MyCardioAdvocate™

Residual Risk After a Heart Attack

Surviving the first event doesn't mean you're protected from the next

Updated March 2026 — Reflects the 2026 ACC/AHA/NLA Dyslipidemia Guidelines

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Why This Matters

Congratulations on surviving your heart attack. You've won the immediate battle. But the war is far from over.

After a heart attack, approximately **20% of patients experience a recurrent cardiac event (another MI, stroke, or death) within 5 years** — even while taking medications. Your stent may have fixed the blockage that caused the first event, but the underlying disease process — atherosclerosis — is systemic. It affects all your arteries, not just the one that was treated.

This **residual risk** — the risk that persists despite aggressive lipid-lowering therapy — is driven by multiple factors: inflammation, dyslipidemia, thrombosis, metabolic dysfunction, and sometimes incomplete medication optimization. The 2026 guidelines provide a clearer roadmap for addressing this residual risk than ever before, with new target values, new drugs, and new strategies.

Why Residual Risk Flies Under the Radar

After hospitalization for MI, many patients and clinicians fall into a false sense of security. "We fixed it" — meaning the stent is in place. But this mindset misses the bigger picture:

- **~20% recurrent event risk within 5 years, even on optimal therapy** — This is substantial. If your first MI had a 5% annual risk without treatment, a 20% recurrent risk in 5 years means therapy isn't enough; we need more.
- **Many patients leave hospital undertreated** — Discharge medications are often incomplete. You might receive a statin but no PCSK9 inhibitor, no inclisiran, no ezetimibe, and no anticoagulation for residual thrombotic risk. Each omission adds risk.
- **Stents treat the blockage, not the disease** — This is critical. A percutaneous coronary intervention (PCI) with stent placement opens the artery locally. But atherosclerotic disease is **systemic**. If your left main coronary had a 95% blockage causing your MI, your right coronary, LAD, and circumflex likely have disease too — and any of them could rupture and cause the next event. Treating 1 blockage ≠ treating atherosclerosis.
- **"Fire and forget" mentality after discharge** — Too many MI survivors are discharged with "go home, take your meds, see you in 3 months." There's no aggressive follow-up on whether LDL-C or other targets are achieved.
- **Medication changes during hospitalization cause confusion** — During the acute MI, doses may be adjusted or medications changed. At discharge, patients don't always understand the new regimen. Did you start or stop medications? At what doses? Did your cardiologist and primary care doctor communicate?
- **Residual inflammatory risk unaddressed** — Even with LDL-C <55 mg/dL, if hsCRP is elevated, residual inflammatory risk persists. Colchicine (supported by COLCOT and LoDoCo2 trials) can reduce this risk — but it's not in guidelines, so it's rarely prescribed.
- **No screening for Lp(a) in secondary prevention** — In 2026, **all ASCVD patients should be screened for Lp(a)**. If yours is elevated, treatment strategy changes. Yet many post-MI patients have never had Lp(a) measured.

What Changed in 2026

> **Clear Absolute Goals for Secondary Prevention**
> The 2026 guidelines specify precise LDL-C targets (not just "as low as possible"): **LDL-C <55 mg/dL**, **non-HDL-C <85 mg/dL**, and optional **ApoB <55 mg/dL**

Very High Risk Criteria

Patients post-MI are classified as "Very High Risk" and require intensive therapy:

- **Multiple recurrent events or events within 2 years**
- **Age <55 years at first event** (implies aggressive atherosclerosis)
- **Proximal LAD occlusion** (high-risk location)
- **LVEF <40% or cardiogenic shock at presentation**
- **Multivessel disease** (atherosclerosis in multiple coronary arteries)
- **Diabetes + prior MI**

Secondary Prevention Medication Cascade (2026)

- **Step 1 — Antiplatelet therapy:** Aspirin + P2Y12 inhibitor (clopidogrel, prasugrel, or ticagrelor). Duration of dual antiplatelet therapy (DAPT) depends on stent type and bleeding risk (typically 12 months, sometimes 6 or 24).
- **Step 2 — Lipid therapy:** High-intensity statin + ezetimibe (not sequentially but combined from start). Target LDL-C <55 mg/dL.
- **Step 3 — If LDL-C not at goal:** Add PCSK9 monoclonal antibody (evolocumab, alirocumab) OR inclisiran (siRNA; Class I, B-R). Inclisiran is dosed subcutaneously at 0, 3 months, then every 6 months.
- **Step 4 — For statin intolerance:** Bempedoic acid (xanthine oxidase inhibitor; uric acid-lowering bonus). Ezetimibe no longer required first before adding other agents.
- **Step 5 — Residual inflammatory risk:** If hsCRP elevated on intensive therapy, consider colchicine (COLCOT, LoDoCo2 data; not yet in guideline but strong evidence). IL-6 inhibitors being studied (ZEUS trial).

Lp(a) Screening (NEW in 2026)

All ASCVD patients (including post-MI) should be screened for elevated Lp(a) at least once. If elevated, it changes your treatment strategy and risk profile.

MyCardioAdvocate™ Checklist

These 7 items should be addressed in the weeks and months after your MI. Use them to guide conversations with your cardiologist and primary care doctor.

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1. Confirm Your Secondary Prevention Status

You should be on specific medications with clear goals.

- ■ *Am I on aspirin + a P2Y12 inhibitor (clopidogrel, prasugrel, or ticagrelor)?*
- ■ *For how long should I stay on dual antiplatelet therapy (DAPT)?*
- ■ *Am I on a beta-blocker and ACE inhibitor/ARB? (Standard post-MI medications)*
- ■ *Has my cardiologist discussed your secondary prevention plan in detail?*
- ■ **Dual antiplatelet therapy is foundational. Non-adherence increases MI recurrence risk. Understand your DAPT duration (typically 12 months; shorter or longer based on bleeding vs. stent thrombosis risk).**

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2. Know Your Numbers: LDL-C, Non-HDL-C, ApoB, Lp(a), hsCRP

Your lipid panel should be measured 4–12 weeks post-MI, then regularly (every 4–12 weeks if adjusting therapy).

- ■ *What is my current LDL-C? What is my target? (Should be <55 mg/dL)*
- ■ *What is my non-HDL-C? (Target <85 mg/dL)*
- ■ *Has my ApoB been measured? (Optional but informative; target <55 mg/dL if possible)*
- ■ *What is my Lp(a)? (All ASCVD patients should be screened; if elevated, strategy changes)*
- ■ *What is my hsCRP? (If elevated despite LDL-C on goal, residual inflammatory risk present)*
- ■ **Write down these numbers. Bring them to every visit. Don't leave the office without knowing them.**

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3. Know Your Lipid Therapy Goals

Secondary prevention targets are aggressive — and specific.

- ■ *What is my LDL-C target and what medications am I on to achieve it?*
- ■ *Am I on high-intensity statin + ezetimibe combination (not sequential)?*
- ■ *If not at goal after statin + ezetimibe, am I on a PCSK9 inhibitor or inclisiran?*
- ■ *Has my doctor discussed a specific target (e.g., <55) rather than vague "lower is better"?*

2026 Secondary Prevention Targets:

• LDL-C goal: <55 mg/dL
• Non-HDL-C goal: <85 mg/dL
• ApoB goal: <55 mg/dL (if measured)

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4. Am I at LDL-C Goal? Demand Combination Therapy if Not

If you're not at goal on statin + ezetimibe, you need a third agent. Period.

- ■ *Is my LDL-C at <55 mg/dL?*
- ■ *If not, have I discussed adding a PCSK9 inhibitor (evolocumab, alirocumab) or inclisiran?*
- ■ *If PCSK9i or inclisiran is "not covered" or "too expensive": have you appealed with your insurance?*

Do not accept being below goal for months. Under-treatment is a driver of recurrent events. If your cardiologist doesn't prescribe to goal, ask why. If the answer is cost/insurance, ask for help with appeals. Don't just accept the refusal.

> **Pro Tip:** "My LDL-C is 80 and I'm feeling fine" is not a valid reason to stay at 80. You had a heart attack at rest or with minimal stress. The old target of 70–100 is obsolete for post-MI patients. You need <55. Insist on it.

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5. Medication Reconciliation After Discharge

Hospitals and offices often miscommunicate on discharge meds.

- ■ *Did my inpatient medications change during hospitalization?*
- ■ *Do I have a written discharge summary with the exact medication list, doses, and frequency?*
- ■ *Did my primary care doctor receive and review my discharge summary?*
- ■ *Are there any discrepancies between what my cardiologist said and what my PCP has in the computer?*
- ■ **Medication errors and omissions are common at discharge. Verify your medication list with both your cardiologist and primary care doctor. Bring a list to your appointments.**

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6. Check Your Lp(a) Status

This is NEW in 2026 guidelines: all ASCVD patients, including post-MI, should be screened for Lp(a).

- ■ *Has my Lp(a) been measured?*

- ■ *If elevated (≥125 nmol/L or ≥50 mg/dL), does my cardiologist know?*
- ■ *Has elevated Lp(a) changed my treatment strategy or risk assessment?*

Elevated Lp(a) is a risk enhancer that contributes to thrombotic and inflammatory risk. If yours is high, it explains part of why you had an early MI and informs aggressiveness of treatment going forward.

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7. Address Inflammation and Metabolic Drivers

Cholesterol is not the only culprit in MI recurrence.

- ■ *What is my hsCRP (high-sensitivity C-reactive protein)? Is it <1 mg/L (ideal) or elevated?*
- ■ *Has my cardiologist discussed colchicine or other anti-inflammatory therapy?*
- ■ *Do I have diabetes? Is my HbA1c <7%?*
- ■ *What is my blood pressure? Is it <130/80 (secondary prevention target)?*
- ■ *Am I exercising regularly and maintaining a healthy weight?*

Colchicine (COLCOT, LoDoCo2): Reduces MI recurrence by ~30% in post-MI patients with elevated hsCRP, even on intensive lipid therapy. Not yet in dyslipidemia guidelines but supported by strong evidence.

CPR Opportunities — Shared Decision-Making

Dual Antiplatelet Therapy Duration: Shorten, Extend, or Standard?

The standard DAPT duration post-MI is 12 months. But for some patients, shorter (6 months) or longer (24 months) durations may be appropriate — and this is an area for shared decision-making.

• **Shorten to 6 months if:** High bleeding risk (age >75, low platelets, GI ulcer hx, anticoagulation), uncomplicated MI with single stent, no multiple lesions

• **Extend to 24 months if:** Very high stent thrombosis risk (small vessel, diabetes, poor runoff, complex lesions), recurrent events on 12-month DAPT, high-risk thrombophilia

Applying CPR:

Calculate — Assess your bleeding risk (HAS-BLED, PRECISE-DAPT score)
Personalize — Consider your stent type, number of lesions, comorbidities
Reclassify — Clinical events (stent thrombosis signs, recurrent ischemia) or labs (dropping platelets) may argue for shorter duration

12 months is standard, but discuss with your cardiologist whether your individual risk profile suggests shortening or extending.

Colchicine for Residual Inflammatory Risk

Even with aggressive lipid therapy (LDL-C <55), some post-MI patients have elevated hsCRP, indicating residual inflammatory risk. Colchicine has strong trial evidence for reducing recurrent events.

• **COLCOT trial (2019):** 4,745 post-MI patients with elevated hsCRP and metabolic syndrome. Colchicine 0.5 mg daily reduced MACE by 31% (relative risk reduction) over median 2.3 years.

• **LoDoCo2 trial (2020):** 5,522 stable CAD patients (many post-MI) with elevated hsCRP. Colchicine 0.5 mg daily reduced MACE by 28% (RRR) with no serious safety signals.

• **Mechanism:** Anti-inflammatory (blocks IL-1β), reduces thrombotic risk, may stabilize plaques

Applying CPR:

Calculate — Is your hsCRP elevated (>1 mg/L) despite LDL-C on goal? This indicates residual inflammatory risk.
Personalize — Colchicine is inexpensive (~$10/month generic) with few side effects. GI upset is most common.
Reclassify — COLCOT and LoDoCo2 support colchicine in post-MI + elevated hsCRP. Not in guidelines yet, but ask your cardiologist about it.

Colchicine is an underutilized therapy for residual inflammatory risk. If your hsCRP is elevated, discuss with your cardiologist.

On the Horizon

Several emerging therapies may further reduce residual risk in post-MI patients:

- **IL-6 inhibitors (ZEUS trial ongoing):** Tocilizumab (IL-6 receptor antagonist) shows promise in post-MI patients with elevated inflammatory markers. Could complement colchicine.
- **Ziltivekimab:** Direct IL-6 inhibitor (monoclonal antibody) in development for post-MI residual inflammatory risk.
- **Finerenone (Kerendia):** Non-steroidal mineralocorticoid receptor antagonist; reduces ASCVD events and is being studied more broadly in secondary prevention.
- **SGLT2 inhibitors:** Dapagliflozin (Farxiga) and empagliflozin (Jardiance) reduce heart failure and death post-MI and are increasingly being used in all post-MI patients, not just those with diabetes.
- **Advanced lipid-lowering therapy:** New PCSK9 inhibitors with longer dosing intervals, bempedoic acid combinations, and investigational agents to get LDL <50 mg/dL safely.

Key Takeaways

- **~20% of post-MI patients have recurrent events within 5 years** — even on therapy
- **Your stent fixed the blockage, but you still have atherosclerosis** — treat the disease, not just the lesion
- **2026 targets are aggressive: LDL-C <55, non-HDL-C <85, ApoB <55 mg/dL**
- **Combination therapy (statin + ezetimibe + PCSK9i OR inclisiran) is standard** — don't settle for two-drug therapy
- **Inclisiran (newer) dosed every 6 months; consider if PCSK9i adherence or cost is an issue**
- **All post-MI patients should be screened for Lp(a)** — if elevated, adjust your strategy
- **Colchicine reduces recurrent events in post-MI patients with elevated hsCRP** — ask your cardiologist about it
- **Medication reconciliation is critical** — confirm your discharge medications with both cardiologist and PCP

Next Steps

- Get a copy of your discharge summary and medications list
- Schedule a post-MI visit with your cardiologist 2–4 weeks after discharge (if not already done)
- Ask your cardiologist: **"What is my LDL-C goal, and what medications will it take to get there?"**
- Have Lp(a), hsCRP, and ApoB measured if not done already
- Ask about colchicine if your hsCRP is elevated despite aggressive therapy
- Verify medication reconciliation with both your cardiologist and primary care doctor

- Get a written secondary prevention plan: medications, targets, follow-up schedule

Learn more at **CardioAdvocate.com**

Related CardioAdvocate Content

- **Cheating Death** — Post-MI comprehensive management
- **Lipid Guidelines** — 2026 secondary prevention cascade
- **Inflammation** — Residual inflammatory risk and colchicine
- **ApoB** — Beyond LDL-C: apolipoprotein B as superior marker
- **Lp(a)** — When elevated in post-MI patients
