**ROLE OF CAC TESTING IN 2016: SHARED DECISION MAKING FOR INFORMED CHOICES**

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The 2013 American College of Cardiology and the American Heart Association (ACC–AHA) parted the emphasis on cholesterol concentrations and target goals; instead accentuate the importance of absolute risk in guiding treatment decisions, matching of statin intensity with increasing individualized risk as well as support flexible goals for those with lower risk. Most importantly, it firmly placed the patient in driver seat to make informed choices based on their preferences, values, understanding of risk. However the guidelines considerably broadened the scope of statin candidates with more than half of adults age>40 years without established CVD are candidates for lifelong statin therapy. The dilemma of mass ‘statinization’ adding burden on an already cost-constrained healthcare system, are heightened by emerging data that suggest half of those eligible for statin therapy have a significantly lower 10-year risk than the threshold suggested by guidelines to consider them. With significant increase in population eligible for treatment, accurate identification of low-risk statin candidates who are less likely to yield meaningful benefit is critical to facilitate appropriate resource allocation and shared decision-making processes. A recent study from the Multi-ethnic of Atherosclerosis (MESA) study has demonstrated that nearly half of statin candidates had no detectable coronary artery calcium (CAC), and absence of CAC reclassified approximately half of statin therapy candidates, especially in the intermediate risk range of 5-20%, to a group that would not be considered eligible for therapy by current recommendations. Absence of CAC can afford significant value in promoting shared decision-making for flexible treatment goals in uncertain individuals deemed eligible for lifelong statins.