

UPDATE ON STATIN THERAPY AS PRIMARY PREVENTION OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE IN PEOPLE WITH HIV

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In February 2024, the Panel for the Use of Antiretroviral Agents in Adults and Adolescents With HIV (the Panel), in collaboration with representatives from the American College of Cardiology (ACC), American Heart Association (AHA), and HIV Medicine Association (HIVMA), issued recommendations for the use of statin therapy as primary prevention of atherosclerotic cardiovascular disease (ASCVD) in people with HIV.¹ These recommendations were developed following publication of the REPRIEVE trial,² which specifically evaluated statin therapy among people with HIV.

In March 2026, an updated ACC/AHA/Multisociety Dyslipidemia Management Guideline was published with new recommendations specifically for people with HIV. Given that the new recommendations for statin therapy in people with HIV were developed by experts in dyslipidemia management, the Panel will retire its “Statin Therapy as Primary Prevention of Atherosclerotic Cardiovascular Disease in People With HIV” section and defer to the ACC/AHA/Multisociety Dyslipidemia Management Guideline for statin guidance.³ The table below provides an overview of statin therapy recommendations relevant to people with HIV. The Panel will provide further considerations on the role of statins and other strategies for the primary prevention of ASCVD for people with HIV as part of a future update of the Cardiovascular Complications section of the Adult and Adolescent Antiretroviral Guidelines.

Guidance on Statin Therapy for People With HIV
<ul style="list-style-type: none">• For people with HIV aged 40–75 years, the ACC/AHA/Multisociety Dyslipidemia Management Guideline recommends statin therapy for primary prevention of ASCVD.• For people with HIV aged <40 years, the ACC/AHA/Multisociety Dyslipidemia Management Guideline does not issue a recommendation specific to people with HIV, and data are insufficient for the Panel to recommend for or against statin therapy as primary prevention of ASCVD.<ul style="list-style-type: none">◦ Decisions to initiate statin therapy in these patients should be based on the ACC/AHA/Multisociety Dyslipidemia Management Guideline and involve shared decision-making that considers the presence or absence of HIV-related risk factors^a and ACC/AHA risk enhancers^b that increase the risk of ASCVD events.
Key Consideration
<ul style="list-style-type: none">• Coadministration of certain statins and ARV drugs may result in significant drug–drug interactions. In some cases, the interaction may require statin dose adjustment, a switch to another statin, or increased monitoring for statin-related adverse effects (see Tables 24a, 24b, 24d, 24f, and 24g and the Liverpool Drug Interaction Checker).

^a HIV-related factors that may increase ASCVD risk but are not considered in traditional risk estimation tools may strengthen the rationale for initiating statin therapy in this population. Examples include prolonged duration of HIV infection, delayed antiretroviral therapy initiation, long periods of HIV viremia and/or treatment nonadherence, low current or nadir CD4 T lymphocyte cell count (e.g., <350 cells/mm³), exposure to older ARV drugs associated with cardiometabolic toxicity, and/or hepatitis C virus coinfection.

^b Risk enhancers, as reported in the [ACC/AHA/Multisociety Dyslipidemia Management Guideline \(Table 13\)](#), include: history of premature ASCVD in a parent or sibling (aged <55 years for men and <65 years for women), higher-risk ancestry (e.g., South Asian), high polygenic risk (if measured), chronic inflammatory diseases (e.g., systemic lupus), Lp(a) ≥125 nmol/L (or ≥50 mg/dL), hsCRP ≥2 mg/L on more than one occasion, CKM syndrome, TG persistently ≥150mg/dL (fasting), LDL-C persistently ≥160–189 mg/dL, non-HDL-C ≥190–219 mg/dL, or apoB ≥120mg/dL.

Key: ACC = American College of Cardiology; AHA = American Heart Association; ARV = antiretroviral; apoB = apolipoprotein B; ASCVD = atherosclerotic cardiovascular disease; CKM = cardiovascular-kidney-metabolic; hsCRP = high-sensitivity C-reactive protein; LDL-C = low-density lipoprotein cholesterol; Lp(a) = lipoprotein(a); non-HDL-C = non-high-density lipoprotein cholesterol; TG = triglycerides

References

1. Panel for the Use of Antiretroviral Agents in Adults and Adolescents With HIV. Statin therapy as primary prevention of atherosclerotic cardiovascular disease in people with HIV. 2024. February 27, 2024. Available at: <https://clinicalinfo.hiv.gov/sites/default/files/guidelines/archive/adult-adolescent-arv-statin-therapy-2024-02-27.pdf>.
2. Grinspoon SK, Fitch KV, Zanni MV, et al. Pitavastatin to prevent cardiovascular disease in HIV infection. *N Engl J Med*. 2023;389(8):687-699. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/37486775>.
3. Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APHA/ASPC/NLA/PCNA guideline on the management of dyslipidemia: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol*. 2026. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/41824590>.