Patronat polskiej prezydencji w Radzie UE
Patronage of the Polish presidency of the Council of the EU
Patronage de la présidence polonaise du Conseil de l'UE

The Brussels International Declaration on Lp(a) Testing and Management

(an abbreviated version)

In the framework of the

Lp(a) Global Summit

24 and 25 March 2025

FH Europe Foundation

THE BRUSSELS INTERNATIONAL DECLARATION ON Lp(a) TESTING AND MANAGEMENT

AN OVERVIEW

One in five people globally—**over 1.4 billion individuals**—are living with elevated **lipoprotein(a)**, a significant, yet widely **undetected** inherited cardiovascular risk factor[1]. Despite its clear link to **premature heart attacks, strokes, peripheral artery disease and aortic stenosis**, only **1%-2% of the population is tested**, leaving **millions vulnerable** to preventable, life-threatening cardiovascular events[1-3].

The economic and healthcare burden of cardiovascular diseases (CVD) is staggering, with CVD alone costing the EU €282 billion annually.

The public health impact of testing for elevated Lp(a), as an important risk factor for CVD, and its effective management, would be enormous and should be a key pillar of countries' prevention strategies worldwide.

KEY ASKS TO NATIONAL, REGIONAL AND INTERNATIONAL POLICY-MAKERS ACROSS THE GLOBE

- **Lp(a) in Cardiovascular Health Plans**: Integrate elevated Lp(a) Testing and Management into Global, European and National Cardiovascular Health Plans

- **Investment, workable policy and programmes**: Ensure appropriate investment, policy and programmes in Lp(a) Testing and Management based on the recent study demonstrating the significant overall cost saving to health systems across the globe

- **Political Leadership and Commitment**: Advocate for political commitment to mandate systematic Lp(a) testing at least once during a person's lifetime, ideally at an early age, with full reimbursement

- **Global Cardiovascular Risk Assessment**: Ensure testing is undertaken in the context of global cardiovascular risk assessment, and to develop personalised cardiovascular health roadmaps as needed, without fear of discrimination

- **Raising Awareness:** Drive investment in public and healthcare professional education to increase awareness of Lp(a) and its impact on cardiovascular health

Transformational digital tools and ethical artificial intelligence will facilitate the implementation of systematic testing for, and effective personalised management of elevated Lp(a). Shared learning beyond borders, impact assessment, monitoring and evaluation will chart progress on an annual basis.

PREFACE

As we navigate the complexities of global health and well-being, it is crucial for policy-makers to remain informed about scientific research and its implications on public health strategies. One such advancement lies in the understanding and management of lipoprotein(a), or Lp(a), a lipid particle linked to cardiovascular risk. Despite the growing body of evidence highlighting the role of Lp(a) in heart disease, its significance remains under-recognised and under-addressed in many healthcare systems worldwide. Testing rates are low – 1-2% – yet elevated Lp(a) affects one in five people[1].

The Brussels International Declaration on Lp(a) Testing and Management emphasizes the importance of integrating Lp(a) testing into routine cardiovascular risk assessments. With research showing that elevated levels of Lp(a) are genetically determined and often not influenced by lifestyle changes, early detection and proper management of overall global risk in individuals could dramatically reduce the burden of cardiovascular events, especially when there is a family history of heart disease.

For policy-makers, the implications of this declaration are clear: the healthcare systems must be equipped to identify individuals at risk due to elevated Lp(a) levels, offer targeted management plans, and prevent unnecessary cardiovascular morbidity and mortality. By prioritizing Lp(a) testing, we can ensure more comprehensive, personalised, and effective healthcare for individuals worldwide. And systematic testing has shown to be not only cost-effective but also cost-saving.

This declaration calls for collaboration across sectors—healthcare professionals, scientists, patient ambassadors, industry leaders, and government bodies—to raise awareness, fund research, and improve healthcare protocols. As leaders, your involvement in this issue can drive the legislative and policy changes necessary to integrate Lp(a) testing and management into clinical practice, potentially saving millions of lives and reducing the long-term financial burden of cardiovascular diseases.

It is our collective responsibility to act, to implement the asks of the Declaration, harnessing the power of science and innovation to safeguard the future of public health.

As representatives of the European Parliament, we are proud to support the Declaration and commit to working with our colleagues and other stakeholders to ensure we fulfil its ambition, impacting on the lives of millions across the globe.

Co-signed by

MEP **Romana JERKOVIĆ**, Co-Chair of the SANT (Health) Committee in the European Parliament and Chair of the MEP Cardiovascular Health Group in the European Parliament

MEP **Adam JARUBAS**, Chair of the SANT (Health) Committee in the European Parliament

MEP **András KULJA,** Member of the SANT (Health) Committee in the European Parliament

MEP **Tomislav SOKOL**, Member of the SANT (Health) Committee in the European Parliament

The Brussels International Declaration on Lp(a) was co-created by the **Lp(a) International Task Force** and global leaders at the **Global Summit**, held in Brussels on March 24th and 25th. This pivotal event brought together world-renowned experts, organised by the **FH Europe Foundation** and hosted by **MEP Jerković**.

The Summit reached a powerful consensus among diverse stakeholders: the urgent need for **systematic Lp(a) testing** and **personalised, effective management**. Experts pointed to irrefutable evidence: testing is **cost-effective, simple**, and while effective therapies are still in development, significant steps can be taken to **empower** those with elevated Lp(a) to better manage their condition and lead **fulfilling lives**.

The Summit concluded on a note of **hope and optimism**—with a renewed commitment to overcome the alarmingly low testing rates and reach the **1 in 5 individuals affected**, many living with Lp(a) unknowingly.

This Declaration serves as a **clear roadmap** for policy-makers to implement practical, life-changing policies and systemic reforms. It aligns with the growing global shift from treating **cardiovascular diseases** to embracing a more proactive approach to **cardiovascular health**. It calls for wise investment in **personalised prevention**.

The **FH Europe Foundation** and the **Lp(a) International Task Force** are dedicated to advancing this Declaration and advocating for the individuals, families and communities impacted by elevated Lp(a) worldwide.

We urge your **endorsement** and **active involvement** in bringing the vision to life – a future in which elevated Lp(a) is recognised, understood, tested and effectively managed. We hope we can count on your endorsement, and your active engagement in bringing the Declaration to life.

Our warmest thanks,

Prof. Florian Kronenberg,
Chair of the Lp(a) International Taskforce

Magdalena Daccord,
Chief Executive Officer of FH Europe Foundation

PREAMBLE

Lp(a) in the context of the cardiovascular landscape

Approximately **one third of the world's population dies from cardiovascular diseases (CVD)** such as heart attacks, strokes and other vascular diseases, many prematurely. These diseases are the **main cause of death worldwide**[1,2]. The socio-economic impact of CVD is substantially exacerbated by the limited availability of primary and secondary prevention programmes.

Well known risk factors are high LDL cholesterol, high blood pressure, diabetes and their precursors, obesity, smoking, lack of physical exercise and an unhealthy diet. All these "traditional" risk factors are key components of the global cardiovascular risk of a person and can be influenced by lifestyle interventions and approved medications, thereby reducing the risk of atherosclerosis and CVD. The social and commercial determinants of health and profound health inequities across and within countries also play a fundamental role in the landscape of CVD[5].

Lp(a) is a blood lipid that is independent from other lipids and other risk factors. **An elevated Lp(a) concentration is an additional and causal risk factor** which can add tremendously to the global risk of CVD[6].

It is a common risk factor: one in five people has concentrations above 50 mg/dL (105 nmol/L), a level associated with an increased risk[7]. Therefore, approximately **1.4 billion individuals worldwide are exposed** to this condition and the vast majority of them do not know that they are living with elevated Lp(a)[8]. The **testing rate worldwide is only 1-2%**[2,3].

It is a family condition: about 90% of the Lp(a) concentration can be explained by genetic variants[6]. These are passed on from generation to generation. Elevated Lp(a) concentration is **the most frequent inherited condition in the cardiovascular field**.

In summary, the public health burden of not testing Lp(a) levels is enormous, as elevated Lp(a) is a common condition: across the globe, a fifth of the world population is exposed to the consequences of elevated Lp(a), and annually, one third of deaths are caused by CVD.

The Lp(a) International Community's Key Asks to international and regional institutions, national governments and health decision-makers across the Globe

- *Welcoming the World Health Organization's renewed commitment to addressing inherited lipid conditions*
- *Recalling the European Atherosclerosis Consensus Statement on Lp(a) which highlights that everyone should be tested for elevated Lp(a) once in a lifetime, a recommendation which meanwhile is included in several international guidelines*[6,9]
- *Noting the Lancet Article (2024) Lipoprotein(a) and Cardiovascular Disease*[10]
- *Acknowledging the political and economic trends around health systems' sustainability and strengthening, and the recent international study on the cost effectiveness of testing for elevated Lp(a) demonstrating unequivocally a return on investment*[11]
- *Recognising the evidence base and lived experience of Lp(a) Ambassadors*
- *Acknowledging the importance of competitiveness and innovation in cardiovascular health, and equally the value of collaboration across the globe to serve the unmet needs of those who are, and who are yet to be diagnosed*
- *Highlighting the explicit reference to the importance of addressing inherited lipid conditions in the Hungarian EU Presidency Conclusions in the context of a new European Plan on Cardiovascular Health, as well as reference therein to the importance of tackling the social and commercial determinants of health, prevention and health promotion*[12]
- *Recalling the public commitment of the EU Commissioner for Health to a European Plan on Cardiovascular Health*
- *Welcoming the EU Presidency Trio's focus prevention and health promotion (Poland, Denmark, Cyprus)*
- *Having regard to the Prague Declaration on Familial Hypercholesterolaemia (FH) Paediatric Screening and the potential to test for both FH and Lp(a) simultaneously*[13]
- *Acknowledging landmark projects in the areas of population health, public health communication, testing, screening in cardiovascular health, diabetes and FH*[14-16]
- *Recognising the diversity of health systems and access across the globe*

The Lp(a) International Community calls for

1. The explicit inclusion of testing and management of elevated Lp(a) in the World Health Organization's Cardiovascular Health / Non-Communicable Disease policy instruments and programmes, in the European Cardiovascular Health Plan and other regional plans, National Cardiovascular Health Plans and national guidelines across the world.

Testing and management of elevated Lp(a) is inherent to a new narrative and culture towards cardiovascular health, rather than CVD, and a personalised approach towards prevention and care pathways, reflected in the current progressive policy discourse at international and European level.

Historically, however, elevated Lp(a) has been invisible in broader public health discussions. Given its prevalence and its profound impact on individuals, society and health systems, testing and management of elevated Lp(a) should be a critical pillar of future global policies, programmes and action plans on cardiovascular health. Emphasis should be placed on strategies to ensure access to testing in low-income countries.

2. Appropriate investment, workable and effective policies and programmes in Lp(a) Testing and Management based on the recent study demonstrating the significant overall cost-saving to health systems across the globe

The recent cost-effectiveness analysis undertaken for high income countries such as Australia, Austria, Canada, France, Germany, Italy, the Netherlands, Spain, Poland, United Kingdom and the United States of America reveals that Lp(a) testing to reclassify cardiovascular risk in the primary prevention population is a highly cost-saving strategy for preventing CVD[11]. This is under the assumption that those with high Lp(a) concentrations are considered in a higher risk category which results ideally in preventive treatment management of e.g. lowering LDL cholesterol and blood pressure. For countries aiming to achieve economically sustainable healthcare systems—particularly those with universal healthcare policies—the proven cost-effectiveness of routine Lp(a) testing presents an opportunity to significantly reduce future expenditure associated with CVD. Early detection via routine testing can reclassify and manage individuals at higher risk effectively, thereby optimising national health spending and improving population health outcomes. Implementation of Lp(a) testing is not only highly warranted

from a clinical perspective but is likely to come with a financial return on investment within a relatively short time considered from a societal perspective. These results support the immediate implementation of Lp(a) testing in high income countries. With higher testing volume, the cost of testing will decrease, also making it affordable for low- and middle-income countries.

3. Political commitment and leadership to ensure systematic testing of Lp(a) at least once in a lifetime, initially as early as possible in the life course with full reimbursement. This is country-specific and should be established in harmony with other testing protocols.

Based on current scientific evidence and recommendations from international guidelines and consensus statements in addition to cost-effectiveness analysis, political leaders should commit to ensuring that everyone in their country is offered voluntary testing of Lp(a) and LDL-cholesterol, free of charge, as early as possible in their life. This also reflects the perspective of a growing number of advocates living with elevated Lp(a) who are experiencing the serious consequences of inertia in testing policy in their country. Many countries already have established national prevention and screening programmes. Systematically integrating Lp(a) testing into these existing frameworks would allow timely identification of high-risk individuals without significant new administrative burdens.
Testing for elevated Lp(a) comes too late for those for whom the first cardiovascular event was fatal. The earlier a test can be offered, the more the impact of elevated Lp(a) can be mitigated, with due sensitivity and compassion regarding the fear this diagnosis may provoke, for example, in younger individuals.

4. Testing of Lp(a) undertaken in the context of a global cardiovascular risk assessment to develop a personalised cardiovascular health roadmap, without fear of discrimination.

Lp(a) should never be seen in isolation but always in relation to other (modifiable) risk factors. It would be too narrow a view to focus on a single risk factor. Therefore, to be even more cost-effective, assessment of the global risk of a given person should be undertaken together with the other established risk factors. Future risk calculators should include the Lp(a) concentration to improve risk assessment with the goal to identify possible lifestyle interventions and treatment targets to prolong a healthy life. These should be followed by a lifetime risk calculator, and personalised

cardiovascular health roadmap including psychological and social support.

Testing should be undertaken in primary as well as secondary prevention settings.
Testing should be undertaken in primary as well as secondary prevention settings as an increased Lp(a) concentration is genetically determined in almost all cases. Actionable interventions aimed at decreasing global cardiovascular risk by addressing lifestyle factors and treatment are recommended for both primary and secondary prevention. In parallel appropriate global policies and instruments to address the social and commercial determinants of health should be adopted and implemented effectively.

Extended Lp(a) testing should be offered to families of an index patient with elevated Lp(a).
As Lp(a) concentrations are strongly genetically determined, elevated Lp(a) is a family condition. It can be expected that other family members (e.g. parents, siblings and children) might be identified with high Lp(a) concentrations and their traditional risk factors need assessment and management.
In the case of a positive family history for atherosclerotic CVD (ASCVD) in particular, family members should be invited for an extensive examination of other cardiovascular risk factors, followed by appropriate support for their management.

As countries transition towards systematic testing of elevated Lp(a), the testing of high-risk individuals should only be seen as a temporary measure until testing is widely implemented.
High risk individuals include those with a personal or a family history of premature CVD, a family history of high Lp(a), a familial hypercholesterolaemia, a moderate to high cardiovascular risk or aortic valve stenosis. These conditions can only be a starting point and have the major disadvantage that some of them provide only a post-hoc explanation of an event (for instance, a personal history of an ASCVD) with lost years of prevention.

A combination of testing programmes for elevated Lp(a) and familial hypercholesterolaemia should be considered depending on the health systems' readiness in individual countries.
Lp(a) concentrations are low at birth but testing of Lp(a) in an infant provides an indication as to whether they will develop markedly elevated concentrations when grown up. Since FH pediatric screening is becoming more widely adopted in some health systems, due to the advantages of

early intervention, testing for both conditions at the same time should be considered in countries where this is viable.

Testing for Lp(a) should not discriminate against an individual who is diagnosed with elevated Lp(a)

Early testing is important to begin effective preventive measures early, and those diagnosed with elevated Lp(a) should not experience discrimination in any area of their life on the grounds of health status. Insurers should not penalise those who are detected early and are able to protect themselves. Knowledge and management of one's own risk factors should be regarded as a greater asset, minimising the overall risk compared to an individual who chooses not to test and subsequently has a serious cardiovascular event.

The cardiovascular risk of individuals with high Lp(a) concentrations should be reclassified into a higher risk category with access to appropriate management of these risk factors according to an individualised plan.

In case of high Lp(a) concentrations combined with traditional risk factors, it is of utmost importance that all these risk factors are treated accordingly, to reduce the global risk of an individual. This is even more important in the case of a family or a personal history of cardiovascular disease. This will remain the case in the future, should Lp(a)-lowering drugs become available. Therefore, this is a further reason not to postpone measuring Lp(a).

5. Government investment, as part of wider public health prevention and management campaigns, to enhance public awareness about cardiovascular risk factors including Lp(a)

Governments should invest in raising public awareness and literacy about cardiovascular health and cardiovascular risk factors including elevated Lp(a). Campaigns should draw on sociological and behavioural factors linked to other successful movements such as smoking bans. They should also build on innovation in the field, including personalised communications models, implementation research through "living labs" and social science, digitalisation and application of artificial intelligence[17]. Emphasis should be placed on young people in school settings and on General Practitioners through medical curricula and continuous professional development, to enable the General Practices and Community Health Centres be trusted and accessible sources of information and advice on Lp(a).

Responsible data sharing, transformational digital tools and ethical artificial intelligence will facilitate the implementation of systematic testing for, and effective personalised management of elevated Lp(a), enhancing efficiency, interoperability and evidence-based decision making.

Additionally, any research gaps identified could be addressed by Research and Innovation funding programmes such as Horizon Europe and the Innovative Health Initiative and successor programmes in Europe, and similar programmes in other regions of the world.

Shared learning beyond borders, impact assessment, monitoring and evaluation will chart progress on an annual basis

A commitment to shared learning, monitoring and evaluation through exchange and comparisons beyond borders is important to ensure the implementation of this Declaration. Through funding programmes such as EU4Health, and similar schemes in other regions, there could be investment in the transferability and uptake of best practice models in individual's risk assessment including Lp(a) testing from other countries, and country level 'score cards' to measure progress according to safety, efficacy, cost-effectiveness, organisational, ethical, legal and social criteria. The experience of Lp(a) testing will be carefully observed and documented for analysis in the context of wider efforts towards better cardiovascular health through collaboration with relevant national, European and Global alliances.

Closing

We invite national and regional and international policy-makers, medical societies, patient and public health organisations, and individual experts across the globe to support this Declaration and to help ensure that systematic testing of Lp(a) as early as possible in the life course becomes a reality for all, and those diagnosed are supported in managing their condition effectively.

In the coming months, the FH Europe Foundation and the Lp(a) International Task Force will publish model testing and care pathways to accompany and support the implementation of the Brussels International Declaration on Lp(a) Testing and Management.

Endorsement from:

International
European Alliance for Cardiovascular Healt (EACH), www.cardiovascular-alliance.eu
European Atherosclerosis Society (EAS), www.eas-society.org
European Federation of Clinical Chemistry and Laboratory Medicine (EFLM),
www.eflm.eu
European Heart Network (EHN), www.ehnheart.org
European Society of Preventive Medicine (ESPM), www.espm.org
FH Europe Foundation, www.fhef.org
Global Alliance for Patient Access (GAFPA), www.gafpa.org
Global Heart Hub (GHH), www.globalhearthub.org
HeartCharged, www.getheartcharged.org
International Atherosclerosis Society (IAS), www.athero.org
The Healthy Heart, www.healthy-heart.org

Argentina
Argentine Lipid Society (SAL), www.sociedadargentinadelipidos.com
Argentine Society of Cardiology, www.sac.org.ar
GAELp(a)

Austria
Austrian Atherosclerosis Society, www.aas.at
FHchol Austria, www.fhchol.at
Österreichische Gesellschaft für Kinder- und Jugendheilkunde, www.paediatrie.at

Bulgaria
Bulgarian Hypertension League, www.hypertensionleaguebg.info/about-bhl

Chile
Corporación Grupo Chileno de Trabajo en Ateroesclerosis (AterosChile), www.ateroschile.cl

China
FH China Patient Network

Croatia
Croatian Atherosclerosis Society, www.ateroskleroza.healthmed.hr

Czech Republic
Czech Society for Atherosclerosis, www.athero.cz

Finland
Finnish Atherosclerosis Society, www.satyryfi.wordpress.com

France
ANHET.F, www.anhet.fr

Georgia
Georgian Association of Atherosclerosis, www.gaavs.org.ge

Germany
Deutsche Gesellschaft für Angiologie - Gesellschaft für Gefäßmedizin e.V.dga, www.dga-gefaessmedizin.de
Deutsche Gesellschaft für Lipidologie e. V. (DGFL), www.lipid-liga.de/fuer-aerztinnen/fortbildung-und-zertifizierung/lipidologie-dgfl

Herzquartier Mülheim an der Ruhr, www.herzquartier.de
KIZ Kardiologie im Zentrum, www.kardiologie-im-zentrum.de
Section Diabetes, Obesity and Metabolic disease of the German Society of endokrinology, www.endokrinologie.net

Hungary
Hungarian Atherosclerosis Society, www.atherosclerosis.hu

Iraq
Iraqi Hypertension League
The Iraqi Lipid Clinics Network

Italy
Italian Association of patients with Heart failure and Cardiovascular prevention (AISC), www.associazioneaisc.org

Ireland
Croí, the West of Ireland Cardiac and Stroke Foundation, www.croi.ie
Heart & Stroke Voice Ireland, www.croi.ie/heart-and-stroke-voice-ireland

Japan
Japan Cardiovascular Association (JCVA), www.j-iscp.com

Kazakhstan
Kazakh Atherosclerosis Society, www.zhurek.org.kz

Lithuania
Lithuanian Heart Association, www.heart.lt/lithuanian-heart-association
Lithuanian Heart Failure Association, www.sirdiesnepakankamumas.lt

Macedonia
Macedonian Society of Cardiology, www.mscardiology.org.mk/en/home-v1-2
University Clinic for Cardiology, Faculty of Medicine, Ss. Cyril and Methodius University in Skopje, www.medf-ukim.com/med

Mexico
Asociacion ALE, www.asociacionale.org.mx
Pacientes de Corazón (PACO), www.pacientesdecorazon.org

Peru
Medicina del Laboratorio, www.medicinadellaboratorio.com

Romania
Center for Innovation in Medicine (InoMed), www.ino-med.ro

Russia
Russian National Atherosclerosis Society, www.old.noatero.ru/en/about-rnas

Slovakia
Coordination center for familial hyperlipidemias, Srdce rodiny, nf, MedPed Slovakia

Switzerland
Roche Diagnostics International, www.diagnostics.roche.com

The Netherlands
Hart in Shape, www.hartinshape.nl
LEEFH, www.leefh.nl

USA
pRxEngage Inc., www.prxengage.com


AAS


ALE
Donación de Órganos
ASOCIACIÓN ALE, I.A.P.


anhet.f


BULGARIAN
HYPERTENSION LEAGUE


CORPORACIÓN
GRUPO CHILENO DE TRABAJO EN
ATEROESCLEROSIS


CRoÍ
Fighting Heart Disease & Stroke


CSAT
CZECH SOCIETY
FOR ATHEROSCLEROSIS


DGFL
Deutsche Gesellschaft
für Lipidologie e.V.–
Lipid-Liga


DGA
Deutsche Gesellschaft für Angiologie
Gesellschaft für Gefäßmedizin e.V.


EAS
European
Atherosclerosis
Society


each
European Alliance for
Cardiovascular Health


EFLM
EUROPEAN FEDERATION OF CLINICAL CHEMISTRY
AND LABORATORY MEDICINE


ehn
European Heart Network
Fighting heart disease and stroke


EUROPEAN SOCIETY OF
PREVENTIVE MEDICINE


红米粒互助之家
FH China Patient Network


FHcholAustria


Finnish Atherosclerosis Society


GAAVS


GAfPA
Global Alliance for Patient Access


Global
Heart Hub


hart
in shape


HEART & STROKE
VOICE
IRELAND


HeartCharged


HERZQUARTIER
MÜLHEIM


HOA


IAS
INTERNATIONAL
ATHEROSCLEROSIS
SOCIETY


IHL
Iraqi
Hypertension
League


ILCN
Iraqi lipid clinics network


InoMed
Centre for Innovation
in Medicine


ITALIAN HEART FAILURE ASSOCIATION
ITAHFA


KAZAKHSTAN
ATHEROSCLEROSIS
SOCIETY


KIZ


LEEFH


LIETUVOS ŠIRDIES ASOCIACIJA


Macedonian
Society of Cardiology


MAGYAR ATHEROSCLEROSIS TÁRSASÁG
MAT


MEDICINA DEL
LABORATORIO


ÖGKJ
ÖSTERREICHISCHE GESELLSCHAFT
FÜR KINDER- UND JUGENDHEILKUNDE


PACO
PACIENTES DE CORAZÓN

pRxEngage

Roche

SAC
Sociedad Argentina de Cardiología

SAL

ŠIRDIES
NEPAKANKAMUMU
SERGANČIŲJŲ ASOCIACIJA

SRDCE RODINY

References:

1. Luengo-Fernandez R, Walli-Attaei M, Gray A, et al. Economic burden of cardiovascular diseases in the European Union: a population-based cost study. *Eur Heart J*. 2023;44(45):4752-4767. doi:10.1093/eurheartj/ehad583
2. Bhatia HS, Hurst S, Desai P, Zhu W, Yeang C. Lipoprotein(a) Testing Trends in a Large Academic Health System in the United States. *J Am Heart Assoc*. 2023;12(18):e031255. doi:10.1161/JAHA.123.031255
3. Stürzebecher PE, Schorr JJ, Klebs SHG, Laufs U. Trends and consequences of lipoprotein(a) testing: Cross-sectional and longitudinal health insurance claims database analyses. *Atherosclerosis*. 2023;367:24-33. doi:10.1016/j.atherosclerosis.2023.01.014
4. NCD Risk Factor Collaboration (NCD RisC). Global country profile: GHE110. NCD Portal. Accessed September 24, 2025. https://ncdportal.org/CountryProfile/GHE110/Global
5. Powell-Wiley TM, Baumer Y, Baah FO, et al. Social Determinants of Cardiovascular Disease. *Circ Res*. 2022;130(5):782-799. doi:10.1161/CIRCRESAHA.121.319811
6. Kronenberg F, Mora S, Stroes ESG, et al. Lipoprotein(a) in atherosclerotic cardiovascular disease and aortic stenosis: a European Atherosclerosis Society consensus statement. *Eur Heart J*. 2022;43(39):3925-3946. doi:10.1093/eurheartj/ehac361
7. Langsted A, Kamstrup PR, Nordestgaard BG. High lipoprotein(a) and high risk of mortality. *Eur Heart J*. 2019;40(33):2760-2770. doi:10.1093/eurheartj/ehy902
8. Tsimikas S, Stroes ESG. The dedicated "Lp(a) clinic": A concept whose time has arrived?. *Atherosclerosis*. 2020;300:1-9. doi:10.1016/j.atherosclerosis.2020.03.003
9. Mach F, Koskinas KC, Roeters van Lennep JE, et al. 2025 Focused Update of the 2019 ESC/EAS Guidelines for the management of dyslipidaemias. *Eur Heart J*. Published online August 29, 2025. doi:10.1093/eurheartj/ehaf190
10. Nordestgaard BG, Langsted A. Lipoprotein(a) and cardiovascular disease. *Lancet*. 2024;404(10459):1255-1264. doi:10.1016/S0140-6736(24)01308-4
11. Morton JI, Kronenberg F, Daccord M, et al. Lp(a) testing for the primary prevention of cardiovascular disease in high-income countries: a cost-effectiveness analysis. *Atherosclerosis*. 2025;120447. doi:10.1016/j.atherosclerosis.2025.120447
12. European Council. European Council conclusions. Council of the European Union. Accessed September 24, 2025. https://www.consilium.europa.eu/en/european-council/conclusions/
13. Bedlington N, Abifadel M, Beger B, et al. The time is now: Achieving FH paediatric screening across Europe - The Prague Declaration. *GMS Health Innov Technol*. 2022;16:Doc04. Published 2022 Sep 30. doi:10.3205/hta000136
14. PERFECTO. PERFECTO — Leading Familial Hypercholesterolaemia Paediatric Screening for a Heart-Healthy Europe. Accessed September 24, 2025. https://perfecto-fh.eu/
15. FH-EARLY. FH-EARLY: Transforming the future of Familial Hypercholesterolaemia (FH) Diagnosis and Care. Accessed September 24, 2025. https://fh-early.eu/
16. JACARDI. Joint Action on cardiovascular diseases and diabetes. Accessed September 24, 2025. https://jacardi.eu
17. European Network of Living Labs. Living Labs. Accessed September 24, 2025. https://enoll.org/living-labs/#living-labs

ACKNOWLEDGMENTS

FH Europe Foundation would like to thank warmly Romana Jerković, Member of the European Parliament (MEP) and Chair of the MEP Cardiovascular Health Group for hosting the Summit. FH Europe Foundation is grateful to Olivér Várhelyi EU Commissioner for Health, MEP Adam Jarubas, Chair of SANT, (European Parliament Health Committee), MEP András Kulja, MEP Tomislav Sokol and Caroline Bollars, Senior Advisor, WHO EU office who all kindly contributed to the Summit and its follow-up.

We also acknowledge and thank all those who contributed to the research, drafting, development, editing, and design of this declaration. Finally, we extend our appreciation to the organisations and individuals who have endorsed the Brussels Declaration and continue to support efforts to raise awareness of Lp(a) and advance cardiovascular health across Europe.

CITATION

Kronenberg F, Bedlington N, Ademi Z, et al. The Brussels International Declaration on Lipoprotein(a) Testing and Management. *Atherosclerosis*. 2025;406:119218. doi:10.1016/j.atherosclerosis.2025.119218

DISSEMINATION

FUNDING

The Lp(a) Global Summit was made possible through funding from FH Europe Foundation's industry partners: Amgen, Novartis, Roche Diagnostics, and Silence Therapeutics. We gratefully acknowledge their support. The Summit and the development of the Brussels Declaration, including its content, priorities, and recommendations, were conducted independently and without influence from funding partners.

Endorse the Brussels Declaration

CONTACT

FH Europe Foundation
www.fhef.org
info@fheurope.org