BACKGROUND

The ACC Health Equity Webinar Companion Guides are a complementary resource for the ACC Health Equity Webinar series. The webinar series, produced by the ACC D&I Committee, offers clinically relevant, evidence-based findings focused on health care disparities as it pertains to minority racial and ethnic groups and under-represented populations in cardiovascular care. This Companion Guide provides the background, highlights, and clinical pearls from the “Dispelling Disparity – Achieving Health Equity for those of South Asian Ancestry” webinar.

South Asians as those with origins from Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, or Sri Lanka.

South Asians are the fastest growing minority population in the United States.

Cardiovascular risk is highest in Bangladeshi, Pakistani, and Indian adults.

South Asian men and women have higher cardiovascular mortality rates compared to other Asian populations, and the prevalence is increasing in U.S.

Risk prediction is challenging for the following reasons:
- Risk algorithms for U.S. populations have not been derived from or prospectively validated in South Asian adults.
- Limited considerations have been given for U.S.-born versus migrant populations.
- Paucity of disaggregated data.

Disaggregation of South Asians into narrower groups based on their country of origin is required to highlight the disparities between sub-populations.

Highest concentrations of South Asian in the U.S.
(% of state population is >20% based on 2019 Pew Report)

1 Baylor Scott and White Health Heart Hospital Baylor Plano, Plano, TX. 2 Houston Methodist South Asian Cardiovascular Health Program Department of Cardiology, Houston Methodist DeBakey Heart & Vascular Center, TX. 3 Division of Cardiology, Baylor College of Medicine, Houston, TX. 4 South Asian Cardiovascular Health Initiative (SACHI) on behalf of The Ciccarone Center for the Prevention of Cardiovascular Disease, Johns Hopkins Hospital and University, Baltimore, MD. 5 VCU Pauley Heart Center, Division of Cardiology, Department of Internal Medicine, Virginia Commonwealth University, Richmond, VA. 6 Department of Medicine (Cardiology) and Preventive Medicine (Epidemiology), Northwestern University Feinberg School of Medicine, Chicago, IL. 7 Center for Outcomes Research, Houston Methodist, Houston, TX.
### HIGHLIGHTS

1. **Awareness of traditional risk factors** is essential.

2. **Prevention of risk factors early in life is best**, but optimal risk factor management at any age will help to reduce ASCVD risk.

3. **Calculate Cardiovascular risk** using the 2013 Pooled Cohort Equations and/or QRISK3.

4. **Consider use of coronary artery calcium (CAC)** to further stratify risk, particularly for those at borderline and intermediate risk.

5. If available, refer to **South Asian Cardiovascular and Metabolic specialty program**.

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Alarms to trigger screening for traditional risk factors

- Blood pressure ≥130/≥80 mmHg - screen for smoking, diabetes, dyslipidemia, excessive weight, low fitness, unhealthy diet, psychosocial stress, and sleep apnea.
- Dyslipidemia - screen for diabetes. BMI ≥23 kg/m² or waist-to-hip ratio (≥90 cm in men; ≥80 cm in women) - screen for diabetes.
- Family history of coronary artery disease (premature or any first degree) - screen for dyslipidemia.
- Family history of diabetes - screen for diabetes.
- For females, a history of gestational diabetes, hypertensive disorders of pregnancy, or polycystic ovary syndrome.

A coronary artery calcium (CAC) study may be a useful test to improve risk stratification and guide primary preventive efforts*.

*Particularly for Asian Indian adults based on available data.