The editors of the Revista del Hospital Italiano de Buenos Aires invite readers to reflect on issues currently under debate within the scientific community. To this end, we invited two distinguished experts with differing perspectives on cholesterol-lowering pharmacotherapy to present their arguments based on a hypothetical clinical scenario. Below, we share the perspectives of Drs. Karin Kopitowski* and Walter Masson on the following case:

> *A healthy, asymptomatic 24-year-old man presents for a routine health checkup. He does not smoke, exercises regularly, and has no history of hypertension, diabetes, or obesity. His LDL cholesterol levels are 175 and 180 mg/dL on two separate occasions. He has no family history of premature cardiovascular disease. His short-term cardiovascular risk is very low. However, persistently elevated LDL cholesterol may lead to greater cumulative exposure over his lifetime. In this situation, should a statin be prescribed to a young adult with elevated LDL cholesterol, or is it preferable to continue lifestyle interventions and periodic monitoring?*

The Patient Is More Than His LDL: The Case for Active Monitoring

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I would not initiate statin therapy in this patient. Not because his cholesterol does not matter, but because he matters more than his cholesterol. An LDL cholesterol level of 175–180 mg/dL, confirmed on two separate measurements, warrants attention. The question is what form that attention should take: whether the response to a number should be, almost reflexively, a prescription that, at age 24, will likely remain part of his life for half a century.

The argument concerning cumulative exposure is compelling, and I do not intend to dispute it. Epidemiological, genetic, and clinical trial evidence shows that LDL cholesterol plays a causal role in atherosclerotic disease and that the extent of damage depends on both its concentration and the duration of exposure[1]. However, a molecule's causal role does not mean every intervention benefits every person at every age. Between pathophysiology and prescribing lies a step that evidence-based medicine does not allow us to skip: determining how much this particular person stands to benefit, and at what cost.

That step has not been taken in this case. The 2026 U.S. guideline, which has moved toward earlier treatment, considers statin therapy reasonable for adults aged 30–59 years with low cardiovascular risk and LDL cholesterol levels of 160–189 mg/dL. However, this is a weak recommendation, based on limited evidence and contingent on a prior attempt at lifestyle modification[2]. For adults younger than 30 years, the guideline is explicit: no clinical trials have demonstrated a reduction in cardiovascular events, and the decision is left to clinical judgment and patient preference[2]. Its only strong recommendation for young adults focuses on diet, physical activity, and weight management. European guidelines consider pharmacological treatment in low-risk individuals only if LDL cholesterol remains elevated despite optimization of nonpharmacological measures[3]. The United States Preventive Services Task Force, for its part, limits its recommendation to adults aged 40–75 years with cardiovascular risk factors and an estimated 10-year risk of at least 7.5%, with treatment at the lower end of this risk range depending on patient preference[4].

*Comments by Dr. Walter Masson, "LDL-C: The Level Matters, but So Does the Duration of Exposure" [link]

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Received: 10/29/2026 | Accepted: 11/5/2026 | Published: 11/06/2026

DOI: http://doi.org/10.51987/Rev.Hosp.Ital.B.Aires.v46i4.1388

How to cite: Kopitowski K. The Patient Is More Than His LDL: The Case for Active Monitoring. Rev Hosp Ital B.Aires. 2026;46(4):e0001388

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ISSN (en línea) 2314-3312

When a guideline acknowledges the lack of evidence and leaves the decision to us, it is not asking us to prescribe; it is asking us to have a conversation.

Let us assume that the cumulative exposure argument does not apply. Suppose, generously, that this young man's 10-year cardiovascular risk is 1% and that statin therapy reduces it by 30%: his risk would fall to 0.7%. More than 300 people like him would need to be treated for a decade to prevent one event, while nearly all the others would take the medication without deriving that benefit.

The balance of benefits and harms over forty years might prove more favorable; we do not know, because no one has measured it. What we do know is the cost of initiating treatment: turning a healthy person into a patient with a chronic condition, with the associated monitoring, adverse effects, financial costs, and diagnostic label. Avoiding this harm when the benefit is uncertain has a name: quaternary prevention[5].

This is not therapeutic nihilism; it is the principle of first, do no harm applied to someone who is not yet ill.

Defending this position does not justify doing nothing. "Take care of yourself and come back in a few years" is just as reflexive a response as writing a prescription. Active monitoring means, first, understanding the problem: ruling out secondary causes, assessing non-HDL cholesterol and triglyceride levels, measuring lipoprotein(a) once[2], and revisiting the family history, which is often incomplete at this age.

If familial hypercholesterolemia is suspected, the discussion changes entirely. Second, active monitoring involves a specific dietary intervention tailored to the patient's everyday life, while recognizing his nonsmoking status and regular physical activity as existing health assets. Third, it means agreeing now on a reassessment in six to twelve months and establishing what findings would change the decision: LDL cholesterol levels that fail to decrease or continue to rise, new risk factors, a family history of premature cardiovascular disease, or elevated lipoprotein(a).

And the most important consideration remains: what he wants. If, after understanding the actual magnitude of the potential benefit and the uncertainty involved, he prefers to begin treatment, that is a legitimate choice. What I question is not the statin itself, but the assumption that a number alone is sufficient grounds for turning him into a patient. At age 24, time allows for careful deliberation. Deferring a prescription does not mean abandoning treatment, and acting early does not necessarily mean prescribing early. Sometimes, the most powerful preventive intervention we have is not a medication, but the clinical encounter.

Conflicts of Interest: The author declares no conflicts of interest related to the content of this article.

Funding: The author declares that this study received no external funding.

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