# Distribution of Coronary Artery Calcification in a Cardiology Practice Population of more than 13.000 Patients in Germany. Do we Need to Correct the Thresholds for Pharmacological Prevention? 

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## Introduction:

Despite all efforts in preventive medicine, coronary artery disease (CAD) is still killer nr. 1 in many countries as it is in Germany. For over 20 years we know that heart attack occur suddenly and unexpectedly, based on a previous "hemodynamically non-significant" lesion. Therefore, the non-obstructive CAD is related to an increased risk of myocardial infarction and mortality. The noninvasive diagnosis of a non-obstructive CAD can easily be performed by the measurement of the coronary artery calcification (CAC)-score. Recent guidelines recommend pharmacological prevention with statins in pats with a CAC-score $\geq 75$ th percentile. Since the published data bases are usually from the USA and relatively old, we prospectively collected these data in our practice.

## Methods:

13.385 primary prevention pats were analyzed, those with known CAD or another cardiovascular disease as well as those with exercise depending symptoms were excluded. CTs were performed with a 16 slice scanner by prospective triggering ("step and shoot") at a slice thickness of 2.5 mm .

## Results:

Percentile distribution in men

|  | $35-39 \mathrm{yrs}$ | $40-44 \mathrm{yrs}$ | $45-49 \mathrm{yrs}$ | $50-54 \mathrm{yrs}$ | $55-59 \mathrm{yrs}$ | $60-64 \mathrm{yrs}$ | $65-69 \mathrm{yrs}$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| 25. perc. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 3.8 | 16.4 |
| 50. perc. | 0.0 | 0.0 | 0.3 | 4.3 | 25.7 | 63.7 | 102.2 |
| 75. perc. | 0.78 | 2.4 | 20.5 | 65.3 | 167.9 | 281.0 | 440.8 |
| 90. perc. | 12.2 | 42.3 | 130.9 | 234.4 | 555.1 | 815.2 | 1106.3 |

Percentile distribution in women

|  | $35-39 \mathrm{yrs}$ | $40-44 \mathrm{yrs}$ | $45-49 \mathrm{yrs}$ | $50-54 \mathrm{yrs}$ | $55-59 \mathrm{yrs}$ | $60-64 \mathrm{yrs}$ | $65-69 \mathrm{yrs}$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| 25. perc. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 50. perc. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 9.9 |
| 75. perc. | 0.0 | 0.0 | 0.0 | 1.5 | 7.4 | 27.4 | 85.0 |
| 90. perc. | 1.2 | 1.1 | 14.5 | 52.7 | 88.6 | 166.3 | 290.3 |

$45 \%$ of the pats had arterial hypertension, $52 \%$ hyperlipidemia, $20 \%$ were active smokers, 37\% previous smokers and 7\% diabetics.
8657 pats were asymptomatic whereas 4728 had atypical chest symptoms. There were no clinical relevant differences between these groups regarding the CAC-score of left main (5.5 / 5.2), LAD (89.6 / 78.2), RCx (25.3 / 24.0) and RCA (52.6 / 46.5).

Distribution histogram age


Score overall in relation to age and gender

|  | $<35$ | $>=35<40$ | $>=40<45$ | $>=45<50$ | $>=50<55$ | $>=55<60$ | $>=60<65$ | $>=65<70$ | $>=70$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Men (9281) | $(161)$ | $(430)$ | $(821)$ | $(1276)$ | $(1540)$ | $(1657)$ | $(1563)$ | $(1020)$ | $(813)$ |
| 10. perc. | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 5.78 |
| 25. perc. | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 3.80 | 16.43 | 62.80 |
| 50. perc. | 0.0 | 0.0 | 0.0 | 0.3 | 4.3 | 25.7 | 63.7 | 107.2 | 240.3 |
| 75. perc. | 0.00 | 0.78 | 2.40 | 20.48 | 65.32 | 167.90 | 281.00 | 440.77 | 280.00 |
| 90. perc. | 2.10 | 12.17 | 42.30 | 130.95 | 234.41 | 555.10 | 815.22 | 1106.26 | 1665.22 |
| Mean | 2.1 | 10.2 | 23.7 | 49.8 | 88.7 | 200.4 | 285.3 | 390.3 | 609.5 |
| SD | 10.4 | 48.6 | 97.5 | 168.4 | 268.5 | 487.7 | 578.2 | 313.5 | 916.8 |
| Women (4104) | $(29)$ | $(68)$ | $(169)$ | $(368)$ | $(575)$ | $(763)$ | $(835)$ | $(676)$ | $(621)$ |
| 10. perc. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 25. perc. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 |
| 50. perc. | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 9.85 | 41.40 |
| 75. perc. | 0.00 | 0.00 | 0.00 | 0.00 | 1.50 | 4.70 | 27.35 | 85.03 | 227.60 |
| 90. perc. | 0.00 | 1.22 | 1.12 | 14.52 | 52.74 | 88.58 | 166.32 | 290.25 | 509.90 |
| Mean | 0.5 | 2.9 | 4.2 | 13.1 | 27.1 | 40.2 | 72.7 | 121.4 | 216.2 |
| SD | 2.4 | 13.2 | 22.2 | 64.0 | 116.8 | 152.9 | 295.0 | 342.4 | 528.3 |



Percentage of different risk factors

| Group | n | pct | Mean SD | Group | n | pct | Mean SD |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Gender | 13385 | 100\% |  | Hyperlipidaemia | 13141 | 98\% |  |
| Male |  |  | 69\% (9281) | Yes |  |  | 52\% (6857) |
| Female |  |  | 31\% (4104) | No |  |  | 45\% (5857) |
| Age | 13385 | 100\% | 56.8+-10.3 | Unk |  |  | 3\% (427) |
| Current smoker | 13160 | 98\% |  | Diabetes mellitus | 13123 | 98\% |  |
| Yes |  |  | 20\% (2640) | Yes |  |  | 7\% (860) |
| No |  |  | 80\% (10520) | No |  |  | 93\% (12171) |
| Former smoker | 11984 | 90\% |  | Unk |  |  | 1\% (92) |
| Yes |  |  | 37\% (4491) | MI_family | 12987 | 97\% |  |
| No |  |  | 63\% (7493) | Yes |  |  | 45\% (5787) |
| Hypertension | 13167 | 98\% |  | No |  |  | 55\% (7081) |
| Yes |  |  | 45\% (5898) | ASS | 2258 | 17\% |  |
| No |  |  | 55\% (7185) | Yes |  |  | 12\% (265) |
| Unk |  |  | 1\% (84) | No |  |  | 88\% (1990) |

Linear Modell of overall scores (logarithm) in relation to different risk factors

|  | Coefficient | Lower CI <br> $(95 \%)$ | Upper CI <br> $(95 \%)$ | $p$ value |
| :--- | :--- | :--- | :--- | :--- |
| Intercept | 0.03 | 0.02 | 0.04 | $<0.01$ |
| Age (years) | 1.10 | 1.10 | 1.11 | $<0.01$ |
| Male sex | 2.88 | 2.57 | 3.23 | $<0.01$ |
| Former smoker | 1.38 | 1.25 | 1.53 | $<0.01$ |
| Current smoker | 1.79 | 1.57 | 2.04 | $<0.01$ |
| Diabetes mellitus | 1.52 | 1.29 | 1.81 | $<0.01$ |
| Hypertension | 1.33 | 1.21 | 1.46 | $<0.01$ |
| Hyperlipidaemia | 1.15 | 1.04 | 1.26 | $<0.01$ |
| MI in family history | 1.44 | 1.31 | 1.59 | $<0.01$ |
| Atypical angina | 1.03 | 0.93 | 1.14 | n.s. |

## Conclusion:

The limits for the percentile distribution in our population of 13.385 pats are consistently lower than a previous standard data base published 18 years ago in 9728 pats. Differences may be due to methodological and/or regional reasons, may be our population is more aware of a healthy life style. Nevertheless, the guideline-oriented recommendation of a certain CAC-score threshold for statin administration in primary prevention should be made on a regional, up-to-date data base.

