

HEART HEALTH FIELD GUIDE

Heart disease

before it happens.

Heart attacks can feel sudden. Risk often builds quietly. A useful prevention plan sees the whole picture - numbers, history, and real life.

WHY SILENT RISK MATTERS

#1

Heart disease is the leading cause of death in the United States.

~50%

of people with a first heart attack had no heart-related symptoms documented beforehand.

~20%

fewer major cardiovascular events with each 10 mmHg drop in systolic blood pressure in treatment trials.

~21%

fewer major vascular events with each ~40 mg/dL LDL-C reduction in statin trials.

Sources: CDC; Nurmohamed et al., Eur Heart J 2025; Ettehad et al., Lancet 2016; CTT Collaboration, Lancet 2012.

Risk reductions are averages from large studies and are expressed as relative risk. Your personal benefit depends on your starting risk, health history, treatment, and how long the improvement is maintained.

YOUR HEART-RISK PICTURE

A risk estimate is a starting point, not a verdict.

01

Pressure

One reading is a snapshot. A reliable home average tells a better story. Normal blood pressure is below 120/80; treatment goals depend on the full picture.

HOME AVERAGE: / DATE:

02

Particles

A standard lipid panel is the starting point. LDL-C and non-HDL-C reflect cholesterol carried in particles that can enter artery walls. Non-HDL-C = total cholesterol - HDL-C.

LDL-C: NON-HDL-C: TRIGLYCERIDES:

03

Metabolic + medical context

Blood sugar, kidney disease, tobacco exposure, sleep apnea, and chronic inflammatory conditions can change the plan - even when one cholesterol number looks acceptable.

A1c OR GLUCOSE: OTHER CONDITIONS:

04

Your story

Family heart attack or stroke at a younger age, pregnancy complications, early menopause, and past cancer treatment can matter. Write down who, what happened, and the age.

WHO / WHAT / AGE:

YOUR CONTEXT COUNTS

Cost, access, work, caregiving, chronic stress, neighborhood, and past care experiences shape what a realistic plan looks like. Start where you are.

HEART HEALTH FIELD GUIDE

From information to a plan.

The useful question is not “How many tests can I get?” It is “What information would change the next decision?”

SIX USEFUL ADD-ONS - WHEN THEY ANSWER A REAL QUESTION

Lp(a)

Largely inherited. Check once in adulthood; high levels raise lifetime risk even when the standard lipid panel looks reassuring.

ApoB

Counts plaque-forming particles. Useful with high triglycerides, metabolic disease, or conflicting cholesterol results.

hs-CRP

Measures inflammation. A persistent result of 2 mg/L or higher can add risk information; acute illness can temporarily raise it.

UACR

Urine albumin-to-creatinine ratio. Detects albumin leakage; a persistent result of 30 mg/g or higher signals kidney damage and higher heart risk.

CAC scan

Low-dose, no-contrast CT for calcified plaque. Best when a prevention decision remains uncertain.

CCTA

Contrast CT showing plaque and narrowing. Usually for symptoms or a specific anatomy question - not routine screening.

HEART HEALTH IS MORE THAN CORONARY DISEASE

The tests above do not rule out rhythm problems, valve disease, heart-muscle disease, or conditions present from birth. New or persistent palpitations, fainting, unexplained breathlessness, reduced exercise tolerance, or a newly detected murmur deserve clinical evaluation.

A SIMPLE DECISION PATH

01

CALCULATE

Ask about your 10- and 30-year PREVENT estimate. It uses routine visit information; UACR can further personalize it.

02

PERSONALIZE

Add what a calculator may miss: family and pregnancy history, Lp(a), ApoB, hs-CRP, kidney health (eGFR/UACR), inflammatory disease, medications, and context.

03

RECLASSIFY - ONLY IF NEEDED

Use CAC when a prevention decision remains uncertain. CCTA is different: it usually evaluates symptoms or a specific coronary anatomy question.

04

ACT

Build the plan: food pattern, movement, sleep, tobacco cessation, blood pressure control, and medication when appropriate.

05

RECHECK

Agree on what will be measured, when, and what would count as meaningful progress.

FIVE QUESTIONS FOR YOUR NEXT VISIT

01

What is my overall heart risk - not just whether each number is “normal”?

02

Have I had Lp(a) checked once? Would ApoB, hs-CRP, or UACR add useful information?

03

Does my family, pregnancy, kidney, inflammatory, or cancer-treatment history change the plan?

04

Would CAC change the prevention plan? Is CCTA appropriate for a specific symptom or clinical question?

05

What target are we aiming for, and when should we recheck?

MY NEXT STEP

ONE NUMBER OR DETAIL I NEED:

ONE QUESTION I WILL ASK:

ABOUT DAILY ASPIRIN

Do not start it on your own for first-event prevention. Benefit is small for many people, and bleeding risk matters.

WHEN TO CALL 911

New chest pressure, shortness of breath, cold sweat, nausea, lightheadedness, or pain in the arm, back, neck, jaw, or stomach can be a heart attack - even if you are not sure.

GENERAL EDUCATION ONLY. This handout cannot diagnose disease or replace care from your own clinician.

Evidence: CDC; Nurmohamed 2025; Ettehad 2016; CTT 2012; AHA/ACC BP 2025; dyslipidemia & CKM 2026; AHA PREVENT; KDIGO 2024; ADA 2026; ACC inflammation 2025; chest pain guideline 2021; multimodality AUC 2023; USPSTF; AHA rhythm, valve & CHD resources 2024-26.

THE LONG VIEW, TOGETHER.