The obesity epidemic and its metabolic consequences are a major focus of current cardiovascular research. Increased visceral adiposity is thought to be a marker of cardiovascular risk through production and regulation of atherogenic inflammatory cytokines. Total intrathoracic fat (ITF) is a combination of both epicardial adipose tissue (EAT) and thoracic fat (TF). Unlike TF, EAT has a common embryological origin with abdominal visceral fat. The latter is associated with both coronary artery disease (CAD) and atherosclerotic plaque. All of these fat volumes (v) (ie, ITFv, EATv, and TF volume) can be directly measured by noncontrast cardiac computed tomography (CT).

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The coronary artery calcium score (CACS) measured by CT is directly related to the extent of coronary atherosclerotic plaque burden. CACS severity is known to predict risk for cardiac events in asymptomatic individuals and beyond that provided by the Framingham risk score (FRS) or C-reactive protein. CACS can also risk stratify low to intermediate-risk patients with acute chest pain (ACP) of unclear cardiac pathogenesis who present to the emergency department for evaluation. There are preliminary data that fat volumes may add prognostic value in patients with CACS >400, CACS is most strongly correlated with outcome.

Background—Noncontrast cardiac computed tomography allows calculation of coronary artery calcium score (CACS) and measurement of epicardial adipose tissue (EATv) and intrathoracic fat (ITFv) volumes. It is unclear whether fat volume information contributes to risk stratification.

Methods and Results—Cardiac computed tomography was performed in 760 consecutive patients with acute chest pain admitted through the emergency department. None had prior coronary artery disease. CACS was calculated using the Agatston method. EATv and ITFv were semiautomatically calculated. Median patient follow-up was 3.3 years. Mean patient age was 54.4±13.7 years and Framingham risk score 8.2±8.2. The 45 patients (5.9%) with major acute cardiac events (MACE) were older (64.8±13.9 versus 53.7±13.4 years), more frequently male (60% versus 40%), and had a higher median Framingham risk score (16 versus 4) and CACS (268 versus 0) versus those without events (all P<0.01). The MACE group had a higher median of EATv (154 versus 116 mL) and ITFv (330 versus 223 mL), and a higher prevalence of EATv >125 mL (67% versus 44%) and ITFv >250 mL (64% versus 42%) (all P<0.01). CACS, EATv, and ITFv were all independently associated with MACE. CACS was associated with MACE after adjustment for fat volumes (P<0.0001), whereas EATv and ITFv improved the risk model only in patients with CACS >400.

Conclusions—CACS and fat volumes are independently associated with MACE in acute chest pain patients and beyond that provided by clinical information alone. Although fat volumes may add prognostic value in patients with CACS >400, CACS is most strongly correlated with outcome.

Key Words: angina ◼ atherosclerosis ◼ coronary artery disease ◼ coronary computed tomography ◼ epicardial fat
The CACS, which was reviewed by a cardiologist. CACS results were categorized as normal (CACS = 0), mild (1–100), moderate (101–400), or severe (>400) calcification. The interpreting physician was blinded to both fat volume results and patient outcome.

**Table 1. Baseline Patient Characteristics**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Included Patients</th>
<th>Excluded Patients</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age, y</td>
<td>54.4±13.7</td>
<td>52.9±12.9</td>
<td>0.12</td>
</tr>
<tr>
<td>Female</td>
<td>450 (59.2)</td>
<td>168 (62.0)</td>
<td>0.43</td>
</tr>
<tr>
<td>Mean BMI, kg/m²</td>
<td>30.6±7.3</td>
<td>30.5±6.9</td>
<td>0.85</td>
</tr>
<tr>
<td>Family history of CAD</td>
<td>36 (4.7)</td>
<td>16 (5.9)</td>
<td>0.42</td>
</tr>
<tr>
<td>Hypertension</td>
<td>430 (56.6)</td>
<td>160 (59.0)</td>
<td>0.52</td>
</tr>
<tr>
<td>Abnormal lipids</td>
<td>252 (33.2)</td>
<td>100 (36.9)</td>
<td>0.26</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigarette smoking</td>
<td>112 (14.7)</td>
<td>40 (14.8)</td>
<td>1.00</td>
</tr>
<tr>
<td>FRS</td>
<td>8.2±8.2</td>
<td>8.0±8.1</td>
<td>0.66</td>
</tr>
<tr>
<td>Median CACS</td>
<td>4 (1–16)</td>
<td>4 (1–16)</td>
<td>0.56</td>
</tr>
<tr>
<td>Median ITFv, mL</td>
<td>255±132</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median EATv, mL</td>
<td>227 (163–321)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤125</td>
<td>345 (54.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;125</td>
<td>345 (45.4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data are presented as mean±SD or median (interquartiles) for continuous variables and number (%) for categorical variables. BMI indicates body mass index; CACS, coronary artery calcium score; CAD, coronary artery disease; EATv, epicardial adipose tissue volume; FRS, Framingham risk score; and ITFv, intrathoracic fat volume.

troponin level, or hemodynamic instability. All patients underwent noncontrast CT after admission. The present study consisted of those 760 patients who had CT data available for calculation of both CACS and fat volumes. There were no significant differences in baseline characteristics (Table 1) between the 760 patients in the present study and the 271 who were excluded from analysis.

**Calcium Scoring Procedure**

Patients underwent CACS on a 16-slice multidetector CT scanner (Philips Precedence, Best, The Netherlands) without pretreatment with β-blockers. Images were acquired during a single breath hold using prospective electrocardiographic gating with imaging triggered at 75% of the R-R interval (collimation 8x2.5 mm, voltage 120 keV, current 75 mAs). Reconstructed axial images of 2.5 mm thickness were displayed for review, and the CACS was calculated as previously described. The computer software automatically defined the presence of calcified lesions as those >130 Hounsfield units and calculated the CACS, which was reviewed by a cardiologist. CACS results were categorized as normal (CACS = 0), mild (1–100), moderate (101–400), or severe (>400) calcification. The interpreting physician was blinded to both fat volume results and patient outcome.

**Quantification of ITFv and EATv**

EATv and ITFv were measured offline on a Philips Extended Brilliance Workspace Workstation, version 4.02.145 (Philips Healthcare, Cleveland, OH) on previously acquired noncontrast cardiac CT scans performed for measurement of CACS. A semiautomated volumetric method using the Volume software module was used to quantify the amount of ITF and EAT (Figure 1). Adipose tissue was defined by an attenuation coefficient between −40 and −200 Hounsfield units. Regions of interest for ITF measurements were defined semiautomatically by the program as any adipose tissue present in the thoracic cavity, excluding the posterior mediastinum, from the level of the pulmonary trunk bifurcation to the diaphragm. The anterior and posterior limits for ITF were the ribcage and descending aorta and esophagus, respectively. A similar method was used for EAT measurement where regions of interest were defined for any adipose tissue located within the pericardial sac from the level of the pulmonary trunk bifurcation to the visceral layer of the pericardium beyond the apex of the heart. In both measurements all automatically traced slices were reviewed and verified for accuracy. Necessary adjustment was made manually on both axial images and the 3-dimensional rendered fat shell. Because EAT is incorporated within the ITF measurement, we also calculated the extent of ITF volume by subtracting EAT from ITF. Abdominal visceral fat was not evaluated because CT imaging was limited to the chest.

One investigator quantified all fat measurements blinded to clinical, CACS, and patient outcome information. Fat measurements were performed by an investigator who was not trained in the measurement of CACS.

Intra- and interobserver reproducibility for quantification of ITFv and EATv were assessed from 20 randomly selected CT scans. The mean intraobserver difference was 0.4±7.8 mL for ITFv and 3.1±10.5 mL for EATv (Wilcoxon signed-rank nonparametric test; P=0.88 for ITFv and 0.36 for EATv) with corresponding Spearman correlation coefficients of 0.99 and 0.98 (both P<0.0001). The mean interobserver difference was 4.1±2.5 mL for ITFv and 2.6±3.8 mL for EATv (Mann–Whitney nonparametric test; P=0.75 for ITFv and 0.78 for EATv) with corresponding Spearman correlation coefficient of 0.99 and 0.98 (both P<0.0001).

**Data Collection and Patient Follow-up**

All clinical information was obtained on admission by research study personnel. All subjects had calculation of their FRS based on standard criteria. Serial cardiac biomarkers, ECG tracings, and the results of all cardiac procedures performed during hospitalization were collected by research personnel at the time of hospital discharge.

After hospital discharge, patients were prospectively contacted by phone at 1 week, 1 month and >6 months after admission, and then in November 2010 to identify those with a new cardiac event. Research personnel asked specific, scripted questions regarding subsequent visits to the emergency department or readmission to the hospital for evaluation of chest pain symptoms, myocardial infarction, cardiac catheterization, or coronary revascularization (angioplasty, stenting, or bypass procedures). One qualified and blinded physician investigator reviewed the medical records of all patients who reported subsequent hospitalizations or cardiac procedures after the index admission. Death was confirmed by either immediate family members or through the Social Security death index. The time from performance of cardiac CT to a new cardiac event or the final contact encounter in those without events was chosen for outcome analysis.

**Cardiac Events**

Major acute cardiac events (MACE) were defined as cardiac death, nonfatal myocardial infarction, and unstable angina pectoris.
Cardiac death was defined as death caused by myocardial infarction, congestive heart failure or arrhythmia, or any unknown causes of death not explained by a noncardiac pathogenesis. The diagnosis of myocardial infarction was defined as chest pain associated with typical ECG findings and a troponin I >0.10 ng/dL. Unstable angina was defined as follows: (1) new onset or worsening ACP at rest necessitating hospitalization, (2) normal troponin levels, and (3) significant (>70%) major epicardial CAD by invasive angiography with or without revascularization. In patients who had multiple events, MACE were counted only once. The median follow-up was 3.3 years.

Statistical Analysis

Baseline characteristics were summarized by MACE status and are presented as mean±SD for continuous variables, as medians and interquartiles for skewed continuous variables, and as numbers and percentages for categorical variables.

Kaplan–Meier estimates of MACE rates and overall survival were calculated in strata defined by the following: (1) CACS categories 0, 1 to 100, 101 to 400, and >400; and (2) EATv and ITFv dichotomized at 125 mL and 250 mL, respectively. The CT date was used as time 0. Two-sided log-rank tests were used to determine significance. Cox proportional hazards model was used to calculate unadjusted and adjusted hazard ratios and corresponding 95% CIs with respect to CACS, EATv, and ITFv. The baseline model included FRS and body mass index (BMI). Subsequent models were further adjusted for ITFv (dichotomized at 250 mL) and EATv (dichotomized at 125 mL) when evaluating CACS; and CACS (0 versus >0 and 400 versus <400) when evaluating ITFv or EATv. An identical analysis was also performed to define the relationships between CACS and TF volume. The proportionality assumption of Cox models was verified by including the time-dependent interaction of each covariate with survival time in the model. There was no evidence of violation of this assumption for any covariate. Global χ² statistic by likelihood ratio test was also used to determine whether addition of fat volume would improve MACE prediction accuracy beyond clinical and CACS variables. All analyses were performed with STATA version 11 (StataCorp. 2009; Stata Statistical Software; Release 11; College Station, TX; StataCorp LP). Statistical significance was defined as 2-tailed P<0.05 for all tests.

Results

Baseline Characteristics

The mean age for all patients was 54.4±13.7 years, with 59% female and 15% diabetic. In the 760 patients, 450 (59.2%) had CACS 0, 174 (22.9%) had CACS 1 to 100, 71 (9.3%) had CACS 101 to 400, and 65 (8.6%) had CACS >400. The mean ITFv was 255±132 mL, and 327 patients (43%) had an ITFv >250 mL. The mean EATv was 127±61 mL, and 345 patients (45.4%) had an EATv >125 mL (Table 1).

Cardiac Events

Forty-five patients (5.9%) had at least 1 MACE (6 cardiac deaths, 17 nonfatal myocardial infarctions, and 22 with unstable angina) during a median follow-up period of 3.3 (range 0–5.03) years.

Relationships Between BMI, CACS, and Fat Volume

Overall, there was a weak direct relationship among BMI, EATv, and ITFv and a weak inverse relationship between BMI and CACS (Figure 2).
Higher CACS severity was associated with significantly higher fat volumes. The mean EATv based on CACS severity was 113±53 mL for CACS 0; 142±65 mL for CACS 1 to 100; 149±70 mL for CACS 101 to 400; and 159±70 mL for CACS >400 (P<0.001). The mean ITFv was 222±107 mL for CACS 0; 293±138 mL for CACS 1 to 100; 297±150 mL for CACS 101 to 400; and 337±167 mL for CACS >400 (P<0.001). Despite these overall group relationships, a very poor correlation was observed between fat volumes and CACS in individual patients (Figure 3).

Cardiac Events Based on CACS and Fat Volume
The 45 patients with MACE had a significantly higher median CACS (268 versus 0, P<0.0001) and events increased with increasing CACS severity. Annual MACE rates in each of the CACS categories were as follows: 0.40% (CACS of 0); 2.38% (CACS 1–100); 6.51% (CACS 101–400); and 11.20% (CACS >400), respectively (P<0.0001 for trend) (Figure 4A). The unadjusted hazard ratio for development of MACE in patients with a CACS >0 was 11.95 (95% CI, 4.71–30.28; P<0.0001) (Table 2). Only 5 of 450 patients with a CACS of 0 had a subsequent cardiac event. Two patients had an isolated troponin elevation during their initial hospitalization but died from unknown causes 12 and 36 months later.

The median EATv (154 mL versus 116 mL; P=0.006) and ITFv (330 mL versus 223 mL; P=0.001) were significantly larger in patients with events versus those without events, respectively. A significantly higher percentage of patients with MACE had a large EATv (>125 mL (67% versus 44%; P=0.005) or ITFv >250 mL (64% versus 42%; P=0.003), respectively. Annual MACE rates were 3.23% versus 1.31% for EATv dichotomized at 125 mL (P=0.003) and 3.25 versus 1.35% for ITFv dichotomized at 250 mL (P=0.004) (Figure 4B). The unadjusted hazard ratios for log2(EATv) and log2(ITFv) were 2.02 (95% CI, 1.3–3.1; P=0.002) and 2.16 (95% CI, 1.43–3.27; P<0.0001), respectively (Table 2). The unadjusted hazard ratios for the fourth versus the first quartiles of EATv and ITFv were 3.62 (95% CI, 1.46–8.97; P=0.005) and 3.34 (95% CI, 1.43–7.80; P=0.005), respectively.

Cardiac Events Based on Combined CACS and Fat Volume Analysis
Overall risk stratification was improved by combining fat volume and CACS severity information (Figure 5). Annual MACE rates significantly increased with increasing CACS severity in both the low and high EATv and ITFv categories (P<0.0001 for each trend). Annual MACE rates also showed nonsignificant increases with higher fat volumes among most CACS categories. However, when individual fat volumes were plotted within each CACS category, no specific cutpoints for

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**Figure 2.** Linear regression analysis showing significant but weak correlations between body mass index (BMI) and log2(EATv) (A), log2(ITFv) (B), and log2(CACS) (C) results. BMI indicates body mass index; CACS, coronary artery calcium score; EATv, epicardial adipose tissue volume; and ITFv, intrathoracic fat volume.
EATv or ITFv were found that better defined patients with and without MACE beyond CACS alone (Figure 6).

**Multivariable Risk Analyses**

By multivariable analysis, CACS, EATv, and ITFv were independently associated with MACE, even after adjustment for FRS and BMI (Table 2, Model 1A and Table 3, Model 1B). However, fat volumes lost significance after adding CACS into the model ($P = 0.128$ for log$_2$EATv and $P = 0.05$ for log$_2$ITFv), whereas with CACS there remained a significant independent association with MACE after adjustment for either EATv or ITFv ($P < 0.0001$) (Table 2, Model 2A and Table 3, Model 2B). EATv and ITFv retained statistical significance only when the CACS was dichotomized at 400 (Table 3, Model 2B). These relationships were similar whether using continuous or specific cutpoints of fat volumes. Similar results were obtained when using TF volume in the above analysis.

Global $\chi^2$ statistic by likelihood ratio test was used to further evaluate the relationship between CACS and fat volumes (Figure 7). As in the multivariable analysis, CACS, EATv, and ITFv all added significantly to the clinical model (FRS and BMI), but EATv and ITFv did not improve risk prediction once CACS was known (Figure 7A and 7B). Conversely, CACS improved risk prediction beyond the combined clinical and EATv or ITFv models (Figure 7A and 7B). The only model where EAT and ITF fat volumes significantly increased the global $\chi^2$ values was when CACS was dichotomized at 400 (Figure 7C and 7D).

**Discussion**

Our study demonstrates the independent value of CACS and fat volumes for defining risk beyond clinical variables alone in a large cohort of patients admitted through the emergency department with ACP of uncertain cardiac pathogenesis. Our results confirm that CACS, as a marker of the presence and

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**Figure 3.** Linear regression analysis showing significant but poor correlations between log(CACS) and log$_2$(EATv) (A) and log$_2$(ITFv) (B) results. CACS indicates coronary artery calcium score; EATv, epicardial adipose tissue volume; and ITFv, intrathoracic fat volume.

**Figure 4.** Survival Curves for Major Acute Cardiac Events (MACE). Events increased with increasing CACS severity (A), and larger EAT and ITF fat volumes (B). CACS indicates coronary artery calcium score; EATv, epicardial adipose tissue volume; and ITFv, intrathoracic fat volume.
Table 2. Multivariable Risk Analysis: CACS>0 (n=310) Vs CACS=0 (n=450)

<table>
<thead>
<tr>
<th></th>
<th>Unadjusted</th>
<th></th>
<th>Adjusted Model 1A</th>
<th></th>
<th>Adjusted Model 2A</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hazard Ratio (95% CI)</td>
<td>P</td>
<td>Hazard Ratio (95% CI)</td>
<td>P</td>
<td>Hazard Ratio (95% CI)</td>
<td>P</td>
</tr>
<tr>
<td>CACS&gt;0 vs CACS=0</td>
<td>11.95 (4.71–30.28)</td>
<td>&lt;0.0001</td>
<td>8.60 (3.28–22.56)</td>
<td>&lt;0.0001</td>
<td>7.56 (2.85–20.05)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Log₂(ITFv)</td>
<td>2.16 (1.43–3.27)</td>
<td>&lt;0.0001</td>
<td>2.18 (1.38–3.44)</td>
<td>0.006</td>
<td>1.62 (1.00–2.64)</td>
<td>0.050</td>
</tr>
<tr>
<td>Log₂(TFv)</td>
<td>2.61 (1.60–4.30)</td>
<td>&lt;0.0001</td>
<td>2.66 (1.53–4.60)</td>
<td>0.001</td>
<td>1.89 (1.04–3.42)</td>
<td>0.036</td>
</tr>
<tr>
<td>Log₂(EATv)</td>
<td>2.02 (1.30–3.13)</td>
<td>0.002</td>
<td>1.95 (1.21–3.14)</td>
<td>0.001</td>
<td>1.46 (0.90–2.39)</td>
<td>0.128</td>
</tr>
<tr>
<td>ITFv&gt;250 mL vs ≤250 mL</td>
<td>2.39 (1.30–4.40)</td>
<td>0.005</td>
<td>2.36 (1.24–4.50)</td>
<td>0.009</td>
<td>1.68 (0.86–3.30)</td>
<td>0.129</td>
</tr>
<tr>
<td>EATv&gt;125 mL vs ≤125 mL</td>
<td>2.44 (1.31–4.54)</td>
<td>0.005</td>
<td>2.31 (1.21–4.42)</td>
<td>0.011</td>
<td>1.59 (0.81–3.09)</td>
<td>0.175</td>
</tr>
</tbody>
</table>

Model 1A: adjusted for FRS and BMI.
Model 2A: adjusted for FRS, BMI, and CACS (dichotomized at 0) for evaluation of ITF, TFv and EAT; or FRS, BMI and ITFv (dichotomized at 250 mL) for evaluation of CACS.

*When adjusted for FRS, BMI, and EATv (dichotomized at 125 mL), hazard ratio=7.66, 95% CI (2.80–20.38), P<0.0001.
BMI indicates body mass index; CACS, coronary artery calcium score; EATv, epicardial adipose tissue volume; FRS, Framingham risk score; TFv, thoracic fat volume; and ITFv, total intrathoracic fat volume.

Table 3. Multivariable Risk Analysis: CACS >400 (n=65) Vs CACS ≤400 (n=695)

<table>
<thead>
<tr>
<th></th>
<th>Unadjusted</th>
<th></th>
<th>Adjusted Model 1B</th>
<th></th>
<th>Adjusted Model 2B</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Hazard Ratio (95% CI)</td>
<td>P</td>
<td>Hazard Ratio (95% CI)</td>
<td>P</td>
<td>Hazard Ratio (95% CI)</td>
<td>P</td>
</tr>
<tr>
<td>CACS &gt;400 vs CACS ≤400</td>
<td>7.22 (3.95–13.21)</td>
<td>&lt;0.0001</td>
<td>4.21 (2.11–8.40)</td>
<td>&lt;0.0001</td>
<td>3.74 (1.86–7.51)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Log₂(ITFv)</td>
<td>2.16 (1.43–3.27)</td>
<td>&lt;0.0001</td>
<td>2.18 (1.38–3.44)</td>
<td>0.006</td>
<td>1.91 (1.19–3.04)</td>
<td>0.007</td>
</tr>
<tr>
<td>Log₂(TFv)</td>
<td>2.61 (1.60–4.30)</td>
<td>&lt;0.001</td>
<td>2.66 (1.53–4.60)</td>
<td>0.001</td>
<td>2.22 (1.25–3.92)</td>
<td>0.006</td>
</tr>
<tr>
<td>Log₂(EATv)</td>
<td>2.02 (1.30–3.13)</td>
<td>0.002</td>
<td>1.95 (1.21–3.14)</td>
<td>0.001</td>
<td>1.77 (1.09–2.87)</td>
<td>0.021</td>
</tr>
<tr>
<td>ITFv &gt;250 mL vs ≤250 mL</td>
<td>2.39 (1.30–4.40)</td>
<td>0.005</td>
<td>2.36 (1.24–4.50)</td>
<td>0.009</td>
<td>2.03 (1.06–3.90)</td>
<td>0.033</td>
</tr>
<tr>
<td>EATv &gt;125 mL vs ≤125 mL</td>
<td>2.44 (1.31–4.54)</td>
<td>0.005</td>
<td>2.31 (1.21–4.42)</td>
<td>0.011</td>
<td>2.01 (1.04–3.89)</td>
<td>0.037</td>
</tr>
</tbody>
</table>

Model 1B: adjusted for FRS and BMI.
Model 2B: adjusted for FRS, BMI, and CACS (dichotomized at 400) for evaluation of ITF, TFv and EAT; FRS, BMI, and ITFv (dichotomized at 250 mL) for evaluation of CACS.

*When adjusted for FRS, BMI, and EATv (dichotomized at 125 mL), hazard ratio=3.75, 95% CI (1.87–7.52), P<0.0001.
BMI indicates body mass index; CACS, coronary artery calcium score; EATv, epicardial adipose tissue volume; FRS, Framingham risk score; TFv, thoracic fat volume; and ITFv, total intrathoracic fat volume.
at defining risk with minimal additional contribution from the ITF or EAT results. In this regard, we could not identify a specific cutoff for fat volume, which would further discriminate low from high-risk patients within specific CACS categories.

Previous Studies
To the best of our knowledge, there is only 1 other study examining the clinical value of fat volume in relation to CACS for defining risk in patients without known CAD. In this registry study by Cheng et al, 58 patients with MACE were propensity matched to 174 same-sex, event-free control subjects based on age, risk factors, and CACS. As in our study, mean EATv and ITFv and the percentage of patients with large fat volumes (EATv >125 mL and ITFv >250 mL) were significantly greater in patients with, as compared to those without, events. EATv and ITFv were independently associated with MACE after correcting for age, traditional risk factors, and CACS. Both our study and that of Cheng et al showed a possible additional contribution from fat burden for defining outcome in patients with a severe (>400) CACS. Because patients with a severe CACS >400 already merit aggressive risk factor modification and clinical surveillance, the additional clinical value of fat burden remains unclear. Nonetheless, the similar results reported in these 2 studies are particularly striking considering the differences in study design and patient cohorts evaluated.

Limitations
Because CAD is a chronic disease that develops over decades, our follow-up duration may not have been long enough to fully capture the clinical significance of increased fat burden. However, despite this limitation, CACS still proved to be robust for defining risk as verified in other studies.

Our study had only 30% to 50% power to identify any additional value of fat volumes over CACS for defining risk. This power calculation was based on testing for an increase in developing MACE from 46% to 89% in a Cox proportional hazards model with a sample of 760 observations at a 0.05 significance level assuming an anticipated event rate of 5.92%.
CACS and fat volumes are independently associated with MACE in low to intermediate-risk patients with ACP and improve risk stratification beyond that provided by clinical information alone. Although fat volumes may add value in patients with CACS >400, CACS remains the strongest overall marker for defining risk.

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Disclosures
None.

References
Does Quantifying Epicardial and Intrathoracic Fat With Noncontrast Computed Tomography Improve Risk Stratification Beyond Calcium Scoring Alone?

Farshad Forouzandeh, Su Min Chang, Kamil Muhyieddeen, Rashid R. Zaid, Alejandro R. Trevino, Jiaqiong Xu, Faisal Nabi and John J. Mahmalian

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