

UCLA

UCLA Previously Published Works

Title

Relation of Lipoprotein(a) Levels to Incident Type 2 Diabetes and Modification by Alirocumab Treatment.

Permalink

<https://escholarship.org/uc/item/5h6931kv>

Authors

Schwartz, Gregory G
Szarek, Michael
Bittner, Vera A
et al.

Publication Date

2021-03-15

Data Availability

The data associated with this publication are within the manuscript.

Peer reviewed



Relation of Lipoprotein(a) Levels to Incident Type 2 Diabetes and Modification by Alirocumab Treatment

<https://doi.org/10.2337/dc20-2842>

Gregory G. Schwartz,¹ Michael Szarek,^{1,2,3} Vera A. Bittner,⁴ Deepak L. Bhatt,⁵ Rafael Diaz,⁶ Shaun G. Goodman,^{7,8} J. Wouter Jukema,⁹ Megan Loy,¹⁰ Garen Manvelian,¹¹ Robert Pordy,¹¹ Harvey D. White,¹² and Philippe Gabriel Steg,^{13,14,15} for the ODYSSEY OUTCOMES Committees and Investigators*

OBJECTIVE

In observational data, lower levels of lipoprotein(a) have been associated with greater prevalence of type 2 diabetes. Whether pharmacologic lowering of lipoprotein(a) influences incident type 2 diabetes is unknown. We determined the relationship of lipoprotein(a) concentration with incident type 2 diabetes and effects of treatment with alirocumab, a PCSK9 inhibitor.

RESEARCH DESIGN AND METHODS

In the ODYSSEY OUTCOMES trial alirocumab was compared with placebo in patients with acute coronary syndrome. Incident diabetes was determined from laboratory, medication, and adverse event data.

RESULTS

Among 13,480 patients without diabetes at baseline, 1,324 developed type 2 diabetes over a median 2.7 years. Median baseline lipoprotein(a) was 21.9 mg/dL. With placebo, 10 mg/dL lower baseline lipoprotein(a) was associated with hazard ratio 1.04 (95% CI 1.02–1.06, $P < 0.001$) for incident type 2 diabetes. Alirocumab reduced lipoprotein(a) by a median 23.2% with greater absolute reductions from higher baseline levels and no overall effect on incident type 2 diabetes (hazard ratio 0.95, 95% CI 0.85–1.05). At low baseline lipoprotein(a) levels, alirocumab tended to reduce incident type 2 diabetes, while at high baseline lipoprotein(a) alirocumab tended to increase incident type 2 diabetes compared with placebo (treatment–baseline lipoprotein(a) interaction $P = 0.006$). In the alirocumab group, a 10 mg/dL decrease in lipoprotein(a) from baseline was associated with hazard ratio 1.07 (95% CI 1.03–1.12; $P = 0.0002$) for incident type 2 diabetes.

CONCLUSIONS

In patients with acute coronary syndrome, baseline lipoprotein(a) concentration associated inversely with incident type 2 diabetes. Alirocumab had neutral overall effect on incident type 2 diabetes. However, treatment-related reductions in lipoprotein(a), more pronounced from high baseline levels, were associated with increased risk of incident type 2 diabetes. Whether these findings pertain to other therapies that reduce lipoprotein(a) is undetermined.

¹Division of Cardiology, University of Colorado School of Medicine, Aurora, CO

²CPC Clinical Research, Aurora, CO

³Downstate School of Public Health, State University of New York, Brooklyn, NY

⁴University of Alabama at Birmingham, Birmingham, AL

⁵Brigham and Women's Hospital and Harvard Medical School, Boston, MA

⁶Estudios Cardiológicos Latinoamérica, Instituto Cardiovascular de Rosario, Rosario, Argentina

⁷Canadian VIGOUR Centre, University of Alberta, Edmonton, Alberta, Canada

⁸St. Michael's Hospital, University of Toronto, Toronto, Ontario, Canada

⁹Leiden University Medical Center, Leiden, the Netherlands

¹⁰Sanofi, Bridgewater, NJ

¹¹Regeneron Pharmaceuticals, Tarrytown, NY

¹²Green Lane Cardiovascular Services, Auckland City Hospital, Auckland, New Zealand

¹³Hôpital Bichat, Université de Paris, Assistance Publique – Hôpitaux de Paris, Paris, France

¹⁴INSERM 1148, Paris, France

¹⁵Royal Brompton Hospital, Imperial College London, London, U.K.

Corresponding author: Gregory G. Schwartz, gregory.schwartz@cuanschutz.edu

Received 20 November 2020 and accepted 8 February 2021

Clinical trial reg. no. NCT01663402, clinicaltrials.gov

This article contains supplementary material online at <https://doi.org/10.2337/figshare.13805825>.

*The ODYSSEY OUTCOMES Committee members, investigators, and contributors are listed in the supplementary materials online.

© 2021 by the American Diabetes Association. Readers may use this article as long as the work is properly cited, the use is educational and not for profit, and the work is not altered. More information is available at <https://www.diabetesjournals.org/content/license>.

Lipoprotein(a) is an LDL particle whose concentration is primarily under genetic control and is believed to have atherogenic, proinflammatory, and prothrombotic properties (1). Epidemiologic and genetic studies show an association of elevated lipoprotein(a) concentration with the risk of coronary, peripheral artery, and cerebrovascular disease events (2–4).

For many years, no pharmacologic therapy was identified that both lowered lipoprotein(a) concentration and reduced the risk of major adverse cardiovascular events (MACE). This changed with the advent of inhibitors of proprotein convertase subtilisin/kexin type 9 (PCSK9). These agents reduce the concentration of LDL cholesterol (LDL-C) substantially (by 50–60%), reduce the concentration of lipoprotein(a) modestly (by 20–25%), and reduce MACE (5,6). In large placebo-controlled trials that evaluated PCSK9 inhibitors, the risk of MACE among patients assigned to placebo was associated with lipoprotein(a) concentration (7–10) and reduction in the risk of MACE with the PCSK9 inhibitor alirocumab was associated with the magnitude of lipoprotein(a) reduction (7,10). Pharmacologic agents under development that inhibit the synthesis of apolipoprotein(a) may reduce lipoprotein(a) concentration by >70% and are being evaluated for effects on MACE (11,12).

An unexplained observation in cohort studies and clinical trials has been an association of lower lipoprotein(a) levels with greater prevalence of type 2 diabetes (13–15). Some genetic and observational cohort studies in populations without evident cardiovascular disease have also shown an association of lower levels of lipoprotein(a) with greater incidence of diabetes (13,16–18). To date, an association between lower levels of lipoprotein(a) and incident diabetes has not been demonstrated in patients with established cardiovascular disease. Importantly, to date there has been no evidence to indicate whether the incidence of diabetes is modulated by pharmacologic therapy that lowers lipoprotein(a).

In this analysis, we determined whether the incidence of diabetes was related to lipoprotein(a) concentration in patients with recent acute coronary syndrome and whether that risk was modulated by treatment with alirocumab.

RESEARCH DESIGN AND METHODS

Patients and Treatments

This report is a post hoc analysis of the ODYSSEY OUTCOMES trial (Evaluation of Cardiovascular Outcomes After an Acute Coronary Syndrome During Treatment With Alirocumab) (clinicaltrials.gov, NCT01663402) (6,19), which compared the effects of alirocumab or placebo in 18,924 patients with recent acute coronary syndrome and persistent dyslipidemia despite intensive or maximum tolerated statin treatment. The protocol was approved by the institutional review board at each site, and all patients provided informed consent. Qualifying patients were hospitalized for acute myocardial infarction or unstable angina 1–12 months prior to randomization and had LDL-C ≥ 70 mg/dL, non-HDL cholesterol ≥ 100 mg/dL, or apolipoprotein B ≥ 80 mg/dL despite treatment with atorvastatin 40–80 mg daily, rosuvastatin 20–40 mg daily, or the highest tolerated dose of one of these statins. Lipoprotein(a) concentration was not considered in qualification. Qualifying patients were randomized in a 1:1 ratio to receive alirocumab 75 mg or matching placebo, administered subcutaneously every 2 weeks. As previously described (19), the alirocumab dose was blindly titrated between 75 and 150 mg for maximization of the number of patients who achieved an LDL-C level of 25–50 mg/dL or blindly replaced by placebo in cases of sustained LDL-C levels < 15 mg/dL. Participants and physicians were blinded to the treatment allocation. For protection of the blind, all treatment kit boxes had the same look and feel and were labeled with a double-blind label. Details on randomization procedures are described in supplementary material. The primary outcome of MACE comprised death from coronary heart disease, nonfatal myocardial infarction, ischemic stroke, or hospitalization for unstable angina.

Definition of Baseline and Incident Diabetes

Classification of patients according to presence of diabetes at baseline and criteria for incident diabetes after randomization have previously been published (20). In brief, diabetes was considered present at baseline if there was a medical history of type 1 or type 2 diabetes, treatment with an antihyperglycemic

medication, hemoglobin A_{1c} at least 6.5% (48 mmol/mol), or fasting plasma glucose at least 126 mg/dL. The primary end point in this analysis was incident diabetes in those without diabetes at baseline. Incident diabetes was adjudicated by a blinded panel of expert physicians based on adverse events indicating new type 1 or type 2 diabetes, initiation of antihyperglycemic medication, two measurements of hemoglobin A_{1c} at least 6.5% (unless only one measurement was available or only the last value was at least 6.5%), or two measurements of fasting plasma glucose at least 126 mg/dL.

Measurement of Lipoproteins

Plasma lipids, including LDL-C and lipoprotein(a), were measured at baseline and at specified time points thereafter. LDL-C was calculated by the Friedewald formula unless levels were < 15 mg/dL or the accompanying triglyceride concentration was > 400 mg/dL; in those cases, LDL-C was measured by β quantification. Lipoprotein(a) mass was measured per protocol at baseline, month 4, and month 12 with an automated immunoturbidimetric assay on a Siemens BNII nephelometric analyzer (Siemens Healthcare Diagnostics, Malvern, PA) with a lower limit of detection of 2 mg/dL and an interassay coefficient of variation of 3.1–4.8% depending on the lipoprotein(a) concentration. Heterogeneity in apolipoprotein(a) size has only a moderate effect on lipoprotein(a) recovery with this assay (21). Calculated or measured LDL-C includes the concentration of cholesterol contained in lipoprotein(a). To account for this, we calculated LDL-C corrected for lipoprotein(a) cholesterol as $LDL-C_{corrected} = LDL-C - [lipoprotein(a) \times 0.3]$ (22,23).

Statistical Analysis

Median (quartile 1–3) baseline lipoprotein(a) was compared in patients with or without diabetes at baseline and by baseline quartile among patients without diabetes at baseline. Levels below the lower limit of detection were assigned a value of 2 mg/dL.

The probability of new-onset (incident) type 2 diabetes during follow-up as a function of baseline lipoprotein(a) as a spline effect of degree 3 (piecewise cubic curve) was estimated for each treatment group by logistic regression

with a logit link function and the logarithm of follow-up time as an offset variable in the models. Additionally, the relative treatment effects on incident type 2 diabetes overall and as a function of baseline lipoprotein(a) were estimated in competing risks proportional hazards models, where death was treated as a competing terminal event. These relative relationships were also determined after adjustment for variables associated with lipoprotein(a) concentration including sex, race, geographical region, and plasma triglycerides. To determine whether assigned treatment (alirocumab or placebo) modified the relationship of baseline lipoprotein(a) with the relative risk of type 2 diabetes, P values for interaction were calculated.

Incident type 2 diabetes (cases per 100 patient-years of observation) was also determined in each treatment group according to baseline quartile of lipoprotein(a). Treatment hazard ratios (alirocumab/placebo) for incident type 2 diabetes were calculated in each baseline lipoprotein(a) quartile in competing risks models, and P_{trend} was calculated.

The change in lipoprotein(a) concentration from baseline to month 4 and month 12 of assigned treatment with alicumab was calculated. Within the alicumab group, that change was related to the subsequent risk of incident type 2 diabetes as a time-varying covariate in Cox regression models [hazard ratio per 10 mg/dL decrease in lipoprotein(a)] with death as a competing terminal event. The following models were developed: model 1, without covariates; model 2, adjusted for baseline lipoprotein(a); and model 3, additionally adjusted for demographic and clinical variables (sex, race, and geographic region; baseline statin treatment intensity, BMI, triglycerides, hemoglobin A_{1c} , and LDL-C_{corrected}); and time-varying change in LDL-C_{corrected} from baseline to month 4 and month 12).

In patients with diabetes at baseline, we determined whether changes from baseline to month 12 in hemoglobin A_{1c} and fasting serum glucose were influenced by baseline lipoprotein(a) concentration. There was no imputation for missing hemoglobin A_{1c} or glucose values.

Comparisons of independent groups were by Wilcoxon rank-sum tests for continuous variables and χ^2 tests for categorical variables. For all analyses, two-tailed P values <0.05 were considered

statistically significant, with no adjustment for multiple testing. All analyses were conducted according to intention to treat, including all patients and events from randomization to the common study end date (11 November 2017). Analyses were performed in SAS, version 9.4 (IBM, Armonk, NY).

RESULTS

Patient Characteristics and Association With Baseline Lipoprotein(a) Concentration

A total of 18,924 patients underwent randomization at 1,315 sites in 57 countries (Supplementary Table 1). Of these, 9,462 were assigned to alicumab and 9,462 to placebo. In consideration of all trial participants, quartile boundaries for baseline lipoprotein(a) were 6.7, 21.2, and 59.6 mg/dL. The prevalence of diabetes decreased across increasing baseline lipoprotein(a) quartiles (30.7%, 29.0%, 29.0%, and 26.5%; $P_{\text{trend}} = 0.0001$).

At baseline, diabetes was present in 5,444 (28.8%) patients ($n = 37$ with type 1 diabetes) and not present in 13,480 patients (71.2%). Table 1 shows the characteristics of those with diabetes at baseline and by quartile of baseline lipoprotein(a) for those without diabetes at baseline. LDL-C and LDL-C_{corrected} did not differ in patients with or without diabetes at baseline, and neither did the use of intensive statin therapy. However, baseline lipoprotein(a) concentration was lower among those with diabetes (median 19.5 mg/dL [quartile 1–3 6.2–55.0]) in comparison with those without diabetes at baseline (21.9 mg/dL [6.9–61.1]; $P < 0.0001$). Among patients without diabetes at baseline, higher baseline quartile of lipoprotein(a) was associated with characteristics including female sex, black race, enrollment in North America, absence of current smoking, higher LDL-C, lower LDL-C_{corrected}, and lower triglycerides.

Incident Type 2 Diabetes, According to Baseline Lipoprotein(a) Concentration, and Effect of Alirocumab Treatment

Median follow-up for incident diabetes was 2.7 years (quartile 1–3 2.2–3.4). Overall, 1,324 patients developed diabetes during the trial (all type 2), of whom 648 were assigned to alicumab and 676 to placebo, corresponding to a treatment hazard ratio of 0.95 (95% CI 0.85–

1.05) with death as a competing event. Supplementary Table 2 shows the criteria that were fulfilled for the diagnosis of incident type 2 diabetes in each treatment group.

Figure 1 shows incident type 2 diabetes by treatment group according to splines of continuous baseline lipoprotein(a) among those without diabetes at baseline. In the placebo group, decreasing baseline lipoprotein(a) was associated with increasing risk of incident type 2 diabetes. In proportional hazards models, each 10 mg/dL decrease in baseline lipoprotein(a) concentration was associated with a hazard ratio of 1.04 (95% CI 1.02–1.06; $P < 0.0001$) in unadjusted analysis and a hazard ratio of 1.03 (95% CI 1.01–1.05; $P = 0.0024$) in adjusted analysis. In contrast, in the alicumab group the incidence rate for type 2 diabetes was essentially constant across the range of baseline lipoprotein(a), with a hazard ratio of 1.00 (95% CI 0.98–1.02; $P = 0.96$) per 10 mg/dL decrease in baseline lipoprotein(a) in unadjusted and 1.00 (95% CI 0.98–1.01; $P = 0.56$) in adjusted analysis. Treatment assignment significantly modified the relationship between baseline lipoprotein(a) and incident type 2 diabetes with $P_{\text{interaction}} = 0.003$ in unadjusted analysis and $P_{\text{interaction}} = 0.006$ with adjustment for baseline characteristics. As shown in Fig. 1, the crossover point of the spline curves was at a baseline lipoprotein(a) level of 50 mg/dL. Thus, in patients with baseline lipoprotein(a) <50 mg/dL the estimated incidence of type 2 diabetes was lower with alicumab than placebo. In contrast, in patients with baseline lipoprotein(a) ≥ 50 mg/dL the estimated incidence of type 2 diabetes was higher with alicumab than placebo.

Similar findings were derived from analysis by baseline quartile of lipoprotein(a) (Fig. 2). In the placebo group, the incidence rate of type 2 diabetes (cases per 100 patient-years) decreased monotonically from 4.6 (95% CI 4.0–5.2) in quartile 1 to 3.6 (95% CI 3.1–4.2) in quartile 2, 3.5 (95% CI 3.0–4.1) in quartile 3, and 3.1 (95% CI 2.6–3.6) in quartile 4 ($P_{\text{trend}} = 0.0003$) (Fig. 2, left panel). In contrast, in the alicumab group there was no apparent relationship between baseline lipoprotein(a) quartile and incident type 2 diabetes, with incidences of 3.6 (95% CI 3.1–4.2), 3.3 (95% CI 2.8–3.9),

Table 1—Baseline characteristics in patients with and patients without diabetes at baseline and according to quartile of lipoprotein(a) in patients without diabetes at baseline

Characteristic	Diabetes at baseline (n = 5,444)	No diabetes at baseline					P†	P*
		All (n = 13,480)	Quartile 1 (<6.9 mg/dL) (n = 3,370)	Quartile 2 (6.9 to <21.9 mg/dL) (n = 3,370)	Quartile 3 (21.9 to <61.1 mg/dL) (n = 3,363)	Quartile 4 (≥61.1 mg/dL) (n = 3,377)		
Age, years	59 (53–66)	58 (51–65)	58 (51–65)	58 (52–65)	58 (51–65)	58 (51–64)	0.36	<0.0001
Female sex	31.9	22.4	18.0	21.2	21.9	28.6	<0.0001	<0.0001
Race								
White	71.6	82.5	86.4	83.1	79.0	81.6	<0.0001	<0.0001
Black	3.7	2.0	0.6	0.7	2.6	4.1		
Asian	19.2	10.8	8.2	11.7	13.9	9.4		
Other	5.5	4.7	4.8	4.4	4.5	4.9		
Geographic region								
Western Europe	14.9	25.0	24.3	23.8	25.9	25.9	<0.0001	<0.0001
Eastern Europe	26.0	29.8	37.1	31.5	26.8	24.0		
North America	17.8	14.1	11.2	12.3	14.1	18.8		
South America	15.0	13.1	13.3	13.4	11.5	14.3		
Asia	17.2	10.1	7.8	11.0	12.9	8.5		
Rest of world	9.1	7.9	6.4	8.0	8.7	8.5		
Current smoking	20.1	25.7	27.7	27.1	25.0	23.0	<0.0001	<0.0001
High-intensity statin	87.9	89.2	89.1	87.9	88.6	91.3	0.0006	0.03
ACE inhibitor or ARB	81.9	76.1	77.0	76.4	75.7	75.3	0.35	<0.0001
β-Blocker	85.9	84.0	84.7	83.5	83.3	84.3	0.35	0.0009
BMI, kg/m ²	29 (26–33)	28 (25–30)	28 (25–31)	28 (25–30)	27 (25–30)	27 (25–30)	<0.0001	<0.0001
Fasting blood glucose, mmol/L	7.4 (6.2–9.4)	5.4 (5.0–5.8)	5.5 (5.1–5.9)	5.4 (5.1–5.8)	5.4 (5.0–5.8)	5.4 (5.0–5.8)	<0.0001	<0.0001
Hemoglobin A _{1c} %	7.0 (6.5–8.2)	5.7 (5.4–5.9)	5.7 (5.4–5.9)	5.7 (5.5–5.9)	5.7 (5.5–5.9)	5.7 (5.4–5.9)	0.72	<0.0001
mmol/mol	53 (48–66)	39 (36–41)	39 (36–41)	39 (37–41)	39 (37–41)	39 (36–41)		
LDL-C, mg/dL	85 (71–103)	87 (74–104)	84 (70–101)	85 (72–102)	87 (74–104)	92 (79–109)	<0.0001	<0.0001
LDL-C _{corrected} , mg/dL	74 (59–93)	76 (61–94)	83 (69–100)	81 (68–98)	75 (62–92)	61 (48–78)	<0.0001	0.0006
HDL-C, mg/dL	41 (35–48)	43 (37–51)	43 (37–51)	43 (37–51)	44 (37–51)	44 (37–52)	0.21	<0.0001
Triglycerides, mg/dL	148 (106–204)	124 (90–171)	136 (96–189)	123 (90–172)	119 (88–162)	119 (88–161)	<0.0001	<0.0001
Lipoprotein(a), mg/dL	19.5 (6.2–55.0)	21.9 (6.9–61.1)	2.0 (2.0–4.9)	12.6 (9.6–16.6)	39.0 (29.5–49.6)	93.8 (74.6–121.0)	<0.0001	<0.0001
Estimated glomerular filtration rate, mL/ min per 1.73 m ²	77.6 (64.1–91.7)	78.2 (68.3–89.7)	78.5 (68.5–90.4)	78.2 (68.5–89.3)	78.5 (68.3–90.1)	77.9 (68.1– 89.7)	0.15	0.0011

Data are percentages or (for continuous variables) median (quartile 1–3). ARB, angiotensin receptor blocker; HDL-C, HDL cholesterol; LDL-C_{corrected}, LDL cholesterol corrected for cholesterol content of lipoprotein(a). *P values for comparison of characteristic between patients with diabetes at baseline and all patients without diabetes at baseline. †P values for comparison across lipoprotein(a) quartiles in patients without diabetes at baseline.

3.7 (95% CI 3.1–4.3), and 3.4 (95% CI 2.9–3.9) in quartiles 1–4, respectively ($P_{\text{trend}} = 0.70$). The treatment hazard ratio (alirocumab:placebo) for incident type 2 diabetes increased monotonically across baseline lipoprotein(a) quartiles, from 0.79 (95% CI 0.64–0.96) in quartile 1 to 1.09 (95% CI 0.87–1.38) in quartile 4 ($P_{\text{trend}} = 0.025$) (Fig. 2, right panel).

MACE in Patients Without Diabetes at Baseline According to Baseline Lipoprotein(a) Concentration

Among all trial participants, the primary MACE outcome occurred in 1,052 patients

(11.1%) treated with placebo versus 903 patients (9.5%) treated with alirocumab ($P < 0.001$). Among patients without diabetes at baseline assigned to placebo, the 3-year incidence of MACE in baseline lipoprotein(a) quartiles 1–4 was 7.7%, 9.9%, 9.8%, and 12.1%, respectively. Among patients without diabetes at baseline assigned to alirocumab, 3-year incidence of MACE in baseline lipoprotein(a) quartiles 1–4 was 7.5%, 8.2%, 7.6%, and 10.4%. Thus, the risk of MACE was lower with alirocumab than placebo in each baseline lipoprotein(a) quartile, particularly in quartiles 2–4.

Lipoprotein(a) Lowering by Alirocumab and Its Association With Incident Type 2 Diabetes

Among patients without diabetes at baseline, alirocumab reduced lipoprotein(a) from baseline to month 4 by a median of 23.2% (quartile 1–3 –45.8 to 0), with the absolute decrease from baseline increasing across baseline lipoprotein(a) quartiles (Supplementary Fig. 1A). The median decrease in lipoprotein(a) with alirocumab was nil in quartile 1, increasing to 20.2 mg/dL in quartile 4. In contrast, alirocumab produced similar reductions in LDL-C_{corrected} across baseline lipoprotein

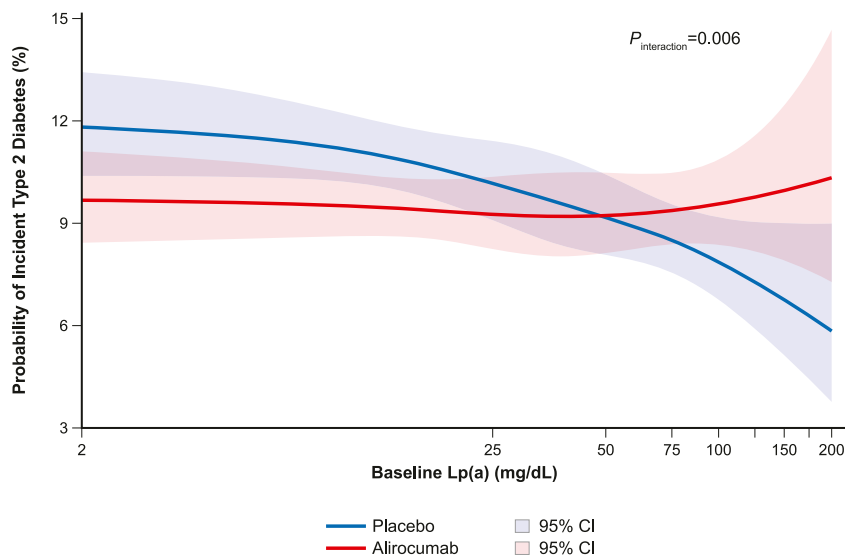


Figure 1—Spline analysis of probability of incident type 2 diabetes by baseline lipoprotein(a) [Lp(a)] and treatment group. The probability of incident type 2 diabetes during follow-up is shown as a function of baseline lipoprotein(a) for each treatment group, estimated from a logistic regression model with a logit link function, the logarithm of follow-up time as an offset variable, and adjustment for race, current smoking, and baseline BMI and triglyceride level. Spline effect is a piecewise cubic curve with degree = 3 with knots at quartiles of baseline lipoprotein(a). Spline effect $P = 0.0002$ for placebo group, $P = 0.82$ for alirocumab group. The interaction P value of treatment and baseline lipoprotein(a) on incident type 2 diabetes ($P_{interaction}$) was 0.003 unadjusted and 0.006 adjusted for the baseline characteristics indicated above.

diabetes at baseline, each 10 mg/dL decrease in lipoprotein(a) from baseline was associated with an unadjusted hazard ratio of 1.07 (95% CI 1.03–1.12; $P = 0.0002$) for subsequent incident type 2 diabetes (model 1). This association was similar after adjustment for baseline lipoprotein(a) (model 2) and after additional adjustment for baseline demographic and clinical characteristics (model 3).

Relationship Between Lipoprotein(a) and Glycemic Measures in Patients With Diabetes at Baseline

In patients with diabetes at baseline, Supplementary Table 3 shows absolute change in hemoglobin A_{1c} and fasting glucose from baseline to month 12. There were no differences according to quartile of baseline lipoprotein(a).

CONCLUSIONS

This analysis, comprising 13,480 patients in the ODYSSEY OUTCOMES trial without diabetes at baseline, provides three key insights into the relationship between lipoprotein(a) concentration and risk of type 2 diabetes. First, incident type 2 diabetes in the placebo group increased with decreasing baseline lipoprotein(a) concentration, corroborating prior observations in healthy populations (13,15,17,18), and demonstrating this for the first time in a cohort with established atherosclerotic

(a) quartiles. Similar results were observed for absolute decreases to month 12 (Supplementary Fig. 1B). Median percent change in lipoprotein(a) from baseline to month 4 in the placebo group was 0%

(quartile 1–3 –17 to 13.3), with median changes ranging from nil in quartile 1 to 5.8 mg/dL increase in quartile 4.

As summarized in Table 2, among patients in the alirocumab group without

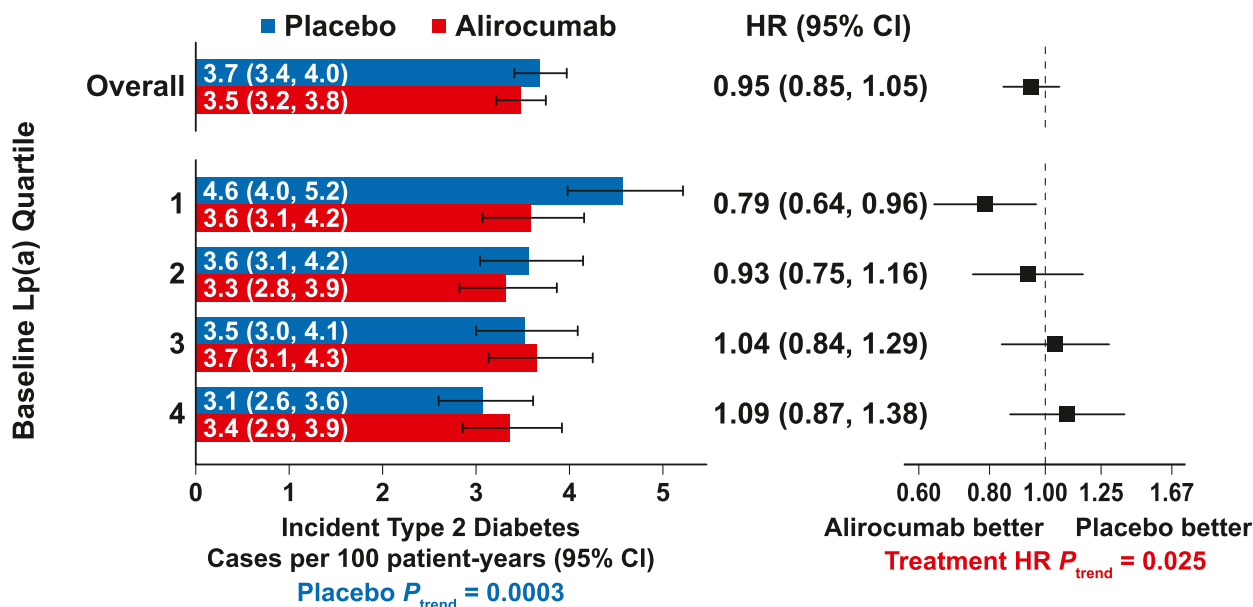


Figure 2—Incidence rate for type 2 diabetes by baseline lipoprotein(a) [Lp(a)] quartile and treatment with placebo or alirocumab. Left panel: incidence rates for type 2 diabetes by treatment group and quartile of baseline lipoprotein(a) for patients without diabetes at baseline (total $n = 13,480$). Baseline lipoprotein(a) quartile ranges are: quartile 1, <6.9 mg/dL; quartile 2, 6.9 to <21.9 mg/dL; quartile 3, 21.9 to <61.1 mg/dL; and quartile 4, ≥ 61.1 mg/dL. In the placebo group, increasing quartile of baseline lipoprotein(a) was associated with decreasing incidence rate for type 2 diabetes ($P_{trend} = 0.0003$). Right panel: Forest plot depicting treatment hazard ratio (HR) (95% CI) for incident type 2 diabetes by quartile of baseline lipoprotein(a). The point estimate for the treatment hazard ratio increased monotonically from baseline lipoprotein(a) quartile 1 to quartile 4 ($P_{trend} = 0.025$).

Table 2—Relationship of time-varying change in lipoprotein(a) with subsequent incident type 2 diabetes in the alirocumab group

Model	Model adjustments	HR (95% CI) per 10 mg/dL decrease in lipoprotein(a) from baseline	P
1	None	1.07 (1.03–1.12)	0.0002
2	Baseline lipoprotein(a)	1.10 (1.05–1.15)	<0.0001
3	Baseline lipoprotein(a), baseline LDL-C _{corrected} , time-varying change in LDL-C _{corrected} , demographic and clinical characteristics*	1.08 (1.04–1.13)	0.0001

HR, hazard ratio for incident type 2 diabetes; LDL-C_{corrected}, LDL cholesterol corrected for cholesterol content of lipoprotein(a). *Sex, race, geographic region, statin treatment intensity (none, low to moderate, or high), baseline BMI, baseline triglycerides, baseline hemoglobin A_{1c}.

cardiovascular disease receiving intensive or maximum tolerated statin treatment.

Second, the relationship between baseline lipoprotein(a) concentration and incident type 2 diabetes was modified by alirocumab treatment. At low baseline lipoprotein(a) concentrations, alirocumab had minimal effect on lipoprotein(a) levels and tended to reduce the estimated risk of incident type 2 diabetes compared with placebo. This was particularly evident in the lowest quartile of baseline lipoprotein(a) (<6.9 mg/dL). Conversely, at high baseline lipoprotein(a) levels, alirocumab produced notable reductions in lipoprotein(a) concentrations and tended to increase the estimated risk of incident type 2 diabetes compared with placebo. Treatment and baseline lipoprotein(a) had significant interaction on the risk of incident type 2 diabetes. The concentration of lipoprotein(a) at which alirocumab had a neutral effect on incident type 2 diabetes was ~50 mg/dL.

Third, within the alirocumab group, each 10 mg/dL decrease in lipoprotein(a) from baseline to month 4 was associated with a significant hazard ratio for incident type 2 diabetes after adjustment for demographic and clinical variables, baseline lipoprotein(a), and the concurrent change from baseline in LDL-C_{corrected}. This finding suggests that treatment-induced reduction in lipoprotein(a) concentration may increase the risk of incident type 2 diabetes.

Mechanisms Linking Lipoprotein(a) With Type 2 Diabetes

Potential mechanisms linking lipoprotein(a) and type 2 diabetes remain uncertain. Specifically, it is unknown whether the association is due to an effect of insulin resistance or hyperinsulinemia to suppress levels of lipoprotein(a) or whether low levels of lipoprotein(a) are causally related to the development of insulin

resistance and type 2 diabetes. In a study of 607 subjects without diabetes, those with, compared with those without, metabolic syndrome had lower lipoprotein(a) concentrations in conjunction with higher levels of insulin, C-peptide, and HOMA of insulin resistance (HOMA-IR) (24). In another study of 1,685 individuals without diabetes, lipoprotein(a) levels were also inversely associated with HOMA-IR, and lipoprotein(a) levels fell in the period immediately preceding a transition to type 2 diabetes (16). The latter finding led the authors to postulate that autoimmune phenomena might be responsible for an association of low lipoprotein(a) and incident type 2 diabetes.

In some cases, genetic data support a relationship between lipoprotein(a) levels and incident type 2 diabetes. In analyses of Chinese and Danish cohorts, increased risk of type 2 diabetes was found in individuals with genetically determined low lipoprotein(a) plasma concentration due to large lipoprotein(a) isoform size related to the number of kringle IV type 2 repeats (25–27). However, a Mendelian randomization analysis showed that genetic variants associated with fasting insulin levels bore no relation to lipoprotein(a) concentration (28), and in analyses of the European Prospective Investigation into Cancer (EPIC)-Norfolk and DIABetes Genetics Replication And Meta-analysis (DIAGRAM) cohorts (15) there was no association found of rs10455872, a single nucleotide polymorphism of the *LPA* gene affecting lipoprotein(a) plasma concentration, with incident type 2 diabetes.

Effect of PCSK9 Inhibition With Alirocumab on Incident Type 2 Diabetes

Genetic data have indicated that polymorphisms affecting the *HMGCR*, *PCSK9*,

or *NPC1L1* genes that result in lower levels of LDL-C are associated with an increased risk of diabetes (29–31) and, conversely, that elevated LDL-C due to familial hypercholesterolemia is associated with a lower risk of diabetes (32). In the current analysis, despite substantial lowering of LDL-C levels, alirocumab had an overall neutral effect on incident type 2 diabetes. The difference in these findings may reflect a shorter duration of observation in the current study. Alternatively, the contrasting findings might be related to a protective effect of higher lipoprotein(a) concentration. In healthy observational cohorts such as those contributing to the genetic analyses, the median lipoprotein(a) concentration is typically ~10 mg/dL (15–18); at baseline in the ODYSSEY OUTCOMES trial, the median lipoprotein(a) concentration was 21 mg/dL.

A neutral overall effect of alirocumab on incident type 2 diabetes could also be related to circulating PCSK9 levels, which have been positively correlated with levels of glucose, insulin, and HOMA-IR (33–35) and associated with the presence of metabolic syndrome (36). A rise in PCSK9 levels is observed in response to a short-term high-fructose diet in healthy subjects (37). Treatment with a PCSK9 antibody lowers the circulating concentration of free PCSK9 (38), but limited data do not indicate that treatment affects insulin sensitivity (39).

Relation of Lipoprotein(a) and Alirocumab Treatment to Glycemic Measures in Patients With Diabetes at Baseline

Among patients with established diabetes, we did not observe differential changes in hemoglobin A_{1c} or fasting glucose over time according to baseline lipoprotein(a) quartile. We cannot exclude the possibility that a potential

influence of lipoprotein(a) concentration on glycemic measures in these patients was mitigated by changes in patient behaviors (i.e., lifestyle modification) or physician practice (i.e., intensification of antihyperglycemic drug therapy) in response to laboratory values.

Strengths and Limitations

Strengths of this analysis include a large, multinational cohort of patients at high risk for diabetes, a high incidence rate for type 2 diabetes, and a systematic, blinded process for the adjudication of incident diabetes. Among the limitations, the effect of alirocumab on incident type 2 diabetes was observed on a background of intensive statin treatment. Whether alirocumab modulated an effect of statin treatment or exerted an independent effect on the risk of incident diabetes cannot be determined. Lipoprotein(a) was measured with a mass assay. The correlation of lipoprotein(a) mass and molar concentration is imperfect. We cannot exclude the possibility that an analysis based on lipoprotein(a) molar concentration or isoform size might have yielded different results. The current findings associate lipoprotein(a) reduction due to PCSK9 inhibition with the risk of incident type 2 diabetes; however, it is unknown whether a similar association exists when lipoprotein(a) is reduced by other mechanisms. For example, niacin lowers lipoprotein(a) and increases incident diabetes (40), but to date no patient-level analysis has investigated whether these effects are associated.

Clinical Implications

LDL is the primary atherogenic lipoprotein. PCSK9 inhibitors, when added to background statin therapy, reduce LDL-C substantially and consistently across a range of concomitant lipoprotein(a) concentrations, with a corresponding reduction in the risk of MACE and without an overall increase in the risk of incident diabetes (5,6). PCSK9 inhibitors also produce a modest relative reduction in lipoprotein(a) levels, the absolute magnitude of which becomes notable in those with high baseline levels. As elevated levels of lipoprotein(a) are associated with an increased risk of MACE, patients with higher baseline lipoprotein(a) levels also achieve larger reductions in MACE with PCSK9 inhibition (7,8,10).

The current analysis indicates that among patients assigned to placebo, those with higher lipoprotein(a) levels have a lower risk of incident type 2 diabetes. Under treatment with alirocumab, patients with higher baseline lipoprotein(a) have larger absolute decreases in its concentration that in turn are associated with greater risk of incident type 2 diabetes. It remains to be determined whether the treatment hazard ratio for incident type 2 diabetes per unit decrease in lipoprotein(a) concentration determined in this analysis will apply to innovative therapies that target the synthesis of apolipoprotein(a) and reduce lipoprotein(a) concentration substantially more than PCSK9 inhibitors (12).

In the current analysis, alirocumab tended to increase incident diabetes at baseline lipoprotein(a) concentrations >50 mg/dL. However, this is also a threshold concentration of lipoprotein(a) that has been used to define significantly elevated cardiovascular risk (41). Accordingly, the current findings should not dissuade practitioners from using PCSK9 inhibitors in patients at very high cardiovascular risk who have elevated levels of LDL-C and lipoprotein(a). In such patients, the cardiovascular benefits of treatment will most likely outweigh a possible increased risk of incident diabetes, and the decision to treat should draw upon a calculus akin to the estimation of cardiovascular benefits and diabetes risk with intensive statin treatment (42). For example, the projected effects of alirocumab treatment may be considered in two hypothetical patients with recent acute coronary syndrome: one with baseline lipoprotein(a) ≤ 6.7 mg/dL (in quartile 1) and the other with baseline lipoprotein(a) >59.6 mg/dL (in quartile 4).

For the first patient, alirocumab treatment is projected to reduce the 3-year incidence of MACE by 0.2%. Concurrently, alirocumab would have no meaningful effect on absolute lipoprotein(a) concentration and would be projected to reduce the 3-year incidence of type 2 diabetes by 2.9%. These point estimates correspond to numbers needed to treat for 3 years of 500 to prevent one MACE and 34 to prevent one case of type 2 diabetes. In the second patient, alirocumab treatment is estimated to reduce the 3-year incidence of MACE by 1.6%. Concurrently, alirocumab would reduce lipoprotein(a) by a median of 20.2 mg/dL,

associated with an increase in the 3-year incidence of type 2 diabetes of 0.9%. These point estimates correspond to a number needed to treat for 3 years of 62 to prevent one MACE and a number needed to harm of 111 to result in an additional case of type 2 diabetes. Thus, the former patient achieves a small reduction in MACE accompanied by a reduction in incident type 2 diabetes, while the latter patient achieves a larger reduction in MACE but with an increase in incident type 2 diabetes.

Conclusion

Among patients with recent acute coronary syndrome and elevated LDL-C levels despite optimized statin therapy, the prevalence and the incidence of type 2 diabetes increased with decreasing levels of baseline lipoprotein(a). Treatment with alirocumab modified the relationship between baseline lipoprotein(a) and incidence of type 2 diabetes. In patients with low baseline lipoprotein(a), alirocumab had minimal effect on lipoprotein(a) and was associated with a lower estimated incidence of type 2 diabetes compared with placebo. In contrast, in patients with high baseline lipoprotein(a), alirocumab decreased lipoprotein(a) levels in association with a higher estimated incidence of type 2 diabetes compared with placebo. An increased incidence of type 2 diabetes may be a consequence of therapeutic lipoprotein(a) reduction through PCSK9 inhibition.

Acknowledgments. The authors thank the patients, study coordinators, and investigators who participated in this trial. Sophie Rushton-Smith (MedLink Healthcare Communications) provided editorial assistance in the preparation of the manuscript (limited to editing for style, referencing, and figure and table editing) and was funded by Sanofi, Paris, France.

Funding. D.L.B. reports serving as chair for the American Heart Association Quality Oversight Committee; serving as Trustee for the American College of Cardiology; and honoraria as follows: American College of Cardiology (ACC) (Senior Associate Editor, Clinical Trials and News, ACC.org, and Vice-Chair, ACC Accreditation Committee) and *Journal of the American College of Cardiology* (Guest Editor, Associate Editor) NCDR-ACTION Registry Steering Committee (Chair), and VA CART [Veterans Administration Clinical Assessment, Reporting and Tracking System for Cath Labs] Research and Publications Committee (Chair); and board of directors for Boston VA Research Institute, Society of Cardiovascular Patient Care. J.W.J. reports research grants from the Netherlands Heart Foundation, the Interuniversity Cardiology Institute of the

Netherlands, and the European Commission Seventh Framework Programme.

Duality of Interest. The ODYSSEY OUTCOMES trial was funded by Sanofi and Regeneron Pharmaceuticals. The sponsors participated in study site selection, monitoring, and supervision of data collection. G.G.S. reports research support to the University of Colorado from AstraZeneca, Resverlogix, Roche, Sanofi, and The Medicines Company and is coinventor of pending U.S. patent 62/806,313 ("Methods for Reducing Cardiovascular Risk") assigned in full to the University of Colorado. M.S. reports serving as a consultant or on advisory boards (or both) for CiVi, Resverlogix, Baxter, Esperion, and Regeneron Pharmaceuticals. D.L.B. reports serving on advisory boards for Cardax, CellProthera, Cereno Scientific, Elsevier Practice Update Cardiology, Level Ex, Medscape Cardiology, Phase Bio, PLx Pharma, and Regado Biosciences; reports serving on the board of directors for TobeSoft; reports serving on data monitoring committees for Baim Institute for Clinical Research (formerly Harvard Clinical Research Institute, for the PORTICO trial [PORTopulmonary Hypertension Treatment with maCitentan - a randOmized Clinical Trial], funded by St. Jude Medical [now Abbott]), Cleveland Clinic (including for the ExCEED trial [CENTERA THV System in Intermediate Risk Patients Who Have Symptomatic, Severe, Calcific, Aortic Stenosis Requiring Aortic Valve Replacement], funded by Edwards), Contego Medical (Chair, for PERFORMANCE [Protection Against Emboli During Carotid Artery Stenting Using the Neuroguard IEP System] 2), Duke Clinical Research Institute, Mayo Clinic, Mount Sinai School of Medicine (for the ENVISAGE [Edoxaban Compared to Standard Care After Heart Valve Replacement] trial, funded by Daiichi Sankyo), and Population Health Research Institute; reports honoraria from Baim Institute for Clinical Research (formerly Harvard Clinical Research Institute, RE-DUAL PCI [Triple Therapy With Warfarin in Patients With Nonvalvular Atrial Fibrillation Undergoing Percutaneous Coronary Intervention] clinical trial steering committee funded by Boehringer Ingelheim, AEGIS-II [Study to Investigate CSL112 in Subjects With Acute Coronary Syndrome] executive committee funded by CSL Behring), Belvoir Publications (Editor in Chief, Harvard Heart Letter), Canadian Medical and Surgical Knowledge Translation Research Group (clinical trial steering committees), Duke Clinical Research Institute (clinical trial steering committees, including for the PRONOUNCE [Prostate Cancer and Cardiovascular Disease] trial, funded by Ferring Pharmaceuticals), HMP Global (Editor in Chief, Journal of Invasive Cardiology), K2P (Co-Chair, interdisciplinary curriculum), Level Ex, Medtelligence/ReachMD (Continuing Medical Education [CME] steering committees), MJH Life Sciences, Population Health Research Institute (for the COMPASS [Cardiovascular Outcomes for People Using Anticoagulation Strategies] operations committee, publications committee, steering committee, and U.S. national co-leader, funded by Bayer), Slack Publications (Chief Medical Editor, Cardiology Today's Intervention), Society of Cardiovascular Patient Care (Secretary/Treasurer), WebMD (CME steering committees); reports associations with Clinical Cardiology (Deputy Editor); reports research funding from Abbott,

Afimmune, Amarin, Amgen, AstraZeneca, Bayer, Boehringer Ingelheim, Bristol-Myers Squibb, Cardax, Chiesi, CSL Behring, Eisai, Ethicon, Ferring Pharmaceuticals, Forest Laboratories, Fractyl, Idorsia, Ironwood, Ischemix, Lexicon, Lilly, Medtronic, Pfizer, PhaseBio, PLx Pharma, Regeneron, Roche, Sanofi, Synaptic, and The Medicines Company; reports royalties from Elsevier (Editor, Cardiovascular Intervention: A Companion to Braunwald's Heart Disease); reports serving as site co-investigator for Biotronik, Boston Scientific, CSI, St. Jude Medical (now Abbott), and Svelte; and unfunded research from FlowCo, Merck, Novo Nordisk, and Takeda. V.A.B. reports grant support from Sanofi, AstraZeneca, DalCor, Esperion, Bayer, The Medicines Company, and Amgen, all paid direct to her institution, and personal fees from Sanofi. R.D. reports research grants from Sanofi, DalCor Pharmaceuticals, Population Health Research Institute, Duke Clinical Research Institute, the TIMI group, Amgen, Cirius, Montreal Health Innovations Coordinating Center, and Lepetit and personal fees, as a member of the executive steering committees, from Amgen and Cirius. S.G.G. reports research grants from Daiichi-Sankyo, Luitpold Pharmaceuticals, Merck, Novartis, Servier, Regeneron Pharmaceuticals, Sanofi, Amgen, AstraZeneca, Bayer, Boehringer Ingelheim, Bristol-Myers Squibb, CSL Behring, Eli Lilly, Pfizer, and Tenax Therapeutics; honoraria from Bristol-Myers Squibb, Eli Lilly, Esperion, Fenix Group International, Ferring Pharmaceuticals, Merck, Novartis, Pfizer, Servier, Regeneron Pharmaceuticals, Sanofi, Amgen, AstraZeneca, Bayer, and Boehringer Ingelheim; and serving as a consultant or on advisory boards (or both) for AstraZeneca, Boehringer Ingelheim, Bristol-Myers Squibb, Eli Lilly, HLS Therapeutics, Pfizer, Servier, Tenax Therapeutics, Sanofi, Amgen, and Bayer. J.W.J. reports research support from Amgen, Astellas, AstraZeneca, Daiichi-Sankyo, Lilly, Merck-Schering-Plough, Pfizer, Roche, and Sanofi. M.L. is an employee of Sanofi. G.M. and R.P. are employees of Regeneron Pharmaceuticals. H.D.W. reports receiving grant support paid to the institution and fees for serving on a steering committee for the ODYSSEY OUTCOMES trial from Sanofi and Regeneron Pharmaceuticals, for the ACCELERATE study (A Study of Evacetrapib in High-Risk Vascular Disease) from Eli Lilly, for the STRENGTH trial (Outcomes Study to Assess Statin Residual Risk Reduction With EpaNova in High CV Risk Patients With Hypertriglyceridemia) from Omthera Pharmaceuticals, for the SPIRE trial (The Evaluation of Bococizumab [PF-04950615, RN 316] in Reducing the Occurrence of Major Cardiovascular Events in High Risk Subjects) from Pfizer, for the HEART-FID study (Randomized Placebo-Controlled Trial of FCM as Treatment for Heart Failure With Iron Deficiency) from American Regent, for the CAMELLIA-TIMI study (A Study to Evaluate the Effect of Long-term Treatment With BELVIQ [Lorcaserin HCl] on the Incidence of Major Adverse Cardiovascular Events and Conversion to Type 2 Diabetes Mellitus in Obese and Overweight Subjects With Cardiovascular Disease or Multiple Cardiovascular Risk Factors) from Eisai Inc, for the dal-GenE study (Effect of Dalcetrapib vs. Placebo on CV Risk in a Genetically Defined Population With a Recent ACS) from DalCor Pharma UK, for the AEGIS-II study from CSL Behring, for the SCORED trial (Effect of Sotagliflozin on Cardiovascular and

Renal Events in Patients With Type 2 Diabetes and Moderate Renal Impairment Who Are at Cardiovascular Risk) and the SOLOIST-WHF trial (Effect of Sotagliflozin on Cardiovascular Events in Patients With Type 2 Diabetes Post Worsening Heart Failure) from Sanofi Australia Pty Ltd, and for the CLEAR Outcomes Study (Evaluation of Major Cardiovascular Events in Patients With, or at High Risk for, Cardiovascular Disease Who Are Statin Intolerant Treated With Bempedoic Acid [ETC-1002] or Placebo) from Esperion Therapeutics. H.D.W. was on the advisory boards for Acetelion, Sirtex, and Genentech (an affiliate of F. Hoffmann-La Roche, "Roche," Lytics Post-PCI Advisory Board at European Society of Cardiology) and received lecture fees from AstraZeneca. P.G.S. reports grants and non-financial support (co-chair of the ODYSSEY OUTCOMES trial; as such, he received no personal fees, but his institution has received funding for the time he has devoted to trial coordination, and he has received support for travel related to trial meetings) from Sanofi; research grants and personal fees from Bayer (Steering Committee MARINER [A Study of Rivaroxaban (JNJ-39039039) on the Venous Thromboembolic Risk in Post-Hospital Discharge Patients], grant for epidemiological study), Merck (speaker fees, grant for epidemiological studies), Sanofi (co-chair of the ODYSSEY OUTCOMES trial, co-chair of the SCORED trial, consulting, speaking), Servier (Chair of the CLARIFY registry [Prospective observational Longitudinal Registry of patients with stable coronary artery disease], grant for epidemiological research), and Amarin (executive steering committee for the REDUCE-IT [Reduction of Cardiovascular Events with Icosapent Ethyl-Intervention Trial], consulting); and personal fees from Amgen, Bristol-Myers Squibb, Boehringer Ingelheim, Pfizer, Novartis, Regeneron Pharmaceuticals, Lilly, and AstraZeneca. P.G.S. also has a European application number/patent number, issued on 26 October 2016 (no. 15712241.7), for a method for reducing cardiovascular risk. No other potential conflicts of interest relevant to this article were reported.

Author Contributions. G.G.S. conceived the research question. G.G.S. and M.S. designed the analysis plan. M.S. performed the data analysis. G.G.S. drafted the manuscript. All authors interpreted the results and critically revised the manuscript for important intellectual content and gave final approval of the version to publish. G.G.S. and M.S. are the guarantors of this work and, as such, had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. **Prior Presentation.** Parts of this study were presented in abstract form at the American Heart Association Scientific Sessions 2020, 13–17 November 2020.

References

1. Tsimikas S. A test in context: lipoprotein(a): diagnosis, prognosis, controversies, and emerging therapies. *J Am Coll Cardiol* 2017;69:692–711
2. Gurdasani D, Sjouke B, Tsimikas S, et al. Lipoprotein(a) and risk of coronary, cerebrovascular, and peripheral artery disease: the EPIC-Norfolk prospective population study. *Arterioscler Thromb Vasc Biol* 2012;32:3058–3065
3. Langsted A, Nordestgaard BG, Kamstrup PR. Elevated lipoprotein(a) and risk of ischemic stroke. *J Am Coll Cardiol* 2019;74:54–66

4. Laschkolnig A, Kollerits B, Lamina C, et al. Lipoprotein (a) concentrations, apolipoprotein (a) phenotypes, and peripheral arterial disease in three independent cohorts. *Cardiovasc Res* 2014;103:28–36
5. Sabatine MS, Giugliano RP, Keech AC, et al.; FOURIER Steering Committee and Investigators. Evolocumab and clinical outcomes in patients with cardiovascular disease. *N Engl J Med* 2017; 376:1713–1722
6. Schwartz GG, Steg PG, Szarek M, et al.; ODYSSEY OUTCOMES Committees and Investigators. Alirocumab and cardiovascular outcomes after acute coronary syndrome. *N Engl J Med* 2018;379:2097–2107
7. Bittner VA, Szarek M, Aylward PE, et al.; ODYSSEY OUTCOMES Committees and Investigators. Effect of alirocumab on lipoprotein(a) and cardiovascular risk after acute coronary syndrome. *J Am Coll Cardiol* 2020;75:133–144
8. O'Donoghue ML, Fazio S, Giugliano RP, et al. Lipoprotein(a), PCSK9 inhibition, and cardiovascular risk. *Circulation* 2019;139:1483–1492
9. Marston NA, Gurmu Y, Melloni GEM, et al. The effect of PCSK9 (proprotein convertase subtilisin/kexin type 9) inhibition on the risk of venous thromboembolism. *Circulation* 2020;141:1600–1607
10. Schwartz GG, Steg PG, Szarek M, et al.; ODYSSEY OUTCOMES Committees and Investigators*. Peripheral artery disease and venous thromboembolic events after acute coronary syndrome: role of lipoprotein(a) and modification by alirocumab: prespecified analysis of the ODYSSEY OUTCOMES randomized clinical trial. *Circulation* 2020;141:1608–1617
11. Tromp TR, Stroes ESG, Hovingh GK. Gene-based therapy in lipid management: the winding road from promise to practice. *Expert Opin Investig Drugs* 2020;29:483–493
12. Tsimikas S, Karwatowska-Prokopczuk E, Gouni-Berthold I, et al.; AKCEA-APO(a)-LRx Study Investigators. Lipoprotein(a) reduction in persons with cardiovascular disease. *N Engl J Med* 2020;382:244–255
13. Gudbjartsson DF, Thorgeirsson G, Sulem P, et al. Lipoprotein(a) concentration and risks of cardiovascular disease and diabetes. *J Am Coll Cardiol* 2019;74:2982–2994
14. Kronenberg F. Human genetics and the causal role of lipoprotein(a) for various diseases. *Cardiovasc Drugs Ther* 2016;30:87–100
15. Ye Z, Haycock PC, Gurdasani D, et al. The association between circulating lipoprotein(a) and type 2 diabetes: is it causal? *Diabetes* 2014;63:332–342
16. Kaya A, Onat A, Yüksel H, Can G, Yüksel M, Ademoğlu E. Lipoprotein(a)-activated immunity, insulin resistance and new-onset diabetes. *Postgrad Med* 2017;129:611–618
17. Mora S, Kamstrup PR, Rifai N, Nordestgaard BG, Buring JE, Ridker PM. Lipoprotein(a) and risk of type 2 diabetes. *Clin Chem* 2010;56:1252–1260
18. Paige E, Masconi KL, Tsimikas S, et al. Lipoprotein(a) and incident type-2 diabetes: results from the prospective Bruneck study and a meta-analysis of published literature. *Cardiovasc Diabetol* 2017;16:38
19. Schwartz GG, Bessac L, Berdan LG, et al. Effect of alirocumab, a monoclonal antibody to PCSK9, on long-term cardiovascular outcomes following acute coronary syndromes: rationale and design of the ODYSSEY outcomes trial. *Am Heart J* 2014;168:682–689
20. Ray KK, Colhoun HM, Szarek M, et al.; ODYSSEY OUTCOMES Committees and Investigators. Effects of alirocumab on cardiovascular and metabolic outcomes after acute coronary syndrome in patients with or without diabetes: a prespecified analysis of the ODYSSEY OUTCOMES randomised controlled trial. *Lancet Diabetes Endocrinol* 2019;7:618–628
21. Scharnagl H, Stojakovic T, Dieplinger B, et al. Comparison of lipoprotein (a) serum concentrations measured by six commercially available immunoassays. *Atherosclerosis* 2019;289:206–213
22. Dahlen GH. *Incidence of Lp(a) Among Populations*. San Diego, CA, Academic Press, 1990
23. Kinpara K, Okada H, Yoneyama A, Okubo M, Murase T. Lipoprotein(a)-cholesterol: a significant component of serum cholesterol. *Clin Chim Acta* 2011;412:1783–1787
24. Vaverková H, Karásek D, Halenka M, Cibičková L, Kubičková V. Inverse association of lipoprotein (a) with markers of insulin resistance in dyslipidemic subjects. *Physiol Res* 2017;66(Suppl. 1):S113–S120
25. Kamstrup PR, Nordestgaard BG. Lipoprotein(a) concentrations, isoform size, and risk of type 2 diabetes: a Mendelian randomisation study. *Lancet Diabetes Endocrinol* 2013;1:220–227
26. Mu-Han-Ha-Li D-L-D-E, Zhai T-Y, Ling Y, Gao X. LPA kringle IV type 2 is associated with type 2 diabetes in a Chinese population with very high cardiovascular risk. *J Lipid Res* 2018;59: 884–891
27. Tolbus A, Mortensen MB, Nielsen SF, Kamstrup PR, Bojesen SE, Nordestgaard BG. Kringle IV type 2, not low lipoprotein(a), as a cause of diabetes: a novel genetic approach using SNPs associated selectively with lipoprotein(a) concentrations or with kringle IV type 2 repeats. *Clin Chem* 2017;63:1866–1876
28. Buchmann N, Scholz M, Lill CM, et al. Association between lipoprotein(a) level and type 2 diabetes: no evidence for a causal role of lipoprotein(a) and insulin. *Acta Diabetol* 2017; 54:1031–1038
29. Betteridge DJ, Carmena R. The diabetogenic action of statins - mechanisms and clinical implications. *Nat Rev Endocrinol* 2016;12:99–110
30. Ference BA, Robinson JG, Brook RD, et al. Variation in PCSK9 and HMGCR and risk of cardiovascular disease and diabetes. *N Engl J Med* 2016;375:2144–2153
31. Lotta LA, Sharp SJ, Burgess S, et al. Association between low-density lipoprotein cholesterol-lowering genetic variants and risk of type 2 diabetes: a meta-analysis. *JAMA* 2016;316:1383–1391
32. Besseling J, Kastelein JJ, Defesche JC, Hutten BA, Hovingh GK. Association between familial hypercholesterolemia and prevalence of type 2 diabetes mellitus. *JAMA* 2015;313: 1029–1036
33. Lakoski SG, Lagace TA, Cohen JC, Horton JD, Hobbs HH. Genetic and metabolic determinants of plasma PCSK9 levels. *J Clin Endocrinol Metab* 2009;94:2537–2543
34. Baass A, Dubuc G, Tremblay M, et al. Plasma PCSK9 is associated with age, sex, and multiple metabolic markers in a population-based sample of children and adolescents. *Clin Chem* 2009;55: 1637–1645
35. Hamamura H, Adachi H, Enomoto M, et al. Serum proprotein convertase subtilisin/kexin type 9 (PCSK9) is independently associated with insulin resistance, triglycerides, lipoprotein(a) levels but not low-density lipoprotein cholesterol levels in a general population. *J Atheroscler Thromb*. 4 July 2020 [Epub ahead of print]. DOI: 10.5551/jat.56390
36. Ferri N, Ruscica M. Proprotein convertase subtilisin/kexin type 9 (PCSK9) and metabolic syndrome: insights on insulin resistance, inflammation, and atherogenic dyslipidemia. *Endocrine* 2016;54:588–601
37. Cariou B, Langhi C, Le Bras M, et al. Plasma PCSK9 concentrations during an oral fat load and after short term high-fat, high-fat high-protein and high-fructose diets. *Nutr Metab (Lond)* 2013; 10:4
38. Desai NR, Giugliano RP, Wasserman SM, et al. Association between circulating baseline proprotein convertase subtilisin kexin type 9 levels and efficacy of evolocumab. *JAMA Cardiol* 2017;2:556–560
39. Blom DJ, Koren MJ, Roth E, et al. Evaluation of the efficacy, safety and glycaemic effects of evolocumab (AMG 145) in hypercholesterolaemic patients stratified by glycaemic status and metabolic syndrome. *Diabetes Obes Metab* 2017;19:98–107
40. Haynes R, Valdes-Marquez E, Hopewell JC, et al.; HPS2-THRIVE Collaborative Group; HPS2-THRIVE Writing Committee members; HPS2-THRIVE Steering Committee members. Serious adverse effects of extended-release niacin/laropiprant: results from the Heart Protection Study 2-Treatment of HDL to Reduce the Incidence of Vascular Events (HPS2-THRIVE) trial. *Clin Ther* 2019;41:1767–1777
41. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation* 2019;139:e1082–e1143
42. Preiss D, Seshasai SR, Welsh P, et al. Risk of incident diabetes with intensive-dose compared with moderate-dose statin therapy: a meta-analysis. *JAMA* 2011;305:2556–2564