

## THE PRESENT AND FUTURE

### REVIEW TOPIC OF THE WEEK

# The Risk Continuum of Atherosclerosis and its Implications for Defining CHD by Coronary Angiography



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#### ABSTRACT

Patients undergoing coronary angiography for suspected coronary heart disease who are found to have coronary atherosclerotic disease with <50% diameter stenosis may carry a risk of adverse cardiac events similar to that in patients with single-vessel obstructive disease. Yet clinical practice guidelines offer no direction for managing symptomatic patients with nonobstructive coronary atherosclerosis because current diagnostic criteria for coronary heart disease are not met. Accordingly, secondary preventive measures are not endorsed, and their role is not defined in this setting. Available data suggest that we are missing the opportunity to provide effective preventive measures in millions of patients with nonobstructive coronary heart disease. The emergence of noninvasive coronary angiography in patients with suspected coronary heart disease provides the opportunity to transition from a categorical perspective on the presence or absence of coronary heart disease to accepting the risk continuum from atherosclerosis and its implications for diagnosis and management. (J Am Coll Cardiol 2016;68:2467-78)  
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A 43-year-old woman presents to a physician's office complaining of intermittent chest discomfort that is not related to identifiable triggers. She carries a history of arterial hypertension and achieved good blood pressure control on a diuretic agent/angiotensin-receptor-antagonist combination. Her physical examination is unremarkable, except for mild obesity. A baseline electrocardiogram is normal. Her serum cholesterol and low-density lipoprotein levels are in a low-risk range. She underwent exercise stress testing with myocardial imaging, which did not provoke symptoms or reveal evidence of myocardial ischemia. The patient's symptoms persisted, and she eventually underwent computed tomography (CT) coronary angiography to conclusively rule out coronary heart disease (CHD). CT angiography revealed noncalcified atherosclerotic disease

in her proximal left anterior descending artery (LAD) with an approximately 40% lumen diameter stenosis (Figure 1). Very mild atherosclerotic disease was also noted in her left circumflex and right coronary arteries, both with <30% lumen narrowing. Although her symptoms may or may not be related to these angiographic findings, the question of whether preventive measures (e.g., aspirin and statin therapy) are indicated to lower her risk of adverse cardiac events arises.

#### DEFINING THE ISSUE

The case example illustrates several problems with our present concept of defining CHD using coronary angiography. According to current practice guidelines, the diagnosis and management of CHD center



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**ABBREVIATIONS  
AND ACRONYMS**

**CHD** = coronary heart disease

**CT** = computed tomography

**FFR** = fractional flow reserve

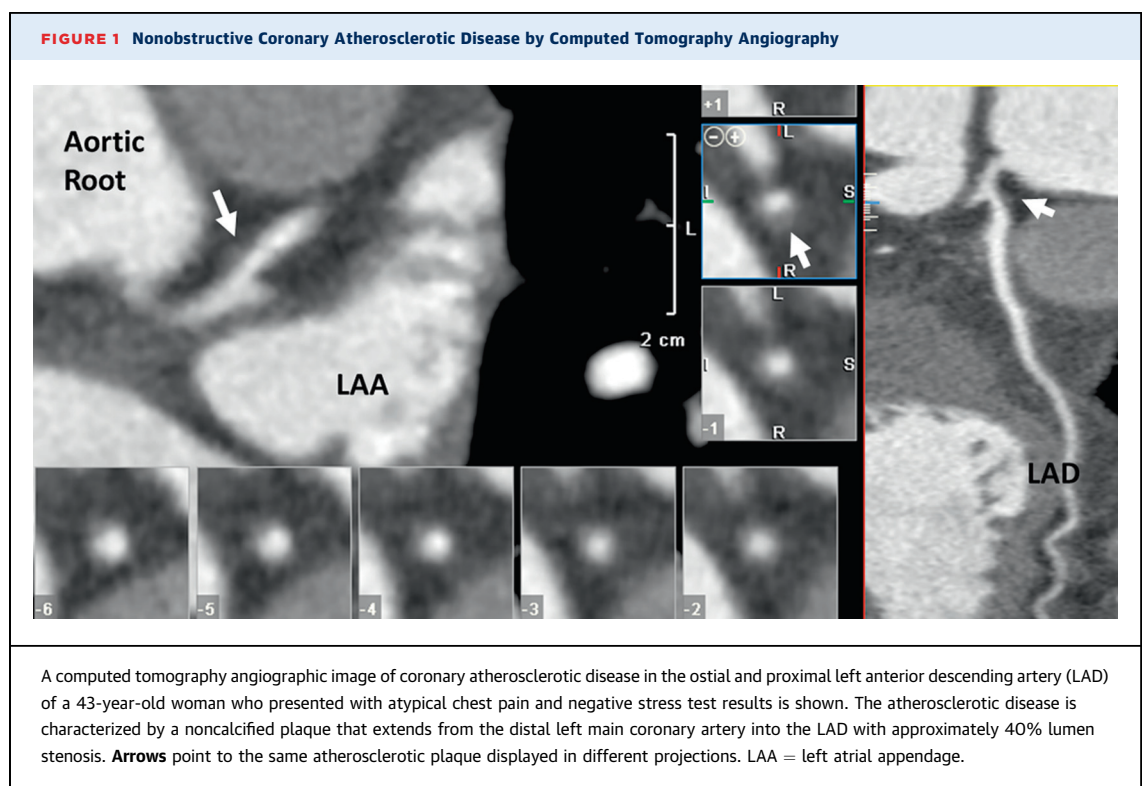
**LAD** = left anterior descending artery

on the presence of either provokable myocardial ischemia or at least 1 coronary arterial stenosis of 50% or greater (1-3). Such patients are at high risk for adverse cardiac events and are candidates for comprehensive secondary preventive measures (4). Conversely, symptomatic patients without history of myocardial infarction or coronary artery revascularization who have evidence of coronary atherosclerotic disease, but have no provokable ischemia or high-grade stenoses, are presumed to have neither CHD nor clinical atherosclerotic cardiovascular disease (1-5). These patients are considered low risk for death from cardiovascular causes, and the appropriate use of preventive measures (e.g., high-intensity statin therapy) is neither established nor endorsed by practice guidelines (1,4,5). As a result, secondary prevention is less frequently implemented in these patients (6).

Several large clinical datasets, using both conventional and CT coronary angiography, have demonstrated that symptomatic patients with non-obstructive coronary atherosclerotic disease (<50% diameter stenosis) carry risk of myocardial infarction and death, which may be similar to that of patients with single-vessel obstructive disease (7-10). Among more than 11,000 patients undergoing invasive

coronary angiography, men and women with diffuse coronary atherosclerotic disease, but without a  $\geq 50\%$  stenosis, had indistinguishable adverse event rates after 7 years compared with patients with single-vessel CHD (Figure 2) (10). In a registry of 37,674 Veteran Affairs patients undergoing cardiac catheterization, patients with nonobstructive disease in 3 coronary arteries had an annual risk of myocardial infarction and death exceeding 3% (i.e., consistent with high risk), which was similar to the risk in patients with single-vessel CHD (9). Another large registry demonstrated that the mortality risk gradually increased with the extent of nonobstructive coronary atherosclerotic disease by CT angiography (11). Indeed, these data from more than 80,000 patients consistently demonstrate a risk continuum of adverse events with the extent of atherosclerotic disease without a threshold effect for lumen obstruction or hemodynamically significant CHD (12).

An analysis of chest pain characteristics of 15,888 patients without history of CHD undergoing elective coronary angiography revealed that only 37% had typical angina, whereas most had atypical chest pain or symptoms not ascribed to cardiac disease (13). Yet more than 80% of patients in this cohort had evidence of either obstructive (48%) or nonobstructive (33%) coronary disease by cardiac catheterization. Chest



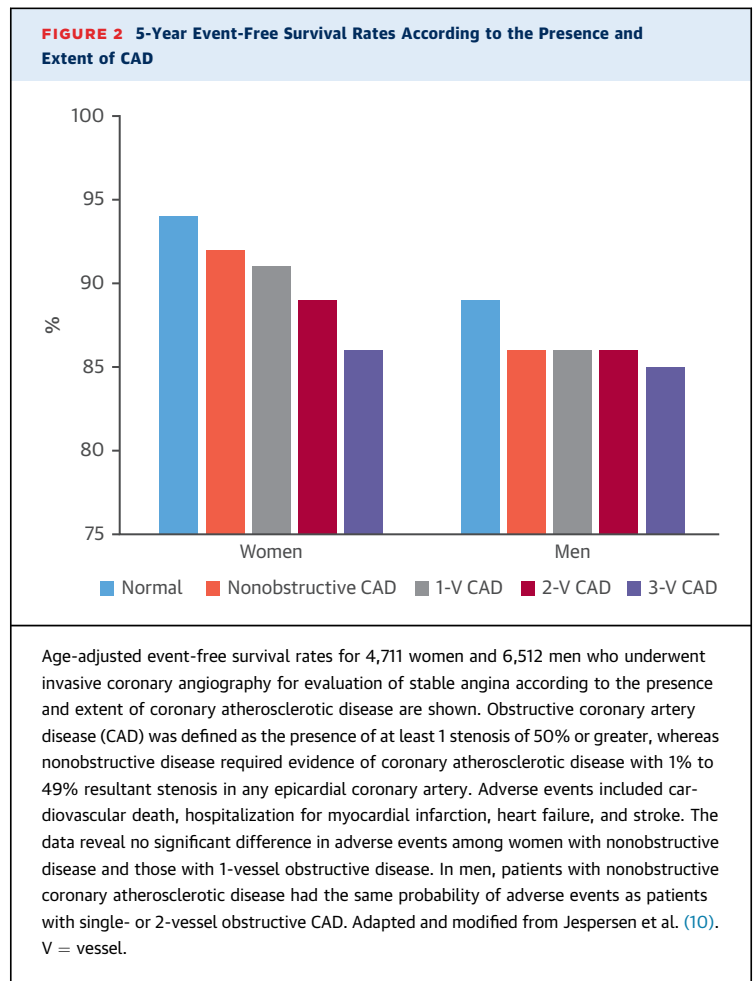
pain symptoms in patients with nonobstructive CHD are often attributed to other causes than coronary atherosclerosis because the resultant lumen narrowing is unlikely to reduce coronary flow reserve. However, intermittent myocardial ischemia may yet be elicited via different mechanisms. Vascular endothelial dysfunction is commonly encountered in the presence of coronary atherosclerotic disease, which may lead to vasospasm and/or reduced coronary flow reserve (14). Coronary microvascular dysfunction is an important, frequent cause of myocardial ischemia in women with angina, but without evidence of obstructive CHD (15,16). Last, intermittent myocardial ischemia may occur in the setting of peripheral thrombotic embolization from proximal, nonobstructive coronary atherosclerotic plaques in patients with stable CHD (17,18).

Until recently, patients with nonobstructive CHD were rarely identified because stress tests are insensitive to coronary atherosclerotic disease without advanced lumen narrowing (19); only patients with high suspicion for obstructive CHD undergo cardiac catheterization in which more sensitive tools for detecting atherosclerotic disease are used. With the emergence of noninvasive coronary angiography by CT and, to some extent, cardiac magnetic resonance imaging, even small atherosclerotic plaques are now detectable, but the implications of these findings for patient management remained unclear until recently.

There is strong and consistent evidence from clinical studies that risk from CHD does not abruptly increase with the presence of a stenosis, but reflects the burden of disease on a wide spectrum, rising from very low to very high with the extent of atherosclerotic disease (Figure 3) (20). Multivessel CHD is associated with a worse patient outcome than the involvement of only a single artery (21). To appropriately allocate resources, we need to adjust our current approach to CHD and recognize the risk continuum associated with the burden of atherosclerotic disease. Such a view mandates expanding risk assessment in patients from our current simple categorization of presence or absence of obstructive CHD to a wider risk spectrum (i.e., ranging from very low to very high risk).

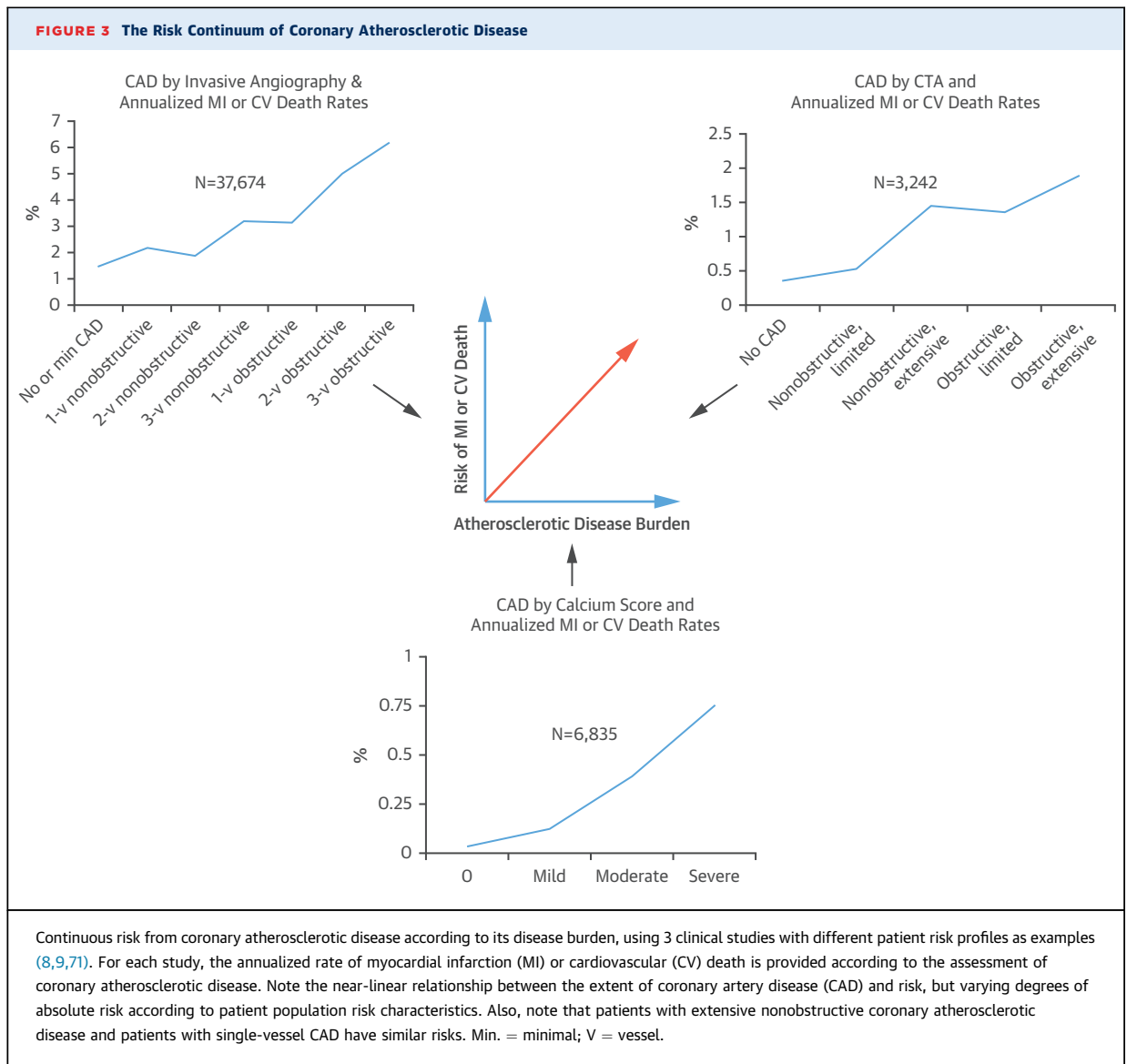
### SCOPE OF THE PROBLEM

The PESA (Progression of Early Subclinical Atherosclerosis) study revealed coronary artery calcification (evidence of coronary atherosclerotic disease) in 18% of an asymptomatic, middle-aged cohort, including many subjects categorized as low risk by traditional risk scores (22). Among 4,184 subjects



(mean 45.8 years of age), 63% had evidence of atherosclerotic disease in at least 1 vascular bed (22). Importantly, 39% of subjects in the PESA study had multiterritory disease involvement, indicating the common trait of general manifestation of atherosclerotic disease. In the BIOIMAGE (A Clinical Study of Burden of Atherosclerotic Disease in an At-Risk Population) study, the prevalence of polyatherosclerosis was 58% among 5,808 asymptomatic subjects (mean 69 years of age) with risk factors for CHD (23). Thus, most middle-aged adults in Western industrialized nations have some form of cardiovascular disease.

More than 17 million Americans have symptomatic coronary atherosclerotic disease (i.e., CHD), and given the aging of our population, these numbers are expected to rise (24). Among patients presenting with symptoms suspicious for CHD, approximately one-third reveal evidence of nonobstructive coronary atherosclerotic disease, which is associated with a 6-fold increased risk of myocardial infarction or



cardiac death over the ensuing 2 years compared with patients without coronary atherosclerosis (Central Illustration) (25). Nonobstructive CHD is twice as common among women compared with men undergoing cardiac catheterization for symptoms concerning for CHD (10), representing a major, unaddressed public health problem (15).

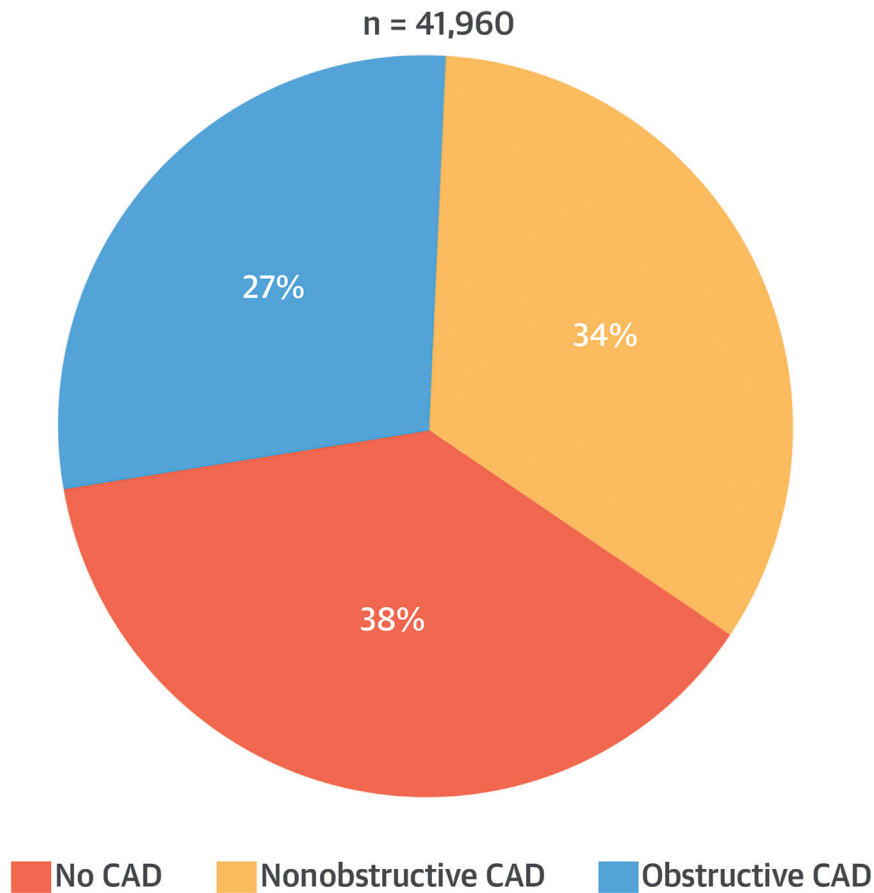
Considering that approximately 15 million patients present to health care providers with symptoms concerning for CHD every year in the United States alone (26), several million patients at risk for adverse events are not being identified as having CHD because our current diagnostic criteria do not take into account recent data documenting the considerable risk in patients with nonobstructive CHD (Figures 2 and 3). Growing recognition of this issue led to a recent

position paper by the European Society of Cardiology on myocardial infarction with nonobstructed coronary arteries (27). However, the magnitude of the problem requires us to go further and include the entity of symptomatic, nonobstructive coronary atherosclerosis in the disease spectrum of CHD.

#### HISTORICAL PERSPECTIVE

Our understanding of CHD and its associated manifestations has considerably evolved over the past decades. Angina pectoris has been known to arise from reaching a critical threshold of myocardial blood flow reserve. Classic experiments by Gould et al. (28) demonstrated coronary flow reserve to progressively decrease with diameter stenoses exceeding 50% by

**CENTRAL ILLUSTRATION** Prevalence of Nonobstructive Coronary Atherosclerotic Disease by Coronary Angiography

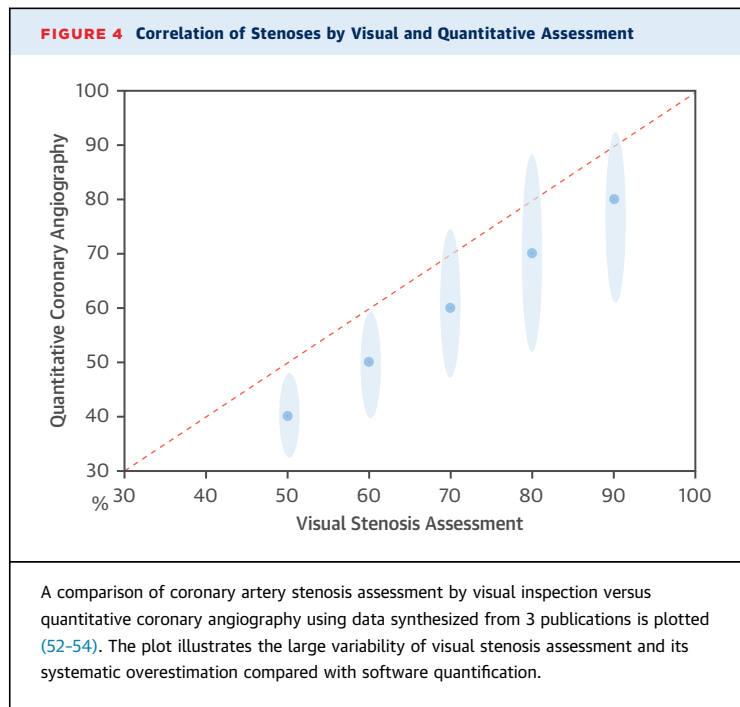


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The distribution of coronary angiographic findings among 41,960 patients who underwent computed tomography (CT) angiography for the evaluation of coronary artery disease (CAD) is shown. Adapted and modified from Habib et al. (25).

quantitative assessment in an animal model. These results were later confirmed in humans using myocardial flow reserve assessment (29). Presumably because angina is the most common manifestation of CHD, the diagnosis of CHD was defined by the presence of a coronary artery stenosis of 50% or greater (by quantitative evaluation). Such diagnosis, however, does not consider mechanisms leading to other, more critical, manifestations of CHD (i.e., myocardial infarction and sudden cardiac death). Although the involvement of arterial thrombosis in myocardial infarction had been known for decades, its causative role was not widely accepted until the 1980s (30). Importantly, pathology and clinical studies revealed that culprit lesions triggering occlusive coronary arterial thrombosis and myocardial

infarction not infrequently have <50% lumen narrowing (pathology assessment overestimates stenoses compared with angiographic evaluation) (31-33). These findings are consistent with contemporary clinical data aggregates documenting approximately 0.5% to 2% annual rates of myocardial infarction or cardiac death in symptomatic patients with non-obstructive CHD (9-11,25). Because such a degree of disease is common, there is concern that a majority of adverse events from CHD affect patients without high-grade coronary artery stenoses (34). Indeed, a recent analysis of the PROMISE trial revealed that more than 50% of adverse cardiac events occurred in patients with normal stress test findings, that is, without evidence of provokable myocardial ischemia (35).



Our understanding of the pathophysiology of acute coronary events also has evolved in the past decades. Acute coronary events are the result of a complex interplay of coronary atherosclerotic characteristics and the organism's response to the stimulus for vascular thrombosis (36). Among the coronary atherosclerotic risk factors, the burden of atherosclerotic disease is most strongly related to the risk of myocardial infarction and death (37). Location, metabolic activity, and characteristics of the atherosclerotic disease in the coronary tree also influence the risk of adverse events (21,38,39).

#### **OBSTRUCTIVE VERSUS HEMODYNAMICALLY SIGNIFICANT CHD**

Angiographic coronary artery stenosis assessment correlates only modestly with measurements of blood flow restriction in humans (40). Myocardial perfusion imaging or fractional flow reserve (FFR) assessment is necessary to determine if a coronary stenosis is of clinically meaningful hemodynamic impact unless the coronary anatomy is unequivocal (41). However, mechanisms leading to myocardial infarction and death are not dependent on hemodynamically significant coronary artery stenoses (37). Eliminating FFR-proven blood flow obstruction and/or myocardial ischemia by percutaneous coronary intervention has not been shown to

reduce rates of myocardial infarction or death compared with medical therapy in clinical studies (42-44). Numerous investigations documented an escalating risk of myocardial infarction and death in patients with increasing coronary atherosclerotic disease burden, even below hemodynamic thresholds (Figures 2 to 4) or in the absence of provokable myocardial ischemia (45-47). The FAME-2 (Fractional Flow Reserve versus Angiography for Multi-vessel Evaluation-2) study revealed no statistically significant risk differences for myocardial infarction or death at follow-up among patients with FFR-positive lesions versus those without (43). Results from myocardial stress testing failed to predict patient outcomes in large databases, and performed inferiorly compared with an assessment of disease burden in clinical trials (13,35,47). Thus, evaluating the functional significance of CHD is critical for managing angina symptoms, but its use for determining the risk of myocardial infarction and cardiac death independently of coronary anatomic information remains poorly supported (12,37,48). Pending the availability of more conclusive data (e.g., the ISCHEMIA [International Study of Comparative Health Effectiveness with Medical and Invasive Approaches] trial) (49), our focus for defining CHD should continue to rest on proven information for effective risk stratification (i.e., the presence, extent, and location of coronary atherosclerotic disease).

#### **CONTROVERSIES OVER THE NOMENCLATURE AND ANATOMIC THRESHOLD DEFINING CHD**

The terms *coronary artery disease*, *coronary heart disease*, and *ischemic heart disease* are often used interchangeably. For example, the European practice guidelines refer to the management of stable *coronary artery disease*, whereas the U.S. guidelines use the term stable *ischemic heart disease* for the entity of symptomatic coronary atherosclerotic disease (1,2). The American College of Cardiology/American Heart Association guideline on the treatment of serum cholesterol to reduce cardiovascular risk in adults addresses *clinical atherosclerotic cardiovascular disease*, which encompasses CHD (5). The issue of defining the entity of coronary atherosclerotic disease is further complicated by the fact that it may be associated with symptoms, even though lumen obstruction is mild (e.g., through vascular dysfunction or by triggering vascular thrombosis), but it also may remain entirely asymptomatic, despite extensive manifestation with severe lumen obstruction (50).



Notwithstanding uncertainty as to whether patients' symptoms are always related to coronary atherosclerotic disease, there is strong evidence of increased adverse event risk in symptomatic versus asymptomatic patients, even when accounting for disease burden (10). The precise mechanisms for this difference remain unclear at this time. Symptomatic patients may be at greater risk than asymptomatic patients because of less well-adapted responses to the presence of coronary atherosclerotic disease (e.g., inadequate vascular function or permission of clinically relevant vascular thrombosis) (36). Accordingly, it is critical to differentiate risk evaluation and management in asymptomatic and symptomatic patients. Our terminology may reflect this differentiation by applying the term *coronary artery disease* to asymptomatic coronary atherosclerotic disease, while reserving *coronary heart disease* for patients with clinical manifestations of coronary artery disease (51). The term *ischemic heart disease* may encompass additional causes of myocardial ischemia (e.g., microvascular dysfunction), and thus refers to a more inclusive view of the disease spectrum.

Currently, we use anatomic criteria (e.g., the presence of at least 1 coronary stenosis) to establish the diagnosis of CHD by coronary angiography. However, the threshold for defining a significant or obstructive stenosis varies in clinic and research. In clinical practice, a 70% or greater diameter stenosis by conventional coronary angiography is typically considered diagnostic, but research studies almost invariably use a 50% stenosis threshold for defining CHD. The reason for these discrepant criteria is founded in the mode of assessment. In clinical practice, coronary artery stenoses are assessed by visual estimate, whereas research studies utilize software tools (quantitative coronary angiography) for semiautomated quantification of stenoses. It has been consistently demonstrated that quantitative tools yield lower stenosis degrees compared with visual evaluation (52-54) (Figure 4). Studies generated in the 1990s suggested that a 50% stenosis by quantitative coronary angiography corresponds to an approximately 70% stenosis by visual assessment, which led to using these different thresholds depending on the mode of evaluation (52,53). More recently, a large multicenter evaluation suggested the difference between visual and quantitative evaluation to be smaller, although with large variability of individual estimates (54). Because of inconsistent results with visually interpreting coronary artery stenoses, experts have long been advocating the mandated use of quantitative tools (55,56). Descriptions of mild, moderate, or

severe CHD are common in research and clinical reports, but there is considerable variability in interpreting these categories. Because software tools are available for fast and easy stenosis quantification by conventional angiography, intravascular ultrasound, and CT, they indeed should be used routinely for more consistent reporting.

## STENOSIS ASSESSMENT VERSUS ATHEROSCLEROTIC BURDEN EVALUATION

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The coronary atherosclerotic burden is a strong, consistent predictor of adverse cardiac events in patients with suspected CHD (37). As opposed to evaluating total coronary atherosclerotic burden, clinical trials almost exclusively use percent stenosis assessment and the number of involved coronary arteries to predict patient outcome, as well as to guide management. At this time, it remains unclear if the prognostic information from assessing the severity of CHD by the number of vessels with obstructive coronary artery disease is entirely due its correlation with atherosclerotic disease burden or if there is independent value of stenosis severity assessment over plaque burden evaluation (20). A large observational registry found no difference in risk prediction when using percent stenosis assessment or coronary calcium scanning (a crude surrogate for coronary atherosclerotic disease burden that does not directly account for noncalcified disease) in patients without chest pain (57). Several clinical studies demonstrated similar adverse event rates in patients with extensive nonobstructive CHD and those with single-vessel obstructive disease, which may suggest that the burden of disease is indeed the predominant mechanism of risk prediction (7-10). However, these studies also suggest that extensive nonobstructive disease involving several vessels equates the risk of a *single* vessel with obstructive disease. Because only semiquantitative methods (e.g., number of segments), but no quantitative plaque volume evaluations were used to assess nonobstructive disease, it remains unclear from these investigations if obstructive disease is merely a surrogate for greater disease burden, or if there is indeed an independent predictive role for stenosis severity (20). The former is supported by a good correlation of semiquantitative assessment of coronary disease burden with CHD severity graded by the number of obstructive stenoses (58).

Pathology studies suggest that a certain lesion atherosclerotic plaque volume is required (corresponding to an approximately 30% to 40% diameter stenosis) to be capable of triggering fatal coronary events, but there is no conclusive evidence that

**TABLE 1 Proposed Classification of CHD by Coronary Angiography**

CHD Stage	Description	Risk of MI or CV Death/Year (%)
Stage 0	No coronary atherosclerotic disease by coronary angiography	<0.1
Stage 1	Mild coronary atherosclerotic disease: <30% lumen stenosis affecting 1 or 2 vessels	0.1-0.9
Stage 2	Moderate coronary atherosclerotic disease: 30%-49% lumen stenosis affecting 1 or 2 vessels or mild disease in 3 vessels	1-1.9
Stage 3	Severe coronary atherosclerotic disease: ≥50% lumen stenosis affecting 1 or 2 vessels or moderate disease in 3 vessels	2-4
Stage 4	Very severe coronary atherosclerotic disease: ≥50% lumen stenosis affecting 3 vessels, or 2 vessels including pLAD, or left main disease	>4

Stenosis values as determined by quantitative assessment.  
CHD = coronary heart disease; CV = cardiovascular; MI = myocardial infarction; pLAD = proximal left anterior descending artery.

higher-grade stenoses confer greater risk of myocardial infarction and death (31). The Providing Regional Observations to Study Predictors of Events in the Coronary Tree (PROSPECT) study merely found an association between individual lesion plaque burden at baseline and subsequent risk of hospitalization for angina, but not for acute myocardial infarctions (36,38).

Assessing total coronary atherosclerotic disease burden continues to be technically challenging for both invasive and noninvasive coronary angiography. Ongoing software improvements show promise for noninvasive, accurate, and fully automated coronary artery contour detection in the near future (59). It remains to be seen if total plaque burden determination offers clinically meaningful advantage over stenosis assessment and vessel involvement. In the meantime, stenosis assessment has not only been shown to approximate plaque burden (58), it has been validated as an effective, practical method for categorizing the severity of CHD and for risk stratifying patients using coronary angiography. The body of supporting published reports, ease of application, and the familiarity of researchers and practitioners support the continued classification of CHD by the severity and location of coronary arterial stenosis, as well as by the number of affected coronary arteries.

**EXPANDING THE CRITERIA FOR CHD BY ANGIOGRAPHY**

Diagnostic criteria should allow identification of a pathological process and characterize it according to its implications for medical management. Diagnostic criteria should also allow effective risk stratification, identifying patients at low, intermediate, high, and very high risk (Table 1). Such risk stratification is critical for appropriately allocating treatment, which ranges from low- to high-intensity medical therapy, to coronary artery revascularization.

Coronary atherosclerotic disease by pathology examination is present in most adult subjects in Western

industrialized countries (50). Yet the associated risk of myocardial infarction or cardiovascular death is exceedingly low unless disease is detectable by coronary artery imaging. In a large meta-analysis including mostly symptomatic patients with a wide range of risk characteristics, only 2 patients of 4,460 with no evidence of CHD by CT angiography suffered myocardial infarction or cardiovascular death at a mean of 2 years' follow-up; neither of these 2 events were related to CHD (25). These data are consistent with our understanding of the pathophysiology of acute coronary events, which mandates macroscopic atherosclerotic disease as a prerequisite for increased risk (36).

Based on the foregoing, CHD stage 0 may be defined as the absence of coronary atherosclerotic disease by coronary angiography, despite the possibility of microscopic disease being present. Stage 0 CHD identifies patients who are at exceedingly low risk of adverse cardiac events (<0.1%/year) (25). Only patients without any evidence of coronary atherosclerotic disease are included in stage 0. Notably, the presence of very mild disease (e.g., luminal irregularities) on conventional angiography or CT is associated with increased risk compared with patients with normal coronary arteries, and thus should indicate a more advanced CHD stage (9,25).

Stage I CHD may indicate the presence of mild atherosclerotic disease detected by imaging stenosis severity of <30% (by quantitative assessment) with no more than 2 coronary arteries affected. These patients have greater risk of myocardial infarction and cardiovascular death compared with patients with normal imaging findings, but are overall of low risk (approximately 0.1% to 1.0%/year) (25,60,61). In contrast to patients with stage 0 CHD, the risk of adverse events more strongly depends on the presence of other risk factors.

Stage II may identify patients with moderate atherosclerotic disease with diameter stenoses of 30% to 49% (by quantitative analysis) confined to 2 coronary arteries or <30% stenosis in 3 arteries. The rationale for differentiating Stage I and II by these



criteria stems from data demonstrating a gradual increase in risk from mild to moderate nonobstructive disease (7-11). It is conceivable that these 2 groups require different degrees of preventive measures. Patients with these characteristics generally have moderate annual risk of adverse events, approximately 1% to 2% (7-11,60,62).

Stage III indicates high risk (>2%/year) and involves patients with 50% or greater stenosis (by quantitative assessment) in 1 artery or in 2 arteries without involving the proximal LAD. This stage encompasses most of the traditionally defined CHD patients. An important addition to this group is the inclusion of patients with severe nonobstructive disease (i.e., 30% to 49% stenoses in 3 arteries) on the basis of data from several reports suggesting risk equivalence to patients with single-vessel obstructive disease (7-10).

Stage IV indicates very high risk (>4% year), and includes patients with  $\geq$ 50% stenoses (by quantitative assessment) in all 3 coronary arteries, 2 arteries with involvement of the proximal LAD, or left main disease (21,63). Patients with stage IV CHD are likely to derive a survival benefit from coronary artery bypass grafting compared with medical therapy alone (21,63).

## RISK MODIFIERS

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Acute coronary events commonly result from the combination of a stimulus for arterial thrombosis (i.e., coronary atherosclerotic disease) and an inadequate host response, which allows clinically significant vascular thrombosis and resultant myocardial ischemia to occur (36). Accordingly, thrombosis-promoting factors (e.g., diabetes mellitus, inflammatory diseases, hyperlipidemia, among others) increase the risk of acute coronary events in patients with comparable disease burdens (22). The evaluation of CHD risk should therefore consider anatomic risk criteria in the context of the overall patient risk profile. The Framingham risk score or similar scores may serve as convenient metrics to adjust a patient's individual risk assessment for a given CHD stage (22). However, many hypercoagulable conditions are not considered in common risk scores and will require further individualization of risk evaluation (e.g., advanced laboratory or genetic testing) (36).

Compromise of left ventricular systolic function is associated with poorer outcomes compared with patients with normal function (21). Even among patients with depressed left ventricular systolic function, worse ejection fraction is associated with greater risk of mortality (63). Similarly, patients with documentation of myocardial infarction are at greater risk than

patients without such history (64). Therefore, imaging evidence of prior myocardial infarction should be strongly considered for risk stratification, in addition to the degree of atherosclerotic disease. It remains unclear to what extent myocardial function assessment modifies patient risk for each CHD stage, and prospective investigations will be needed to further define these risk categories.

In addition to the presence, extent, and severity of CHD, a number of other anatomic features may indicate increased risk of adverse events in patients (e.g., noncalcified atherosclerotic plaques with external remodeling, large lipid pool, speckled calcification, and other vulnerable characteristics) (65,66). None of these features, however, has shown to be predictive of myocardial infarction and death independently of a comprehensive evaluation of coronary atherosclerotic disease burden (37). Furthermore, risk information on these characteristics is still limited, and their assessment is neither standardized nor adequately validated (20). Future studies may define their role in patient risk evaluation in association with standard assessment.

Rapid progression of coronary atherosclerotic disease is a strong predictor of adverse patient outcome (39,66). Markers and tools for assessing coronary artery disease progression are likely to further enhance our ability to risk stratify patients and to adjust treatment intensity. At this time, however, their role is insufficiently defined to be considered in our standard approach to patients with CHD.

## IMPLICATIONS FOR MANAGEMENT

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Patients with symptomatic coronary atherosclerotic disease benefit from secondary preventive measures (1-4). The intensity of secondary prevention should be adjusted to the patient's risk profile. Patients with stage I or II CHD are likely to require less intense treatment goals than patients with CHD stage III or IV. It remains to be seen if patients in stage I merely require risk factor modification or specific preventive measures. Symptomatic patients assigned to an anatomic strategy in the Prospective Multicenter Imaging Study for Evaluation of Chest Pain (PROMISE) and Scottish Computed Tomography of the Heart (SCOT-HEART) trials were found to have lower rates of myocardial infarction at follow-up than those randomized to functional testing, which is attributed to greater utilization of secondary preventive measures in response to visualizing (mostly nonobstructive) CHD (67-69). These data support the effectiveness of secondary prevention in patients with nonobstructive CHD, and suggest

that atherosclerosis imaging would be of merit in our approach to patients with suspected CHD (69). The value of atherosclerosis imaging should be addressed in future secondary prevention guidelines. Further research is required to identify the appropriate intensity of preventive measures for each stage of CHD, particularly given our expanding options for lipid-lowering drugs and antiplatelet/anticoagulation agents. Although patients with CHD stage III clearly require comprehensive secondary prevention, coronary artery revascularization may be reserved for addressing angina that is not responding to adequate medical therapy (2). For identifying high-risk patients in need of revascularization, with the intent of improving survival, numerous clinical and imaging characteristics have been proposed (2). However, in prospective clinical studies, only 2 risk features identified patients with stable CHD who derive a survival benefit with coronary artery revascularization (coronary artery bypass surgery): high-risk coronary anatomy (i.e., left main, 3-vessel CHD, or 2-vessel CHD with involvement of the proximal LAD) and severely impaired left ventricular systolic function (21,70). Therefore, these criteria should be considered for selecting patients for coronary artery revascularization with the intention of decreasing mortality.

## CONCLUSIONS

Nonobstructive CHD is linked to adverse patient outcomes and may be associated with angina-like symptoms. Given the wide availability of noninvasive coronary angiography capable of detecting non-obstructive coronary atherosclerotic disease, it is time to expand the diagnosis of CHD by coronary angiography for this important entity. A large body of evidence supports the concept of a risk continuum from coronary atherosclerotic disease on the basis of its presence, extent, location, and severity. Data also support the concept of allocating treatment intensity according to the extent of coronary atherosclerotic disease. Provided with more refined criteria for risk stratification, we will be better positioned to identify the most effective management strategies for patients with different stages of stable CHD.

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