In 2013, the American College of Cardiology/American Heart Association prevention (ACC/AHA) released a new guideline for the primary prevention of atherosclerosis cardiovascular disease (ASCVD). The guideline states the following: “the Work Group focused on estimation of first hard ASCVD events (defined as first occurrence of nonfatal myocardial infarction, coronary heart disease (CHD) death, or fatal or nonfatal stroke) as the outcome of interest because they were deemed to be of greater relevance to both patients and providers”1). The notion of focusing on hard ASCVD event and not on CHD event alone was also stated in a document published by the American Heart Association and American Stroke Association2), suggesting the clinical importance of the comprehensive assessment of polyvascular atherosclerosis for preventing ASCVD and reducing its risk. Non-invasive cardiac imaging for atherosclerosis may play a key role in identifying patients at ASCVD risk3).

For symptomatic patients, coronary computed tomographic angiography (CTA) has been widely used to evaluate the presence, extent, severity, and characteristics of coronary artery disease (CAD). Considering the high diagnostic accuracy of CAD, particularly in terms of high sensitivity and negative predictive value, the recent National Institute for Health and Care Excellence (NICE) clinical guidelines state that coronary CTA has served as the first-line approach for the assessment of CAD among patients with stable atypical anginal chest pain or those with non-anterior chest pain presenting with electrocardiogram changes6). In the current study, Kawai and Hoshino et al. investigated whether patients who were scheduled to undergo carotid artery stenting (CAS) or carotid endarterectomy (CEA) presented with increased prevalence of various CAD characteristics, such as the presence, extent, severity, and high-risk plaque (HRP), using coronary CTA. Interestingly, they demonstrated the possible diagnostic workflow to evaluate CAD among patients with CAS/CEA5). The current study using CTA revealed that patients who were scheduled to undergo CAC/CEA presented with more significant stenosis, three vessel disease/left main trunk (TVD/LMT), or HRP compared with those without CAS/CEA. The finding regarding the high prevalence of severe CAD (>50%) (>50% of the patients) is consistent with the prevalence reported in prior studies of patients with significant cervical carotid artery stenosis and/or those undergoing CAS6, 7). Of clinical interest, three-fold increase in HRP was observed among patients with CAS/CES compared with that in patients without CAS/CEA. Approximately 90% of patients with CAS/CEA in the current study were asymptomatic. Considering the possibility of limited exercise capacity among these patients, the findings regarding such a high prevalence of severe stenosis of CAD without any symptoms should be interpreted with caution. In a recent ACC/AHA appropriate use criteria for coronary revascularization in patients with stable ischemic heart disease (IHD), chest symptoms and/or the presence of ischemia have been highlighted as indicators for appropriate care8) because the anatomical assessment of CAD per se failed to show the benefit to identify patients who would require revascularization9, 10). Similarly, the Ministry of Health, Labor and Welfare in Japan has recently announced the revision of medical treatment fees for stable IHD, which does not allow to perform coronary revascularization for lesions with 75%–95% stenosis but without any documentation of ischemia on the basis of symptoms or using non-invasive/invasive modalities. Although the findings of the current study are interesting, the possibility of increased downstream test...
utilization and coronary revascularization should be cautiously considered. Overall, the current study demonstrated that the presence of chest symptoms was a significant predictor of an increased prevalence of TVD/LMT among patients with CAS/CEA. These findings highlight the importance of the evidence of ischemic findings to identify patients at a high risk of CAD. More data in terms of clinical perspective of improving outcomes to evaluate CAD using coronary CTA among patients with CAS/CEA should be gathered.

**Conflict of Interest**

Dr. Rine Nakanishi declares that there are no conflicts of interest. Dr. Takanori Ikeda has received a grant support through his institution and from Bristol-Myers Squibb and Daiichi Sankyo as well as honoria for lectures from Bayer Healthcare, Bristol-Myers Squibb, Pfizer, Daiichi Sankyo, Tanabe-Mitsubishi, and Ono Pharmaceutical.

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