Supplementary Material

**Supplementary Table 1. Questionnaire for Professionals**

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| **SOCIODEMOGRAPHIC VARIABLES** |
| **Age: \_\_\_\_\_\_\_\_\_\_\_\_years** |
| **Gender:**  □ Man  □ Woman |
| **Time practicing the profession? \_\_\_\_\_\_\_ years** |
| **Personal history of atherogenic dyslipidemia (have you been diagnosed or treated for atherogenic dyslipidemia?):**  □Yes □No |
| **Approximate number of patients with atherogenic dyslipidemia that visits per month: \_\_\_\_\_\_\_\_** |
| **Province where you practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **In what sort of area is your healthcare center located?**  □ Rural area (<5,000 inhabitants)  □ Semi-urban area (5,000-19,999 inhabitants)  □ Urban area (≥20,000 inhabitants) |
| **RESIDUAL CARDIOVASCULAR RISK** |
| **1.1 Do you evaluate residual cardiovascular risk in your routine clinical practice?**  □ Yes, but only in patients in secondary prevention.  □ I’m not sure what residual cardiovascular risk is.  □ Yes, whenever I remember.  □ No, because residual risk is a theoretical concept with no clinical impact. |
| **1.2 What do you think lipid-related residual cardiovascular risk refers to?**  □ The risk that persists after controlling the patient’s weight.  □ The risk that persists after treating the patient with statins and achieving LDL-C objectives.  □ The risk that persists after controlling all modifiable risk factors.  □ The risk that persists after quitting smoking as a major risk factor. |
| **1.3 To what do you attribute lipid-related residual cardiovascular risk?**  □ Age.  □ Arterial hypertension.  □ Obesity.  □ Atherogenic dyslipidemia. |

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| **ATHEROGENIC DYSLIPIDEMIA** | |
| **2.1 In your opinion, what are the characteristics of atherogenic dyslipidemia?**  □ Elevated LDL-C.  □ Normal or moderately elevated LDL-C levels and a phenotype of small, dense LDL-C particles.  □ Low HDL-C and elevated triglycerides (TG).  □ Low HDL-C, elevated TG, and elevated small, dense LDL-C particles. | |
| **2.2 Please indicate any phenotype you think is associated with atherogenic dyslipidemia:**  □ Early coronary disease.  □ Metabolic syndrome.  □ Type 2 diabetes.  □ All of the above. | |
| **2.3 Please tick the statement that you think is the most accurate:**  □ AD is not associated with a high or very high cardiovascular risk.  □ AD is of no particular importance in type 2 diabetes, either with regard to macrovascular or microvascular complications.  □ AD is a determinant factor for cardiovascular risk, even if LDL-C levels are correct.  □ AD does not occur in obese patients. | |
| **2.4 What prompts you to specifically assess AD in your clinical practice?**  □ Because cardiovascular risk is increased.  □ Because cardiovascular risk is increased by concomitant obesity.  □ Because treatment with fibrates must be given.  □ Because if it occurs along with diabetes, it should always be treated with insulin. | |
| **ATHEROGENIC DYSLIPIDEMIA DIAGNOSIS** |
| **3.1 What parts of the lipid profile do you consider essential for evaluating a patient with atherogenic dyslipidemia?**  □ Total cholesterol.  □ Total cholesterol and HDL-C.  □ Total cholesterol, TG, and HDL-C.  □ Total cholesterol, TG, HDL-C, LDL-C and non-HDL cholesterol. |
| **3.2 In a 58-year-old man with a diagnosis of metabolic syndrome, what would be the target for lipid control?**  □ Triglycerides.  □ HDL-C.  □ LDL-C.  □ Non-HDL cholesterol. |
| **3.3 In your clinical practice, can you request fractionated total cholesterol to assess HDL-C and LDL-C?**  □ No.  □ Yes, but I am guided by total cholesterol only.  □ Yes, but by referring the patient.  □ Yes, routinely and without restrictions. |
| **3.4 How often do you use the following lipoprotein ratios? Considering 1: never; 2: almost never; 3: sometimes; 4: often; 5: very often.**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Never** | **Almost never** | **Sometimes** | **Often** | **Very often** | | **TC/HDL-C ratio** |  |  |  |  |  | | **LDL-C/HDL-C ratio** |  |  |  |  |  | | **ApoB/ApoA1 ratio** |  |  |  |  |  | | **Non-HDL-C/HDL-C ratio** |  |  |  |  |  | | **TG/HDL-C ratio** |  |  |  |  |  | | **LDL-C/ApoB ratio** |  |  |  |  |  | |
| **3.5 Please indicate how useful each of the atherogenic indexes is in clinical practice, even if you do not use them (Considering 1: not useful and 5: very useful)**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **Not useful** | **Of little use** | **Useful** | **Very useful** | | **TC/HDL-C ratio** |  |  |  |  | | **LDL-C/HDL-C ratio** |  |  |  |  | | **ApoB/ApoA1 ratio** |  |  |  |  | | **Non-HDL-C/HDL-C ratio** |  |  |  |  | | **TG/HDL-C ratio** |  |  |  |  | | **LDL-C/ApoB ratio** |  |  |  |  | |
| **ATHEROGENIC DYSLIPIDEMIA TREATMENT** | |
| **4.1 What do you think should be the first step in the treatment of atherogenic dyslipidemia?**  □ A diet adapted to achieve an appropriate BMI.  □ In addition to diet, smoking cessation, if applicable.  □ The above, plus regular physical exercise.  □ Diet, regular physical exercise, quitting smoking, and pharmacological treatment, if necessary. | |
| **4.2 How would you approach a patient with atherogenic dyslipidemia associated with obesity?**  □ Refer the patient to the nurse.  □ Refer the patient to the endocrinologist.  □ Treat the patient in conjunction with the nursing staff.  □ I emphasize the importance of lifestyle changes and I evaluate the use of pharmacological treatment. | |
| **4.3 Please indicate how far you agree with each of the following statements about treatment with statins.**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Completely disagree** | **Partially disagree** | **Indifferent** | **Partially agree** | **Completely agree** | | **Statins eliminate all residual cardiovascular risk if target LDL-C levels are achieved.** |  |  |  |  |  | | **Pravastatin has an active hepatic metabolism and should not be used in poly-treated patients.** |  |  |  |  |  | | **The residual risk associated with high triglycerides and/or low HDL-C is not eliminated with statins alone.** |  |  |  |  |  | | **If correctly undertaken, diet and quitting smoking are generally sufficient to eliminate the residual risk.** |  |  |  |  |  | | |
| **4.4 How would you manage a patient with slightly elevated LDL-C, low HDL-C, and TG over 150 mg/dl, who cannot achieve lipid control with a statin?**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Completely disagree** | **Partially disagree** | **Indifferent** | **Partially agree** | **Completely agree** | | **I would double the dose of statins.** |  |  |  |  |  | | **I would add ezetimibe.** |  |  |  |  |  | | **I would add nicotinic acid.** |  |  |  |  |  | | **I would add a fibrate.** |  |  |  |  |  | | **I would add exchange resins.** |  |  |  |  |  | | |
| **4.5 What treatment do you think is the most appropriate for managing low HDL-C?**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **Not useful** | **Of little use** | **Useful** | **Very useful** | | **Fibrates.** |  |  |  |  | | **Statins.** |  |  |  |  | | **Omega-3.** |  |  |  |  | | **Nicotinic acid.** |  |  |  |  | | |
| **4.6 With regard to TG, please indicate how much you agree with the following statements:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Completely disagree** | **Partially disagree** | **Indifferent** | **Partially agree** | **Completely agree** | | **They are not a cardiovascular risk “per se”.** |  |  |  |  |  | | **They are a cardiovascular risk factor when they are associated with other abnormal lipid parameters.** |  |  |  |  |  | | **They are an independent cardiovascular risk factor.** |  |  |  |  |  | | |
| **4.7 Please indicate which statement you think is correct:**  □ Overall control of the lipid profile in a patient with AD usually needs combined lipid-lowering treatment.  □ Administering fibrates to patients with type 2 diabetes mellitus reduces macro and microvascular complications, if they already present.  □ The ACCORD study showed that treating AD in diabetic patients conferred a benefit in cardiovascular prevention.  □ All the above statements seem correct to me. | |
| **4.8 Which fibrate, in your opinion, is the most appropriate for combination with statins:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Completely disagree** | **Partially disagree** | **Indifferent** | **Partially agree** | **Completely agree** | | **Gemfibrozil is the most appropriate fibrate for combination with statins.** |  |  |  |  |  | | **Fenofibrate is the most appropriate fibrate for combination with statins.** |  |  |  |  |  | | **Either of the two.** |  |  |  |  |  | | **Fibrates must not be used concomitantly with statins.** |  |  |  |  |  | | |
| **4.9 A 67-year-old man with acute coronary syndrome without ST elevation (NSTE-ACS), DM2, and obesity, receiving treatment with atorvastatin 80 mg, has the following lipid profile: LDL-C 66 mg/dl, TG 260 mg/dl, and HDL-C 36 mg/dl. Please indicate how you would manage this patient:**  □ Target LDL-C has been achieved so the residual cardiovascular risk has been reduced.  □ The patient has no residual risk and does not need treatment.  □ The patient has AD and a fibrate should be added.  □ A fibrate must never be associated with a statin at these doses. | |
| **4.10 If your patient has atherogenic dyslipidemia, what is the treatment?**  □ Statin + fibrate from the start.  □ High-dose statin and once target LDL-C is achieved, evaluate another drug.  □ Statin and nicotinic acid.  □ Begin with a fibrate and evaluate a statin if targets are not achieved. | |
| **4.11 Which of the following statements do you NOT consider correct?**  □ Controlling overall lipid profile in patients with AD quite often needs combined lipid-lowering treatment.  □ Fenofibrate is the drug of choice for combination with statins.  □ Gemfibrozil is the drug with least potential for interactions when used in combination with statins.  □ Fibrates are the treatment of choice for treating hypertriglyceridemia. | |

**Supplementary Table 2. Residual cardiovascular risk**

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| **Do you evaluate residual cardiovascular risk in your routine clinical practice?** | | **n** | **Percentage** |
| Yes, but only in patients in secondary prevention | | 287 | 27.89% |
| I’m not sure what residual cardiovascular risk is | | 113 | 10.98% |
| Yes, whenever I remember | | 623 | 60.54% |
| No, because residual risk is a theoretical concept with no clinical impact | | 6 | 0.58% |
| Total | | 1029 | 100.00% |
| **What do you think lipid-related residual cardiovascular risk refers to?** | **n** | | **Percentage** |
| The risk that persists after controlling the patient’s weight | | 6 | 0.58% |
| The risk that persists after treating the patient with statins and achieving LDL-C objectives | | 654 | 63.56% |
| The risk that persists after controlling all modifiable risk factors | | 368 | 35.76% |
| The risk that persists after quitting smoking as a major risk factor | | 1 | 0.10% |
| Total | | 1029 | 100.00% |
| **To what do you attribute lipid-related residual cardiovascular risk?** | | **n** | **Percentage** |
| Age | | 12 | 1.17% |
| Arterial hypertension | | 6 | 0.58% |
| Obesity | | 23 | 2.24% |
| AD | | 988 | 96.02% |
| Total | | 1029 | 100.00% |

LDL-C: cholesterol transported by low-density lipoproteins; AD: atherogenic dyslipidemia.

**Supplementary Table 3. Atherogenic dyslipidemia. General aspects**

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| --- | --- | --- |
| **What are the characteristics of atherogenic dyslipidemia?** | **n** | **Percentage** |
| **Elevated LDL-C** | 44 | 4.28% |
| **Normal or moderately elevated LDL-C levels and a phenotype of small, dense LDL-C particles** | 68 | 6.61% |
| **Low HDL-C and elevated TG** | 128 | 12.44% |
| **Low HDL-C, elevated TG, and elevated small, dense LDL-C particles** | 789 | 76.68% |
| Total | 1029 | 100.00% |
| **Which phenotype is associated with atherogenic dyslipidemia?** | **n** | **Percentage** |
| **Early coronary disease** | 14 | 1.36% |
| **Metabolic syndrome** | 36 | 3.50% |
| **Type 2 diabetes mellitus** | 22 | 2.14% |
| **All of the above** | 957 | 93.00% |
| Total | 1029 | 100.00% |
| **Which statement do you consider the most accurate?** | **n** | **Percentage** |
| **AD is not associated with a high or very high cardiovascular risk** | 12 | 1.17% |
| **AD is of no particular importance in type 2 diabetes, either with regard to macrovascular or microvascular complications** | 13 | 1.26% |
| **AD is a determinant factor for cardiovascular risk, even if LDL-C levels are correct** | 998 | 96.99% |
| **AD does not occur in obese patients** | 6 | 0.58% |
| Total | 1029 | 100.00% |
| **What prompts you to specifically assess atherogenic dyslipidemia in your clinical practice?** | **n** | **Percentage** |
| **Cardiovascular risk is increased** | 901 | 87.56% |
| **Cardiovascular risk is increased by concomitant obesity** | 61 | 5.93% |
| **Treatment with fibrates must be given** | 65 | 6.32% |
| **If it occurs along with diabetes, it should always be treated with insulin** | 2 | 0.19% |
| Total | 1029 | 100.00% |

LDL-C: cholesterol transported by low-density lipoproteins; HDL-C: cholesterol transported by high-density lipoproteins; TG:triglycerides. AD: atherogenic dyslipidemia**;**

**Supplementary Table 4 A. Diagnosis of atherogenic dyslipidemia**

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| --- | --- | --- |
| **What parts of the lipid profile do you consider essential for evaluating a patient with atherogenic dyslipidemia?** | **n** | **Percentage** |
| Total cholesterol | 3 | 0.29% |
| Total cholesterol and HDL-C | 13 | 1.26% |
| Total cholesterol, TG, and HDL-C | 167 | 16.23% |
| Total cholesterol, TG, HDL-C, LDL-C and non-HDL cholesterol. | 846 | 82.22% |
| Total | 1029 | 100.00% |
| **In your clinical practice, can you request fractionated total cholesterol to assess HDL-C and LDL-C?** | **n** | **Percentage** |
| No | 38 | 3,69% |
| Yes, but I am guided by total cholesterol only | 15 | 1.46% |
| Yes, but by referring the patient | 12 | 1.17% |
| Yes, routinely and without restrictions | 964 | 93.68% |
| Total | 1029 | 100.00% |

HDL-C: cholesterol transported by high-density lipoproteins; TG:triglycerides; LDL-C: cholesterol transported by low-density lipoproteins.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do you use the following lipoprotein ratios?** | | | | | | |
| **Ratios** | **Never** | **Almost never** | **Sometimes** | **Often** | **Very often** |  |
| **n ; %** | **n ; %** | **n ; %** | **n ; %** | **n ; %** | Total (n) |
| **TC / HDL-C** | 134 ; 13.02% | 124 ; 12.05% | 225 ; 21.87% | 302 ; 29.35% | 244 ; 23.71% | 1029 |
| **LDL-C / HDL-C** | 149 ; 14.48% | 143 ; 13.90% | 227 ; 22.06% | 294 ; 28.57% | 216 ; 20.99% | 1029 |
| **ApoB / ApoAI** | 617 ; 59.96% | 253 ; 24.59% | 112 ; 10.88% | 34 ; 3.30% | 13 ; 1.26% | 1029 |
| **Non-HDL-C / HDL-C** | 447 ; 43.44% | 271 ; 26.34% | 200 ; 19.44% | 71 ; 6.90% | 40 ; 3.89% | 1029 |
| **TG / HDL-C** | 277 ; 26.92% | 213 ; 20.70% | 250 ; 24.30% | 180 ; 17.49% | 109 ; 10.59% | 1029 |
| **LDL-C / ApoB** | 621 ; 60.35% | 260 ; 25.27% | 99 ; 9.62% | 36 ; 3.50% | 13 ; 1.26% | 1029 |

**Supplementary Table 4 B. Diagnosis of atherogenic dyslipidemia: ratios**

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| --- | --- | --- | --- | --- | --- |
| **How useful is each of the following atherogenic indexes in clinical practice, even if you do not use them?** | | | | | |
| **Ratios** | **Not useful** | **Of little use** | **Useful** | **Very useful** |  |
| **n ; %** | **n ; %** | **n ; %** | **n ; %** | Total (n) |
| **TC / HDL-C** | 25 ; 2.43% | 116 ; 11.27% | 509 ; 49.47% | 379 ; 36.83% | 1029 |
| **LDL-C / HDL-C** | 29 ; 2.82% | 125 ; 12.15% | 470 ; 45.68% | 405 ; 39.36% | 1029 |
| **ApoB / ApoAI** | 94 ; 9.14% | 324 ; 31.49% | 444 ; 43.15% | 167 ; 16.23% | 1029 |
| **Non-HDL-C / HDL-C** | 88 ; 8.55% | 325 ; 31.58% | 483 ; 46.94% | 133 ; 12.93% | 1029 |
| **TG / HDL-C** | 62 ; 6.03% | 254 ; 24.68% | 464 ; 45.09% | 249 ; 24.20% | 1029 |
| **LDL-C / ApoB** | 107 ; 10.40% | 347 ; 33.72% | 434 ; 42.18% | 141 ; 13.70% | 1029 |

TC: total cholesterol; LDL-C: cholesterol transported by low-density lipoproteins; HDL-C: cholesterol transported by high-density lipoproteins; ApoB: Apolipoprotein B; ApoA1: Apolipoprotein A1; TG:triglycerides.

**Supplementary** **Table 5. Treatment of atherogenic dyslipidemia**

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| **What do you think should be the first step in the treatment of atherogenic dyslipidemia?** | | | | | | | **n** | | | | **Percentage** | | |
| **A diet adapted to achieve an appropriate BMI** | | | | | | | 6 | | | | 0.58% | | |
| **In addition to diet, smoking cessation, if applicable** | | | | | | | 4 | | | | 0.39% | | |
| **The above, plus regular physical exercise** | | | | | | | 35 | | | | 3.40% | | |
| **Diet, regular physical exercise, quitting smoking, and pharmacological treatment, if necessary** | | | | | | | 984 | | | | 95.63% | | |
| Total | | | | | | | 1029 | | | | 100.00% | | |
| **How would you approach a patient with atherogenic dyslipidemia associated with obesity?** | | | | | | | **n** | | | **Percentage** | | | |
| **Refer the patient to the nurse** | | | | | | | 4 | | | 0.39% | | | |
| **Refer the patient to the endocrinologist** | | | | | | | 27 | | | 2.62% | | | |
| **Treat the patient in conjunction with the nursing staff** | | | | | | | 237 | | | 23.03% | | | |
| **I emphasize the importance of lifestyle changes and I evaluate the use of pharmacological treatment** | | | | | | | 761 | | | 73.96% | | | |
| Total | | | | | | | 1029 | | | 100.00% | | | |
| **Treatment with statins: how far you agree with each of the following statements?** | | | | | | | | | | | | | |
| **Statements** | **Completely disagree** | **Partially disagree** | | **Indifferent** | | **Partially agree** | | | **Completely agree** | | | |  |
| **n ; %** | **n ; %** | | **n ; %** | | **n ; %** | | | **n ; %** | | | | Total (n) |
| **Statins eliminate all residual cardiovascular risk if target LDL-C levels are achieved** | 252 ; 24.49% | 246 ; 23.91% | | 39 ; 3.79% | | 411 ; 39.94% | | | 81 ; 7.87% | | | | 1029 |
| **Pravastatin has an active hepatic metabolism and should not be used in poly-treated patients”** | 437 ; 42.47% | 306 ; 29.74% | | 92 ; 8.94% | | 150 ; 14.58% | | | 44 ; 4.28% | | | | 1029 |
| **The residual risk associated with high TGs and/or low HDL-C is not eliminated with statins alone** | 25 ; 2.43% | 38 ; 3.69% | | 24 ; 2.33% | | 287 ; 27.89% | | | 655 ; 63.65% | | | | 1029 |
| **If correctly undertaken, diet and quitting smoking are generally sufficient to eliminate the residual risk** | 254 ; 24.68% | 402 ; 39.07% | | 60 ; 5.83% | | 286 ; 27.79% | | | 27 ; 2.62% | | | | 1029 |
| **What treatment do you think is the most appropriate for managing low HDL-C?** | | | | | | | | | | | | | |
| **Options** | **Not useful** | | **Of little use** | | **Useful** | | | **Very useful** | | | | |  |
| **n ; %** | | **n ; %** | | **n ; %** | | | **n ; %** | | | | | Total (n) |
| **Fibrates** | 72 ; 7.00% | | 260 ; 25.27% | | 413 ; 40.14% | | | 284 ; 27.60% | | | | | 1029 |
| **Statins** | 62 ; 6.03% | | 303 ; 29.45% | | 443 ; 43.05% | | | 221 ; 21.48% | | | | | 1029 |
| **Omega-3** | 59 ; 5.73% | | 299 ; 29.06% | | 498 ; 48.40% | | | 173 ; 16.81% | | | | | 1029 |
| **Nicotinic acid** | 167 ; 16.23% | | 559 ; 54.32% | | 243 ; 23.62% | | | 60 ; 5.83% | | | | | 1029 |
| **With regard to TG, please indicate how much you agree with the following statements:** | | | | | | | | | | | | | |
| **Options** | **Completely disagree** | **Partially disagree** | | **Indifferent** | | **Partially agree** | | | **Completely agree** | | | |  |
| **n ; %** | **n ; %** | | **n ; %** | | **n ; %** | | | **n ; %** | | | | Total (n) |
| **They are not a cardiovascular risk factor “per se”** | 434 ; 42.18% | 322 ; 31.29% | | 58 ; 5.64% | | 162 ; 15.74% | | | 53 ; 5.15% | | | | 1029 |
| **They are a cardiovascular risk factor when they are associated with other abnormal lipid parameters** | 67 ; 6.51% | 93 ; 9.04% | | 26 ; 2.53% | | 353 ; 34.31% | | | 490 ; 47.62% | | | | 1029 |
| **They are an independent cardiovascular risk factor** | 61 ; 5.93% | 138 ; 13.41% | | 116 ; 11.27% | | 354 ; 34.40% | | | 360 ; 34.99% | | | | 1029 |
| **Please indicate which statement you think is correct:** | | | | | | | **n** | | | | | **Percentage** | |
| **Overall control of the lipid profile in a patient with AD usually needs combined lipid-lowering treatment** | | | | | | | 44 | | | | | 4.28% | |
| **Administering fibrates to patients with type 2 diabetes mellitus reduces macro and microvascular complications, if they already present** | | | | | | | 1 | | | | | 0.10% | |
| **The ACCORD study showed that treating AD in diabetic patients conferred a benefit in cardiovascular prevention** | | | | | | | 13 | | | | | 1.26% | |
| **All the above statements seem correct to me** | | | | | | | 971 | | | | | 94.36% | |
| Total | | | | | | | 1029 | | | | | 100.00% | |
| **Which fibrate, in your opinion, is the most appropriate for combination with statins?** | | | | | | | | | | | | | |
| **Options** | **Completely disagree** | **Partially disagree** | | **Indifferent** | | **Partially agree** | | | **Completely agree** | | | |  |
| **n ; %** | **n ; %** | | **n ; %** | | **n ; %** | | | **n ; %** | | | | Total (n) |
| **Gemfibrozil** | 455 ; 44.22% | 239 ; 23.23% | | 138 ; 13.41% | | 167 ; 16.23% | | | 30 ; 2.92% | | | | 1029 |
| **Fenofibrate** | 18 ; 1.75% | 18 ; 1.75% | | 30 ; 2.92% | | 193 ; 18.76% | | | 770 ; 74.83% | | | | 1029 |
| **Either of the two** | 444 ; 43.15% | 269 ; 26.14% | | 143 ; 13.90% | | 130 ; 12.63% | | | 43 ; 4.18% | | | | 1029 |
| **Fibrates must not be used concomitantly with statins** | 743 ; 72.21% | 180 ; 17.49% | | 28 ; 2.72% | | 56 ; 5.44% | | | 22 ; 2.14% | | | | 1029 |
| **If your patient has atherogenic dyslipidemia, what is the treatment?** | | | | | | | **n** | | | **Percentage** | | | |
| **Statin + fibrate from the start** | | | | | | | 720 | | | 69.97% | | | |
| **High-dose statin and once target LDL-C is achieved, evaluate another drug** | | | | | | | 197 | | | 19.14% | | | |
| **Statin and nicotinic acid** | | | | | | | 1 | | | 0.10% | | | |
| **Begin with a fibrate and evaluate a statin if targets are not achieved** | | | | | | | 111 | | | 10.79% | | | |
| Total | | | | | | | 1029 | | | 100.00% | | | |
| **Which of the following statements do you not consider correct?** | | | | | | | **n** | | | **Percentage** | | | |
| **Controlling overall lipid profile in patients with AD quite often needs combined lipid-lowering treatment** | | | | | | | 73 | | | 7.09% | | | |
| **Fenofibrate is the drug of choice for combination with statins.** | | | | | | | 81 | | | 7.87% | | | |
| **Gemfibrozil is the drug with least potential for interactions when used in combination with statins** | | | | | | | 833 | | | 80.95% | | | |
| **Fibrates are the treatment of choice for treating hypertriglyceridemia** | | | | | | | 42 | | | 4.08% | | | |
| Total | | | | | | | 1029 | | | 100.00% | | | |

BMI: body mass index LDL-C: cholesterol transported by low-density lipoproteins; TG: triglycerides; HDL-C: cholesterol transported by high-density lipoproteins. AD: atherogenic dyslipidemia