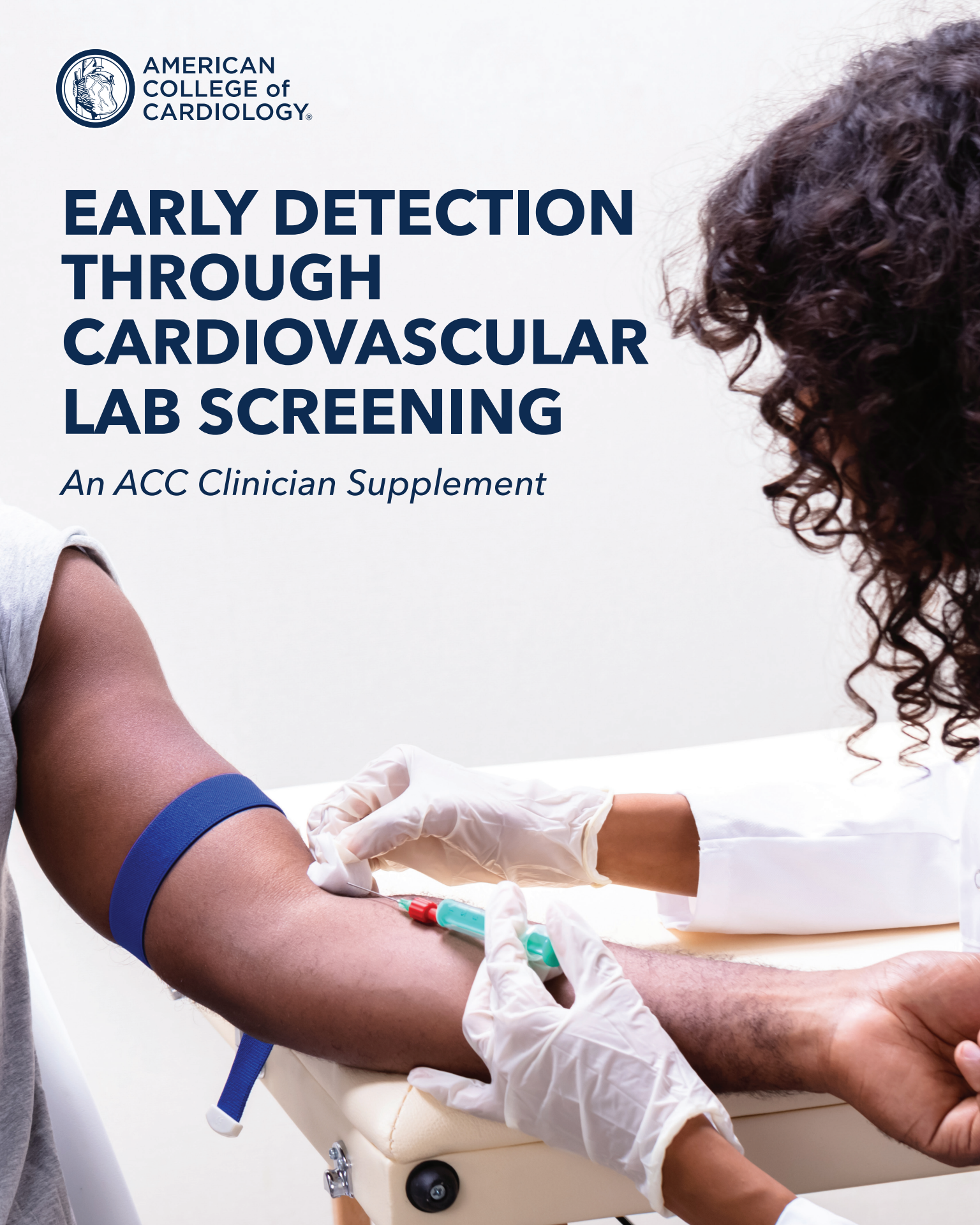




EARLY DETECTION THROUGH CARDIOVASCULAR LAB SCREENING

An ACC Clinician Supplement



Why Cardiovascular Screening?



Richard Kovacs,
MD, MACC,
ACC Chief
Medical Officer

Despite major advances in therapeutics and risk stratification, a significant proportion of cardiovascular events still occur in individuals who would not have been flagged as at risk using traditional tools alone. For today's cardiovascular clinicians, this gap underscores an urgent reality: earlier, more precise screening is both necessary and essential to the prevention of cardiovascular diseases and related risk factors before they occur.

This supplement focuses on three underutilized yet powerful markers – lipoprotein(a) [Lp(a)], urine albumin-to-creatinine ratio (UACR), and high-sensitivity C-reactive protein (hs-CRP) – that can meaningfully refine cardiovascular risk assessment and inform earlier intervention. Each offers a distinct window into pathophysiology that standard lipid panels and risk calculators may miss, particularly in patients with “normal” traditional risk factors who nonetheless experience premature or unexpected events.

Lp(a) is a genetically determined, causal risk factor for atherosclerotic cardiovascular disease and calcific aortic valve disease. Elevated levels are common, lifelong, and largely unaffected by lifestyle modification, yet testing remains inconsistent in routine practice. A single measurement can identify patients at substantially increased lifetime risk, inform intensity of preventive strategies, and prompt cascade screening among family members. As targeted Lp(a)-lowering therapies advance through clinical development, early identification is becoming increasingly relevant to both present-day management and future care planning.

UACR, long recognized in nephrology, is gaining attention as a cardiovascular risk marker. Even low-grade albuminuria reflects endothelial dysfunction and microvascular injury and is associated with higher rates of myocardial infarction, stroke, heart failure and cardiovascular death, independent of diabetes or high blood pressure. Incorporating UACR into cardiovascular screening offers a simple, inexpensive way to detect systemic vascular disease at an early, potentially modifiable stage.

Hs-CRP provides a complementary perspective by capturing residual inflammatory risk. Inflammation is now firmly established as a driver of atherosclerosis and plaque instability, and hs-CRP helps identify patients whose risk persists despite optimal lipid lowering. For clinicians seeking to individualize prevention strategies through lifestyle interventions, pharmacotherapy or patient engagement, hs-CRP can serve as both a risk marker and a tool to guide shared decision-making.

Taken together, these markers move cardiovascular screening beyond a one-size-fits-all approach toward a more nuanced, personalized approach. This supplement is designed to support clinicians in that shift. Within these pages, you'll find concise overviews of Lp(a), UACR, and hs-CRP; practical guidance on whom to test; and information on clinician-focused education, such as podcasts, infographics, and digital tools, created to fit seamlessly into busy clinical workflows. You'll also find links to CardioSmart patient-facing resources that can help facilitate meaningful conversations about cardiovascular disease and risk.

Early detection changes trajectories and saves lives. By broadening how we screen and whom we identify as at risk, cardiovascular clinicians have an opportunity to intervene sooner, personalize care more effectively, and ultimately reduce the burden of preventable disease. This supplement aims to be a practical companion in that effort.

The State of CV Health in the US

The **inaugural Cardiovascular Statistics 2026** is more than numbers - it's a roadmap for action. Drawing on nationally representative surveys, clinical registries, administrative claims and vital statistics, the JACC Stats Report provides a comprehensive view of cardiovascular health in the U.S. and reveals progress, persistent challenges and opportunities for change. ■

The data tell a powerful story - but what comes next starts with you.

Scan the QR code to explore the full JACC Stats Report and related infographics and join JACC in turning these numbers into meaningful action.



Scan the QR code for the downloadable JACC Stats Report Infographic Library.



“We cannot improve what we do not measure, and we cannot accelerate progress without a shared understanding of where we are and where we have been.” — Harlan M. Krumholz, MD, SM, FACC



20

The number of years over which hypertension-related cardiovascular deaths have nearly doubled in the U.S.



2009-2023

The span in which diabetes has increased in the U.S., with sharp rises seen among younger, low-income and Black populations.



40%

The percentage of U.S. adults affected by obesity, with rates climbing across all demographics.



<1 in 4

The proportion of high-risk adults who achieve guideline-recommended LDL targets.



2x

The rate of cigarette use among low-income adults is twice as high compared with the average.



50%

The percentage decline in mortality from coronary artery disease since 2000. However, widening inequities threaten these gains. Stroke mortality shows similar troubling trends.

Integrating Lp(a) Into Clinical Assessments and Encounters



Assessing and Managing ASCVD: Another Piece of the Puzzle

When dyslipidemia is considered alongside hypertension, diabetes, age, sex, race, tobacco use, and other factors to assess and reduce atherosclerotic cardiovascular disease (ASCVD) risk and events, the historical focus has been on identifying and managing elevated low-density lipoprotein cholesterol (LDL-C).

However, a growing body of research demonstrates that elevated levels of lipoprotein(a), or Lp(a), can exert a substantial impact beyond traditional risk factors.

High Lp(a) has been causally linked to both ASCVD and aortic valve disease and is also associated with a higher risk of future events among individuals with established ASCVD.

Although Lp(a) is not universally screened, it is increasingly addressed in clinical guidelines, creating more opportunities to discuss Lp(a) and its potential role in cardiovascular disease with patients.

The ACC's Elevating Lp(a) Awareness initiative aims to bridge the CVD knowledge gap by providing clinicians with education and patient-facing resources.



Scan the QR code to access the [online program](#).

START THE CONVERSATION

There is an urgent need to heighten awareness of Lp(a) among clinicians and patients alike. Elevated Lp(a) levels, which are largely inherited, are now recognized as an independent and robust risk factor for myocardial infarction, ischemic stroke, peripheral artery disease, and calcific aortic valve disease. Lp(a) may be useful in improving ASCVD risk stratification and risk prediction in high-risk groups, especially.



Scan the QR code to download a [Discussion Guide](#) with more information and suggested talking points to facilitate conversations with patients.



Scan the QR Code to download [CardioSmart's "Cholesterol: What is Lipoprotein\(a\) or Lp\(a\)?" infographic](#) and share with patients and/or display in hospitals, exam rooms, community boards, etc.

Lp(a) Assessment and Management: A Clinician's Guide

Who to Screen For Lp(a):

1. All adults (at least once [in a lifetime] for ASCVD risk assessment)
2. Children at high risk
 - those with family history of FH and premature CVD
 - ischemic stroke
 - family history of elevated Lp(a)

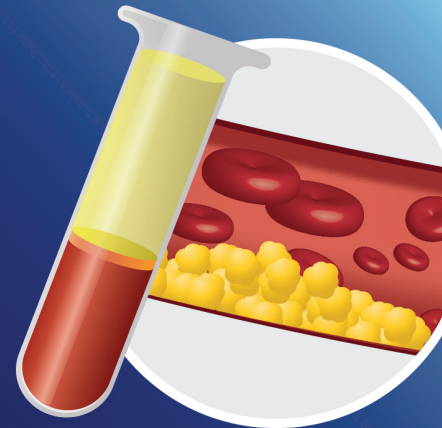
When to Screen For Lp(a)?

- At least once (in a lifetime) for ASCVD risk assessment

Why Screen For Lp(a)?

- Identify individuals with high Lp(a)
- Reclassify low risk or borderline, intermediate, and high risk individuals*
- Optimize management and treatment of other CVD risk factors
- Identify familial risk, cascade testing
- *Elevated Lp(a) is actionable now*

*SEE EXAMPLE RISK CALCULATION TOOLS BELOW



Lp(a) concentrations are approximately 90% genetically determined

Available ICD-10-CM Diagnosis Codes:



E78.41
Elevated Lp(a)



Z83.430
Family history of
elevated Lp(a)

Available CPT® Code:



83695
Lp(a) blood test

Available Direct-to- Consumer Lp(a) Assays:



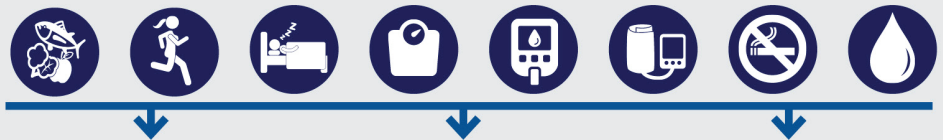
Measurement
in nmol/L;
preferred

ASCVD RISK ASSESSMENT INCORPORATING Lp(a)

In all individuals with elevated Lp(a) (≥ 125 nmol/L or ≥ 50 mg/dL), optimal early control of modifiable cardiovascular risk factors is recommended to reduce ASCVD risk

RISK-BASED PREVENTION APPROACH*

LIFE'S ESSENTIAL 8



Low Risk

Lifestyle Modification
Diet, exercise, sleep,
body weight control

Intermediate Risk

Lifestyle Modification
+ Lower LDL-C/ApoB/
non-HDL-C to target
+ Consider lipid
specialist or preventive
cardiologist referral

High Risk

Lifestyle Modification
+ LDL-C/ApoB/non-HDL-C
lowering to target
+ Consider aspirin
+ Consider additional risk-
modifying agents as
otherwise indicated†
+ Consider lipid
specialist or preventive
cardiologist referral

*Example Risk Calculation tools:

- Lp(a) Clinical Guidance Risk Calculator
- AHA PREVENT Online Calculator
- ASCVD Risk Estimator - Pooled Cohort Equations

Please refer to the
2026 ACC/AHA
Guideline on the
Management of
Dyslipidemia for
further information

†Recommendations to Consider Offering to Patients:

- Lifestyle modification
- Statins
- Ezetimibe
- Bempedoic acid
- PCSK9-directed therapies
- Aspirin
- Lipoprotein apheresis

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Visit [ACC.org/ElevatedLpa](https://www.acc.org/ElevatedLpa) to learn more

Educational Grant Support Provided by Novartis

Elevating Lp(a) Awareness: Bridging the CVD Risk Knowledge Gap

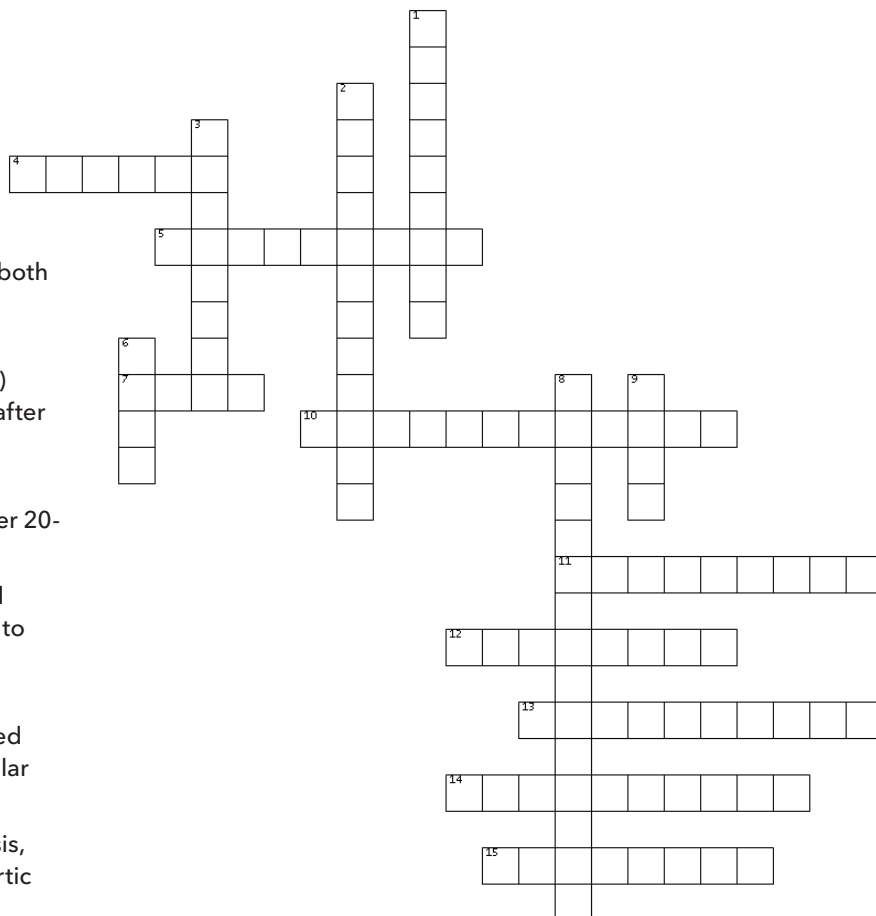
ACROSS

4. In addition to myocardial infarction, elevated Lp(a) also contributes to this ischemic cerebrovascular condition in both adults and children
5. Although levels are generally stable in individuals after age 5, in women, Lp(a) levels increase during pregnancy and after _____
7. Inhibitors of this protein not only significantly lower LDL-C but also confer 20-25% reduction in Lp(a) levels
10. Particles that transport cholesterol and triglycerides through the bloodstream to cells throughout the body
11. This is small interfering RNA (siRNA) targeting Lp(a) that is being investigated in the Ocean(a) Outcomes cardiovascular outcome trial
12. In addition to promoting atherosclerosis, Lp(a) increases the risk of _____ aortic stenosis
13. This is an antisense oligonucleotide (ASO) targeting Lp(a) that is being investigated in the Lp(a)HORIZON cardiovascular outcome trial
14. Given its homology to plasminogen, Lp(a) is also thought to cause _____
15. Lp(a) is the primary lipoprotein carrier of _____ phospholipids in plasma



Visit [ACC.org/ElevatedLpa](https://www.acc.org/ElevatedLpa) to learn more.

Educational grant support provided by Novartis.



DOWN

1. This is the only FDA approved treatment for Lp(a), reserved for patients with established CVD, familial hypercholesterolemia and elevated Lp(a), but uptake has been poor due to invasive, time-consuming nature and lack of availability to many patients with high Lp(a)
2. Elevated Lp(a) also promotes vascular _____, through several pathways including stimulating the recruitment of circulating monocytes, secretion of chemoattractants and cytokines, upregulation of adhesion molecules, and increased migration of leukocytes into artery wall
3. >90% of variation in Lp(a) levels are due to
6. Lp(a) is an LDL-like particle containing an _____ protein covalently linked by a disulfide bond to the apo(a) protein
8. Disease of the arteries where cholesterol, fats, calcium and other materials build up inside the walls of arteries
9. Approximately one in _____ individuals worldwide have elevated Lp(a) ≥ 50 mg/dL (~ 125 nmol/L)

The Growing Burden of Cardiovascular Disease Worldwide

The latest report from the Global Burden of Disease study paints a stark picture of the continuing increase in the rates of cardiovascular diseases (CVD) and its impact on morbidity and mortality around the world.

The report highlights the wide global, regional and national variation in CVD burden, even among countries with similar economies. It also identifies potential drivers of this growth, including a continued increase in population size, an aging population and growing exposure to risk factors like diabetes, obesity, tobacco use, air pollution, etc.



Scan the QR code
to read the [full
report in JACC.](#)



204

The number of countries where the global burden of disease was assessed between 1990 and 2023.



1 in 3

The proportion of deaths globally due to CVD in 2023.

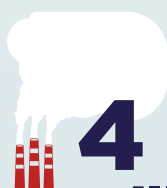
**626
million**

The number of people globally who are living with CVD - twice the number in 1990.



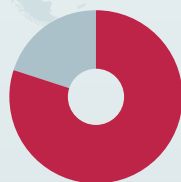
**19.2
million**

The number of deaths due to CVD in 2023, up from 13.1 million in 1990.



**4
million**

The number of CVD deaths in 2023 due to ambient air pollution.



80%

The proportion of the burden of CVD that is preventable and attributed to modifiable risk factors including high blood pressure, high fasting plasma glucose, obesity, poor diet and air pollution.

**437
million**

The number of disability-adjusted life years (DALYs) lost to CVD, with a 16-fold difference between the countries with the lowest and highest CVD DALY rates and a 1.4-fold increase from 320 million in 1990.



376

The number of diseases assessed in the report, with ischemic heart disease, intracerebral hemorrhage, ischemic stroke and hypertensive heart disease being the top four leading CV causes of DALYs.



**122
million**

The number of people worldwide with lower extremity peripheral arterial disease.



50

The age when CV mortality increased steeply in men. Globally, women had lower mortality rates than men.

POCKET POWER:

ACC Mobile Tools For Smarter Patient Care

Mobile applications are valuable tools in helping to assess cardiovascular risk, guide evidence-based management, and engage patients in shared decision-making.

Leveraging digital tools at the point of care can help translate guidelines into timely, actionable insights that fit seamlessly into clinical workflows. Advancing the thoughtful use of digital health is a priority of the ACC, which has developed a suite of mobile apps to help clinicians provide more consistent, informed, and patient-centered cardiovascular care.

Examples include:



LIPID MANAGER

Reduce ASCVD risk by managing a patient's LDL-C and triglycerides, in one continuous process. Make the most of three tools in one: LDL-C Lowering Therapies app, Statin Intolerance app and the Hypertriglyceridemia app.

High-Sensitivity C-Reactive Protein as a Potential Biomarker in Cardiovascular Inflammation

Cardiovascular Disease (CVD) is the most common cause of death of adults in the United States

795,000

Annual incidence of stroke

580,000

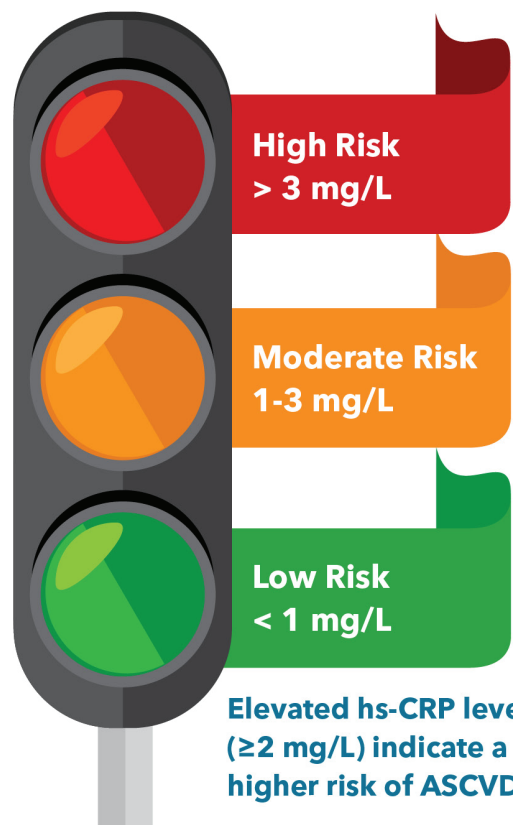
Annual incidence of myocardial infarction

80%

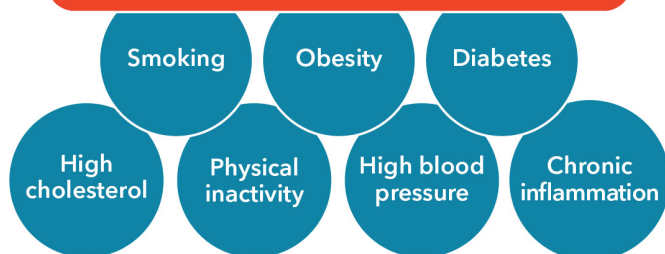
or more CV events are preventable

Together, CVD and stroke account for **14%** of total health expenditures in the US with an estimated annual cost of **> \$200 billion**

hs-CRP Range



FACTORS THAT INFLUENCE CHRONIC ELEVATIONS IN CRP LEVELS



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What is hs-CRP and How is it Measured?

C-reactive protein (CRP)

Protein produced by the liver

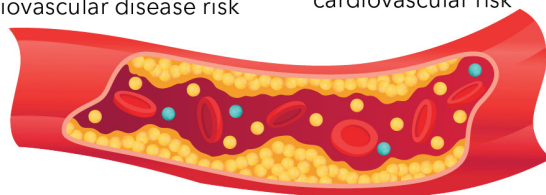
Indicates inflammation in the body, which can sometimes reflect an infection

Marker for potential cardiovascular disease risk

High sensitivity C-reactive protein (hs-CRP) tests

Can detect even small increases in CRP levels

Can indicate for more accurate assessment of cardiovascular risk



IMPORTANT POINTS

hs-CRP is just one factor in assessing cardiovascular risk and should be interpreted alongside other tests like cholesterol levels and blood pressure

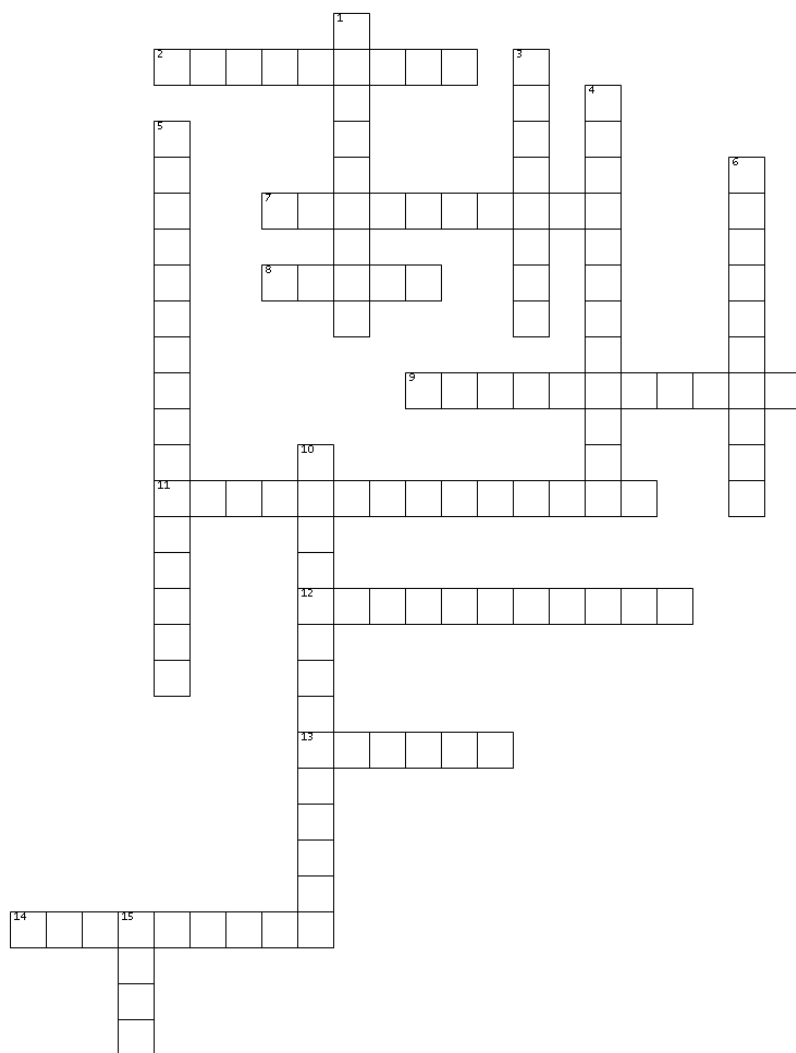
Lifestyle modifications like weight loss, exercise, and smoking cessation are recommended

Medications can be helpful, depending on individual health profiles

The American College of Cardiology (ACC) and the American Heart Association (AHA) recommend using hs-CRP levels to clarify treatment decisions for patients who need further interpretation of their borderline readings from the traditional risk assessment models



Inflammation in Cardiovascular Health: Raising Awareness of the Increasing Role of hs-CRP



ACROSS

2. Numerical value that quantifies the likelihood and potential impact of an outcome
7. Type of synthesized antibody protein that mimics the body's natural antibodies
8. The difference between the highest and lowest values observed
9. Measure of how well a test can identify true positives
11. Systematic process that identifies and analyzes potential outcomes
12. A group of cytokines that modulate the body's immune response; several are being evaluated to address if blocking inflammation leads to a reduction in cardiovascular events
13. Occurs when blood flow to the brain is disrupted; annual incidence is 795,000
14. Measurable factor of biologic processes that can be used in diagnosis or prediction

DOWN

1. Evaluation or investigation as part of a methodical survey to assess suitability for a particular role or purpose
3. When plaque builds up in this artery, blood flow to the heart is reduced
4. A natural response to injury or infection that helps the body heal; can be beneficial or damaging if it lasts too long or affects healthy tissue
5. Produced by the liver; indicates inflammation in the body
6. Occurs when blood flow to the heart is reduced or stopped; annual incidence is 580,000
10. Disease of this system is the most common cause of death of adults in the United States
15. Composite endpoint in cardiovascular research (typically combining several serious cardiovascular events like myocardial infarction, stroke, and cardiovascular death)



Visit [ACC.org/LearnHSCRP](https://www.acc.org/LearnHSCRP) to learn more.

Educational grant support provided by Novartis.

New in Clinical Guidance

DYSLIPIDEMIA

The new **ACC/AHA Guideline on the Management of Dyslipidemia** addresses the evaluation, management, and monitoring of individuals with dyslipidemias, including high blood cholesterol, hypertriglyceridemia and elevated Lp(a). The guideline, which retires and replaces the 2018 Guideline on the Management of Blood Cholesterol, includes recommendations on the implementation of new therapeutic agents, as well as latest advances in risk management across the wide pan of patient populations. It urges earlier treatment of dyslipidemia to reduce lifelong risk of prolonged exposure to atherogenic lipoproteins, as well as use of new PREVENT equations instead of Pooled Cohort Equations for 10- and 30-year risk assessment to guide lipid-lowering therapy in primary prevention in adults.

HIGH BLOOD PRESSURE

The **ACC/AHA Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults** includes several new or revised recommendations addressing topics related to secondary forms of hypertension, primary aldosteronism, lifestyle and psychosocial approaches, hypertension and pregnancy, acute intracerebral hemorrhage, resistant hypertension and renal denervation, diabetes, chronic kidney disease, and mild cognitive impairment and dementia. One of the biggest changes also involves the use of the PREVENT risk calculator to estimate cardiovascular disease risk and guide drug treatment vs. use of pooled cohort equations.

INFLAMMATION AND CV DISEASE

ACC's **Scientific Statement on Inflammation and Cardiovascular Disease** (CVD) provides consensus-based recommendations for screening, evaluation and CVD risk assessment; inflammatory biomarkers in cardiovascular imaging; inflammation inhibition in behavioral and lifestyle risks; and anti-inflammatory approaches in primary and secondary prevention as well as in heart failure and other cardiovascular diseases. Among the key highlights, the document outlines the data confirming the value of high-sensitivity C-reactive protein (hs-CRP) in clinical decision-making in primary and secondary prevention, along with the important role of lifestyle interventions to reduce systemic inflammation, including regular exercise and diet.

WEIGHT MANAGEMENT

As obesity continues to drive cardiovascular risk, the ACC has released two new guidance documents to support clinicians: **Concise Clinical Guidance (CCG) on the Medical Weight Management for Optimization of Cardiovascular Health** and a **Scientific Statement on the Management of Obesity in Adults With Heart Failure**. Both documents underscore the need for individualized, evidence-informed strategies that leverage emerging therapies and evolving clinical insights to reduce weight and improve cardiovascular outcomes.



Access these, along with ACC's complete library of clinical documents, at [ACC.org/Guidelines](https://www.acc.org/Guidelines). Scan the QR code to access comprehensive Clinical Guideline Hubs on [JACC.org](https://www.jacc.org).

Recognizing the Role of Urine Albumin-to-Creatinine Ratio (UACR) in Cardiac Care: A Biomarker for Cardiovascular Risk

WHAT IS URINE ALBUMIN-TO-CREATININE RATIO (UACR)?

The urine albumin-creatinine ratio (UACR) shows whether there is albumin in the urine. Albumin is a type of protein that is normally found in the blood and is not filtered into the urine, while creatinine is a creatine waste product filtered out by the kidneys into the urine. A high urine albumin-to-creatinine ratio may be a sign of kidney disease.

Screening for albuminuria remains low.

WHAT IS A UACR TEST?

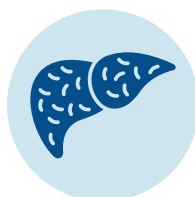
A UACR can be ordered as part of a urinalysis to check kidney health in patients with diabetes or chronic kidney disease (CKD), but may also be ordered in patients with:



Hypertension

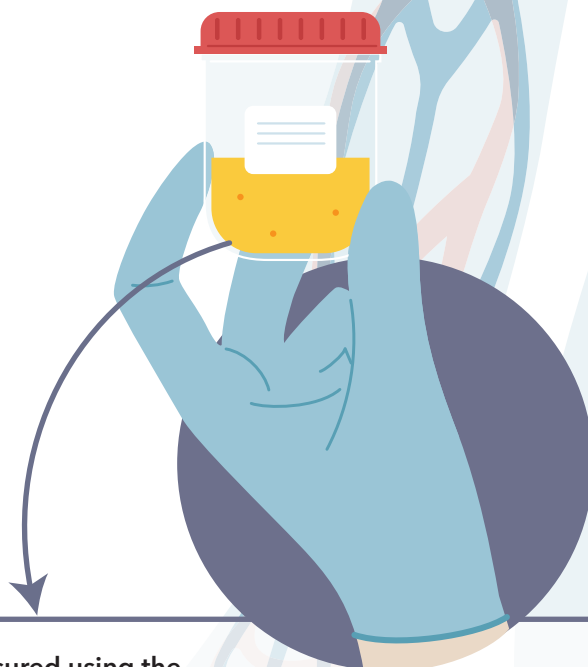
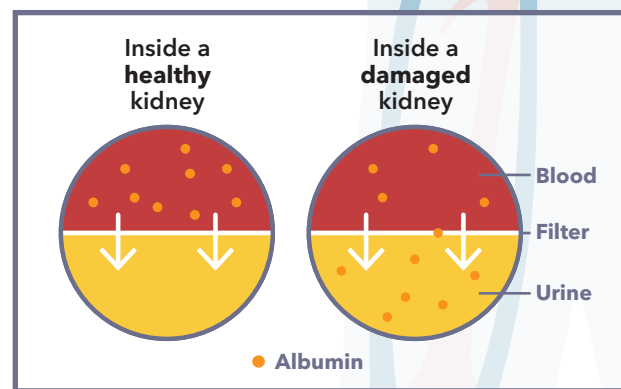


Heart disease



Cirrhosis of the liver

In some cases, a UACR may be appropriate in patients with a body mass index (BMI) greater than 30 (obesity), those who smoke, or those who are over 50.



Albuminuria is measured using the urine albumin-creatinine ratio (UACR) from a spot-urine sample and then classified as:

**<10 mg/g
or 1 mg/mmol**

Normal

**<30 mg/g
or 3 mg/mmol**

**Normal to mildly
increased**

**30 to 300 mg/g
or 3 to 30 mg/mmol**

**Moderately
increased**

**>300 mg/g
or 30 mg/mmol**

**Severely
increased**

Urinary albumin is used in lieu of urinary total protein, as it is a more sensitive and specific early marker of a change in glomerular permeability.

PRIMARY CPT CODES

82043: Urine albumin, quantitative.

82570: Urine creatinine, quantitative.

WHAT DOES UACR HAVE TO DO WITH THE HEART?

Albuminuria is associated with an increased risk of:



Coronary artery disease



Stroke



Heart failure



Arrhythmias



Microvascular disease

The ACC and AHA recommend a UACR test for all patients with hypertension because elevated levels signal kidney damage, a major, and often hidden, risk factor for heart attack, stroke and heart failure. A high UACR indicates albumin leakage from the kidneys, which suggests early kidney disease and increasing cardiovascular risk and should prompt closer monitoring and treatment.

Based on the HOPE (Heart Outcomes Prevention Evaluation) study, every 4 mg/g or 0.4 mg/mmoL increase in UACR increases the risk of heart failure hospitalization by 11%.

UACR is included as a part of the AHA PREVENT™ (Predicting Risk of Cardiovascular Disease EVENTS) equations to further personalize cardiovascular risk estimates.

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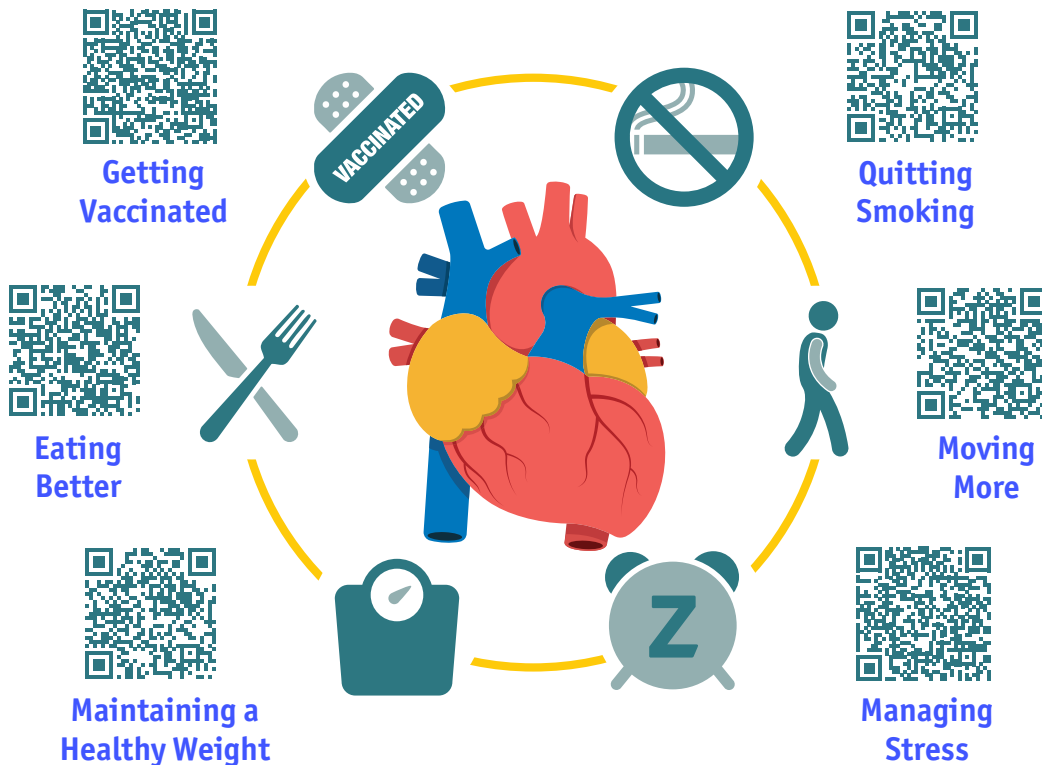
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Prevention Starts at Home

Healthy habits throughout life – eating better, moving more, maintaining a healthy weight and not smoking – are important steps patients should take to protect their heart health. Keeping an eye on health conditions that make heart disease more likely, such as diabetes, hypertension and high cholesterol is also key.

CardioSmart provides resources, infographics and discussion guides, that can help patients learn more about:



CardioSmart360

Use CardioSmart360 to discuss common heart problems and treatment options with patients. This free app has stunning high-resolution cardiac graphics and animations.



Scan this QR code
to find out more and
download the app.

The ACC thanks the following partners for
their efforts to support early detection through
cardiovascular screening.

