beneficial compensatory response to altered systemic metabolic changes in obesity needs further evaluation. Our results also confirm those obtained for skeletal muscle, with reversal of systemic and muscle metabolic derangements only 9 months after BS (3). The improvement in life-style habits may have also contributed to the late reduction in cardiac steatosis. Compared with usual care, BS is the most effective treatment for severe obesity, and the long-term results regarding reduction of cardiovascular mortality have been well established. To the best of our knowledge, this study is the first to show a significant improvement in all types of ectopic fat depots, even cardiac steatosis, long-term after BS. Whether these improvements participate in the reduction of cardiovascular risk and mortality in obese patients needs to be confirmed.

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http://dx.doi.org/10.1016/j.jacc.2015.10.052

Please note: The authors have reported that they have no relationships relevant to the contents of this paper to disclose.

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Getting What the Guidelines Stated Matters

We read with interest the recently published report of the multicenter randomized controlled trial (RCT) known as PRECISE-IVUS (plaque regression with cholesterol absorption inhibitor or synthesis inhibitor evaluated by intravascular ultrasound) (1). While we noted that coronary angiographic outcomes in those assigned to combination statin plus ezetemibe therapy compared favorably to those assigned statin monotherapy, we were concerned that the authors did not refer to the 2013 ACC/AHA guidelines in an accurate fashion. Our evidence-based guidelines were not "fire and forget" as the authors write in their discussion. Moreover, they express a serious misconception about what the guidelines actually said about nonstatins.

In both the guideline recommendations tables, key figures (Figure 3 entitled Initiating Statin Therapy in Individuals with Clinical ASCVD, and Figure 5 entitled Statin Therapy: Monitoring Therapeutic Response and Adherence), and in the text, we indicate clearly what the recommendations and workflow are for secondary prevention patients (2).

We think it is crucial that readers understand what the guidelines recommended. Figure 3 shows that in secondary prevention patients, the clinician initiates high-intensity statin therapy if age ≤75 years and **without** contraindications, conditions, or drug-drug interactions influencing statin safety or a history of statin intolerance. In addition to statin therapy, lifestyle counseling was also recommended. In Figure 5 whose title alone indicates that the phrase "Fire and Forget It" does not refer to the 2013 ACC-AHA guidelines, it clearly shows that the guidelines recommend a follow-up lipid panel 4 to 12 weeks after initiation of statin therapy to assess both response to therapy (the anticipated response to high-intensity statin therapy was given as a ≥50% reduction in low-density lipoprotein cholesterol [LDL-C]) and as a baseline for adherence.

If the ACC/AHA cholesterol guidelines were followed in the participants in this trial, the anticipated LDL-C would have been approximately in the mid-50 mg/dl range since baseline LDL-C in both the LZ and L group were 109.8 and 108.3 mg/dl, respectively. Mindful that not everyone tolerates high-intensity statins, the guidelines addressed the situation where statin intolerance would occur. It specifically noted: "Clinicians treating high-risk patients who have a less-than-anticipated response to statins, who are unable to tolerate a less-than-recommended intensity of a statin, or who are completely statin intolerant, may consider the addition of a nonstatin cholesterol-lowering therapy. High-risk individuals include those with ASCVD, those with LDL-C ≥190 mg/dl, and those with diabetes 40 to 75 years of age. In this situation, this guideline recommends clinicians preferentially prescribe drugs that have been shown in RCTs to provide ASCVD

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risk-reduction benefits that outweigh the potential for adverse effects and drug-drug interactions, and consider patient preference." Based on the findings of IMPROVE-IT (Improved Reduction of Outcomes: Vytorin Efficacy International Trial) (3), ezetemibe would qualify as a nonstatin to be considered with a lower intensity, but tolerated statin in high-risk groups such as those with coronary atherosclerotic disease. Thus, the data from this intravascular ultrasound trial are consistent with what the guidelines recommend if a high-intensity statin cannot be tolerated.

Lastly, there is an implied misconception of the panel's recommendation regarding lipid targets. The ACC/AHA guidelines stated that "the Expert Panel makes no recommendations for or against specific LDL-C or non-HDL-C targets for the primary or secondary prevention of ASCVD." The guidelines go beyond stating that lower LDL-C is better; rather they recommend a strategy for achieving a lower LDL-C that can be safely attained with therapies (lifestyle and medication) proven to provide acceptable net benefit. For example, trials of niacin added to statin therapy that achieved lower LDL-C levels by adding Niacin as compared to placebo, did not show net benefit. Thus, the cholesterol guidelines endorse "lower is better, but it matters how you get there and whether the benefit outweighs the risk for that patient" (4).

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http://dx.doi.org/10.1016/j.jacc.2015.08.1132

Please note: The authors have reported that they have no relationships relevant to the contents of this paper to disclose.

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REPLY: Getting What the Guidelines Stated Matters

We have read with great interest the letter by Dr. Stone and colleagues commenting on our recent paper (1), and we greatly appreciate their valuable comments on the interpretation of 2013 American College of Cardiology/American Heart Association (ACC/AHA) cholesterol guideline (2). Especially pertaining to the "Fire and Forget It" concept misleadingly disseminated among the clinicians, it is of clinical importance that the expert panel members clearly recommend in this letter a follow-up lipid panel 4 to 12 weeks after initiation of statin therapy to assess both response to therapy (the anticipated response to high-intensity statin therapy was given as a ≥50% reduction in low-density lipoprotein cholesterol [LDL-C]) and as a baseline for adherence. In addition, Drs. Stone, Lloyd-Jones, and Smith emphasized that the ACC/AHA guideline endorse "lower is better, but it matters how you get there and whether the benefit outweighs the risk for that patient."

In terms of the specific LDL-C treatment goals in secondary prevention, we totally agree with the guideline statement: the expert panel was unable to find robust evidence to support continued use of specific LDL-C treatment targets (<100 mg/dl or <70 mg/dl). In a recent meta-analysis of statin trials (3), however, among 38,153 participants treated with high-dose statin therapy, patients who achieve very low LDL-C levels have a lower risk for major cardiovascular events than do those achieving moderately low levels, and >40% did not reach an LDL-C target <70 mg/dl, reaffirming "the lower, the better" and the limitation of statin monotherapy. Furthermore, based on the safety and significant clinical net benefit of combination of statin/ezetimibe evidenced by IMPROVE-IT (Improved Reduction of Outcomes Vytorin Efficacy International Trial) (4) and PRECISE-IVUS (Plaque Regression With Cholesterol Absorption Inhibitor or Synthesis Inhibitor Evaluated by Intravascular Ultrasound) (1) trials in contrast with HPS2-THRIVE (Heart Protection Study 2-Treatment of HDL to Reduce the Incidence of Vascular Events) trial (5), ezetimibe added to statin therapy would qualify as a promising non-statin agent to be considered in high-risk patients such as those with coronary atherosclerotic disease.

Finally, we would like to thank Drs. Stone, Lloyd-Jones, and Smith again for the letter which promoted for us and the readers of our article the accurate interpretation of the 2013 ACC/AHA cholesterol guideline.