MyCardioAdvocate™

Coronary Artery Calcium (CAC) & Cardiovascular Risk

When 'normal labs' mask advanced atherosclerosis and missed prevention

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Why This Matters

Your cholesterol is normal. Your blood pressure is controlled. Your EKG is fine. You feel great. Yet a single 10-minute CT scan reveals calcium deposits in your coronary arteries—evidence that plaque has been building silently for years. This is the power and the peril of coronary artery calcium (CAC) imaging: it can reveal atherosclerosis that blood tests and symptoms completely miss. For the right patient at the right time, CAC can be transformative, shifting someone from a sense of invulnerability to appropriate preventive action. For others, an unexpected CAC finding can trigger anxiety, overtreatment, or counterproductive decisions (like stopping the statins that are actually stabilizing the plaque).

Until recently, CAC was treated as a tiebreaker—a way to settle risk-stratification disagreements in borderline cases. But the 2026 guidelines have fundamentally reframed CAC. It is now viewed as a centerpiece of risk assessment, especially when modern scoring systems (PREVENT calculator, CPR framework) are applied. CAC ≥1000 now qualifies as secondary prevention, meaning treatment targets shift dramatically. Incidental CAC detected on routine CT scans (chest imaging for other reasons) is now COR 1 (recommended) for risk reclassification. And a detailed tiered approach—from CAC=0 all the way to CAC ≥1000—provides clarity on what to do next.

This brief demystifies CAC: what it measures, what your score means, how 2026 guidelines reshape management, and how to use it (without anxiety) to advocate for the right prevention strategy.

Why CAC Flies Under the Radar

- Not routine: CAC is not part of standard CVD screening; it requires a dedicated request and referral
- Viewed as tiebreaker, not centerpiece: historically used only when risk was borderline; now recognized as primary tool
- Insurance variability: coverage inconsistent; some plans deny CAC unless high-risk symptoms
- Not in PREVENT calculator: the newer risk calculator does not explicitly call for CAC, though it should inform interpretation
- Clinician hesitation about 'incidental findings': fear of finding something unexpected; actually these findings drive appropriate prevention
- Lack of patient awareness: many patients never offered CAC; if offered, may worry it will reveal catastrophe

What Changed in 2026

2026 Guidelines Transform CAC into a Primary Risk Tool

Detailed tiered thresholds: CAC=0 vs. 1–99 vs. 100–299 vs. 300–999 vs. ≥1000 each have specific management. CAC ≥1000 treated as secondary prevention (LDL-C <55). Incidental CAC on noncardiac CT is COR 1 (recommended) for risk assessment. CPR Framework (Calculate-Personalize-Reclassify) integrates CAC into shared decision-making. CCTA (coronary CT angiography) COR 2b for high-risk plaque burden. Statins increase CAC density (good sign: plaque stabilization).

2026 CAC Score Interpretation:

- **CAC=0:** Very low risk; reassurance for 5-10 years
- **CAC 1–99:** Low risk; statin if risk enhancers present
- **CAC 100–299:** Intermediate; initiate/optimize statin
- **CAC 300–999:** High; treat as secondary prevention (LDL-C <55)
- **CAC ≥1000:** Very high; aggressive multi-drug therapy, LDL-C <55

MyCardioAdvocate Checklist

1. Should I Get a CAC Scan?

■ *Is CAC screening right for me, or am I at low risk and can defer it?*

CAC is most useful for primary prevention in adults aged 40-75 without prior CVD events and intermediate risk (10-year risk 5-20%). If you are very low risk, CAC adds little. If you are already on statins or have prior events, CAC interpretation changes. Discuss with your clinician: Does CAC scanning make sense for MY risk profile?

■ **CAC is not for everyone, but if you are in the intermediate-risk zone and unsure about prevention, it can be very helpful.**

2. Understand What My CAC Score Means

■ *If I have a CAC score, do I know what it signifies and how it changes my management?*

CAC=0 is reassuring but does not eliminate risk if you have risk enhancers. CAC 1–99 suggests beginning atherosclerosis. CAC ≥100 is evidence of significant plaque and typically warrants statin initiation or intensification. CAC ≥1000 means secondary prevention targets (LDL-C <55).

■ **Your CAC score directly informs treatment intensity. Know what it means for YOUR management.**

3. Is My Treatment Matched to My CAC Score?

■ *If I have a high CAC score (≥100), am I on appropriate medications?*

CAC ≥100 warrants statin initiation or intensification. CAC ≥1000 warrants secondary prevention targets (LDL-C <55) and often combination therapy (statin + ezetimibe + PCSK9i). Ask your clinician: What is my LDL-C goal based on my CAC?

■ **High CAC + undertreatment = wasted opportunity. Ensure your medications match your CAC-based risk tier.**

4. Track What CAC Cannot Show

■ *Does a CAC score tell the full plaque story?*

CAC detects calcified (stable) plaque. It misses noncalcified (lipid-rich, rupture-prone) plaque. If you have low CAC but recent chest pain, high lipids, or strong risk factors, you may benefit from CCTA (CT angiography) to visualize soft plaque.

■ **Low CAC does not exclude high-risk lipid-rich plaque. CAC is one tool, not the whole story.**

5. When and Whether to Repeat CAC Scanning

■ *Should I get a repeat CAC scan, and how often?*

Typical intervals: CAC=0 → repeat in 10 years (or defer). CAC 1–99 → repeat in 5–10 years. CAC ≥100 → repeat in 3–5 years. Progressive CAC does not necessarily mean your therapy is failing; it may need intensification or plaque was advanced to begin with.

■ **Stable or slowly progressive CAC on statins is good news; it means plaque is stabilizing.**

> **Pro Tip:** If you started a statin and your next CAC increases, do NOT panic. Statins can increase CAC density by stabilizing plaque. A higher CAC may actually reflect safer, more stable plaque. Ask your clinician to assess the DENSITY and progression rate, not just the score.

CPR Opportunities — Shared Decision-Making

CAC=0 With Risk Enhancers: Can You Safely Defer Statins?

> **The Gray Area:** You have CAC=0 (reassuring) but carry Lp(a) ≥50 mg/dL, strong family history, or diabetes. Should statins be started anyway?

What the data suggests: CAC=0 is reassuring, but not a free pass with strong risk enhancers. Lp(a), family history, and diabetes shift the calculus. A statin may be recommended to prevent FIRST plaque formation. Discuss: wait for CAC progression or start preventive therapy now?

Repeat CAC Scanning: When Does Progression Change Management?

> **The Gray Area:** Your baseline CAC was 50. Two years later, on a statin, it's 150. Clinician says density increased (good) but score increased (concerning?). Intensify therapy?

What the data suggests: Density is more important than absolute score. If density increased (more calcium, less lipid), plaque is stabilizing. Rapid doubling (<2 years) may warrant intensification, but moderate progression with densification is often acceptable. Ask your clinician about DENSITY and RATE.

On the Horizon

AI-Based CAC and Deep Learning

Machine learning can detect coronary calcium from routine chest CTs without dedicated imaging. AI tools can classify plaque stability and predict rupture risk, moving beyond CAC score to actual PLAQUE RISK.

Key Takeaways

- CAC imaging reveals atherosclerosis that labs and symptoms miss.
- 2026 guidelines elevate CAC as a primary risk tool with tiered management from CAC=0 to ≥1000.

- CAC ≥1000 qualifies as secondary prevention (LDL-C <55).
- Incidental CAC on noncardiac CT is now COR 1—recommended for risk assessment.
- CAC=0 is reassuring but doesn't eliminate risk with strong enhancers.
- Rising CAC on statins may reflect beneficial plaque densification.

Next Steps

- Discuss with your clinician whether CAC screening fits your age and risk.
- If offered CAC, know it's a powerful risk-assessment tool, not something to fear.
- If you have a CAC score, know what it means and discuss management with your clinician.
- If CAC ≥100, confirm LDL-C goal and medications match your CAC tier.
- If on statins with CAC, ask about plaque DENSITY and RATE, not just score.

Learn more at CardioAdvocate.com

Related CardioAdvocate Content

- A Picture Worth a Thousand Words: Interpreting Your CAC Score
- The Incidentaloma: What to Do With Unexpected Cardiac Findings
- Risk Calculators Decoded: PREVENT, Framingham, and the CPR Framework
- Lipid Guidelines 2024–2026: When CAC Meets Drug Therapy
