



Prevention

Familial hypercholesterolaemia in children and adolescents: gaining decades of life by optimizing detection and treatment

Albert Wiegman^{1†*}, Samuel S. Gidding^{2†}, Gerald F. Watts³, M. John Chapman^{4,5}, Henry N. Ginsberg^{6,7}, Marina Cuchel⁸, Leiv Ose^{9,10}, Maurizio Averna¹¹, Catherine Boileau^{12,13,14}, Jan Borén^{15,16}, Eric Bruckert¹⁷, Alberico L. Catapano^{18,19}, Joep C. Defesche²⁰, Olivier S. Descamps²¹, Robert A. Hegele²², G. Kees Hovingh²⁰, Steve E. Humphries²³, Petri T. Kovanen²⁴, Jan Albert Kuivenhoven²⁵, Luis Masana²⁶, Børge G. Nordestgaard^{27,28}, Päivi Pajukanta²⁹, Klaus G. Parhofer³⁰, Frederick J. Raal³¹, Kausik K. Ray³², Raul D. Santos^{33,34}, Anton F.H. Stalenhoef³⁵, Elisabeth Steinhagen-Thiessen^{36,37}, Erik S. Stroes²⁰, Marja-Riitta Taskinen³⁸, Anne Tybjærg-Hansen^{39,40}, and Olov Wiklund^{41,42}, for the European Atherosclerosis Society Consensus Panel[‡]

¹Department of Paediatrics, Academic Medical Center, University of Amsterdam, The Netherlands; ²Nemours Cardiac Center, A. I. DuPont Hospital for Children, Wilmington, DE, USA; ³School of Medicine and Pharmacology, Royal Perth Hospital Unit, The University of Western Australia, Western Australia, Australia; ⁴Pierre and Marie Curie University, Paris, France; ⁵National Institute for Health and Medical Research (INSERM), Pitié-Salpêtrière University Hospital, Paris, France; ⁶Columbia University College of Physicians and Surgeons, New York, NY, USA; ⁷Irving Institute for Clinical and Translational Research, Columbia University Medical Center, New York, USA; ⁸Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA, USA; ⁹Department of Nutrition, Institute of Basic Medical Sciences, University of Oslo, Oslo, Norway; ¹⁰Lipid Clinic, Oslo University Hospital, Oslo, Norway; ¹¹Department of Internal Medicine, University of Palermo, Italy; ¹²Diderot Medical School, University Paris 7, Paris, France; ¹³Genetics Department, Bichat University Hospital, Paris, France; ¹⁴INSERM U698, Paris, France; ¹⁵Department of Medicine, Sahlgrenska Academy, Göteborg University, Gothenburg, Sweden; ¹⁶Wallenberg Laboratory for Cardiovascular Research, Gothenburg, Sweden; ¹⁷Department of Endocrinology and Prevention of Cardiovascular Disease, University Hospital Pitié-Salpêtrière, Paris, France; ¹⁸Department of Pharmacology, Faculty of Pharmacy, University of Milano, Milan, Italy; ¹⁹Multimedica IRCSS, Milan, Italy; ²⁰Department of Vascular Medicine, Academic Medical Center, University of Amsterdam, The Netherlands; ²¹Centre Hospitalier Jolimont-Lobbes, Nivelles-Tubize, Belgium; ²²Robarts Research Institute, University of Western Ontario, London, ON, Canada; ²³Centre for Cardiovascular Genetics, University College London, Institute of Cardiovascular Sciences, London, UK; ²⁴Wihuri Research Institute, Helsinki, Finland; ²⁵Department of Pediatrics, Section Molecular Genetics, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands; ²⁶Vascular Medicine and Metabolic Unit, Department of Medicine and Surgery, University Rovira and Virgili, Reus-Tarragona, Spain; ²⁷Department of Clinical Biochemistry, Herlev Hospital, Copenhagen University Hospital, Herlev, Denmark; ²⁸Faculty of Health and Medical Sciences, University of Copenhagen, Copenhagen, Denmark; ²⁹Department of Human Genetics, Center for Metabolic Disease Prevention, University of California, Los Angeles, USA; ³⁰Department of Endocrinology and Metabolism, University of Munich, Munich, Germany; ³¹Carbohydrate & Lipid Metabolism Research Unit, and Division of Endocrinology & Metabolism, University of the Witwatersrand, Johannesburg, South Africa; ³²Department of Primary Care and Public Health, School of Public Health, Imperial College, London, UK; ³³Lipid Clinic of the Heart Institute (InCor), University of São Paulo, São Paulo, Brazil; ³⁴Department of Cardiology, University of São Paulo Medical School, São Paulo, Brazil; ³⁵Department of Medicine, Radboud University Medical Center, Nijmegen, The Netherlands; ³⁶Evangelisches Geriatriezentrum Berlin gGmbH (EGZB), Berlin, Germany; ³⁷Charité – Universitätsmedizin, Berlin, Germany; ³⁸Research Programs Unit, Diabetes & Obesity, University of Helsinki and Heart & Lung Centre, Helsinki University Hospital, Helsinki, Finland; ³⁹Department of Clinical Biochemistry, Section for Molecular Genetics, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark; ⁴⁰Faculty of Health and Medical Sciences, University of Copenhagen, Copenhagen, Denmark; ⁴¹Department of Experimental and Clinical Medicine, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden; and ⁴²Department of Cardiology, Sahlgrenska University Hospital, Gothenburg, Sweden

Received 16 February 2015; revised 8 April 2015; accepted 19 April 2015

Familial hypercholesterolaemia (FH) is a common genetic cause of premature coronary heart disease (CHD). Globally, one baby is born with FH every minute. If diagnosed and treated early in childhood, individuals with FH can have normal life expectancy. This consensus paper aims to improve awareness of the need for early detection and management of FH children. Familial hypercholesterolaemia is diagnosed either on phenotypic criteria, i.e. an elevated low-density lipoprotein cholesterol (LDL-C) level plus a family history of elevated LDL-C, premature coronary artery

* Corresponding author. Tel: +31 205662851, Email: a.wiegman@amc.uva.nl

† Equal first authors.

‡ For list of Panel members, see Appendix.

© The Author 2015. Published by Oxford University Press on behalf of the European Society of Cardiology.

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact journals.permissions@oup.com

disease and/or genetic diagnosis, or positive genetic testing. Childhood is the optimal period for discrimination between FH and non-FH using LDL-C screening. An LDL-C ≥ 5 mmol/L (190 mg/dL), or an LDL-C ≥ 4 mmol/L (160 mg/dL) with family history of premature CHD and/or high baseline cholesterol in one parent, make the phenotypic diagnosis. If a parent has a genetic defect, the LDL-C cut-off for the child is ≥ 3.5 mmol/L (130 mg/dL). We recommend cascade screening of families using a combined phenotypic and genotypic strategy. In children, testing is recommended from age 5 years, or earlier if homozygous FH is suspected. A healthy lifestyle and statin treatment (from age 8 to 10 years) are the cornerstones of management of heterozygous FH. Target LDL-C is < 3.5 mmol/L (130 mg/dL) if > 10 years, or ideally 50% reduction from baseline if 8–10 years, especially with very high LDL-C, elevated lipoprotein(a), a family history of premature CHD or other cardiovascular risk factors, balanced against the long-term risk of treatment side effects. Identifying FH early and optimally lowering LDL-C over the lifespan reduces cumulative LDL-C burden and offers health and socioeconomic benefits. To drive policy change for timely detection and management, we call for further studies in the young. Increased awareness, early identification, and optimal treatment from childhood are critical to adding decades of healthy life for children and adolescents with FH.

Keywords

Familial hypercholesterolaemia • Children • Adolescents • LDL cholesterol • Diagnosis • Treatment • Statin • Ezetimibe • PCSK9 inhibitor • Consensus statement

Introduction

On his 10th birthday, a boy whose father died exactly 1 year ago aged 30 years, comes to consult you with his mother. The mother is worried that her son will have the same fate, because he also has bad cholesterol. What is your approach in this case?

Familial hypercholesterolaemia (FH) is a common genetic cause of premature coronary heart disease (CHD). With one very rare recessive exception, FH is an autosomal dominant disorder. Both homozygous and heterozygous FH result in markedly reduced hepatic capacity to clear atherogenic cholesterol-rich low-density lipoproteins (LDLs) from the circulation, with consequent accumulation of LDL cholesterol (LDL-C).¹ In severe cases, LDL-C levels exceed 13 mmol/L (500 mg/dL).² Beginning in the foetus, sustained exposure of the arterial wall to elevated LDL-C levels accelerates cholesterol deposition and vascular inflammation, developing atherosclerosis, especially in the coronary arteries and aorta, and premature CHD.^{3,4}

Heterozygous FH (HeFH) is common (Figure 1A), present in ~ 1 per 200–250 of the general population, about two-fold higher than previously thought.^{2,5,6} Among a CHD-free control population, 1 in 217 carried a mutation in the gene encoding the LDL receptor (*LDLR*) and had LDL-C > 190 mg/dL.⁷ Consequently, there are potentially as many as 4.5 million individuals in Europe with HeFH and probably 35 million worldwide (Figure 1B), of whom 20–25% are children and adolescents. Given that there are 255 worldwide births per minute,⁸ one baby is born with FH every minute. Children with untreated HeFH have a dramatic increase in risk of premature CHD after age 20 years.^{9,10} Familial hypercholesterolaemia in its homozygous form (HoFH) is a rare disease with an estimated prevalence of 1 per 160 000–300 000 in European populations.^{2,11} Individuals with HoFH are at extremely high risk and, if untreated, many will manifest coronary or other cardiovascular disease in childhood or adolescence.

Familial hypercholesterolaemia is diagnosed either on phenotypic criteria, involving an elevated LDL-C level plus a family history of elevated LDL-C, premature CHD, and/or genetic diagnosis, or with genetic testing. With few exceptions, however, FH is underdiagnosed and undertreated globally,⁵ and systematic screening strategies are inconsistently implemented.¹² Given the proven atherogenicity of LDL-C in experimental models and in humans with FH, with evidence

that exposure to even moderate hypercholesterolaemia increases the long-term risk of a new CHD event,¹³ and given the lifelong benefit of genetically determined low LDL-C concentrations,¹⁴ there is an urgent need to identify and treat FH early to maximize therapeutic benefit (Table 1). Importantly, statins are safe and effective in lowering LDL-C in children,¹⁵ restore endothelial function, and regress thickening of the intima of the vessel wall at a young age.^{16–18}

The aim of this consensus paper is to encourage improvement in early detection, diagnosis and treatment of FH by creating a paradigm shift in its clinical perception in children and adolescents. We discuss the current status of pathophysiology, diagnosis, genetic testing, screening and management of FH. Figure 2 demonstrates the potential of early recognition of FH, combined with treatment from a young age, to substantially delay atherosclerosis progression. New findings support our recommendations to improve recognition and initiation of early treatment with lifestyle, diet, and pharmacotherapy.¹⁹

Pathophysiology

Genetic causes

Familial hypercholesterolaemia is most often caused by mutations in the *LDLR* gene, resulting in absent or dysfunctional receptors on the surface of hepatocytes, identifying the liver as the principal site of LDL catabolism. More than 1700 mutations in the *LDLR* gene on chromosome 19 have been identified, of which 79% are probably expressed as a hypercholesterolaemic phenotype.²⁰ Defects in the genes encoding apolipoprotein B (*APOB*) and proprotein convertase subtilisin/kexin type 9 (*PCSK9*) account for $\sim 5\%$ and $< 1\%$ of FH cases, respectively. The LDL receptor adaptor protein (*LDLRAP1*) gene is a very rare recessive form of FH.^{5,21} However, 5–30% of cases of phenotypic FH may arise from mutations in unidentified genes, or have a polygenic cause as distinct from a dominantly inherited disorder.^{22–24} All of the monogenic defects result in reduced efficiency of LDL uptake and clearance in hepatocytes and increased circulating total cholesterol and LDL-C concentration. Inheritance of a mutation in the gene from one parent causes HeFH; inheritance of a mutation from each parent causes HoFH. Many individuals considered homozygous have two different genetic defects related to

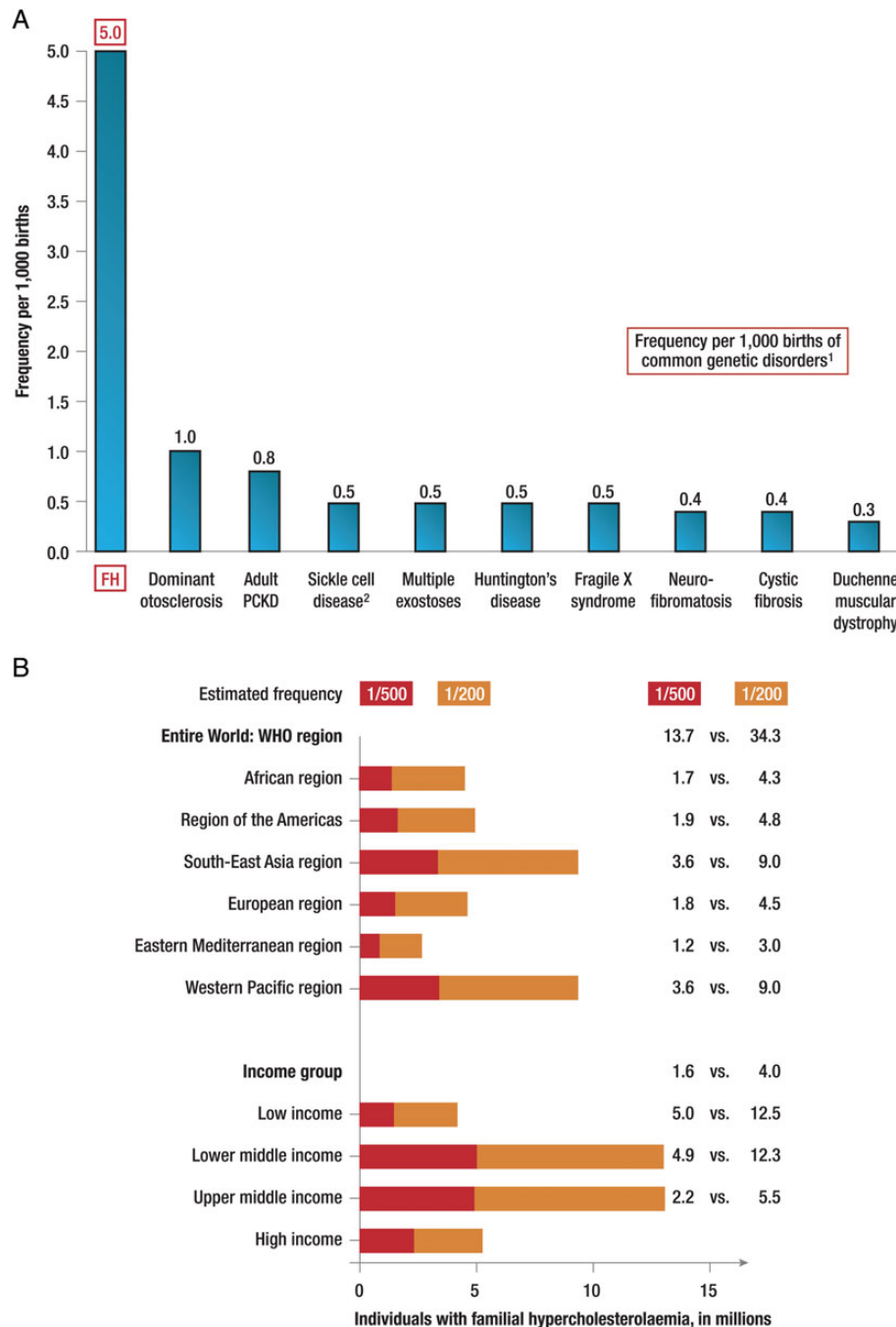


Figure 1 Prevalence of familial hypercholesterolaemia. (A) Familial hypercholesterolaemia is more common than other genetic diseases. 1 Genetic Alliance UK. Incidence of genetic disorders. <http://www.geneticalliance.org.uk/education3.htm> (13 February 2015); 2 Streetly *et al.*¹⁴⁰ FH, familial hypercholesterolaemia; PCKD, polycystic kidney disease. (B) The estimated prevalence of FH globally, based on estimated frequencies of 1:500 and 1:200 (as suggested by recent research), reproduced with permission from Nordestgaard *et al.*⁵

LDLR (i.e. compound HeFH), with mutations in *APOB* or *PCSK9* genes, as well as an *LDLR* mutation.¹¹

Early atherosclerotic disease

In FH, attenuated clearance of plasma LDL-C by the LDL receptor leads to increased numbers of circulating LDL which penetrate and then accumulate in the artery wall, become oxidatively modified,

and subsequently initiate an inflammatory response, which results in vascular injury and formation of atherosclerotic plaque.^{25,26} Additional alterations in the lipoprotein profile in FH may involve elevated levels of lipoprotein(a) [Lp(a)] and triglyceride-rich lipoprotein remnants, together with low levels of dysfunctional high-density lipoproteins (HDLs), which collectively may contribute to accelerated atherosclerosis and CHD.^{27,28}

Both pre-mortem (the Bogalusa Heart Study) and post-mortem studies (the Pathobiological Determinants of Atherosclerosis in Youth [PDAY] study) have revealed a strong, continuous and

graded relationship between non-HDL cholesterol levels (i.e. total cholesterol – HDL-C, comprising the atherogenic apoB-containing lipoproteins) and atherosclerotic disease.^{29,30} Indeed, every 0.25 mmol/L (10 mg/dL) increment in non-HDL-C is associated with an increase in atherosclerotic burden equivalent to 1 year of aging. Although pathology studies have not been systematically performed in children and adolescents with FH, observations in non-FH individuals strongly suggest that very high LDL-C levels sustained from childhood and adolescence in FH subjects would be associated with future vascular disease. Collective evidence demonstrates that elevated circulating markers of vascular inflammation and endothelial dysfunction are present in children with FH, reflecting early atherogenesis.³¹

Increased carotid intima-media thickness (cIMT) and detection of coronary artery calcification by computed tomography (CT) scanning are confirmed markers of early atherogenesis.³¹ A systematic review of published data shows that cIMT is higher in phenotypic FH patients (from age 10 years) than normolipidaemic controls, and that this difference directly relates to LDL-C levels.³² The difference in mean cIMT between children with FH and unaffected siblings may be significant as early as age 7 years (Figure 3A).³³ Similar findings were observed for mean femoral artery IMT.³⁴ Coronary calcification is present in ~25% of 11–23 year olds with phenotypic HeFH,

Table 1 Key points about familial hypercholesterolaemia

- FH is one of the most common genetic disorders, affecting 1 : 200 to 1 : 250 people in the European population, inherited in an autosomal dominant fashion.
- HeFH, and to an even greater degree HoFH, can be disabling at a young age and shorten life expectancy.
- If LDL-C levels are >13 mmol/L (500 mg/dL) and paediatric manifestations include premature CHD, aortic valve disease, and tendon xanthomas in the hands and Achilles tendons, homozygosity is assumed. However, HoFH may be considered at lower LDL-C levels following recent recognition of the clinical and genetic heterogeneity of FH.
- The presence of FH presents a psychological challenge for families because of the inherited nature of the condition, the lack of early symptoms in HeFH, and the need for long-term lifestyle changes and pharmacotherapy.
- Early detection of FH and early initiation of lifestyle and pharmacological treatment is imperative to reduce the lifelong burden of elevated LDL-C levels.

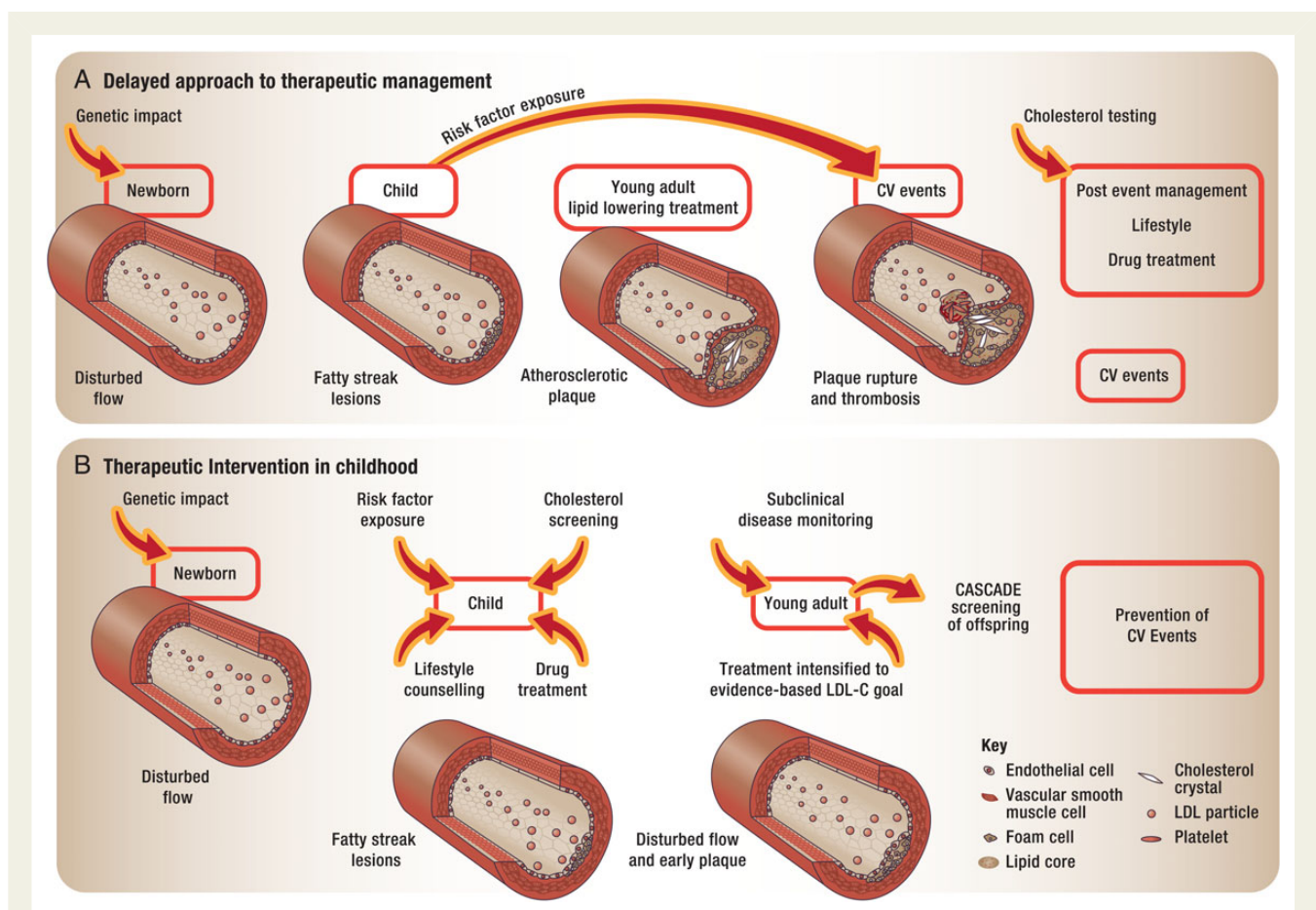


Figure 2 Development of early atherosclerotic vascular disease in familial hypercholesterolaemia showing the potential impact of early recognition and treatment on evolution of the condition. CV, cardiovascular; LDL-C, low-density lipoprotein cholesterol.

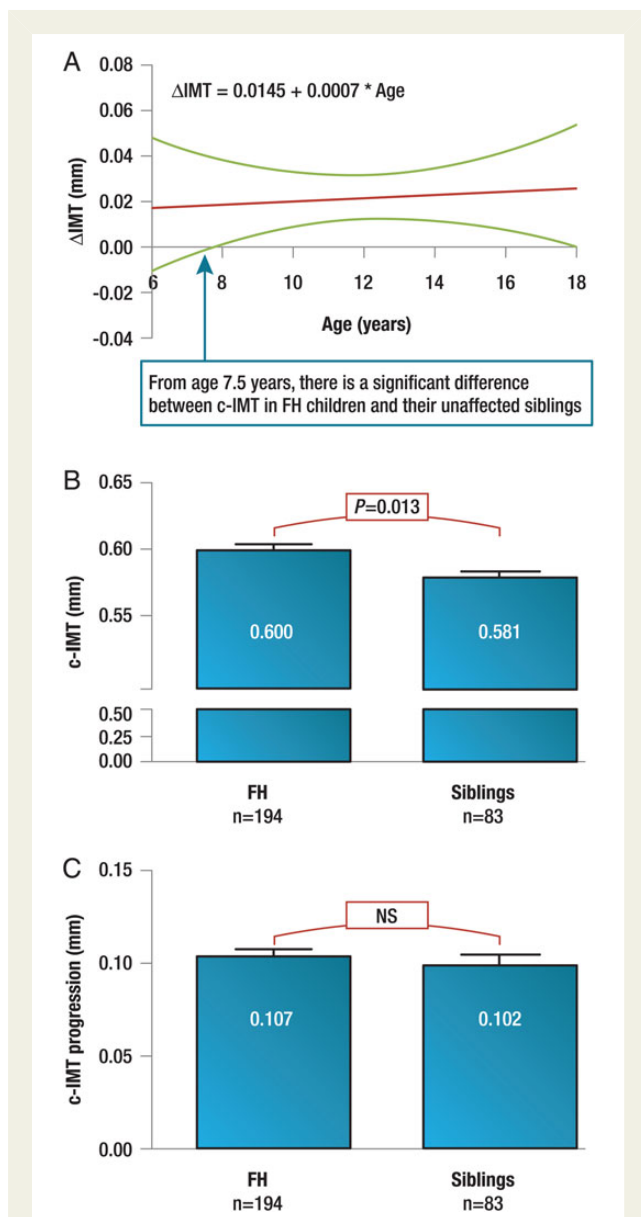


Figure 3 Carotid intima-media thickness is a marker of early atherogenesis in children with familial hypercholesterolaemia. (A) Increased carotid intima-media thickness is already evident at age 7 years in familial hypercholesterolaemia children. Data from Kusters *et al.*³³ After 10 years treatment with a statin, while mean carotid intima-media thickness is higher in familial hypercholesterolaemia children than their unaffected siblings (B), there is no significant difference between the two groups in carotid intima-media thickness progression over this period (C). Data from Kusters *et al.*⁹⁸ Data in (B) and (C) are given as mean \pm SEM and are adjusted for age, gender, blood pressure, body mass index, smoking, and family relations. cIMT, carotid intima-media thickness; FH, familial hypercholesterolaemia; NS, not significant.

and especially in the aorta in most adolescents with HoFH, although coronary and aortic calcium score is rarely, if ever, positive in pre-adolescent HoFH children.^{11,35–37} In contrast, coronary calcium is barely detectable in atherosclerotic lesions in adolescents in

Table 2 Diagnosis of familial hypercholesterolaemia in children and adolescents

- Family history of premature CHD plus high LDL-C levels are the two key selective screening criteria: (F + H = FH).^a
- Cholesterol testing should be used to make a phenotypic diagnosis.
- An LDL-C level ≥ 5 mmol/L (190 mg/dL) on two successive occasions after 3 months diet indicates a high probability of FH. A family history of premature CHD in close relative(s) and/or baseline high cholesterol in one parent, together with an LDL-C ≥ 4 mmol/L (160 mg/dL) indicates a high probability of FH. If the parent has a genetic diagnosis, an LDL-C ≥ 3.5 mmol/L (130 mg/dL) suggests FH in the child.
- Secondary causes of hypercholesterolaemia should be ruled out.
- DNA testing establishes the diagnosis. If a pathogenic *LDLR* mutation is identified in a first-degree relative, children may also be genetically tested.
- If a parent died from CHD, a child even with moderate hypercholesterolaemia should be tested genetically for FH and inherited elevation in Lp(a).

^aAcknowledgement to the FH Foundation (<http://thefhfoundation.org>).

the general population.³⁸ When compared with children with *LDLR*-defective alleles, those with *LDLR*-null (complete loss of function) alleles have higher LDL-C levels, more advanced atherosclerosis and, correspondingly, increased cIMT.^{34,39}

Diagnosis

Paediatric FH is diagnosed phenotypically by the presence of an LDL-C level consistent with FH plus a family history of premature CHD and/or baseline high cholesterol in one parent and/or an FH-causing mutation (Table 2).^{11,21} Childhood is the optimal period to discriminate between FH and non-FH on the basis of LDL-C concentration, due to minimal dietary/hormonal influences. After dietary intervention, any child with an LDL-C level ≥ 5 mmol/L (190 mg/dL) has a high probability of genetically based FH. If there is a family history of premature CHD in close relatives and/or a baseline high cholesterol in one parent, an LDL-C ≥ 4 mmol/L (160 mg/dL) is indicative of a high probability of genetically based FH.

Detection of a pathogenic mutation, usually in the *LDLR* gene, is the gold standard for diagnosis of FH.^{6,21,40–43} A child of a parent with FH has a 50% probability of inheriting FH, thereby emphasizing the importance of a family pedigree to identify relatives for screening. Typically, there will be a marked difference in LDL-C levels between children with and without genetically defined FH. In one study, a functional mutation was identified in 95% of children meeting phenotypic criteria for FH and with an autosomal dominant pattern of inheritance of hypercholesterolaemia.²⁴ If the parent has a genetic diagnosis and the child has an LDL-C ≥ 3.5 mmol/L (130 mg/dL), an *LDLR* mutation is to be anticipated.⁴⁰

The applicability of current diagnostic tools varies. While the Dutch Lipid Clinic Network criteria are not valid in children,⁴¹ the Simon Broome criteria have specific cut-offs for LDL-C in this group. The LDL-C threshold is 4 mmol/L (160 mg/dL) in children with FH aged < 10 years.^{24,44} A lower LDL-C threshold (3.5 mmol/L or 130 mg/dL) may be used when children are tested as part of

cascade screening.^{40,45} LDL-C levels should be measured at least twice over 3 months to confirm the diagnosis of FH.^{5,6} An LDL-C level >13 mmol/L (500 mg/dL) is consistent with phenotypic HoFH, but may be lower given recent recognition of the clinical and genetic heterogeneity of FH.^{2,11}

Factors that complicate diagnostic accuracy include the presence of multiple genes that have a small positive effect on LDL-C concentration, raising levels to those consistent with FH, or the presence of 'compensatory' genes that lower LDL-C below thresholds defined above.^{46–48} There is also overlap between those with HeFH and HoFH at LDL-C levels of ~8–13 mmol/L (~300–500 mg/dL).^{2,11} Secondary causes of elevated LDL-C, including hypothyroidism, nephrotic syndrome, obstructive liver disease, obesity, anorexia nervosa, and drug treatment (e.g. isotretinoids) should be considered in patient evaluation.^{42–44,49} Sitosterolaemia, particularly if xanthoma are present, or cholesteryl ester storage disease when liver transaminases are elevated, although extremely rare, should also be considered.⁴¹ Recent evidence suggests that the marked hypercholesterolaemia in sitosterolaemia may be transient and also diet dependent.⁵⁰

Genetic testing of families

It is best practice to first genetically test a phenotypically affected parent or a second-degree relative in the absence of a parent.^{39,42,51,52} If a mutation is identified, genetic testing and counselling should be offered to all family members, ideally co-ordinated centrally in association with a clinical genetics service.^{39,53} To increase acceptability, genetic testing for FH in children should be available using DNA extracted from buccal samples.³⁹ The psychological sequelae of genetic tests must be considered, with pre-test counselling essential to the consent/assent procedure, taking account of the child's level of comprehension and parental literacy.^{51,52} In circumstances in which FH is suspected but no parents or second-degree relatives are available or the parents refuse testing, after obtaining appropriate assent/consent genetic testing and measurement of Lp(a) should be carried out in minors, especially if a parent died from CHD and the child has only moderate hypercholesterolaemia.

Laboratory aspects

Laboratories for genetic analyses should be fully accredited by local, national, or international authorities. Established procedures should be followed for classifying variants as clearly pathogenic (a mutation), clearly non-pathogenic (a benign variant) or of uncertain significance (5–8% of molecular diagnostic reports), based mainly on *in silico* assessment coupled with a search of the literature and established databases.^{6,39} Failure to detect a mutation does not exclude a diagnosis of FH. One reason may be insufficient sensitivity or specificity of the technology; additionally, some paediatric phenotypic index cases do not have known FH-causing mutations.

Most laboratories involved in FH genetic testing will utilise a number of mutation detection methods, including Sanger-based exon-by-exon sequence analysis and Multiplex Ligation Probe Amplification for large deletions and duplications; whole- and targeted exome sequencing are newer options.^{21,22} All results from commercial chip or kit technology that identify a gene variant as being present

Table 3 Screening for familial hypercholesterolaemia in children and adolescents

- If DNA testing is available, cascade screening of families is recommended using both a phenotypic and genotypic strategy. If DNA testing is not available, a phenotypic strategy based on country, age- and gender-specific LDL-C levels should be used.
- Children with suspected HeFH should be screened from the age of 5 years; screening for HeFH should be undertaken when clinically suspected (both parents affected or xanthoma present) and as early as possible.
- Age at screening should be similar for boys and girls.
- Universal screening in childhood may also be considered.

should be confirmed using a second validated testing method. 'Next Generation' exome sequencing is a newer option, which also identifies insertions and deletions.^{21,22,48}

Screening

Screening for FH meets World Health Organization guidelines:⁵⁴ childhood represents a latent stage of the disease, a simple test to diagnose FH acceptable to the general population exists, there is effective treatment, and case-finding can be made part of routine medical practice. Table 3 summarizes key features of potential screening strategies. Research is needed to ascertain the exact age to begin treatment and the long-term safety of cholesterol-lowering treatment.⁵⁵

In families with a known *LDLR* mutation, molecular testing is the most reliable and effective method to identify affected family members including children and adolescents. Theoretically, genetic testing of first-degree relatives has a sensitivity and specificity of 100%, whereas for clinical diagnosis, sensitivity and specificity is in the range of 70–85%.⁴⁴ In the Netherlands, >28 000 individuals with FH have been identified, almost 23 000 via cascade screening, carrying >500 different mutations.^{56,57} But even with this strategy, ~30% of the 33 300 estimated cases are not identified,⁵ due to lack of an index case. In the Norwegian genetic screening programme, >5600 individuals of the estimated 15 000–20 000 FH patients have been identified, carrying >140 different mutations. Legal restrictions require relatives to contact family members directly, which restricts the efficiency of detecting new FH cases. Clinical diagnosis of FH in general practice has a sensitivity of 46% and a specificity of 88%.⁵⁸ In the UK, a family cascade testing approach for FH is recommended, starting with adults and proceeding to testing children from the age of 10 years in families known to have a clear diagnosis of FH. The programme has been fully implemented in Wales, Scotland, and Northern Ireland.⁵⁹

Universal screening of children for hypercholesterolaemia in Europe has only been implemented in Slovenia from the age of 5 years.⁶⁰ In the USA, universal screening at age 9–11 years has been recommended, in part because selective screening based on family history is not efficient in identifying children with LDL-C in the FH range.^{61,62} Screening can be performed in conjunction with routine health visits such as at the time of immunization,⁴⁴ and cascade screening of first-degree family members can follow

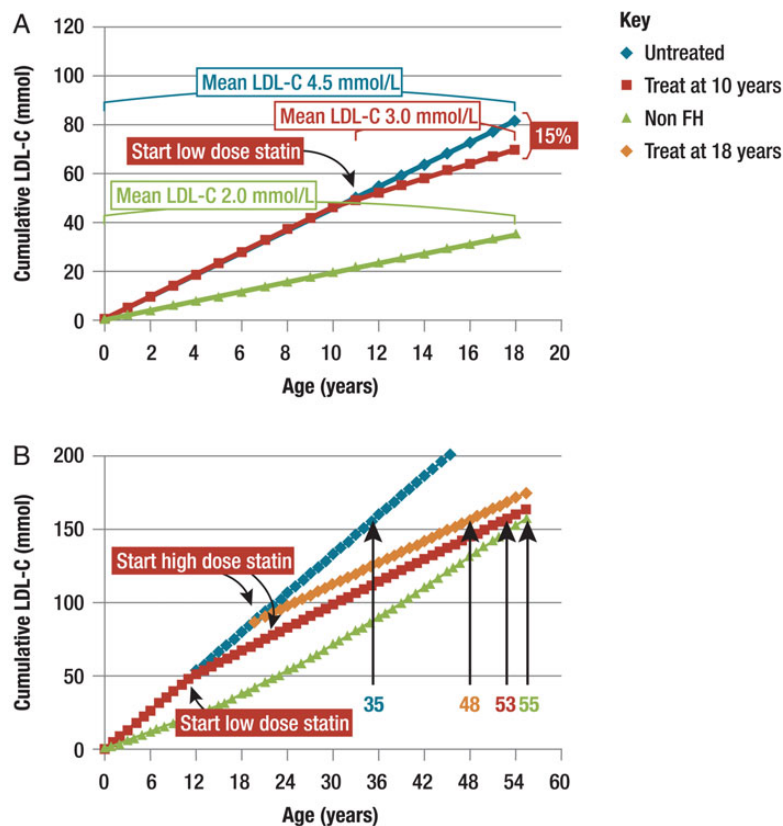


Figure 4 Impact of statin treatment on cholesterol burden in familial hypercholesterolaemia. Early initiation of statin treatment reduces the low-density lipoprotein cholesterol burden* in subjects with familial hypercholesterolaemia. Reproduced with permission from Vuorio *et al.*⁷⁰ (A): Cumulative low-density lipoprotein cholesterol burden by age of 18 years is 15% lower in familial hypercholesterolaemia subjects treated with low dose statin from age 10 years (70 mmol) than in untreated familial hypercholesterolaemia subjects (80 mmol). (B) Cumulative low-density lipoprotein cholesterol burden of a 55-year-old non-familial hypercholesterolaemia subject is 160 mmol. In an untreated familial hypercholesterolaemia subject, this is attained by age 35 years, but is delayed in familial hypercholesterolaemia patients treated from age 18 years (48 years), and further delayed in those treated from age 10 years (53 years). *For calculation of the low-density lipoprotein cholesterol burden, the following assumed mean low-density lipoprotein cholesterol values were used. Non-familial hypercholesterolaemia subjects: 2.0 mmol/L for the age range of 0–15 years; 2.5 mmol/L for 15–24 years; 3.0 mmol/L for 25–34 years; 3.5 mmol/L for 35–44 years; and 3.5 mmol/L for 45–54 years. Familial hypercholesterolaemia subjects: 4.5 mmol/L in untreated familial hypercholesterolaemia patients; 3 mmol/L in familial hypercholesterolaemia patients treated during the age range of 10–18 years, and 2.5 mmol/L in familial hypercholesterolaemia patients with treatment started at the age of 18 years. FH, familial hypercholesterolaemia; LDL-C, low-density lipoprotein cholesterol.

identification of a child with severely elevated LDL-C. However, the acceptability, practicability, specificity, and cost-effectiveness of this approach have yet to be evaluated.⁶³

Other risk factors

Given independent associations of type 2 diabetes, hypertension, tobacco use (including passive smoking), and obesity with atherosclerosis development,³⁸ a patient with FH and an additional risk factor is at even greater risk than a patient with FH alone, as supported by natural history data in FH cohorts.^{64,65} There is also prognostic value in screening for plasma lipoprotein(a) [Lp(a)] concentration given that high Lp(a) (>50 mg/dL or 80th percentile) increases risk for premature CHD (by 1.5-fold).^{64,66} In childhood, FH may co-exist with other diseases known to accelerate atherosclerosis, including type 1 diabetes mellitus, chronic kidney disease, connective tissue disorders, and HIV infection.⁶⁷

Management

Early treatment of FH can reduce LDL-C burden (Figure 4), improve endothelial function, substantially attenuate the progression of atherosclerosis (Figure 3B and C), and improve coronary outcomes (Figure 5),^{17,18,68–71} all of which emphasizes the rationale for greater long-term benefit with initiation of treatment earlier rather than later in life.^{70,71} Furthermore, long-term follow-up from statin trials, albeit not specifically in FH patients, suggests a legacy effect, i.e. better CHD outcomes in those initially randomized to statin treatment.^{72,73} Table 4 summarizes key points related to FH management.

Diet and risk factor control

Diet and lifestyle underpin the management of FH in children. In considering dietary fat content, the major dietary drivers of serum

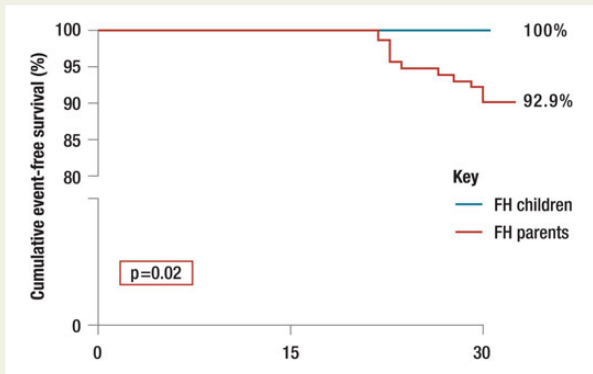


Figure 5 Reduction in low-density lipoprotein cholesterol burden associated with early initiation of statin treatment in children with familial hypercholesterolaemia translates to improvement in coronary outcomes. Kaplan–Meier curves of event-free survival in a cohort of 214 familial hypercholesterolaemia subjects treated from childhood ($n = 214$) compared with their parents with familial hypercholesterolaemia, treated from adulthood ($n = 156$). Data from Braamskamp *et al.*⁹⁹ FH, familial hypercholesterolaemia.

Table 4 Clinical management of FH in children and adolescents

- Early identification of children with FH ensures that adherence with lifestyle intervention is already established before puberty.
- Children with HeFH should be treated with a fat-modified, heart-healthy diet at diagnosis, and begin statins at age 8–10 years.
- In HeFH, pharmacologic treatment should start at diagnosis.
- Early initiation of lifestyle is essential for ensuring long-term adherence.
- Children diagnosed with FH should have lipoprotein(a) [Lp(a)] measured for risk stratification.
- Boys and girls should start treatment at similar ages.
- For children aged 8–10 years, the Panel recommends that LDL-C is ideally reduced by 50% from pre-treatment levels.
- For children aged ≥ 10 years, especially if there are additional cardiovascular risk factors, including elevated Lp(a), the target LDL-C should be < 3.5 mmol/L (130 mg/dL).
- The benefits of LDL-C reduction should be balanced against the long-term risk of treatment side effects.
- Adherence should be checked if HeFH children fail to achieve LDL-C targets with combination lipid-lowering treatment. If patients are non-adherent, consider referral to a dedicated, multidisciplinary clinic.
- Children with HeFH should be referred to and cared for at a specialised centre.

cholesterol levels are saturated fats and trans fats with a small contribution from dietary cholesterol.^{74,75} Limitation of foods high in saturated fat will secondarily limit dietary cholesterol intake; cholesterol-containing foods without saturated or trans fats may be allowed.⁷⁶ Reduction of saturated fat intake has not been associated with altered physical growth during long follow-up.⁷⁷ Consequently, the Panel recommends a heart-healthy, fat-modified diet ($< 30\%$ of calories from total fat, $< 7\%$ of calories from saturated

fat, and < 200 mg of cholesterol/day),^{68,78} ideally incorporating nutrient-dense foods with appropriate energy to maintain optimal body weight. Intake of fruit and vegetables, whole grains, low-fat dairy products, beans, fish, and lean meats should be encouraged. Diet choices are by nature diverse; emphasis should be on a culturally acceptable heart-healthy diet, such as Mediterranean-style diets.

There should be annual or bi-annual monitoring of weight, growth and developmental milestones. Physical activity should be promoted and smoking strongly discouraged. Identifying children with FH early ensures that adherence with lifestyle interventions is established before puberty. Other cardiovascular risk factors should be monitored and treated if indicated.

Pharmacotherapy for heterozygous familial hypercholesterolaemia

Statins are the cornerstone of FH management. Simvastatin, lovastatin, atorvastatin, pravastatin, fluvastatin and rosuvastatin are approved in the USA and Europe for use in children with FH. In the USA, these are approved from age 10 years, except for pravastatin which is approved from age 8 years.⁶ Prescribing information is broadly similar in Europe, although rosuvastatin is approved from the age of 6 years. Atorvastatin is approved from age 6 years in Australia. Treatment may be started earlier in severe cases.⁷⁹ The short-term efficacy and safety of these statins, including during puberty, have been confirmed.^{15,68,80}

Treatment should be initiated at the lowest recommended dose and up-titrated according to the LDL-C lowering response and tolerability. Evidence for an absolute target for LDL-C in children with FH does not exist. Expert consensus recommends a target LDL-C level < 3.5 mmol/L (130 mg/dL) from age 10 years, or ideally 50% reduction from pre-treatment levels for children 8–10 years, particularly in those with high-risk conditions or other major risk factors.^{6,11,42,43,67} In patients with chronic kidney disease, a statin that is not excreted by the kidney, such as atorvastatin or simvastatin, should be used. Clinicians should be aware of the potential for drug-drug interactions with statins, notably, for drugs metabolised by cytochrome P450 (CYP) 3A4 with simvastatin and atorvastatin, and for drugs metabolised by CYP 2C9 with rosuvastatin and fluvastatin. Pravastatin, although a weak statin, does not interfere with CYP enzymes and is therefore a safe drug for initiating treatment in children.

Addition of ezetimibe or a bile-acid sequestrant may be required to attain LDL-C goal in some patients.^{42,43,81,82} Ezetimibe is approved for use from age 10 years in the USA and Europe, and is very well tolerated with minimal side effects. The bile-acid sequestrants cause gastrointestinal side effects; colestevlam is the best tolerated of these agents and is approved in the USA from age 10 years although not in Europe.⁸³ As these agents can affect the absorption of folate and fat-soluble vitamins, appropriate supplementation and monitoring will be required with longer-term use. Niacin should rarely be used to treat paediatric FH due to poor tolerability and concerns regarding the risk of glucose intolerance, myopathy, hyperuricaemia and hepatitis. For all treatments, drug dosing regimens should follow those evaluated in clinical trials and approved by local regulatory agencies, except in severe FH or when FH is complicated by additional cardiovascular risk factors, in which expert clinical judgment is

needed to weigh the risks vs. benefits of more aggressive treatment (Table 4).

Dietary supplementation with functional foods

Several controlled clinical trials have shown that foods containing added plant sterols/stanols (1.5–3 g/day) reduce LDL-C levels by 9–19% in children and adolescents with FH (aged 4–15 years).^{84,85} There was, however, no improvement in endothelial function despite significant LDL-C lowering.^{86,87} Reduction in levels of some fat-soluble vitamins and carotenoids can be compensated by ensuring adequate intake of fruit and vegetables.⁸⁴ Currently, the use of foods enriched with plant sterols/stanols is not recommended for children under 6 years.⁸⁴

Table 5 Monitoring treatment in FH children and adolescents

- Hepatic aminotransferases, creatine kinase (CK) and creatinine levels should be measured before starting treatment.
- After starting treatment, lipid levels, weight, growth, physical and sexual development, and hepatic aminotransferases should be monitored.
- Hepatic aminotransferases should be monitored at least every 3 months if there is a history of liver disease, or more frequently if levels rise to 3-fold greater than the upper limit of normal; bilirubin may be used to gauge liver toxicity.
- Plasma CK levels should be measured if musculoskeletal symptoms are reported.
- Fasting plasma glucose and/or random glycated haemoglobin should be measured every 6 months in children on higher doses of statins who are obese or have impaired glucose tolerance.

A wide range of other nutrients and supplements, including psyllium-enriched cereal, garlic extract, omega-3 fatty acids, rapeseed oil and soy protein, have been assessed in small studies in FH patients and in children with hypercholesterolaemia.^{88–96} No firm recommendation regarding the use of any of these agents in children and adolescents can be made at this time.

Monitoring therapy and adherence

Life-long treatment critically involves collaboration between families and physicians. Recommendations for monitoring the safety and tolerability of lipid-modulating agents in paediatric FH are similar to those in adults (Table 5).^{5,6,61} Particular vigilance is required in patients receiving higher statin doses, or in those predisposed to statin side effects due to participation in vigorous contact sports or the use of other medication, such as fibrates (notably gemfibrozil). Adolescent girls should be counselled to suspend statin therapy when contemplating pregnancy (see below).

At recommended statin doses, the dose–response curve is not linear. Most of the reduction in LDL-C occurs at lower doses, with each subsequent doubling in dose yielding incremental reductions of 6–7% in LDL-C.⁹⁷ Therefore, the need to intensify treatment with higher doses should be balanced against any long-term side effects due to greater exposure to medication. While more data concerning myopathy and the risk of diabetes in children treated with statins over many years is needed, recent long-term follow-up showed an excellent safety profile (Table 6).⁹⁸ Even more importantly, at the age of 30 years, CHD-free survival was 100% in FH children initiated early on statin vs. 93% in their affected parents ($P = 0.02$) (Figure 5).⁹⁹

Adherence and response to statin therapy should be checked in FH patients who fail to achieve target LDL-C levels despite polypharmacotherapy. Non-adherent patients can be optimally managed in a

Table 6 Safety indices of familial hypercholesterolaemia subjects, initiated on pravastatin in childhood (aged 8–18 years) and treated for 10 years, compared with their unaffected siblings

	FH (n = 194)	Siblings (n = 83)	P-value
Effect on liver function; no. (%) of patients			
↑ in AST >3 × ULN	1 (0.5)	1 (1.1)	0.26
↑ in ALT >3 × ULN	1 (0.5)	0	0.51
↑ in CK >10 × ULN	0	2 (2.1)	0.03
Effect on renal function			
eGFR (mL/min/1.73 m ²), median (IQR)	127 (121–131)	125 (119–130)	0.05
Diabetes, n (%)	1 (0.5)	1 (1.2)	0.55
C-reactive protein (mg/dL), median (IQR)	0.9 (0.3–2.3)	1.2 (0.3–3.0)	0.27
Age at menarche (year), mean (95% CI)	13.1 (12.2–13.4)	13.4 (12.8–14.1)	0.27
Level of education, n (%)			
Lower	31 (17.1)	13 (16.0)	0.96
Middle	71 (39.2)	33 (40.7)	
Higher	79 (43.6)	35 (43.2)	

Adapted from Kusters et al.⁹⁸

ALT, alanine aminotransferase; AST, aspartate aminotransferase; CI, confidence interval; CK, creatine kinase; eGFR, estimated glomerular filtration rate; IQR, interquartile range; ULN, upper limit of normal range.

dedicated, multidisciplinary clinic with possible support from psychologists.¹⁰⁰ Action plan interventions may be more effective in FH than interventions aimed at altering perceptions about statin therapy. Health literacy must be also considered. Although rare in childhood, patients who are intolerant of pharmacotherapy, notably statins, require special support and follow-up.^{41,100}

Carotid IMT imaging and coronary artery calcium assessment have been used in research settings to evaluate early subclinical atherosclerosis and response to statins in FH.^{33,34,98,101,102} Long-term statin treatment initiated during childhood in patients with FH was associated with normalization of cIMT progression during aging (Figure 3B and C).⁹⁸ In a recent trial, children with HeFH aged from 6 years treated with rosuvastatin showed slowing of cIMT progression after 2 years, whereas in previous reports, untreated FH children had shown marked progression over this time.^{18,103} There are, however, limitations to the use of these surrogate markers in risk stratification of FH patients,^{5,40} and in monitoring treatment in an individual,¹⁰⁴ as well as uncertainties relating to the potential benefit of repeat measurement, independent of LDL-C lowering, on clinical outcomes. Consequently, the use of IMT for monitoring patients is not recommended until evidence of its clinical utility is established. Nonetheless, the use of vascular imaging, including IMT, can be highly informative for research purposes. Coronary artery calcium measurement is not recommended because it may be absent when significant atherosclerosis is present, does not usually develop until adulthood, and importantly, repeated CT scans carry an increased lifetime risk of exposure to radiation.

Paediatric patients with uncomplicated and well-controlled phenotypic FH may be managed by experienced primary care practitioners.^{5,6,105} However, patients with severely elevated LDL-C levels, multiple cardiovascular risk factors or complications of pharmacologic therapy, or those with HoFH, should be managed with specialist care involving both a (paediatric) cardiologist and lipidologist.⁶ Family and transitional care clinics are recommended.⁴¹ All patients should be offered an annual structured clinical review.^{6,53}

Contraception and pregnancy-related issues

The risks for the patient and foetus should be discussed at least annually with all women and girls of childbearing age. Low oestrogen oral agents, intra-uterine devices and barrier methods are the preferred contraceptive measures in adult women with FH.¹⁰⁶ Oral contraceptives, especially those with high oestrogen content, may increase triglyceride and LDL-C concentrations in FH, so monitoring of the lipid profile after initiation of these agents is required. More research is needed on the long-term implications of oral contraceptive use in FH.

Counselling is recommended for all women considering pregnancy,^{6,106–108} especially when both prospective parents have FH, because of the 25% risk of having a child with HoFH. Statins should be discontinued 3 months before planned conception and during pregnancy and lactation;¹⁰⁶ however, women who become pregnant accidentally while taking a statin should be reassured that the likelihood of foetal complications is small.^{109,110} In most patients, statin therapy can be interrupted safely during pregnancy and lactation, especially when treatment is started early in life. Bile-acid resins are the only safe agents for management of hypercholesterolaemia during

pregnancy and breast-feeding, although efficacy is modest and poor gastrointestinal tolerability is a major problem;¹⁰⁷ colesevelam is the most tolerable. In women with HoFH, LDL apheresis can be safely and successfully continued during pregnancy.^{106,107}

Given increases in maternal cholesterol levels during pregnancy,¹¹¹ maternal FH has been associated with atherosclerosis in the uteroplacental spiral arteries, as well as hypercoagulation, local thrombosis, placental infarctions, and placental insufficiency. Available evidence, however, indicates that women with FH are not at increased risk for pre-term delivery, and infants are not at increased risk of congenital malformations or intra-uterine growth retardation.¹¹² While neonates born to mothers with FH have altered haemostatic profiles regardless of FH status,¹¹³ and infants born to hypercholesterolaemic mothers have increased numbers of fatty streaks in their aortas,¹¹⁴ the long-term consequences of these manifestations are uncertain. More data on the outcomes of pregnancy in women with FH and the effect of statins on fertility and the foetus in the first trimester are required.^{115,116}

Homozygous familial hypercholesterolaemia

Homozygous familial hypercholesterolaemia has been the subject of a recent European Atherosclerosis Society Consensus Paper.¹¹ Low-density lipoprotein cholesterol levels in children with HoFH are typically >13 mmol/L (500 mg/dL), although affected individuals with lower levels have been identified with wider and increased use of genetic testing.² Homozygous familial hypercholesterolaemia should be strongly suspected if the parents have cholesterol levels compatible with heterozygous status; if parental cholesterol levels are normal, a recessive form of FH due to mutations affecting the *LDLRAP1* should be considered and sitosterolaemia excluded.¹¹⁷ Xanthomas can appear within the first few months of life and usually before 10 years of age, and are often the reason why these children come to medical attention; however, their absence or late appearance does not exclude the diagnosis of HoFH.¹¹⁸

Children with suspected HoFH should be referred promptly to specialized centres due to the aggressive nature of this condition. Earlier cardiovascular symptoms and signs are typically related to aortic stenosis and regurgitation due to massive accumulation of cholesterol in the valvular and supra-valvular regions of the aortic valve,¹¹⁸ as well as to coronary ostial stenosis, which contrasts with the distal coronary artery involvement seen in HeFH.¹¹ Angina pectoris, myocardial infarction and death in early childhood have been reported,^{49,119–121} although the first major cardiovascular events usually occur during adolescence, depending on the severity of the mutation(s).¹¹⁸ If HoFH is suspected, an extensive cardiovascular evaluation is imperative, with coronary CT angiography recommended to evaluate the aorta and coronary arteries and magnetic resonance imaging to evaluate the aorta. Invasive coronary angiography is indicated on a patient-by-patient basis depending on clinical status and outcome of non-invasive cardiac investigations. Follow-up investigations should be conducted regularly to monitor aortic and coronary artery disease based on the age of the child and disease severity.

A very aggressive cholesterol-lowering approach should be initiated as soon as possible to prevent or delay the development

of CHD.¹¹ Treatment with a statin and ezetimibe must be started at diagnosis. If available, lipoprotein apheresis should be started as soon as technically possible; this may be as early as age 2 years in specialized centres.¹¹ In retrospective studies, both approaches have delayed cardiovascular events and increased survival.^{122,123} Despite the known risks, liver transplantation is increasingly considered as a therapeutic approach in difficult cases.¹¹ Two new agents, oral lomitapide, a microsomal triglyceride transfer protein inhibitor, and injectable mipomersen, an antisense RNA therapy, both of which target hepatic production of atherogenic apoB-containing lipoproteins, were recently approved in the USA as adjunct therapy for HoFH in patients aged ≥ 18 and ≥ 12 years, respectively; lomitapide is also approved in Europe and Canada. Although there are no data in children, it is pertinent that lomitapide has been shown to be effective in HoFH patients on apheresis.^{11,124} With both agents, fat accumulation in the liver has been observed; other adverse effects include gastrointestinal intolerance with lomitapide and injection site reactions with mipomersen. Given these concerns, the long-term use of these new agents may be limited. Of novel therapies in development, monoclonal antibody therapies to PCSK9 (alirocumab, evolocumab and most recently, bococizumab) show the most promise, lowering both LDL-C and Lp(a),¹²⁵ although patients homozygous for *LDLR*-null mutations showed a poor therapeutic response, as expected from the mechanism of action.¹²⁶ Paediatric trials of these agents are underway or planned.

Health economics of detection and treatment of familial hypercholesterolaemia

In adults, health economic modelling shows that FH treatment leads to considerable savings on healthcare. Compared with universal screening, cholesterol testing in patients in whom the causative mutation is known, together with cascade testing of immediate family and relatives using DNA information is very cost-effective, because $\sim 50\%$ of them inherit the mutation.¹²⁷ Furthermore, intensive lipid-lowering therapy to reduce the LDL-C burden in FH patients is cost-effective.^{128,129}

Studies from the Netherlands,¹³⁰ Spain,¹³¹ and the UK¹³² suggest that the cost per Life Year Gained for DNA-based cascade testing and intensive statin therapy in FH is in the region of €3000–€4000, which compares favourably with other screening strategies, e.g. mammography for breast cancer. Existing cost-effectiveness analyses of cascade screening are limited by different methodologies and assumptions, with most studies from European communities and evaluations restricted to adults.¹³³ Some experts recommend universal screening,^{61,134} particularly in the young, although cost-effectiveness has not been analysed.¹²⁷ Where DNA testing is not feasible, it remains to be seen whether screening with a lipid profile alone is cost-effective, although preliminary data from the UK and USA suggest this to be true.^{135,136}

A recent report on the health, social, and economic benefits of treating FH estimated that high-intensity statin therapy would lead to 101 fewer cardiovascular deaths per 1000 FH patients treated (between the ages of 30 and 85 years), compared with no treatment.¹³⁷ Extrapolating to the 500 million population of the EU

Table 7 Gaps in evidence

- Evaluation of the potential contributions of invasive and non-invasive cardiac imaging for assessment of clinical and incident atherosclerotic vascular disease.
- Clinical trials showing reduction in coronary events as a consequence of lowering of LDL-C, although such studies are not ethically acceptable.
- Efficacy and acceptability of new biologics in refractory FH.
- Long-term safety of current and future cholesterol-lowering treatments, including effects on future fertility.
- Cost–benefit analyses of FH identification in childhood.
- Value, cost-effectiveness, and acceptability of universal screening and reverse cascade screening strategies.
- Organization of care between community and specialist settings.

(with an estimated 1 000 000 [to 2 000 000] FH patients), roughly €4700 million could be saved from cardiovascular events avoided if all relatives of index cases were identified and treated optimally over a 55-year period, equating to €86 million per year. Clearly, more country-specific health economic evaluations, including estimates of societal benefits that focus on the young, are critical to drive policy change and government funding for early detection and management programs for FH.

Gaps in evidence

This document is entirely consistent with current international guidelines for the care of patients with FH.^{6,134,138,139} However, all of these documents recognize that gaps in evidence remain, which require further study (Table 7). Recognition of the value of Mendelian randomization studies as evidence for the benefit of lifelong low LDL-C (e.g. due to loss-of-function genetic variants in *PCSK9*) in the context of FH,¹⁴ together with observational studies comparing outcomes of FH children with FH adult relatives, and equally long-term studies of lipid lowering in FH cohorts, would address these gaps.

Conclusions

Returning to our case . . .

*When the boy was 11, he was referred for genetic testing. A pathogenic *LDLR* mutation within the promoter region was discovered, and he started on lifestyle management. Statin treatment was initiated around his 12th birthday. After nearly 20 years, he is achieving all treatment goals. He is now older than his father was at time of death, and there is no evidence of the chest pain his father first reported when he was 27 (3 years before his death), which was not thought to be angina pectoris. Because of the young age. Recently, his youngest daughter of 5 was found to carry the same gene promoter mutation, and is currently managed with a heart-healthy diet. Within 3 years, she will start statin therapy. Early identification and optimal treatment from childhood should provide decades of healthy life for the man and his daughter. Finally, 33 of the man's relatives took advantage of cascade screening. Fourteen had high LDL-C levels and were positive for the mutation; they are now appropriately treated, with two cousins receiving stents. This family scenario highlights the value of cascade screening for FH.*

It is clear that for FH patients to gain maximum benefit from existing treatments, identification in early childhood is imperative to

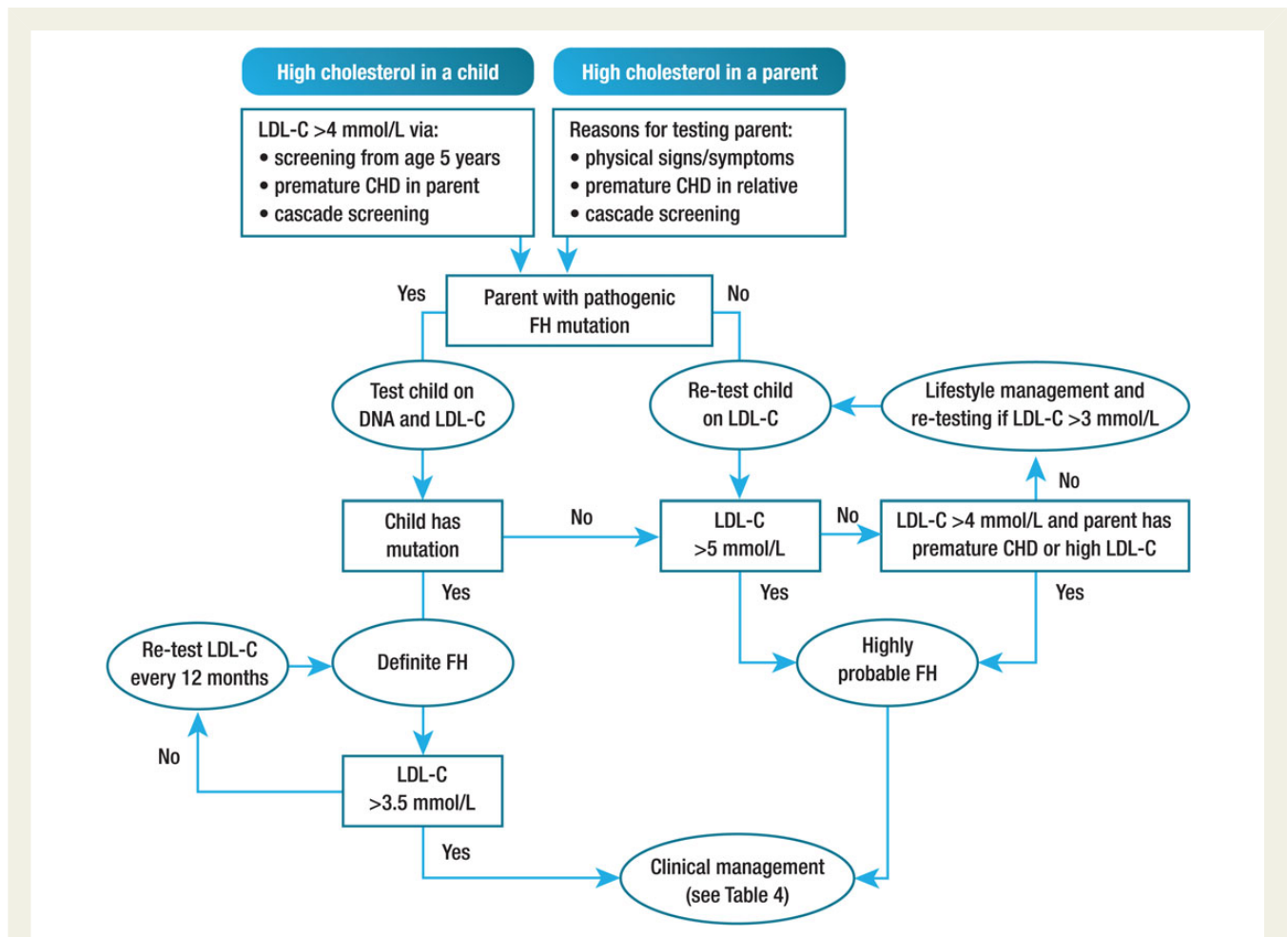


Figure 6 Potential strategy for diagnosis of familial hypercholesterolaemia in children and adolescents. CHD, coronary heart disease; FH, familial hypercholesterolaemia; LDL-C, low-density lipoprotein cholesterol. Definitions: Premature coronary heart disease is defined as a coronary event before age 55 years in men and age 60 years in women. Definite familial hypercholesterolaemia is defined as genetic confirmation of at least one familial hypercholesterolaemia-causing genetic mutation. Close relative is defined as 1st or 2nd degree. Highly probable familial hypercholesterolaemia is based on clinical presentation (i.e. phenotypic familial hypercholesterolaemia), either an elevated low-density lipoprotein cholesterol level ≥ 5 mmol/L in a child after dietary intervention or an low-density lipoprotein cholesterol level ≥ 4 mmol/L in a child with a family history of premature coronary heart disease in close relatives and/or baseline high cholesterol in one parent. Cascade screening from an index case with a familial hypercholesterolaemia-causing mutation may identify a child with elevated low-density lipoprotein cholesterol levels ≥ 3.5 mmol/L.

prevent atherosclerosis at the earliest stage of development. Screening for FH in children should be country specific, utilizing all existing screening strategies, including opportunistic screening in the setting of a positive family history, and cascade screening based on genetic testing where available (Algorithm, Figure 6). Universal screening might be considered by age 10 years in countries where this is feasible, especially where founder effects with markedly increased frequency of FH are prevalent, such as Quebec in Canada, South Africa and Lebanon. Initiation of statin treatment at a young age is safe in both the short and mid-term, and significantly improves cardiovascular outcomes. Better education of young FH patients, together with frequent follow-up, are critical for ensuring long-term adherence.

Despite evidence gaps regarding the long-term safety and cost-effectiveness of drug treatment from childhood, genetic

natural history studies confirm the benefit of lifelong low LDL-C levels.¹⁴ Indeed, recent evidence highlighting the timeliness of statin initiation in FH children on progression of surrogate cardiovascular endpoints implies that statin-mediated LDL-C reduction prevents early cardiovascular events.^{18,32,33,70,97,98} Increasing awareness of FH at both clinical and community levels, and recognition and care of FH from childhood, are key to gaining decades of healthy life in children and adolescents with this common inherited disorder.

Acknowledgements

We are indebted to Dr Jane Stock for critical editorial support. The Co-Chairs and Panel members also thank Sherborne Gibbs Limited for logistical support.

Appendix

European Atherosclerosis Society Consensus Panel

This Consensus Panel was comprised of international experts recognized for contributions through basic or clinical research to FH in children, as identified by literature searches. All experts possess expertise in the areas of diagnosis and management of FH, genetic testing and screening for FH, and/or the basic science of the pathophysiology of premature atherosclerosis in FH. The Panel includes a geographic distribution of experts representative of the membership of the European Atherosclerosis Society. Officers and members of the Executive Committee of the Society also participated.

Members

Maurizio Averna, Catherine Boileau, Jan Borén, Eric Bruckert, Alberico L. Catapano, M. John Chapman, Marina Cuchel, Joep C. Defesche, Olivier S. Descamps, Samuel S. Gidding, Henry N. Ginsberg, Robert A. Hegele, G. Kees Hovingh, Steve E. Humphries, Petri T. Kovanen, Jan Albert Kuivenhoven, Luis Masana, Børge G. Nordestgaard, Leiv Ose, Päivi Pajukanta, Klaus G. Parhofer, Frederick J. Raal, Kausik K Ray, Raul D. Santos, Anton F. H. Stalenhoef, Elisabeth Steinhagen-Thiessen, Erik S. Stroes, Marja-Riitta Taskinen, Anne Tybjærg-Hansen, Gerald F. Watts, Albert Wiegman, and Olov Wiklund.

Writing committee

Albert Wiegman, Samuel S. Gidding, Gerald F. Watts, M. John Chapman, Henry N. Ginsberg, Marina Cuchel, and Leiv Ose.

Co-chairs

M. John Chapman, Henry N. Ginsberg and Albert Wiegman.

Search strategy and consensus process

In line with Consensus Panel policy for other papers published by European Atherosclerosis Society Consensus Panels, this manuscript used existing evidence evaluations to make recommendations supported by observational data. We searched Medline, Current Contents, PubMed, the Cochrane Database, and relevant references with the terms FH, inherited hypercholesterolaemia, LDL-C, LDL receptor, apolipoprotein B, children, premature atherosclerosis, event-free survival, diagnosis, treatment, statin, ezetimibe, and PCSK9 inhibitor. Articles published in English between 2000 and 2015 were included.

This review was based on discussions at two meetings of the European Atherosclerosis Society Consensus Panel in London and Lyon organized and chaired by AW, MJC, and HNG, where the search results and drafts of this review were critically appraised; the review results primarily from a consensus of expert opinions.

AW, SSG, GFW, MJC, HNG, MC, and LO each drafted sections and/or outline for the first version, and AW, SSG, and GFW were responsible for revision of the draft. As per the agreed policy,

recommendations were not codified for level of evidence nor strength of recommendation, as this Consensus paper was intended principally to raise awareness of FH among clinicians and to provide clinical guidance in diagnosis and management, rather than as a specific guideline. The following terminology was adopted:

Should be: based on systematic review/meta-analysis or trials in young FH patients.

May be: based on clinical or observational data in young FH patients.

Not considered on the basis of available evidence.

All Panel members agreed to conception and design, contributed to interpretation of available data, all suggested revisions for this document and all members approved the final document before submission.

Funding

This review was supported by unrestricted educational grants to the EAS from Amgen, Aegerion, AstraZeneca, Genzyme, Hoffman-La Roche, Kowa Europe, Novartis, and Sanofi-Aventis/Regeneron. These companies were not present at the Consensus Panel meetings, had no role in the design or content of the Consensus Statement, and had no right to approve or disapprove the final document. Funding to pay the Open Access publication charges for this article was provided by the European Atherosclerosis Society.

Conflict of interest: Consensus Panel members have received lecture honoraria, consultancy fees and/or research funding from Abbott (K.K.R., G.F.W., K.G.P.), Aegerion (M.C., R.D.S., M.A., A.L.C., E.B., R.A.H., G.K.H., K.K.R., B.G.N.), Amgen (M.J.C., H.N.G., F.J.R., L.M., K.G.P., E.B., R.D.S., R.A.H., B.G.N., A.L.C., G.K.H., K.K.R., E.S.S., P.T.K., M.-R.T., E.S.-T.), Astra Zeneca (B.G.N., H.N.G., J.B., G.F.W., O.S.D., R.D.S., K.K.R., K.G.P., O.W., E.B., P.T.K., A.L.C., F.J.R., E.S.S.), Biolab (R.D.S.), Boehringer Ingelheim (H.N.G., M.-R.T., K.G.P., K.K.R., R.D.S.), Bristol Myers Squibb (H.N.G., K.K.R., R.D.S., K.G.P.), Chiesi (E.B.), CSL (M.J.C.), Daiichi (K.K.R.), Danone (M.J.C., L.M., E.B.), Fresenius (B.G.N., K.G.P.), Genfit (E.B.), Kraft (E.B.), Genzyme (H.N.G., R.D.S., M.A., K.G.P., E.B., A.L.C., G.K.H.), GlaxoSmith Kline (S.S.G.), Hoffman-La Roche (K.K.R., K.G.P.), ISIS Pharmaceuticals (B.G.N., R.D.S.); Kaneka (K.G.P.), Kowa (H.N.G., M.J.C., L.M., M.-R.T., K.K.R., K.G.P.), Kraft (E.B.), Lilly (M.-R.T., K.G.P., A.L.C., K.K.R., R.D.S.), Mediolanum (A.L.C.), Merck/Schering Plough (B.G.N., M.J.C., H.N.G., J.B., G.F.W., O.S.D., A.L.C., M.-R.T., L.M., R.D.S., M.A., G.K.H., K.K.R., K.G.P., O.W., E.B., E.S.S., R.A.H., F.J.R., E.S.-T.), Nestle (R.D.S.); Novartis (H.N.G., M.-R.T., L.M., K.K.R., K.G.P.), Novo-Nordisk (R.D.S., K.K.R., J.B.), Omthera (A.L.C., B.G.N.), Pfizer (B.G.N., M.J.C., H.N.G., J.B., G.F.W., O.S.D., R.D.S., G.K.H., K.K.R., O.W., R.A.H., E.S.S., M.-R.T., E.S.-T.), Raisio (P.T.K.), Recordati (A.L.C.), Rottapharm (A.L.C.), Sanofi-Aventis/Regeneron (B.G.N., M.J.C., H.N.G., J.B., G.F.W., O.S.D., M.-R.T., F.J.R., L.M., M.A., C.B., K.K.R., K.G.P., O.W., E.B., R.D.S., R.A.H., E.S.S., M.C., M.-R.T., L.O., J.C.D., E.S.-T.), Sigma-Tau (A.L.C.), Solvay (O.S.D.), Synageva (G.K.H.), Tribute (R.A.H.), Unilever (E.B., M.J.C., P.T.K., R.D.S.), Valeant (R.A.H.), and VRN (J.C.D.). S.E.H., J.A.K., P.P., A.F.H.S., A.T.-H., and A.W. have no disclosures.

References

1. Brown MS, Goldstein JL. A receptor-mediated pathway for cholesterol homeostasis. *Science* 1986;**232**:34–47.
2. Sjouke B, Kusters DM, Kindt I, Besseling J, Defesche JC, Sijbrands EJ, Roeters van Lennep JE, Stalenhoef AF, Wiegman A, de Graaf J, Fouchier SW, Kastelein JJ, Hovingh G. Homozygous autosomal dominant hypercholesterolaemia in the Netherlands: prevalence, genotype-phenotype relationship, and clinical outcome. *Eur Heart J* 2015;**36**:560–565.
3. Brown MS, Kovanen PT, Goldstein JL, Eeckels R, Vandenbergh K, van den Berghe H, Fryns JP, Cassiman JJ. Prenatal diagnosis of homozygous familial

- hypercholesterolaemia. Expression of a genetic receptor disease in utero. *Lancet* 1978;**1**:526–529.
4. Buja LM, Kovanen PT, Bilheimer DW. Cellular pathology of homozygous familial hypercholesterolemia. *Am J Pathol* 1979;**97**:327–357.
 5. Nordestgaard BG, Chapman MJ, Humphries SE, Ginsberg HN, Masana L, Descamps OS, Wiklund O, Hegele RA, Raal FJ, Defesche JC, Wiegman A, Santos RD, Watts GF, Parhofer KG, Kees Hovingh G, Kovanen PT, Boileau C, Averna M, Borén J, Bruckert E, Catapano AL, Kuivenhoven JA, Pajukanta P, Ray K, Stalenhoef AF, Stroes E, Taskinen MR, Tybjaerg-Hansen A, for the European Atherosclerosis Society Consensus Panel. Familial hypercholesterolaemia is underdiagnosed and undertreated in the general population: guidance for clinicians to prevent coronary heart disease: Consensus Statement of the European Atherosclerosis Society. *Eur Heart J* 2013;**34**:3478–3490a.
 6. Watts GF, Gidding S, Wierzbicki AS, Toth PP, Alonso R, Brown WV, Bruckert E, Defesche J, Lin KK, Livingston M, Mata P, Parhofer KG, Raal FJ, Santos RD, Sijbrands EJ, Simpson WG, Sullivan DR, Susekov AV, Tomlinson B, Wiegman A, Yamashita S, Kastelein JJ. Integrated guidance on the care of familial hypercholesterolaemia from the International FH Foundation. *Int J Cardiol* 2014;**171**:309–325.
 7. Do R, Stitzel NO, Won HH, Jørgensen AB, Duga S, Angelica Merlini P, Kiezun A, Farrall M, Goel A, Zuk O, Guella I, Asselta R, Lange LA, Peloso GM, Auer PL, NHLBI Exome Sequencing Project, Girelli D, Martinelli N, Farlow DN, DePristo MA, Roberts R, Stewart AF, Saleheen D, Danesh J, Epstein SE, Sivapalaratnam S, Hovingh GK, Kastelein JJ, Samani NJ, Schunkert H, Erdmann J, Shah SH, Kraus WE, Davies R, Nikpay M, Johansen CT, Wang J, Hegele RA, Hechter E, Marz W, Kleber ME, Huang J, Johnson AD, Li M, Burke GL, Gross M, Liu Y, Assimes TL, Heiss G, Lange EM, Folsom AR, Taylor HA, Olivieri O, Hamsten A, Clarke R, Reilly DF, Yin W, Rivas MA, Donnelly P, Rossouw JE, Psaty BM, Herrington DM, Wilson JG, Rich SS, Bamshad MJ, Tracy RP, Cupples LA, Rader DJ, Reilly MP, Spertus JA, Cresci S, Hartiala J, Tang WH, Hazen SL, Allayee H, Reiner AP, Carlson CS, Kooperberg C, Jackson RD, Boerwinkle E, Lander ES, Schwartz SM, Siscovick DS, McPherson R, Tybjaerg-Hansen A, Abecasis GR, Watkins H, Nickerson DA, Ardisino D, Sunyaev SR, O'Donnell CJ, Altshuler D, Gabriel S, Kathiresan S. Exome sequencing identifies rare LDLR and APOA5 alleles conferring risk for myocardial infarction. *Nature* 2015;**518**:102–106.
 8. Central Intelligence Agency. *The World Factbook 2014*. <https://www.cia.gov/library/publications/the-world-factbook/fields/2054.html> (3 February 2015).
 9. Stone NJ, Levy RI, Fredrickson DS, Verter J. Coronary artery disease in 116 kindred with familial type II hyperlipoproteinemia. *Circulation* 1974;**49**:476–488.
 10. Daniels SR, Gidding SS, de Ferranti SD, National Lipid Association Expert Panel on Familial Hypercholesterolemia. Pediatric aspects of familial hypercholesterolemias: recommendations from the National Lipid Association Expert Panel on Familial Hypercholesterolemia. *J Clin Lipidol* 2011;**5**(3 Suppl.):S30–S37.
 11. Cuchel M, Bruckert E, Ginsberg HN, Raal FJ, Santos RD, Hegele RA, Kuivenhoven JA, Nordestgaard BG, Descamps OS, Steinagen-Thiessen E, Tybjaerg-Hansen A, Watts GF, Averna M, Boileau C, Borén J, Catapano AL, Defesche JC, Hovingh GK, Humphries SE, Kovanen PT, Masana L, Pajukanta P, Parhofer KG, Ray KK, Stalenhoef AF, Stroes E, Taskinen MR, Wiegman A, Wiklund O, Chapman MJ, European Atherosclerosis Society Consensus Panel on Familial Hypercholesterolaemia. Homozygous familial hypercholesterolaemia: new insights and guidance for clinicians to improve detection and clinical management. A position paper from the Consensus Panel on Familial Hypercholesterolaemia of the European Atherosclerosis Society. *Eur Heart J* 2014;**35**:2146–2157.
 12. Dixon DB, Kornblum AP, Steffen LM, Zhou X, Steinberger J. Implementation of lipid screening guidelines in children by primary pediatric providers. *J Pediatr* 2014;**164**:572–576.
 13. Navar-Boggan AM, Peterson ED, D'Agostino RB, Neely B, Sniderman AD, Pencina MJ. Hyperlipidemia in early adulthood increases long-term risk of coronary heart disease. *Circulation* 2015;**131**:451–458.
 14. Ference BA, Yoo W, Alesh I, Mahajan N, Mirowska KK, Mewada A, Kahn J, Afonso L, Williams KA Sr, Flack JM. Effect of long-term exposure to lower low-density lipoprotein cholesterol beginning early in life on the risk of coronary heart disease: a Mendelian randomization analysis. *J Am Coll Cardiol* 2012;**60**:2631–2639.
 15. Avis HJ, Vissers MN, Stein EA, Wijburg FA, Trip MD, Kastelein JJ, Hutten BA. A systematic review and meta-analysis of statin therapy in children with familial hypercholesterolemia. *Arterioscler Thromb Vasc Biol* 2007;**27**:1803–1810.
 16. Sorensen KE, Celermajer DS, Georgakopoulos D, Hatcher G, Betteridge DJ, Deanfield JE. Impairment of endothelium-dependent dilation is an early event in children with familial hypercholesterolemia and is related to the lipoprotein(a) level. *J Clin Invest* 1994;**93**:50–55.
 17. de Jongh S, Lilien MR, op't Roodt J, Stroes ES, Bakker HD, Kastelein JJ. Early statin therapy restores endothelial function in children with familial hypercholesterolemia. *J Am Coll Cardiol* 2002;**40**:2117–2121.
 18. Wiegman A, Hutten BA, de Groot E, Rodenburg J, Bakker HD, Büller HR, Sijbrands EJ, Kastelein JJ. Efficacy and safety of statin therapy in children with familial hypercholesterolemia: a randomized controlled trial. *JAMA* 2004;**292**:331–337.
 19. Steinberg D. The rationale for initiating treatment of hypercholesterolemia in young adulthood. *Curr Atheroscler Rep* 2013;**15**:296.
 20. Usifo E, Leigh SE, Whittall RA, Lench N, Taylor A, Yeats C, Oregano CA, Martin AC, Celli J, Humphries SE. Low-density lipoprotein receptor gene familial hypercholesterolemia variant database: update and pathological assessment. *Ann Hum Genet* 2012;**76**:387–401.
 21. Humphries SE, Norbury G, Leigh S, Hadfield SG, Nair D. What is the clinical utility of DNA testing in patients with familial hypercholesterolaemia? *Curr Opin Lipidol* 2008;**19**:362–368.
 22. Motazacker MM, Pirruccello J, Huijgen R, Do R, Gabriel S, Peter J, Kuivenhoven JA, Defesche JC, Kastelein JJ, Hovingh GK, Zelcer N, Kathiresan S, Fouchier SW. Advances in genetics show the need for extending screening strategies for autosomal dominant hypercholesterolaemia. *Eur Heart J* 2012;**33**:1360–1366.
 23. Awan Z, Choi HY, Stitzel N, Ruel I, Bamimore MA, Husa R, Gagnon MH, Wang RH, Peloso GM, Hegele RA, Seidah NG, Kathiresan S, Genest J. APOE p.Leu167del mutation in familial hypercholesterolemia. *Atherosclerosis* 2013;**231**:218–222.
 24. van der Graaf A, Avis HJ, Kusters DM, Vissers MN, Hutten BA, Defesche JC, Huijgen R, Fouchier SW, Wijburg FA, Kastelein JJ, Wiegman A. Molecular basis of autosomal dominant hypercholesterolemia: assessment in a large cohort of hypercholesterolemic children. *Circulation* 2011;**123**:1167–1173.
 25. van Wijk DF, Sjouke B, Figueroa A, Emami H, van der Valk FM, MacNabb MH, Hemphill LC, Schulte DM, Koopman MG, Lobatto ME, Verberne HJ, Fayad ZA, Kastelein JJ, Mulder WJ, Hovingh GK, Tawakol A, Stroes ES. Nonpharmacological lipoprotein apheresis reduces arterial inflammation in familial hypercholesterolemia. *J Am Coll Cardiol* 2014;**64**:1418–1426.
 26. Stocker R, Kearney JF Jr. Role of oxidative modifications in atherosclerosis. *Physiol Rev* 2004;**84**:1381–1478.
 27. Widhalm K, Genser D. Increased lipoprotein(a) levels in children with familial hypercholesterolaemia. *Lancet* 1988;**2**:1262.
 28. Bellanger N, Orsoni A, Julia Z, Fournier N, Frisdal E, Duchene E, Bruckert E, Carrie A, Bonnefont-Rousselot D, Pirault J, Saint-Charles F, Chapman MJ, Lesnik P, Le Goff W, Guerin M. Atheroprotective reverse cholesterol transport pathway is defective in familial hypercholesterolemia. *Arterioscler Thromb Vasc Biol* 2011;**31**:1675–1681.
 29. Berenson GS, Srinivasan SR, Bao W, Newman WP 3rd, Tracy RE, Wattigney WA. Association between multiple cardiovascular risk factors and atherosclerosis in children and young adults. The Bogalusa Heart Study. *N Engl J Med* 1998;**338**:1650–1656.
 30. McMahan CA, Gidding SS, Fayad ZA, Zieske AW, Malcom GT, Tracy RE, Strong JP, McGill HC Jr. Risk scores predict atherosclerotic lesions in young people. *Arch Intern Med* 2005;**165**:883–890.
 31. Narverud I, Retterstøl K, Iversen PO, Halvorsen B, Ueland T, Ulven SM, Ose L, Aukrust P, Veierød MB, Holven KB. Markers of atherosclerotic development in children with familial hypercholesterolemia: a literature review. *Atherosclerosis* 2014;**235**:299–309.
 32. Masoura C, Pitsavos C, Aznaouridis K, Skoumas I, Vlachopoulos C, Stefanadis C. Arterial endothelial function and wall thickness in familial hypercholesterolemia and familial combined hyperlipidemia and the effect of statins. A systematic review and meta-analysis. *Atherosclerosis* 2011;**214**:129–138.
 33. Kusters DM, Wiegman A, Kastelein JJ, Hutten BA. Carotid intima-media thickness in children with familial hypercholesterolemia. *Circ Res* 2014;**114**:307–310.
 34. Junyent M, Gilabert R, Zambón D, Pocovi M, Mallén M, Cofán M, Núñez I, Civeira F, Tejedor D, Ros E. Femoral atherosclerosis in heterozygous familial hypercholesterolemia: influence of the genetic defect. *Arterioscler Thromb Vasc Biol* 2008;**28**:580–586.
 35. Gidding SS, Bookstein LC, Chomka EV. Usefulness of electron beam tomography in adolescents and young adults with heterozygous familial hypercholesterolemia. *Circulation* 1998;**98**:2580–2583.
 36. Hoeg JM, Feuerstein IM, Tucker EE. Detection and quantitation of calcific atherosclerosis by ultrafast computed tomography in children and young adults with homozygous familial hypercholesterolemia. *Arterioscler Thromb* 1994;**14**:1066–1074.
 37. Awan Z, Alrasadi K, Francis GA, Hegele RA, McPherson R, Frohlich J, Valenti D, de Varennes B, Marcil M, Gagne C, Genest J, Couture P. Vascular calcifications in homozygote familial hypercholesterolemia. *Arterioscler Thromb Vasc Biol* 2008;**28**:777–785.
 38. McGill HC Jr, McMahan CA, Gidding SS. Preventing heart disease in the 21st century: implications of the Pathobiological Determinants of Atherosclerosis in Youth (PDAY) study. *Circulation* 2008;**117**:1216–1227.
 39. Descamps OS, Gilbeau JP, Leysen X, Van Leuven F, Heller FR. Impact of genetic defects on atherosclerosis in patients suspected of familial hypercholesterolaemia. *Eur J Clin Invest* 2001;**31**:958–965.

40. Wiegman A, Rodenburg J, de Jongh S, Defesche JC, Bakker HD, Kastelein JJ, Sijbrands EJ. Family history and cardiovascular risk in familial hypercholesterolemia: data in more than 1000 children. *Circulation* 2003;**107**:1473–1478.
41. Watts GF, Sullivan DR, Poplawski N, van Bockxmeer F, Hamilton-Craig I, Clifton PM, O'Brien R, Bishop W, George P, Barter PJ, Bates T, Burnett JR, Coakley J, Davidson P, Emery J, Martin A, Farid W, Freeman L, Geelhoed E, Juniper A, Kidd A, Kostner K, Krass I, Livingston M, Maxwell S, O'Leary P, Owaimrin A, Redgrave TG, Reid N, Southwell L, Suthers G, Tonkin A, Towler S, Trent R, Familial Hypercholesterolaemia Australasia Network Consensus Group (Australian Atherosclerosis Society). Familial hypercholesterolemia: a model of care for Australasia. *Atherosclerosis Suppl* 2011;**12**:221–263.
42. Descamps OS, Tenoutasse S, Stephenne X, Gies I, Beauloye V, Lebrethon MC, De Beaufort C, De Waele K, Scheen A, Rietzschel E, Mangano A, Panier JP, Ducobu J, Langlois M, Balligand JL, Legat P, Blaton V, Muls E, Van Gaal L, Sokal E, Rooman R, Carpentier Y, De Backer G, Heller FR. Management of familial hypercholesterolemia in children and young adults: consensus paper developed by a panel of lipidologists, cardiologists, paediatricians, nutritionists, gastroenterologists, general practitioners and a patient organization. *Atherosclerosis* 2011;**218**:272–280.
43. Martin AC, Coakley J, Forbes DA, Sullivan DR, Watts GF. Familial hypercholesterolemia in children and adolescents: a new paediatric model of care. *J Paediatr Child Health* 2013;**49**:E263–E272.
44. Wald DS, Bestwick JP, Wald NJ. Child-parent screening for familial hypercholesterolemia: screening strategy based on a meta-analysis. *BMJ* 2007;**335**:599.
45. Starr B, Hadfield SG, Hutten BA, Lansberg PJ, Leren TP, Damgaard D, Neil HA, Humphries SE. Development of sensitive and specific age- and gender-specific low-density lipoprotein cholesterol cutoffs for diagnosis of first-degree relatives with familial hypercholesterolemia in cascade testing. *Clin Chem Lab Med* 2008;**46**:791–803.
46. Talmud PJ, Shah S, Whittall R, Futema M, Howard P, Cooper JA, Harrison SC, Li K, Drenos F, Karpe F, Neil HA, Descamps OS, Langenberg C, Lench N, Kivimaki M, Whittaker J, Hingorani AD, Kumari M, Humphries SE. Use of low-density lipoprotein cholesterol gene score to distinguish patients with polygenic and monogenic familial hypercholesterolemia: a case-control study. *Lancet* 2013;**381**:1293–1301.
47. Huijgen R, Sjouke B, Vis K, de Randamie JS, Defesche JC, Kastelein JJ, Hovingh GK, Fouchier SW. Genetic variation in APOB, PCSK9, and ANGPTL3 in carriers of pathogenic autosomal dominant hypercholesterolemic mutations with unexpected low LDL-C levels. *Hum Mutat* 2012;**33**:448–455.
48. Futema M, Plagnol V, Whittall RA, Neil HA, Simon Broome Register Group, Humphries SE. Use of targeted exome sequencing as a diagnostic tool for familial hypercholesterolemia. *J Med Genet* 2012;**49**:644–649.
49. Macchiaioli M, Gagliardi MG, Toscano A, Guccione P, Bartuli A. Homozygous familial hypercholesterolemia. *Lancet* 2012;**379**:1330.
50. Hansel B, Carrié A, Brun-Druc N, Leclert G, Chantepie S, Coiffard AS, Kahn JF, Chapman MJ, Bruckert E. Premature atherosclerosis is not systematic in phytosterolemic patients: severe hypercholesterolemia as a confounding factor in five subjects. *Atherosclerosis* 2014;**234**:162–168.
51. Human Genetics Society of Australasia. Position statement: pre-symptomatic and predictive testing in children and young people. 2008. <http://www.hgsa.org.au/2009/12/pre-symptomatic-and-predictive-testing-in-children-and-young-people> (4 February 2015)
52. European Society of Human Genetics. Genetic testing in asymptomatic minors: recommendations of the European Society of Human Genetics. *Eur J Hum Genet* 2009;**17**:720–721.
53. National Institute for Health and Clinical Excellence and The National Collaborating Centre for Primary Care, NICE Clinical Guideline 71. Identification and management of familial hypercholesterolemia. <http://www.nice.org.uk/guidance/CG071> (4 February 2015).
54. Wilson JMG, Jungner G. *Principles and Practice of Screening for Disease*. Geneva: WHO; 1968.
55. Kwiterovich PO, Gidding SS. Universal screening of cholesterol in children. *Clin Cardiol* 2012;**35**:662–664.
56. Huijgen R, Kindt I, Fouchier SW, Defesche JC, Hutten BA, Kastelein JJ, Vissers MN. Functionality of sequence variants in the genes coding for the low-density lipoprotein receptor and apolipoprotein B in individuals with inherited hypercholesterolemia. *Hum Mutat* 2010;**31**:752–760.
57. STOEHL. 2013. <http://leefh.nl/upload/stoeh-jaarverslag-2013/> (6 November 2011).
58. Leren TP, Finborud TH, Manshaus TE, Ose L, Berge KE. Diagnosis of familial hypercholesterolemia in general practice using clinical diagnostic criteria or genetic testing as part of cascade genetic screening. *Community Genet* 2008;**11**:26–35.
59. Datta BN, McDowell IF, Rees A. Integrating provision of specialist lipid services with cascade testing for familial hypercholesterolemia. *Curr Opin Lipidol* 2010;**21**:366–371.
60. Kusters DM, de Beaufort C, Widhalm K, Guardamagna O, Bratina N, Ose L, Wiegman A. Paediatric screening for hypercholesterolemia in Europe. *Arch Dis Child* 2012;**97**:272–276.
61. National Health, Lung, and Blood Institute. *Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents*. <http://www.nhlbi.nih.gov/health-pro/guidelines/current/cardiovascular-health-pediatric-guidelines/index.htm> (29 October 2014).
62. Ritchie SK, Murphy EC, Ice C, Cottrell LA, Minor V, Elliott E, Neal W. Universal versus targeted blood cholesterol screening among youth: the cardiac project. *Pediatrics* 2010;**126**:260–265.
63. U.S. Preventive Services Task Force. *Screening for Lipid Disorders in Children. U.S. Preventive Services Task Force recommendation statement*. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); July 2007.
64. Besseling J, Kindt I, Hof M, Kastelein JJ, Hutten BA, Hovingh GK. Severe heterozygous familial hypercholesterolemia and risk for cardiovascular disease: a study of a cohort of 14,000 mutation carriers. *Atherosclerosis* 2014;**233**:219–223.
65. Alonso R, Mata N, Castillo S, Fuentes F, Saenz P, Muñoz O, Galiana J, Figueras R, Diaz JL, Gomez-Enterria P, Mauri M, Piedecausa M, Irigoyen L, Aguado R, Mata P, Spanish Familial Hypercholesterolemia Group. Cardiovascular disease in familial hypercholesterolemia: influence of low-density lipoprotein receptor mutation type and classic risk factors. *Atherosclerosis* 2008;**200**:315–321.
66. Nordestgaard BG, Chapman MJ, Ray K, Borén J, Andreotti F, Watts GF, Ginsberg H, Amarencu P, Catapano A, Descamps OS, Fisher E, Kovanen PT, Kuivenhovi JA, Lesnik P, Masana L, Reiner Z, Taskiran MR, Tokgözoğlu L, Tybjaerg-Hansen A, European Atherosclerosis Society Consensus Panel. Lipoprotein(a) as a cardiovascular risk factor: current status. *Eur Heart J* 2010;**31**:2844–2853.
67. Kavey R-EW, Allada V, Daniels SR, Hayman LL, McCrindle BW, Newburger JW, Parekh RS, Steinberger J, Endorsed by the American Academy of Pediatrics. Cardiovascular risk reduction in high-risk pediatric patients: A Scientific Statement from the American Heart Association Expert Panel on Population and Prevention Science; the Councils on Cardiovascular Disease in the Young, Epidemiology and Prevention, Nutrition, Physical Activity and Metabolism, High Blood Pressure Research, Cardiovascular Nursing, and the Kidney in Heart disease; and the interdisciplinary working group on quality of care and outcomes research. *Circulation* 2006;**114**:2710–2738.
68. Robinson JG, Goldberg AC, National Lipid Association Expert Panel on Familial Hypercholesterolemia. Treatment of adults with familial hypercholesterolemia and evidence for treatment: recommendations from the National Lipid Association Expert Panel on Familial Hypercholesterolemia. *J Clin Lipidol* 2011;**5**(3 Suppl.): S18–S29.
69. Watts GF, Juniper A, van Bockxmeer F, Ademi Z, Liew D, O'Leary P. Familial hypercholesterolemia: a review with emphasis on evidence for treatment, new models of care and health economic evaluations. *Int J Evidence-Based Healthcare* 2012;**10**:211–221.
70. Vuorio A, Doherty KF, Humphries SE, Kuoppala J, Kovanen PT. Statin treatment of children with familial hypercholesterolemia - trying to balance incomplete evidence of long-term safety and clinical accountability: are we approaching a consensus? *Atherosclerosis* 2013;**226**:315–320.
71. Robinson JG, Gidding S. Curing atherosclerosis should be the next major cardiovascular prevention goal. *J Am Coll Cardiol* 2014;**63**:2779–2785.
72. Sever PS, Chang CL, Gupta AK, Whitehouse A, Poulter NR, ASCOT Investigators. The Anglo-Scandinavian Cardiac Outcomes Trial: 11-year mortality follow-up of the lipid-lowering arm in the U.K. *Eur Heart J* 2011;**32**:2525–2532.
73. Ford I, Murray H, Packard CJ, Shepherd J, Macfarlane PW, Cobbe SM, West of Scotland Coronary Prevention Study Group. Long-term follow-up of the West of Scotland Coronary Prevention Study. *N Engl J Med* 2007;**357**:1477–1486.
74. Müller H, Kirkhus B, Pedersen JL. Serum cholesterol predictive equations with special emphasis on trans and saturated fatty acids. An analysis from designed controlled studies. *Lipids* 2001;**36**:783–791.
75. Brouwer IA, Wanders AJ, Katan MB. Trans fatty acids and cardiovascular health: research completed? *Eur J Clin Nutr* 2013;**67**:541–547.
76. 2015 Dietary Guidelines Advisory Committee. Scientific Report of the 2015 Dietary Guidelines Advisory Committee. 2015. <http://www.health.gov/dietaryguidelines/2015-scientific-report/> (31 March 2015).
77. Simell O, Niinikoski H, Rönnemaa T, Raitakari OT, Lagström H, Laurinen M, Aromaa M, Hakala P, Jula A, Jokinen E, Välimäki I, Viikari J, STRIP Study Group. Cohort Profile: The STRIP Study (Special Turku Coronary Risk Factor Intervention Project), an infancy-onset dietary and life-style intervention trial. *Int J Epidemiol* 2009;**38**:650–655.
78. Gidding SS, Lichtenstein AH, Faith MS, Karpyn A, Mennella JA, Popkin B, Rowe J, Van Horn L, Whitsel L. Implementing American Heart Association Pediatric and Adult Nutrition Guidelines: A Scientific Statement From the American Heart Association Nutrition Committee of the Council on Nutrition, Physical Activity and Metabolism, Council on Cardiovascular Disease in the Young, Council on Arteriosclerosis, Thrombosis and Vascular Biology, Council on Cardiovascular Nursing, Council on

- Epidemiology and Prevention, and Council for High Blood Pressure Research. *Circulation* 2009;**119**:1161–1175.
79. Reiner Z. Impact of early evidence of atherosclerotic changes on early treatment in children with familial hypercholesterolemia. *Circ Res* 2014;**114**:233–235.
 80. Vuorio A, Kuoppala J, Kovanen PT, Humphries SE, Tonstad S, Wiegman A, Drogari E. Statins for children with familial hypercholesterolemia. *Cochrane Database Syst Rev* 2014;**7**:CD006401.
 81. McCrindle BW. Familial hypercholesterolemia in children and adolescents. *Curr Opin Lipidol* 2012;**23**:525–531.
 82. van der Graaf A, Cuffie-Jackson C, Vissers MN, Trip MD, Gagné C, Shi G, Veltri E, Avis HJ, Kastelein JJ. Efficacy and safety of coadministration of ezetimibe and simvastatin in adolescents with heterozygous familial hypercholesterolemia. *J Am Coll Cardiol* 2008;**52**:1421–1429.
 83. Stein EA, Marais AD, Szamosi T, Raal FJ, Schurr D, Urbina EM, Hopkins PN, Karki S, Xu J, Misir S, Melino M. Colesevelam hydrochloride: efficacy and safety in pediatric subjects with heterozygous familial hypercholesterolemia. *J Pediatr* 2010;**156**:231–236.
 84. Gylling H, Plat J, Turley S, Ginsberg HN, Ellegård L, Jessup W, Jones PJ, Lütjohann D, Maerz W, Masana L, Silbernagel G, Staels B, Borén J, Catapano AL, De Backer G, Deanfield J, Descamps OS, Kovanen PT, Riccardi G, Tokgözoğlu L, Chapman MJ, European Atherosclerosis Society Consensus Panel on Phytosterols. Plant sterols and plant stanols in the management of dyslipidaemia and prevention of cardiovascular disease. *Atherosclerosis* 2014;**232**:346–360.
 85. Amundsen AL, Ose L, Nenseter MS, Ntanos FY. Plant sterol ester-enriched spread lowers plasma total and LDL cholesterol in children with familial hypercholesterolemia. *Am J Clin Nutr* 2002;**76**:338–344.
 86. de Jongh S, Vissers MN, RoIP, Bakker HD, Kastelein JJ, Stroes ES. Plant sterols lower LDL cholesterol without improving endothelial function in prepubertal children with familial hypercholesterolemia. *J Inherit Metab Dis* 2003;**26**:343–351.
 87. Jakulj L, Vissers MN, Rodenburg J, Wiegman A, Trip MD, Kastelein JJ. Plant stanols do not restore endothelial function in prepubertal children with familial hypercholesterolemia despite reduction of low-density lipoprotein cholesterol levels. *J Pediatr* 2006;**148**:495–500.
 88. Davidson MH, Dugan LD, Burns JH, Sugimoto D, Story K, Drennan K. A psyllium-enriched cereal for the treatment of hypercholesterolemia in children: a controlled, double-blind, crossover study. *Am J Clin Nutr* 1996;**63**:96–102.
 89. McCrindle BW, Helden E, Conner WT. Garlic extract therapy in children with hypercholesterolemia. *Arch Pediatr Adolesc Med* 1998;**152**:1089–1094.
 90. Engler MM, Engler MB, Arterburn LM, Bailey E, Chiu EY, Malloy MJ, Mietus-Snyder ML. Docosahexaenoic acid supplementation alters plasma phospholipid fatty acid composition in hyperlipidemic children: results from the Endothelial Assessment of Risk from Lipids in Youth (EARLY) study. *Nutr Res* 2004;**24**:721–729.
 91. Engler MM, Engler MB, Malloy MJ, Paul SM, Kulkarni KR, Mietus-Snyder ML. Effect of docosahexaenoic acid on lipoprotein subclasses in hyperlipidemic children (the EARLY study). *Am J Cardiol* 2005;**95**:869–871.
 92. Gulesserian T, Widhalm K. Effect of a rapeseed oil substituting diet on serum lipids and lipoproteins in children and adolescents with familial hypercholesterolemia. *J Am Coll Nutr* 2002;**21**:103–108.
 93. Widhalm K, Brazda G, Schneider B, Kohl S. Effect of soy protein diet versus standard low fat, low cholesterol diet on lipid and lipoprotein levels in children with familial or polygenic hypercholesterolemia. *J Pediatr* 1993;**123**:30–34.
 94. Zhan S, Ho SC. Meta-analysis of the effects of soy protein containing isoflavones on the lipid profile. *Am J Clin Nutrition* 2005;**81**:397–408.
 95. Weghuber D, Widhalm K. Effect of 3-month treatment of children and adolescents with familial and polygenic hypercholesterolemia with a soyasubstituted diet. *Br J Nutr* 2008;**99**:281–286.
 96. Gidding SS, Prospero C, Hossain J, Zappalla F, Balagopal PB, Falkner B, Kwiterovich P. A double-blind randomized trial of fish oil to lower triglycerides and improve cardiometabolic risk in adolescents. *J Pediatr* 2014;**165**:497–503.
 97. Reiner Z, Catapano AL, De Backer G, Graham I, Taskinen MR, Wiklund O, Agewall S, Alegria E, Chapman MJ, Durrington P, Erdine S, Halcox J, Hobbs R, Kjekshus J, Filardi PP, Riccardi G, Storey RF, Wood D. ESC/EAS Guidelines for the management of dyslipidaemias: the Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and the European Atherosclerosis Society (EAS). *Eur Heart J* 2011;**32**:1769–1818.
 98. Kusters DM, Avis HJ, de Groot E, Wijburg FA, Kastelein JJ, Wiegman A, Hutten BA. Ten-year follow-up after initiation of statin therapy in children with familial hypercholesterolemia. *JAMA* 2014;**312**:1055–1057.
 99. Braamskamp MJ, Kusters DM, Avis HJ, Wijburg FA, Kastelein JJ, Wiegman A, Hutten BA. Patients with Familial Hypercholesterolemia who initiated statin treatment in childhood are at lower risk for CHD than their affected parents. *Circulation* 2013;**128**:A17837 [abstract].
 100. Bates TR, Connaughton VM, Watts GF. Non-adherence to statin therapy: a major challenge for preventive cardiology. *Expert Opin Pharmacother* 2009;**10**:2973–2985.
 101. Rodenburg J, Vissers MN, Wiegman A, van Trotsenburg AS, van der Graaf A, de Groot E, Wijburg FA, Kastelein JJ, Hutten BA. Statin treatment in children with familial hypercholesterolemia: the younger, the better. *Circulation* 2007;**116**:664–668.
 102. Juonala M, Magnussen CG, Venn A, Dwyer T, Burns TL, Davis PH, Chen W, Srinivasan SR, Daniels SR, Kahonen M, Laitinen T, Taittonen L, Berenson GS, Viikari JSA, Raitakari OT. Influence of age on associations between childhood risk factors and carotid intima-media thickness in adulthood: the Cardiovascular Risk in Young Finns Study, the Childhood Determinants of Adult Health Study, the Bogalusa Heart Study, and the Muscatine Study for the International Childhood Cardiovascular Cohort (I3C) Consortium. *Circulation* 2010;**122**:2514–2520.
 103. Braamskamp MJAM, Langslet G, McCrindle BW, Cassiman D, Francis GA, Gagne C, Gaudet D, Morrison KM, Wiegman A, Turner T, Miller E, Raichlen JS, Martin PG, Stein EA, Kastelein JJP. Effect of rosuvastatin therapy on carotid intima media thickness in children with familial hypercholesterolemia; findings from the CHARON study. *Atherosclerosis* 2014;**235**:e18–e19.
 104. Urbina EM, Williams RV, Alpert BS, Collins RT, Daniels SR, Hayman L, Jacobson M, Mahoney L, Mietus-Snyder M, Rocchini A, Steinberger J, McCrindle B, on behalf of the American Heart Association Atherosclerosis, and Obesity in Youth Committee of the Council on Cardiovascular Disease in the Young. Noninvasive assessment of subclinical atherosclerosis in children and adolescents: recommendations for standard assessment for clinical research: A Scientific Statement from the American Heart Association. *Hypertension* 2009;**54**:919–950.
 105. Vickery AW, Bell D, Garton-Smith J, Kirke AB, Pang J, Watts GF. Optimising the detection and management of familial hypercholesterolaemia: central role of primary care and its integration with specialist services. *Heart Lung Circ* 2014;**23**:1158–1164.
 106. Thorogood M, Seed M, De Mott K. Guideline Development Group. Management of fertility in women with familial hypercholesterolaemia: summary of NICE guidance. *Br J Obstet Gynaecol* 2009;**116**:478–479.
 107. Ito MK, McGowan MP, Moriarty PM. Management of familial hypercholesterolemias in adult patients: recommendations from the National Lipid Association Expert Panel on Familial Hypercholesterolemia. *J Clin Lipidol* 2011;**5**(3 Suppl):S38–S45.
 108. van der Graaf A, Hutten BA, Kastelein JJ, Vissers MN. Premature cardiovascular disease in young women with heterozygous familial hypercholesterolemia. *Expert Rev Cardiovasc Ther* 2006;**4**:345–351.
 109. Avis HJ, Hutten BA, Twickler MT, Kastelein JJ, van der Post JA, Stalenhoef AF, Vissers MN. Pregnancy in women suffering from familial hypercholesterolemia: a harmful period for both mother and newborn? *Curr Opin Lipidol* 2009;**20**:484–490.
 110. Kusters DM, Homsma SJM, Hutten BA, Twickler MTB, Avis HJ, van der Post JA, Stroes ESG. Dilemmas in treatment of women with familial hypercholesterolaemia during pregnancy. *Neth J Med* 2010;**68**:299–303.
 111. Amundsen AL, Khoury J, Iversen PO, Bergei C, Ose L, Tonstad S, Retterstøl K. Marked changes in plasma lipids and lipoproteins during pregnancy in women with familial hypercholesterolemia. *Atherosclerosis* 2006;**189**:451–457.
 112. Toleike I, Retterstøl K, Leren TP, Iversen PO. Pregnancy outcomes in familial hypercholesterolemia: a registry-based study. *Circulation* 2011;**124**:1606–1614.
 113. Narverud I, Iversen PO, Auksrust P, Halvorsen B, Ueland T, Johansen SG, Nenseter MS, Sandset PM, Ulven SM, Ose L, Retterstøl K, Holven KB. Maternal familial hypercholesterolaemia (FH) confers altered haemostatic profile in offspring with and without FH. *Thromb Res* 2013;**131**:178–182.
 114. Napoli C, D'Armiento FP, Mancini FP, Postiglione A, Witztum JL, Palumbo G, Palinski W. Fatty streak formation occurs in human fetal aortas and is greatly enhanced by maternal hypercholesterolemia. Intimal accumulation of low density lipoprotein and its oxidation precede monocyte recruitment into early atherosclerotic lesions. *J Clin Invest* 1997;**100**:2680–2690.
 115. O'Brien EC, Roe MT, Fraulo ES, Peterson ED, Ballantyne CM, Genest J, Gidding SS, Hammond E, Hemphill LC, Hudgins LC, Kindt I, Moriarty PM, Ross J, Underberg JA, Watson K, Pickhardt D, Rader DJ, Wilemon K, Knowles JW. Rationale and design of the familial hypercholesterolemia foundation CAscade SScreening for Awareness and DEtection of Familial Hypercholesterolemia registry. *Am Heart J* 2014;**167**:342–349.
 116. Hammond E, Watts GF, Rubinstein Y, Farid W, Livingston M, Knowles JW, Lochmüller H, Bellgard M, Dawkins HJ. Role of international registries in enhancing the care of familial hypercholesterolaemia. *Int J Evid Based Health* 2013;**11**:134–139.
 117. Rader DJ, Cohen J, Hobbs HH. Monogenic hypercholesterolemia: new insights in pathogenesis and treatment. *J Clin Invest* 2003;**111**:1795–1803.
 118. Kolansky DM, Cuchel M, Clark BJ, Paridon S, McCrindle BW, Wiegers SE, Araujo L, Vohra Y, Defesche JC, Wilson JM, Rader DJ. Longitudinal evaluation and assessment of cardiovascular disease in patients with homozygous familial hypercholesterolemia. *Am J Cardiol* 2008;**102**:1438–1443.
 119. Widhalm K, Binder CB, Kreissl A, Aldover-Macasaet E, Fritsch M, Kroisboeck S, Geiger H. Sudden death in a 4-year-old boy: a near-complete occlusion of the coronary artery caused by an aggressive low-density lipoprotein receptor mutation (W556R) in homozygous familial hypercholesterolemia. *J Pediatr* 2011;**158**:167.

120. Dumić M, Uroić AS, Francetić I, Purić Z, Matisić D, Kes P, Mikecin M, Reiner Ž. Three-year-old boy - a homozygote for familial hypercholesterolemia. *Lijec Vjesn* 2007;**129**:130–133.
121. Gautschi M, Pavlovic M, Nuoffer JM. Fatal myocardial infarction at 4.5 years in a case of homozygous familial hypercholesterolemia. *JIMD Rep* 2012;**2**:45–50.
122. Raal FJ, Pilcher GJ, Panz VR, van Deventer HE, Brice BC, Blom DJ, Marais AD. Reduction in mortality in subjects with homozygous familial hypercholesterolemia associated with advances in lipid-lowering therapy. *Circulation* 2011;**124**:2202–2207.
123. Thompson GR. The evidence-base for the efficacy of lipoprotein apheresis in combating cardiovascular disease. *Atheroscler Suppl* 2013;**14**:67–70.
124. Stefanutti C, Blom DJ, Aversa MR, Meagher EA, dT Theron H, Marais AD, Hegele RA, Sirtori CR, Shah PK, Gaudet D, Vigna GB, Sachais BS, Di Giacomo S, du Plessis AME, Bloedon LT, Balsler J, Rader DJ, Cuchel M for the Phase 3 HoFH Lomitapide Study Investigators. The lipid-lowering effects of lomitapide are unaffected by adjunctive apheresis in patients with homozygous familial hypercholesterolemia - a post-hoc analysis of a Phase 3, single-arm, open-label trial. *Atherosclerosis* 2015;**240**:408–414.
125. Stein EA, Raal F. Reduction of low-density lipoprotein cholesterol by monoclonal antibody inhibition of PCSK9. *Annu Rev Med* 2014;**65**:417–431.
126. Raal FJ, Honarpour N, Blom DJ, Hovingh GK, Xu F, Scott R, Wasserman SM, Stein EA, for the TESLA Investigators. Inhibition of PCSK9 with evolcumab in homozygous familial hypercholesterolemia (TESLA Part B): a randomised, double-blind, placebo-controlled trial. *Lancet* 2015;**385**:341–350.
127. Marks D, Wonderling D, Thorogood M, Lambert H, Humphries SE, Neil HA. Cost effectiveness analysis of different approaches of screening for familial hypercholesterolemia. *BMJ* 2002;**324**:1303.
128. Nherera L, Calvert NW, Demott K, Humphries SE, Neil HA, Minhas R, Thorogood M. Cost-effectiveness analysis of the use of a high-intensity statin compared to a low-intensity statin in the management of patients with familial hypercholesterolemia. *Curr Med Res Opin* 2010;**26**:529–536.
129. Alonso R, Fernández de Bobadilla J, Méndez I, Lázaro P, Mata N, Mata P. Cost-effectiveness of managing familial hypercholesterolemia using atorvastatin-based preventive therapy. *Rev Esp Cardio* 2008;**61**:382–393.
130. Wonderling D, Umans-Eckenhausen MA, Marks D, Defesche JC, Kastelein JJ, Thorogood M. Cost-effectiveness analysis of the genetic screening program for familial hypercholesterolemia in The Netherlands. *Semin Vasc Med* 2004;**4**:97–104.
131. Oliva J, López-Bastida J, Moreno SG, Mata P, Alonso R. Cost-effectiveness analysis of a genetic screening program in the close relatives of Spanish patients with familial hypercholesterolemia. *Rev Esp Cardiol* 2009;**62**:57–65.
132. Nherera L, Marks D, Minhas R, Thorogood M, Humphries SE. Probabilistic cost effectiveness analysis of cascade screening for familial hypercholesterolemia using alternative diagnostic and identification strategies. *Heart* 2011;**97**:1175–1181.
133. Ademi Z, Watts GF, Pang J, Sijbrands EJ, van Bockxmeer FM, O'Leary P, Geelhoed E, Liew D. Cascade screening based on genetic testing is cost-effective: evidence for the implementation of models of care for familial hypercholesterolemia. *J Clin Lipidol* 2014;**8**:390–400.
134. Goldberg AC, Hopkins PN, Toth PP, Ballantyne CM, Rader DJ, Robinson JG, Daniels SR, Gidding SS, de Ferranti SD, Ito MK, McGowan MP, Moriarty PM, Cromwell WC, Ross JL, Ziajka PE, National Lipid Association Expert Panel on Familial Hypercholesterolemia. Familial hypercholesterolemia: screening, diagnosis and management of pediatric and adult patients: clinical guidance from the National Lipid Association Expert Panel on Familial Hypercholesterolemia. *J Clin Lipidol* 2011;**5**:133–140.
135. Taylor A, Wang D, Patel K, Whittall R, Wood G, Farrer M, Neely RDG, Fairgrieve S, Nair D, Barbir M, Jones JL, Egan S, Everdale R, Lolin Y, Hughes E, Cooper JA, Hadfield SG, Norbury G, Humphries SE. Mutation detection rate and spectrum in familial hypercholesterolemia patients in the UK pilot cascade project. *Clin Genet* 2010;**77**:572–580.
136. Chen CX, Hay JW. Cost-effectiveness analysis of alternative screening and treatment strategies for heterozygous familial hypercholesterolemia in the United States. *Int J Cardiol* 2014;**181C**:417–424.
137. Nherera LM. *Saving Lives, Saving Families: The Health, Social and Economic Advantages of Detecting and Treating Familial Hypercholesterolemia (FH)*. Economics Chapter: Estimating the Benefits from Treatment and Increasing the Implementation of Cascading Screening. http://heartuk.org.uk/files/uploads/documents/HUK_HealthEconomics_FINAL2012_2702.pdf (4 February 2015).
138. Harada-Shiba M, Arai H, Oikawa S, Ohta T, Okada T, Okamura T, Nohara A, Bujo H, Yokote K, Wakatsuki A, Ishibashi S, Yamashita S. Guidelines for the management of familial hypercholesterolemia. *J Atheroscler Thromb* 2012;**19**:1043–1060.
139. Myśliwiec M, Walczak M, Małeczka-Tendera E, Dobrzańska A, Cybulska B, Filipiak K, Mazur A, Jarosz-Chobot P, Szadkowska A, Rynkiewicz A, Chybicka A, Socha P, Brandt A, Bautembach-Minkowska J, Zdrojewski T, Limon J, Gidding SS, Banach M. Management of familial hypercholesterolemia in children and adolescents. Position paper of the Polish Lipid Expert Forum. *J Clin Lipidol* 2014;**8**:173–180.
140. Streetly A, Latinovic R, Henthorn J. Positive screening and carrier results for the England-wide universal newborn sickle cell screening programme by ethnicity and area for 2005–07. *J Clin Pathol* 2010;**60**:626–629.