Review of: "Why Non-HDL Cholesterol is Preferred over Apolipoprotein B-100 (Apo B)"

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Potential competing interests: No potential competing interests to declare.

Good short, well written review on a relevant clinical topic in cardiovascular disease. I have the following two comments:

The author wrote: *Moreover, total C not LDLC is a part of the risk assessment but as shown in Figure 1, it seems to be a less sensitive marker than apo B or non-HDLC, about equivalent to LDLC.*

Comment: Total cholesterol is not shown in Table 1. Table 1 is not easy to read. It could help if the three groups below each measured biomarker (apoB, LDL-C, non-HDL-C) are identified/described better.

The author wrote: *The 2016/2017 AHA/ACC guideline identify LDLC and non-HDLC as equivalent targets,[29][31][32] but disappointingly the 2018 guidelines focused mainly on LDLC. [18][33] The AHA presidential advisory Committee has defined the updated metric for blood lipids to be non-HDL cholesterol as the preferred number to monitor. [34] It seems that non-HDLC should be the focus.*

Comment: The reason may be, because the aim of the ACC/AHA (and EAS) guidelines is to guide health care providers to treat elevated LDL-C because there are mainly lipid lowering dugs that reduce LDL-C but not other apoB-containing lipoproteins, i.e remnants and Lp(a). The day other new therapies will be available to treat elevated triglyceride-rich lipoproteins and Lp(a) with shown CV benefit, then the guidelines will change and become more accurate identifying the type of dyslipdiemia CV patients have and how the recommended treatment.

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