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PATIENT HANDOUT · CALCIUM SCORE

Your Calcium Score

What the number from your heart scan means, who should get one, and what to do with the result.

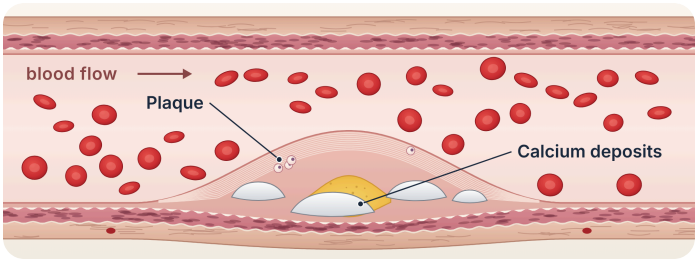
10 min
for the visit, with no IV, contrast dye or fasting

~1 mSv
of radiation, about four months of natural background exposure

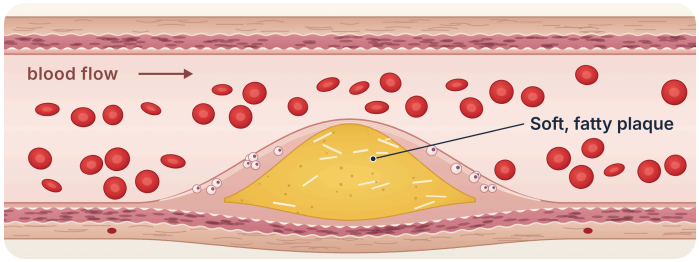
$75–200
typical self-pay price, since insurance usually doesn't cover screening

WHAT THE SCAN SEES

A measure of calcified plaque



Seen: calcium shows up bright white



Missed: soft plaque with no calcium

The scan is a low-dose CT of the chest, timed to your heartbeat. Software measures the bright calcium in each coronary artery and adds it up into one number, the Agatston score. Calcium doesn't appear in healthy coronary arteries, so any calcium means plaque has been building.

READING YOUR NUMBER

What each score range means

0	1–99	100–399	400–999	1,000+
No calcified plaque	**Mild**	**Moderate**	**Severe**	**Extreme**
Very low risk, under 1% a year. In some lower-risk people, a statin can wait.	Treat risk factors. Whether to start a statin depends on age, family history and Lp(a).	A statin is recommended, with a goal LDL under 70 mg/dL.	More aggressive treatment, with the goal LDL still under 70.	The LDL goal drops to under 55, plus a stress test or CT angiogram if you have symptoms.

Your report may also give a percentile, which compares you with people your age and sex. The same number means more in a younger person, so a score that calls for a statin at 45 may not change anything at 75.

Act on the result

A high score marks you as someone who gains the most from prevention, and modern prevention is extremely effective. The expected response is action, starting with the treatment plan, rather than worry.

WHO SHOULD GET ONE IS ON THE BACK

BEFORE AND AFTER THE SCAN

Who should get one, and what it can't tell you

GOOD CANDIDATES

the result will change the plan

Ages 40 to 75, intermediate risk	A borderline or intermediate 10-year risk on the PREVENT calculator, and unsure about starting a statin.
A risk enhancer	At borderline risk, a family history of early heart disease, metabolic syndrome, a chronic inflammatory disease or a high Lp(a) makes the scan more useful.
Strong family history	Heart disease in a male relative before 55 or a female relative before 65 can be a reason to test before 40.

SKIP THE SCAN

another test, or none, fits better

Known heart disease	After a heart attack, stent or bypass, you already need a high-intensity statin, so the score won't change the plan.
Already on a statin	If your LDL is at goal, the score won't change your treatment.
Chest pain or other symptoms	Symptoms of a blocked artery need a stress test or a coronary CT angiogram instead.
Very low or very high risk	At low risk, the scan rarely changes anything. At 10% or more on PREVENT, the 2026 guideline already calls for a high-intensity statin.
A recent chest CT	If the report already describes coronary calcium, a new scan adds little.

COMMON MIX-UPS

Same as a CT angiogram?	A calcium scan uses no dye and sees only calcified plaque, while a CT angiogram uses IV dye to show both hard and soft plaque and any blockages.
A high score means a stent?	The score measures how much plaque you have. It can't show how narrow any one artery is. Without symptoms, a high score is treated with medication and lifestyle changes.
Zero means clear for life?	Soft plaque can be too faint for the scan to see, and calcium builds with age. If your risk stays intermediate, repeat the scan in 5 to 10 years.
Should it drop on a statin?	Calcium doesn't dissolve. The score may creep up on a statin as soft plaque hardens and settles down, which is a sign the statin is working. Track your LDL instead.

A ZERO WITH HIGH CHOLESTEROL

A score of zero is reassuring. A high LDL still raises your lifetime risk, and soft plaque can be too faint for the scan to pick up, especially in younger people and those with a high Lp(a).

READ THE FULL ARTICLE

damianrasch.com/
coronary-artery-calcium-score

For education only, and not a substitute for advice from your own physician. Sources include the MESA study (Detrano, NEJM 2008; Blaha, Circulation 2016), the 2018 ACC/AHA cholesterol guideline, the 2019 ACC/AHA primary prevention guideline and the 2026 ACC/AHA dyslipidemia guideline.

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