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Original Research Article

Rosuvastatin use in contemporary clinical practice: insights from a physician survey on lipid management and cardiovascular risk reduction

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ABSTRACT

Background: Contemporary lipid management guidelines advocate increasingly stringent low-density lipoprotein cholesterol (LDL-C) targets and earlier treatment intensification in patients at elevated cardiovascular risk. Rosuvastatin remains a widely prescribed statin owing to its potent LDL-C-lowering efficacy; however, real-world prescribing practices and treatment preferences continue to evolve with expanding use of combination lipid-lowering strategies. Objectives were to evaluate contemporary physician perspectives and prescribing practices related to rosuvastatin use across the cardiovascular risk continuum and assess alignment with current guideline recommendations.
Methods: A cross-sectional, questionnaire-based survey was conducted among 91 clinicians involved in cardiovascular risk management. The survey assessed rosuvastatin prescribing patterns, dose selection, combination therapy utilization, LDL-C treatment goals, treatment intensification strategies, lipid monitoring practices, post-percutaneous coronary intervention (PCI) lipid management, and integration of lipid-lowering and antiplatelet therapies. Data were analyzed using descriptive statistics and reported as percentages.
Results: Rosuvastatin monotherapy was preferred by 85.4% of clinicians in primary prevention, with rosuvastatin 10 mg being the most frequently prescribed dose (56.1%). Combination therapy use increased with cardiovascular risk, and 62.2% of clinicians preferred combination regimens in secondary prevention. Rosuvastatin plus ezetimibe was the most commonly selected lipid-lowering combination, while rosuvastatin plus aspirin plus clopidogrel was the preferred secondary prevention regimen (44.8%). LDL-C target attainment was the primary driver of treatment intensification, with 55.6% of clinicians targeting LDL-C<70 mg/dl and 44.4% pursuing more aggressive targets. Among high- and very-high-risk ASCVD patients and post-PCI populations, rosuvastatin 40 mg plus ezetimibe 10 mg was the most frequently preferred intensive lipid-lowering strategy. LDL-C remained the primary monitoring parameter, although ApoB and non-HDL-C were increasingly utilized.
Conclusions: Rosuvastatin remains the preferred foundation of lipid-lowering therapy in contemporary clinical practice. Increasing adoption of LDL-C goal-directed treatment intensification, ezetimibe-based combination therapy, prolonged post-PCI lipid management, and integration of lipid-lowering with antiplatelet strategies reflects growing alignment of real-world practice with current evidence-based guideline recommendations.

Keywords: Rosuvastatin, LDL-C, Dyslipidemia, ASCVD, Combination lipid-lowering therapy, Ezetimibe, Secondary prevention, PCI

INTRODUCTION

Cardiovascular disease (CVD) remains the leading cause of mortality worldwide and continues to impose a substantial global healthcare burden.[1] Elevated LDL-C is a well-established causal factor in the development of atherosclerotic CVD (ASCVD), and extensive evidence demonstrates that lowering LDL-C reduces the risk of

major cardiovascular events in a dose-dependent manner.[2,3] Consequently, lipid-lowering therapy remains a fundamental component of both primary and secondary prevention strategies.[3,4]

Over the past decade, international guidelines have undergone a paradigm shift toward increasingly stringent LDL-C targets, reflecting accumulating evidence that "lower is better" and that earlier, more intensive lipid lowering confers greater cardiovascular protection. The 2019 European Society of Cardiology/European Atherosclerosis Society (ESC/EAS) guidelines established aggressive LDL-C goals for high- and very-high-risk patients, recommending a target of <55 mg/dL (<1.4 mmol/L) with a ≥50% reduction from baseline for very-high-risk individuals.[4] This framework has been reinforced and refined by the 2025 ESC/EAS Focused Update, which maintains these treatment targets while broadening therapeutic options to include bempedoic acid for statin-intolerant patients and evinacumab for patients with homozygous familial hypercholesterolemia.[8] The update also emphasizes the principle of "the sooner, the lower, the better" for LDL-C lowering in patients with acute coronary syndromes (ACS), recommending intensification of lipid-lowering therapy during the index ACS hospitalization and earlier initiation of combination lipid-lowering strategies in appropriate patients.[8]

Concurrently, American guidelines have evolved toward more rigorous lipid management. The 2023 AHA/ACC/ACCP/ASPC/NLA/PCNA guideline for the management of patients with chronic coronary disease recommends high-intensity statin therapy as first-line treatment to achieve an LDL-C reduction of at least 50% and emphasizes combination lipid-lowering therapy in very-high-risk ASCVD patients who do not achieve recommended LDL-C targets.[9] The 2022 ACC expert consensus decision pathway further strengthened the role of nonstatin therapies, recommending LDL-C targets of <55 mg/dL in patients with clinical ASCVD at very high risk and providing practical treatment algorithms incorporating ezetimibe, PCSK9 inhibitors, bempedoic acid, and inclisiran.[10] More recently, the 2025 ACC/AHA/ACEP/NAEMSP/SCAI guideline for the management of patients with ACSs reinforced the use of high-intensity statin therapy for all patients with ACS and recommended the addition of nonstatin lipid-lowering therapy when LDL-C levels remain above guideline-recommended thresholds despite maximally tolerated statin treatment.[11] Collectively, these recommendations underscore an increasingly individualized and goal-directed approach to lipid management.[8-11]

Statins remain the cornerstone of lipid-lowering therapy because of their proven efficacy in reducing LDL-C levels and improving cardiovascular outcomes.[3,4] Among available statins, rosuvastatin is widely prescribed owing to its potent LDL-C-lowering efficacy, favorable safety profile, and ability to achieve recommended lipid targets across a broad range of patient populations. Clinical studies have demonstrated that rosuvastatin significantly reduces cardiovascular events and may contribute to regression of atherosclerotic plaque burden with intensive treatment.[5,6] Consequently, rosuvastatin is frequently utilized as a high-intensity statin in patients requiring substantial LDL-C reduction and cardiovascular risk mitigation.[3-6]

As treatment goals become more stringent, clinicians are increasingly required to make decisions regarding statin intensity, dose optimization, duration of therapy, lipid monitoring, treatment escalation, and the use of combination lipid-lowering strategies. Contemporary guidelines have also expanded the importance of additional lipid parameters, including apolipoprotein B (ApoB) and non-high-density lipoprotein cholesterol (non-HDL-C), particularly in patients at elevated cardiovascular risk.[4] Furthermore, the growing availability of adjunctive therapies such as ezetimibe, PCSK9 inhibitors, bempedoic acid, and inclisiran has increased the complexity of lipid management in routine clinical practice.[7-10]

Despite the availability of evidence-based recommendations, substantial variability in real-world lipid management practices continues to exist. The DA VINCI study demonstrated significant gaps between guideline-recommended LDL-C targets and their achievement in routine clinical practice, highlighting persistent challenges in the implementation of evidence-based lipid management strategies. These findings emphasize the need to better understand contemporary prescribing behaviors and treatment decision-making in everyday clinical settings.[12]

Accordingly, the present survey was conducted to assess contemporary prescribing practices related to rosuvastatin use among clinicians involved in cardiovascular risk management and to evaluate the extent to which current lipid-management strategies align with contemporary guideline recommendations. The survey explored preferences regarding dose selection, monotherapy and combination therapy use, lipid monitoring strategies, treatment escalation pathways, LDL-C treatment goals, and factors influencing the choice of rosuvastatin in both primary and secondary prevention settings.

METHODS

Study design

This was a cross-sectional, questionnaire-based survey conducted to evaluate contemporary prescribing practices and physician perspectives regarding rosuvastatin use in cardiovascular risk management. The survey was designed to capture real-world clinical approaches to lipid management across the cardiovascular risk continuum, including primary prevention, secondary prevention, ACS, and post-PCI settings.

Study setting and period

The study was carried out during a scientific meeting organized by the cardiological society of India (CSI) in December 2025. The survey was administered over the duration of 3 days of the conference period.

Study participants

A total of 91 clinicians participated in the survey. Participants included practicing physicians involved in the management of dyslipidemia and CVD. The survey was administered among clinicians attending national cardiology scientific meetings and professional educational programs. Participation was voluntary, and all responses were collected anonymously.

Survey instrument

A structured questionnaire comprising multiple-choice and opinion-based questions was developed to assess contemporary rosuvastatin prescribing practices. The questionnaire explored key aspects of lipid management, including: Preferred treatment strategies in primary and secondary prevention, Rosuvastatin dose selection and duration of therapy, utilization of rosuvastatin-based combination therapies, LDL-C treatment goals and thresholds for treatment intensification, treatment escalation pathways in patients not achieving LDL-C targets, use of rosuvastatin-ezetimibe combination therapy in high-risk ASCVD patients, lipid-lowering strategies following PCI, utilization of rosuvastatin combined with antiplatelet therapies, duration and indications for rosuvastatin-based triple therapy, lipid monitoring practices, including LDL-C, ApoB, and non-HDL-C assessment and factors influencing the selection of rosuvastatin in routine clinical practice.

Data collection and analysis

Survey responses were collected and compiled for analysis. Participation in individual questions was optional; therefore, the number of responses varied across survey items. For each question, analyses were performed using the number of clinicians providing a valid response as the denominator. Data were analyzed using descriptive statistical methods. Categorical variables were summarized as frequencies and percentages. Results were presented to describe prevailing trends in rosuvastatin prescribing patterns, combination therapy preferences, LDL-C target-oriented management, treatment intensification strategies, post-PCI lipid management, and lipid monitoring practices.

Ethical considerations

The survey assessed physician opinions and prescribing preferences and did not involve patient recruitment or collection of patient-identifiable information. All responses were anonymized prior to analysis, and findings were reported in aggregate form to maintain participant confidentiality. Participation in the survey was voluntary, and completion of the questionnaire was considered indicative of informed consent.

RESULTS

A total of 91 clinicians participated in the survey evaluating contemporary lipid-lowering practices and rosuvastatin-based treatment strategies across the cardiovascular risk continuum, including primary prevention, secondary prevention, ACS, and post-PCI settings.

Contemporary rosuvastatin prescribing patterns

Rosuvastatin emerged as the preferred statin across a broad spectrum of cardiovascular risk categories. In primary prevention, 85.4% of clinicians preferred rosuvastatin monotherapy, while only 14.6% favored rosuvastatin-based combination therapy. Rosuvastatin 10 mg was the most frequently prescribed dose (56.1%), followed by rosuvastatin 5 mg (17.1%), rosuvastatin 20 mg (14.6%), and rosuvastatin 40 mg (12.2%).

Regarding treatment duration, 50.0% of clinicians preferred lifelong therapy or treatment beyond five years, whereas 22.2% favored treatment for less than one year and 16.7% preferred treatment for one to two years.

When asked about factors influencing statin selection, superior LDL-C lowering efficacy was the most frequently cited reason for preferring rosuvastatin over atorvastatin (28.6%). Other reasons included suitability for high-risk patients requiring stringent LDL-C control (21.4%), favorable pleiotropic effects (14.3%), improved tolerability (14.3%), affordability or inadequate response to atorvastatin (14.3%), and use in selected heart failure or chronic stable angina patients (14.3%).

Evolution toward combination lipid-lowering therapy

As shown in Figure 1, clinicians demonstrated a clear preference for treatment intensification through combination therapy. Among physicians considering combination therapy in primary prevention, rosuvastatin plus ezetimibe was the most preferred regimen (48.0%), followed by rosuvastatin plus fenofibrate (24.0%). Less frequently selected regimens included rosuvastatin plus aspirin (12.0%), rosuvastatin plus clopidogrel (8.0%), and rosuvastatin plus bempedoic acid (8.0%).

This trend became even more evident in secondary prevention, where 62.2% of clinicians preferred rosuvastatin-based combination therapy compared with 37.8% who favored monotherapy. Among preferred combination regimens, rosuvastatin plus aspirin plus clopidogrel emerged as the most commonly selected strategy (44.8%), followed by rosuvastatin plus aspirin

(24.1%), rosuvastatin plus clopidogrel (17.2%), and rosuvastatin plus ezetimibe (10.3%) (Figure 2).

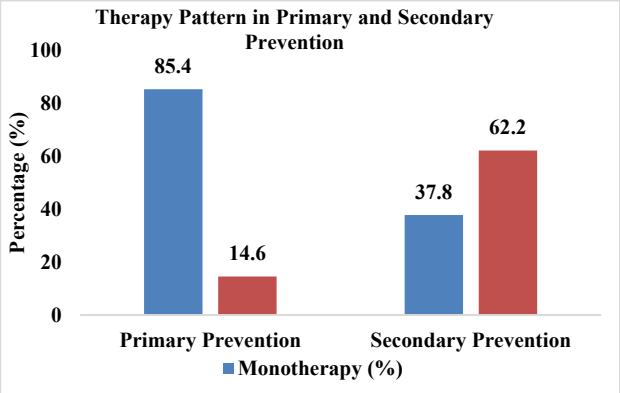

Figure 1: Transition from monotherapy to combination therapy across cardiovascular risk categories.

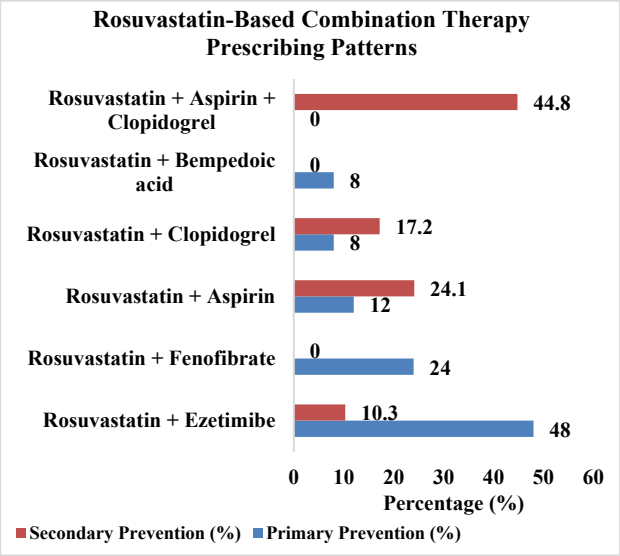

Figure 2: Preferred rosuvastatin-based combination strategies in primary and secondary prevention.

LDL-C targets and goal-directed therapy

Achievement of LDL-C targets emerged as the principal determinant of therapeutic decision-making. Most clinicians reported initiating combination lipid-lowering therapy when LDL-C levels were ≥70 mg/dl (22%). However, a proportion of clinicians adopted more aggressive approaches, initiating combination therapy at LDL-C levels between 55-69 mg/dl (10%) or even at LDL-C ≤55 mg/dl (15%).

Among clinicians specifying LDL-C targets, the most commonly targeted goal was LDL-C <70 mg/dl (55.6%). More intensive targets included LDL-C <50 mg/dl (22.2%), LDL-C ≤55 mg/dl (11.1%), and LDL-C <40 mg/dl (11.1%) (Figure 3).

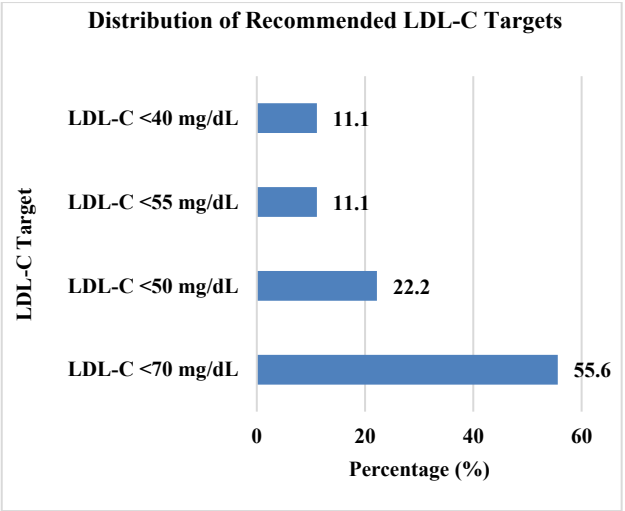

Figure 3: LDL-C targets preferred by clinicians for cardiovascular risk reduction.

Importantly, there was strong physician support for early intensive lipid lowering. A substantial majority of respondents either agreed (35%) or strongly agreed (49%) that early initiation of rosuvastatin plus ezetimibe improves achievement of LDL-C goals and contributes to better long-term cardiovascular outcomes.

Treatment intensification strategies

Clinicians generally followed a structured escalation pathway when LDL-C goals were not achieved. The most frequently reported treatment intensification pathway involved progression from rosuvastatin 20 mg to rosuvastatin 40 mg, followed by rosuvastatin plus aspirin plus clopidogrel and subsequently rosuvastatin plus clopidogrel, reported by 58.6% of respondents.

Another commonly reported pathway involved escalation from rosuvastatin 20 mg to rosuvastatin 40 mg followed by addition of ezetimibe, reported by 24.1% of clinicians.

Failure to achieve LDL-C targets was the predominant factor driving treatment escalation (75.0%). Other considerations included high cardiovascular risk (37.5%), acute coronary events (31.3%), and diabetes with multiple cardiovascular risk factors (31.3%).

Management of high-risk ASCVD patients

Among hospitalized high- and very-high-risk ASCVD patients, rosuvastatin 40 mg plus ezetimibe 10 mg was the most frequently initiated lipid-lowering regimen (26%), exceeding the use of rosuvastatin 40 mg monotherapy (21%). This finding suggests increasing physician confidence in early combination therapy for patients requiring rapid and substantial LDL-C reduction (Figure 4).

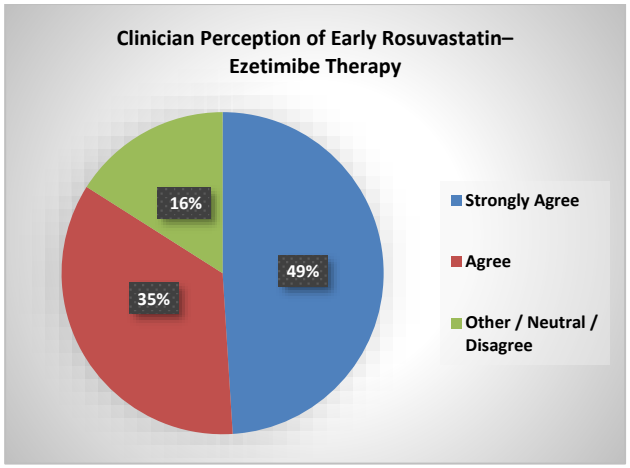

Figure 4: Perception of early rosuvastatin–ezetimibe therapy.

Further supporting this approach, the most commonly observed LDL-C reduction with rosuvastatin 40 mg plus ezetimibe 10 mg was between 40% and 50% (40.6%), whereas 20.3% of clinicians reported LDL-C reductions below 40%.

Lipid management following PCI

Patients undergoing PCI represented a group in whom clinicians frequently adopted more intensive lipid-lowering strategies. In post-PCI patients, rosuvastatin 40 mg plus ezetimibe 10 mg was initiated slightly more frequently (24%) than high-intensity statin monotherapy (23%).

Regarding treatment duration, the largest proportion of clinicians (44%) reported continuing combination lipid-lowering therapy for more than 12 months following PCI.

Integration of lipid-lowering and antiplatelet strategies

Figure 5 shows most common indication for rosuvastatin-based triple therapy was ACS undergoing PCI (62.5%). Other indications included stable coronary artery disease (16.7%), young myocardial infarction patients (12.5%), post-CABG patients (12.5%), post-PCI patients (12.5%), and peripheral or carotid artery disease (8.3%).

Among clinicians reporting duration of rosuvastatin plus aspirin plus clopidogrel therapy, 61.5% preferred treatment for one year, while 23.1% favored treatment beyond one year or lifelong and 15.4% preferred treatment for six months.

Utilization of triple therapy differed substantially according to clinical setting. Among ASCVD patients without PCI, 33.3% of clinicians prescribed triple therapy to fewer than 20% of patients and another 33.3% prescribed it to 20-30% of patients. In contrast, among PCI patients, 37.5% of clinicians reported prescribing triple therapy to more than 75% of eligible patients.

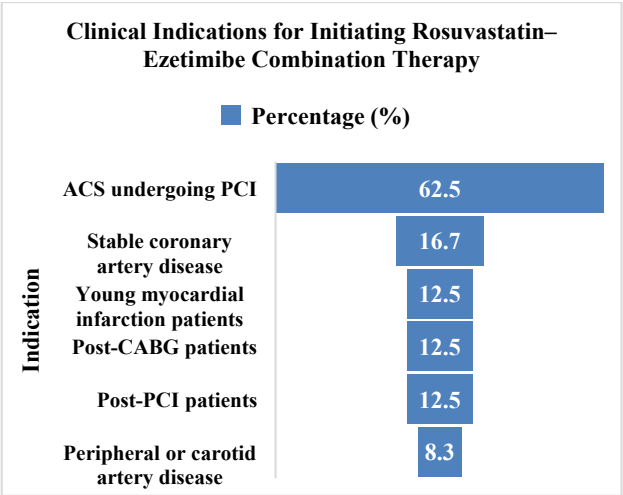

Figure 5: Clinical indications for rosuvastatin-based triple therapy in contemporary practice.

Lipid monitoring practices

LDL-C remained the cornerstone of lipid monitoring in routine clinical practice. Among clinicians recommending specific lipid assessments, LDL-C or lipid profile testing was recommended by 68.2% of respondents. ApoB and non-HDL-C were recommended by 36.4% and 31.8% of clinicians, respectively, while comprehensive lipid assessment was recommended by 13.6%.

Similarly, LDL-C was the most frequently monitored parameter during follow-up (62.5%), whereas ApoB and non-HDL-C were each monitored by 37.5% of the clinicians.

DISCUSSION

The present survey provides insights into contemporary physician perspectives regarding rosuvastatin use and lipid-lowering strategies across the cardiovascular risk continuum.

Several important observations emerged from the survey, including the predominant use of rosuvastatin as the preferred statin in primary prevention, increasing adoption of combination lipid-lowering therapy in higher-risk populations, strong emphasis on LDL-C goal-directed management, growing acceptance of early rosuvastatin-ezetimibe therapy, and the use of intensive lipid-lowering approaches following PCI and in patients with established ASCVD.

A key finding of the survey was the continued preference for rosuvastatin as the foundation of lipid-lowering therapy and clinicians view lipid management as a long-term strategy aimed at sustained cardiovascular risk reduction. Most clinicians favored rosuvastatin monotherapy in primary prevention, with rosuvastatin 10 mg being the most commonly prescribed dose. This preference is consistent with evidence demonstrating the

potent LDL-C-lowering efficacy of rosuvastatin and its established role in cardiovascular risk reduction. In the JUPITER trial, rosuvastatin significantly reduced major cardiovascular events among individuals without prior CVD but with elevated inflammatory risk, supporting its role in primary prevention.[5] Furthermore, the ASTEROID trial demonstrated that intensive rosuvastatin therapy was associated with regression of coronary atherosclerotic plaque burden, highlighting its effectiveness in modifying disease progression.[6] The continued preference for rosuvastatin observed in this survey likely reflects clinician confidence in its ability to achieve substantial LDL-C reductions while maintaining an acceptable safety profile.

Another notable observation was the increasing use of combination lipid-lowering therapy as cardiovascular risk increased. While monotherapy predominated in primary prevention, clinicians demonstrated a clear preference for combination-based approaches in secondary prevention and high-risk ASCVD populations. The transition from rosuvastatin monotherapy in primary prevention to combination therapy in secondary prevention suggests increasing adoption of a risk-based, LDL-C target-oriented treatment approach among clinicians.[3,4] The growing utilization of rosuvastatin-ezetimibe combinations observed in the survey is particularly relevant because combination therapy enables greater LDL-C lowering than statin monotherapy and may facilitate more rapid attainment of guideline-recommended lipid targets. Evidence from the IMPROVE-IT trial demonstrated that the addition of ezetimibe to statin therapy following ACS resulted in incremental LDL-C reduction and significant improvement in cardiovascular outcomes, thereby establishing the clinical value of combination lipid-lowering therapy in high-risk patients.[7]

The survey also highlighted the importance of LDL-C goal-directed management in routine clinical practice. Failure to achieve LDL-C targets was identified as the predominant driver of treatment intensification, and most clinicians reported targeting LDL-C levels below 70 mg/dL, with a substantial proportion pursuing even lower targets. These findings are consistent with current guideline recommendations that advocate increasingly stringent LDL-C goals according to cardiovascular risk.[3,4] More recent ESC/EAS and ACC recommendations have further emphasized aggressive LDL-C lowering, particularly among very-high-risk patients, reflecting accumulating evidence that lower LDL-C levels are associated with greater cardiovascular benefit.[8-11] The findings are also consistent with the causal relationship between LDL-C exposure and ASCVD risk described by Ference et al whereby greater and sustained LDL-C reduction translates into progressive reductions in cardiovascular events.[2] Furthermore, the FOURIER trial demonstrated that intensive LDL-C lowering beyond statin therapy was associated with significant reductions in major cardiovascular events, reinforcing the concept that achieving lower LDL-C levels provides incremental cardiovascular benefit in high-risk populations.[13] The strong physician support for early rosuvastatin-ezetimibe therapy observed in the survey further suggests increasing acceptance of proactive treatment strategies aimed at achieving lipid targets earlier in the disease course. In contrast, the DA VINCI study demonstrated that a substantial proportion of patients across Europe failed to achieve guideline-recommended LDL-C targets despite receiving lipid-lowering therapy, highlighting persistent gaps between evidence and routine clinical practice.[12]

An important finding of the present survey was the adoption of intensive lipid-lowering strategies among patients with established ASCVD and those undergoing PCI. In these settings, clinicians frequently favored rosuvastatin 40 mg combined with ezetimibe and often continued combination therapy for prolonged durations following PCI. These observations are aligned with contemporary recommendations that identify patients with ACS and recent coronary revascularization as being at particularly high risk for recurrent cardiovascular events.[8,11] Recent guideline updates emphasize early initiation and timely intensification of lipid-lowering therapy during and after ACS hospitalization to minimize residual cardiovascular risk. The odyssey outcomes trial further demonstrated that intensive LDL-C lowering after ACS was associated with significant reductions in recurrent cardiovascular events, supporting aggressive lipid management in this high-risk population.[14] The survey findings suggest that many clinicians are increasingly incorporating these principles into routine practice.

The survey additionally demonstrated substantial use of rosuvastatin-based antiplatelet combinations in secondary prevention. Triple therapy containing rosuvastatin, aspirin, and clopidogrel was most commonly utilized in patients undergoing PCI for ACS, reflecting the central role of comprehensive secondary prevention strategies in this population. Although lipid lowering and antiplatelet therapy address different pathophysiological mechanisms, both contribute to reduction of recurrent cardiovascular events following ACS and coronary intervention, as emphasized in contemporary guideline recommendations for the management of ACSs and chronic coronary disease.[9,11] The observed preference for combined approaches is further supported by Indian real-world utilization studies demonstrating widespread use of fixed-dose combinations containing rosuvastatin, aspirin, and clopidogrel among ACS and post-PCI patients as part of the comprehensive secondary prevention strategies.[15-17]

Another noteworthy finding was the continued predominance of LDL-C as the principal lipid parameter used for treatment decisions and follow-up monitoring. However, a considerable proportion of clinicians also reported monitoring ApoB and non-HDL-C. This trend is consistent with growing recognition of the value of these parameters in risk assessment and residual risk evaluation, particularly among patients with mixed dyslipidemia,

diabetes mellitus, or elevated triglyceride levels. Contemporary guidelines increasingly acknowledge the complementary role of ApoB and non-HDL-C in selected patient populations.[4,8]

The findings of the present survey should be interpreted within the context of certain limitations. The survey reflects physician-reported preferences and prescribing behaviors rather than actual patient-level treatment patterns or clinical outcomes. Participation was voluntary, introducing the potential for selection bias. In addition, response rates varied across survey questions, and the relatively modest sample size may limit generalizability. Nevertheless, the survey provides valuable real-world insights into current lipid-management practices among clinicians actively involved in cardiovascular risk management.

Overall, the survey findings demonstrate increasing alignment between contemporary clinical practice and evolving guideline recommendations. While rosuvastatin remains the preferred foundation of lipid-lowering therapy, clinicians are increasingly adopting LDL-C goal-directed treatment strategies, earlier treatment intensification, combination lipid-lowering therapy, and prolonged secondary prevention in high-risk patients. The survey provides contemporary insights into physician decision-making across the lipid-management continuum.

CONCLUSION

The findings of this survey suggest increasing adoption of intensive and goal-directed lipid-lowering strategies among clinicians involved in cardiovascular risk management. Rosuvastatin remains the preferred foundation of lipid-lowering therapy across the cardiovascular risk continuum, while growing use of ezetimibe-based combination therapy, LDL-C target-oriented treatment intensification, prolonged lipid-lowering therapy following PCI, and integration of lipid-lowering with antiplatelet strategies in secondary prevention reflect evolving contemporary clinical practice. Collectively, these findings indicate increasing alignment of real-world prescribing patterns with current evidence-based guideline recommendations aimed at optimizing LDL-C control, minimizing residual cardiovascular risk, and improving long-term cardiovascular outcomes.

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