

Transcript Details

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Evaluating ASCVD Risk with the CPR Framework

Announcer:

You're listening to *Heart Matters* on ReachMD. On this episode, Dr. Roger Blumenthal, Chair of the Writing Committee for the 2026 American College of Cardiology and American Heart Association Guideline on the Management of Dyslipidemia, will explain how the CPR framework can be used to evaluate ASCVD risk. Dr. Blumenthal is also the Kenneth Jay Pollin Professor of Cardiology and Director of the Ciccarone Center for the Prevention of Cardiovascular Disease at Johns Hopkins Medicine. Let's hear from him now.

Dr. Blumenthal:

The CPR framework is largely the brainchild of Dr. Donald Lloyd-Jones. C stands for calculating what a person's risk is based on the PREVENT score. P stands for personalizing, and that's really important because there's a lot of factors that aren't in the PREVENT score but are important. Things such as ethnicity—if you're of South Asian, Filipino, or Native American descent, you're more likely to develop pre-diabetes or diabetes. And I think it's also very important to think about family history of cardiovascular disease.

Triglycerides are very important. We've also added in markers of kidney function, such as glomerular filtration rate, but the risk enhancers also include persistently high LDL cholesterol. And I think by thinking about these other factors that we know are associated with cardiovascular risk but may not have made the cut, so to speak, to get into the risk equation, we can personalize things.

A good example would be factors associated with a woman's reproductive history. So having preeclampsia is known to be associated with a higher lifetime risk. Having gestational diabetes is known to be associated with increased risk. Small for gestational age infants are associated with an increased risk. There's a number of factors that can only really be singled out with a good clinician-patient discussion and history, and I think that's so important.

R stands for reclassify, which means that if indeed a patient may be on the fence about what to do, the presence of, say, moderate coronary calcium would certainly push us to say this person is at much higher risk. And we need to be much more aggressive with cholesterol management, but also lifestyle management and blood pressure control.

I usually think about a second R called reassess. So after that clinician-patient risk-benefit discussion, we may change our minds. People have different priorities, and some patients have absolutely no family history of cardiovascular disease and don't know anyone who's had a heart attack or bypass or stenting, and they're much more concerned about other things in their life, while others may really think about family history or their neighbor or friend who had a bypass surgery or a stroke or a heart attack. They're going to say, "Doc, I don't want that to happen to me. Let's be aggressive from the start, even though I'm young," say 40 or 45 years of age. So personalizing things is so important. And then that final R, as we said, is reassess the need for lipid-lowering therapy or other medication if necessary, if the blood pressure is borderline or if the blood sugar is higher than we like.

So CPR: calculate, personalize, reclassify if needed, and then reassess.

Announcer:

That was Dr. Roger Blumenthal explaining how we can use the CPR framework to evaluate ASCVD risk. To access this and other episodes in our series, visit *Heart Matters* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!