025.120447

About PwC

At PwC, we help clients build trust and reinvent so they can turn complexity into competitive advantage. We're a tech-forward, people-empowered network with more than 370,000 people in 149 countries. Across audit and assurance, tax and legal, deals and consulting we help build, accelerate and sustain momentum. Find out more at www.pwc.com.

PwC refers to the PwC network and/or one or more of its member firms, each of which is a separate legal entity. Please see www.pwc.com/structure for further details.