Prognostic Value of the CHADS2 Score for Adverse Cardiovascular Events in Coronary Artery Disease Patients Without Atrial Fibrillation—A Multi-Center Observational Cohort Study

Noriaki Tabata, MD;* Eiichiro Yamamoto, MD, PhD;* Seiji Hokimoto, MD, PhD; Takayoshi Yamashita, MD; Daisuke Sueta, MD, PhD; Seiji Takashio, MD, PhD; Yuichiro Arima, MD, PhD; Yasuhiro Izumiya, MD, PhD; Sunao Kojima, MD, PhD; Koichi Kaikita, MD, PhD; Kunihiko Matsui, MD, MPH; Kazuteru Fujimoto, MD, PhD; Kenji Sakamoto, MD, PhD; Hideki Shimomura, MD, PhD; Ryusuke Tsunoda, MD, PhD; Toyoki Hirose, MD, PhD; Natsuki Nakamura, MD, PhD; Naritsugu Sakaino, MD, PhD; Shinichi Nakamura, MD, PhD; Nobuyasu Yamamoto, MD, PhD; Toshiyuki Matsumura, MD, PhD; Ichiro Kajiwara, MD, PhD; Shuichi Koide, MD, PhD; Tomohiro Sakamoto, MD, PhD; Koichi Nakao, MD, PhD; Shuichi Oshima, MD, PhD; Kenichi Tsujita, MD, PhD; On behalf of Kumamoto Intervention Conference Study (KICS) Investigators**

Background—The CHADS2 score has mainly been used to predict the likelihood of cerebrovascular accidents in patients with atrial fibrillation. However, increasing attention is being paid to this scoring system for risk stratification of patients with coronary artery disease. We investigated the value of the CHADS2 score in predicting cardiovascular/cerebrovascular events in coronary artery disease patients without atrial fibrillation.

Methods and Results—This was a multicenter, observational cohort study. The subjects had been admitted to one of the participating institutions with coronary artery disease requiring percutaneous coronary intervention. We calculated the CHADS2 scores for 7082 patients (mean age, 69.7 years; males, 71.9%) without clinical evidence of atrial fibrillation. Subjects were subdivided into low (0–1), intermediate (2–3), and high-score (4–6) groups and followed for 1 year. The end point was a composite of cardiovascular/cerebrovascular death, nonfatal myocardial infarction, and ischemic stroke at 1-year follow-up. Rates of triple-vessel/left main trunk disease correlated positively with CHADS2 score categories. CHADS2 scores among single, double, and triple-vessel/left main trunk groups were 2 (1–2), 2 (1–3), and 2 (2–3), respectively (P<0.001). A total of 194 patients (2.8%) had a cardiovascular/cerebrovascular event, and Kaplan–Meier analysis demonstrated a significantly higher probability of cardiovascular/cerebrovascular events in proportion to a higher CHADS2 score (log-rank test, P<0.001). Multivariate Cox hazard analysis identified CHADS2 score (per 1 point) as an independent predictor of cardiovascular/cerebrovascular events (hazard ratio, 1.31; 95% CI, 1.17–1.47; P<0.001).

Conclusions—This large cohort study indicated that the CHADS2 score is useful for the prediction of cardiovascular/cerebrovascular events in coronary artery disease patients without atrial fibrillation. (J Am Heart Assoc. 2017;6:e006355. DOI: 10.1161/JAHA.117.006355.)

Key Words: cardiovascular disease risk factors • cardiovascular events • coronary artery disease • risk stratification
Clinical Perspective

What Is New?

- This large, cohort study first demonstrated a prognostic value of the CHADS2 score in coronary artery disease patients without clinical evidence of atrial fibrillation for predicting subsequent cardiovascular/cerebrovascular events.

What Are the Clinical Implications?

- The CHADS2 score is simple, widely applicable, well validated, and low cost, and it would be a useful tool for general clinicians as well as cardiologists to identify severe coronary artery disease patients with a high risk of subsequent cardiovascular/cerebrovascular events, for optimization of risk-reducing treatments.

Atrial fibrillation (AF) is a common cardiac arrhythmia associated with substantial morbidity and mortality from thromboembolisms, which can induce stroke. The occurrence of stroke is proportional to the presence of certain risk factors.1 The CHADS2 score (scored as 1 point each for congestive heart failure, hypertension, diabetes mellitus, or age ≥75 years, and 2 points each for past stroke or transient ischemic attack) has been used to evaluate the risk for ischemic stroke in AF patients in terms of intracardiac thrombogenesis, allowing tailored initiation of antithrombotic treatments for risk reduction, balancing against the risk of bleeding from long-term anticoagulation.1–3 This score is commonly used in clinical practice to guide decisions regarding anticoagulant as well as antiplatelet therapy.4

Recently, the CHA2DS2-VASc (scored as 1 point each for congestive heart failure, hypertension, diabetes mellitus, vascular disease, age 65 to 75 years, or female sex, and 2 points each for age ≥75 years or past stroke/transient ischemic attack) and R2CHADS2 (adding 2 points for renal failure to the CHADS2 score) scores were developed to improve the precision of risk stratification by including other important predictive factors. These newer scores have been reported to improve the accuracy of the CHADS2 score in estimating the risk of stroke in AF patients.5,6

Each of the components of the CHADS2 score has long been associated with ischemic stroke in patients with coronary artery disease (CAD) in large, cohort studies.7–9 This suggests the possible utility of the score in predicting a wide range of cerebrovascular and cardiovascular diseases in the CAD population. Recently, several studies have reported on the use of CHADS2’s predictive value for cardiovascular events in AF patients10 and cerebrovascular events in non-AF patients.11 It has been suggested that the CHADS2 score might predict cardiovascular events in non-AF patients, though this has been investigated in relatively small populations or in a single-center study.12

The CHADS2 score is the original score to predict cerebrovascular accidents in AF patients, it is more prevalent than the CHA2DS2-VASc and R2CHADS2 scores, and, at present, the score is still described in the guideline and is in use.13 On the other hand, the predictive value of this original score in CAD patients without AF is not fully demonstrated in a large and multicenter study. Thus, we wished to investigate the value of the original CHADS2 score in predicting cardiovascular/cerebrovascular events in CAD patients without AF, in a multicenter and in a large population.

Methods

We conducted a multicenter, observational cohort study of 7082 consecutive CAD patients (mean age, 69.7 years; male, 71.9%) without clinical evidence of AF requiring percutaneous coronary intervention (PCI). They were enrolled between June 2008 and March 2011 through the KICS (Kumamoto Intervention Conference Study) registry, a physician-initiated, non-company-sponsored, multicenter registry involving 15 centers in Japan. The study complied with the Declaration of Helsinki regarding investigation in humans and was approved by each institutional ethics committee. Informed consent was obtained from all patients.

Baseline demographic data, cardiovascular risk factors, and medications on discharge were documented. We defined diabetes mellitus as symptoms of diabetes mellitus and a casual plasma glucose concentration ≥200 mg/dL, fasting plasma glucose concentration ≥126 mg/dL, 2-hour plasma glucose concentration ≥200 mg/dL from a 75-g oral glucose tolerance test, or taking medication for diabetes mellitus. Hypertension was defined as >140/90 mm Hg or taking antihypertensive medication, and dyslipidemia was defined as low-density lipoprotein ≥140 mg/dL (≥3.63 mmol/L), high-density lipoprotein <40 mg/dL (1.04 mmol/L), or triglycerides ≥150 mg/dL (≥1.7 mmol/L). We also evaluated the incremental effect of chronic kidney disease (CKD) on clinical outcome, following the recent suggestion that adding renal function to the score (R2CHADS2) improves stroke risk stratification in AF patients over that of CHADS2.5 CKD was defined as an estimated glomerular filtration rate <60 mL/min per 1.73 m². Smoking status was determined by interview. Acute coronary syndrome was defined as either an acute myocardial infarction (MI; ST-elevation MI or non-ST-elevation MI) or unstable angina pectoris. Patients with past or current intermittent claudication associated with an ankle-brachial index value of <0.9 in either leg were categorized as having peripheral arterial disease. Patients with previous ischemic stroke or transient ischemic attack were defined as having cerebrovascular disease.
The CHADS2 score was calculated for each PCI patient at discharge. The previous studies to investigate the predictive value of the CHADS2 score for cardiovascular events in AF patients and cerebrovascular events in non-AF patients adopted categories of low (0–1), intermediate (2–3), and high (4–6) scores. This categorization had been reported to have a higher value of C-statistic than that of categorization into low and high scores in the original literature of the CHADS2 score. In the present study, we also divided subjects according to score values into 3 subgroups similarly to describe baseline poststenting characteristics and then to evaluate the effect of higher CHADS2 score on clinical outcome. We classified the severity of CAD into single-, double-, and triple-vessel or left main trunk (LMT) disease requiring PCI.

After coronary stent implantation, patients were followed prospectively at outpatient clinics in each institution. Cardiovascular and cerebrovascular events were ascertained from a review of medical records and confirmed by direct contact with the patients, their families, and physicians. The end point was a composite of cardiovascular or cerebrovascular death, nonfatal MI, and ischemic stroke at 1-year follow-up after PCI; it has been reported that patients with atherosclerotic arterial disease or at risk of atherothrombosis experience high incidence of cardiovascular events within 1 year. "Cardiovascular death" was defined as death attributed to MI, congestive heart failure, or documented sudden cardiac death. We used the universal definition of MI in this study. The diagnosis of ischemic stroke was based on clinical and radiological evidence of stroke. For subjects who had ≥2 cardiovascular events, only the first event was considered in the analysis.

The Shapiro–Wilk test was used to assess the normal distribution of continuous data. Continuous variables with a normal distribution are expressed as the mean (SD). The results of the CHADS2 score were expressed by medians and interquartile ranges. Categorical data are presented as numbers or percentages. Differences between 2 groups were tested using Fisher’s exact test or the chi-squared test for categorical variables, as appropriate. Differences in continuous variables were analyzed by the ANOVA or the Kruskal–Wallis test, as appropriate. We used the Kaplan–Meier method to estimate the cardiovascular event probabilities at 365 days and also the log-rank test to compare the distributions of survival times among groups. Cox proportional hazard models were used to calculate hazard ratios. Predictors of clinical outcome identified through univariate analysis were tested in a multivariate analysis. We selected variables of statistically significant in the univariate analyses (P<0.05) and to exclude variables that will cause internal correlations. The factors of age, hypertension, diabetes mellitus, cerebrovascular disease, and heart failure were components of the CHADS2 score, and we thought these variables cause internal correlations with the CHADS2 score variable. Estimates of the C-statistic for the risk factors were calculated after the addition of the CHADS2 score and CKD factor to the risk factors of independent predictive values identified in the multivariate Cox proportional hazards regression analyses; it is generally considered C-statistic above 0.7 acceptable discriminatory power, that above 0.8 excellent discriminatory power, and that above 0.9 outstanding discriminatory power. The incremental effect of adding the CHADS2 score and CKD factor or the to other risk factors in predicting future cardiovascular events was evaluated using the net reclassification improvement (NRI) as previously described. Considering potential center effects, we adjusted predictive models by including center variables as dummy variables. P<0.05 was considered to denote statistical significance. Statistical analyses were performed using commercial software (SPSS version 22; IBM Inc, Armonk, NY).

Results

A total of 7082 CAD patients requiring PCI were recruited into this study. The CHADS2 scores of the patients are shown in Figure 1. The baseline laboratory and clinical findings for the study patients according to low, intermediate, and high scores are listed in Table 1. Patients with high CHADS2 scores were older; had higher rates of dyslipidemia, CKD (including hemodialysis status), past coronary artery bypass graft, peripheral arterial disease, and use of angiotensin-converting enzyme inhibitors/angiotensin receptor blockers and beta-blockers; and lower rates of current smoking.

The left side of Figure 2A shows the distribution of triple-vessel or LMT CAD among the low, intermediate, and high CHADS2 scores. The rate of triple-vessel or LMT disease requiring PCI is shown in Figure 2B. The right side of Figure 2B shows the distribution of CHADS2 scores over the total population. We observed an increase in the rate of triple-vessel or LMT CAD among the low, intermediate, and high CHADS2 scores. The rate of triple-vessel or LMT disease requiring PCI is shown in Figure 2B. The right side of Figure 2B shows the distribution of CHADS2 scores over the total population.
positively correlated with a higher CHADS2 score. The CHADS2 scores among single-, double-, and triple-vessel or LMT CADs were 2 (1–2), 2 (1–3), and 2 (2–3), respectively (P<0.001; the right side).

As detailed in Table 2, a total of 194 patients (2.8%) suffered a cardiovascular or cerebrovascular event. The rates of cardiovascular events among low, intermediate, and high CHADS2 score groups were 1.5%, 3.3%, and 4.9%, respectively (Figure 2B, left side). Patients with cardiovascular/cerebrovascular events had significantly higher CHADS2 scores than those without events, at 2 (2–3) versus 2 (1–3; P<0.001; Figure 2B, right side). We performed a Kaplan–Meier analysis and observed that a significantly higher incidence of cardiovascular/cerebrovascular events was in proportion to a higher CHADS2 score (log-rank test, P<0.001; Figure 3A). Rates of cardiovascular or cerebrovascular death and ischemic stroke were higher in proportion to CHADS2 score (P<0.001; Figure 3B and 3D), respectively, but there was no significant difference in the rates of non-fatal MI among the low, intermediate, and high CHADS2 score groups (P=0.331; Figure 3C). We also evaluated the occurrence of cardiovascular events during 2 periods, from discharge to 30 days and from 30 days to 1 year (Figure 4). The results of Cox proportional hazards analyses are shown in Table 3. We included the CHADS2 score, body mass index, acute coronary syndrome, dyslipidemia, CKD, and peripheral arterial disease, and excluded hemodialysis, 1 vessel disease, LMT/3 vessel disease, and statin attributed to the internal correlation. Multivariate analyses identified CHADS2 score (per 1 point) as an independent and significant predictor of the primary outcome (hazard ratio, 1.31; 95% CI, 1.17–1.47; P<0.001).
From the results of the Cox proportional hazards regression analyses, we calculated the C-statistic for the predictive value of future cardiovascular events. The C-statistic of the variables, including body mass index, acute coronary syndrome, dyslipidemia, and peripheral arterial disease, was 0.69 versus 0.72 when CHADS<sub>2</sub> score was included; the continuous NRI was 16.5% (8.7–23.4%; P<0.001). After including the CKD with these factors, we found an increase in C-statistic from 0.72 to 0.74, and the continuous NRI was 20.8% (13.0–27.6%; P<0.001).

**Discussion**

The main findings of this study were as follows: (1) The CHADS<sub>2</sub> score was higher in relation to the severity of CAD; (2) CAD patients with higher CHADS<sub>2</sub> score points had a...
significantly higher probability of adverse cardiovascular/cerebrovascular events by the log-rank test; (3) multivariate Cox proportional hazards analysis showed that the CHADS2 score and presence of CKD were independent and significant predictors of clinical outcome in CAD patients; and (4) predictive model improvements by significant NRIs after adding the CHADS2 score and CKD status to the model of other independent predictive values.

To our knowledge, this is the largest study to examine the association of CHADS2 score with severity of CAD and with future adverse cardiovascular/cerebrovascular events in CAD patients without clinical evidence of AF. The CHADS2 score was originally developed for risk prediction and stratification of ischemic stroke in patients with nonvalvular AF and for guiding anticoagulant therapy.1,2,5 The CHADS2 score is also reportedly useful in the prediction of cardiovascular events in

Table 2. Primary End Points by CHADS2 Score During 1-Year Follow-up

<table>
<thead>
<tr>
<th>Primary End Point</th>
<th>Total (n=6891)</th>
<th>Low (0–1) (n=2505)</th>
<th>Intermediate (2–3) (n=3615)</th>
<th>High (4–6) (n=771)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (%)</td>
<td>194 (2.8)</td>
<td>38 (1.5)</td>
<td>118 (3.3)</td>
<td>38 (4.9)</td>
</tr>
<tr>
<td>Cardiovascular death (%)</td>
<td>88 (1.3)</td>
<td>14 (0.6)</td>
<td>57 (1.6)</td>
<td>17 (2.2)</td>
</tr>
<tr>
<td>Nonfatal MI (%)</td>
<td>58 (0.8)</td>
<td>16 (0.6)</td>
<td>34 (0.9)</td>
<td>8 (1.0)</td>
</tr>
<tr>
<td>Stroke (%)</td>
<td>48 (0.7)</td>
<td>8 (0.3)</td>
<td>27 (0.7)</td>
<td>13 (1.7)</td>
</tr>
</tbody>
</table>

MI indicates myocardial infarction.

Figure 3. Kaplan–Meier analyses at 1-year follow-up. Kaplan–Meier analyses of primary outcome (A), cardiovascular or cerebrovascular death (B), nonfatal myocardial infarction (C), and ischemic stroke (D). MI indicates myocardial infarction.
AF patients\textsuperscript{10} and of ischemic stroke in non-AF patients.\textsuperscript{11,18} Moreover, although in a relatively small population in a single-center study, 1 report has indicated that the CHADS\textsubscript{2} score might predict adverse cardiovascular events in non-AF patients with vascular dysfunction.\textsuperscript{19} These reports suggest that the CHADS\textsubscript{2} score has the ability to predict severe atherosclerosis and cerebrovascular and cardiovascular events in the presence or absence of AF. It would be reasonable that in this specific population in the present study, the distribution would shift to the higher CHADS\textsubscript{2} score category. Actually, however, we found that the distribution in the present study was similar to the 1 reported on in the original literature.\textsuperscript{14} Not surprisingly, we observed high frequencies of severe CAD (triple-vessel or LMT) in our subjects, and it is well known that adverse cardiovascular events are more frequent in CAD patients with multivessel disease.\textsuperscript{20} Indeed, in the present study, we found that CAD patients with multivessel disease had a significantly higher CHADS\textsubscript{2} score than those with single-vessel disease, and that the CHADS\textsubscript{2} score was a predictor of future cardiovascular/cerebrovascular events in CAD patients by 2 metrics: the C statistic derived from multivariate Cox proportional hazards models, and the NRI. Thus, our results support and demonstrate previous reports in a large population in a multicenter study. We also evaluated the occurrence of cardiovascular events during 2 periods, from discharge to 30 days and from 30 days to 1 year, and found that the impact of the CHADS\textsubscript{2} score on clinical outcome are clearer after 30 days within 1-year follow-up. Within 30 days, many other factors such as medications and intervention results might affect the outcome, and the impact of the CHADS\textsubscript{2} score is more significant in the chronic phase.

A recent study in high-risk patients (CAD, ischemic stroke, and diabetes mellitus) without AF reported that the CHADS\textsubscript{2} score might have clinical applications for prediction of cardiovascular/cerebrovascular events, and that the CHADS\textsubscript{2} score was associated with other biological markers of vascular injury, such as brachial flow-mediated dilation, carotid intimal thickness, and pulse wave velocity.\textsuperscript{19} It has been reported that impaired vascular endothelial function assessed by flow-mediated dilation is related to the severity of CAD,\textsuperscript{21} and that endothelial dysfunction may predict cardiovascular events in patients with CAD.\textsuperscript{22} Impaired vascular endothelial function generally triggers the platelet adhesion and aggregation and fibrin formation that play a critical role in systemic hypercoagulability.\textsuperscript{23} Vascular endothelial dysfunction is associated with cardiovascular risk factors\textsuperscript{24,25} and is 1 of the key agents of not only coronary atherosclerosis/plaque vulnerability, but also other cardiovascular complications such as vascular remodeling.\textsuperscript{26} Chan et al previously reported the significant association of the CHADS\textsubscript{2} score with vascular endothelial function assessed by flow-mediated dilation in non-AF patients.\textsuperscript{19} Even in the absence of AF, patients with heart failure, hypertension, older age, and diabetes mellitus have elevated markers of endothelial dysfunction and hypercoagulability,\textsuperscript{24,27–29} indicating that platelet activation might be attributed to underlying risk factors other than AF. Therefore, the combined factors of the CHADS\textsubscript{2} score can predict adverse events in the absence of AF. In this study, we further evaluated subjects’ peripheral endothelial function in 698 CAD patients without AF using a reactive hyperemia-peripheral arterial tonometry system and found that CAD patients with higher CHADS\textsubscript{2} score had significantly impaired peripheral endothelial function (P<0.001, data not shown). This suggests that more-careful observation and intensive risk reduction treatment might be needed to treat CAD patients with a high CHADS\textsubscript{2} score.

A recent study has reported that the R\textsubscript{2}CHADS\textsubscript{2} score, in which the presence of CKD is factored into the original CHADS\textsubscript{2} score, improves risk stratification for stroke occurrence in AF patients.\textsuperscript{8} In our study, adding CKD status to the other predictors of clinical outcome resulted in an improvement in prognostic ability. It is well known that renal dysfunction is associated with cardiovascular events, and we previously reported that peripheral endothelial function was impaired in CKD patients and was associated with cardiovascular events.\textsuperscript{28} Renal dysfunction–induced hypertension and vascular calcification, leading to increased cardiac afterload, were reported to be associated with cardiovascular events in CKD patients partially through associated lipid disorders, oxidative stress, and abnormal levels of homocysteine and fibrinogen,\textsuperscript{30} suggesting that the R\textsubscript{2}CHADS\textsubscript{2} score is more accurate than the CHADS\textsubscript{2} score in prediction of subsequent cardiovascular/cerebrovascular events in CAD patients. Further investigation on the newer scores, such as CHA\textsubscript{2}DS\textsubscript{2}-VASc and R\textsubscript{2}CHADS\textsubscript{2} scores, will be required in CAD patients without AF.
Perspectives

Although the CHADS2 score was originally developed to predict the risk of stroke in AF patients, accumulating evidence suggests that it works irrespective of the presence or absence of AF. Each of the components of the CHADS2 score is simple and calculating the score is easy in clinical practice and is widely applicable, well validated, and low cost. If this score predicts subsequent cardiovascular events in CAD patients, it would be a useful tool for general clinicians as well as cardiologists. Our large, cohort study first demonstrated the predictive and prognostic values of the CHADS2 score in CAD without AF to identify severe CAD patients with a high risk of subsequent cardiovascular/cerebrovascular events, for optimization of risk-reducing treatments, and found that adding CKD status further honed its accuracy. Our understanding of CAD is moving from simple stenoses to the large role of endothelial dysfunction as the final common pathway of many cardiovascular/cerebrovascular events.

Study Limitations

This study has some limitations. First, it included only Japanese patients. Thus, our results might not be applicable to different ethnic populations all over the world. Second, we enrolled CAD patients without clinical evidence of AF, but we cannot deny the possibility that the study population included those with the potential existence of asymptomatic paroxysmal AF; also, the follow-up at the outpatient clinic was performed at each center and we could not fully monitor cardiac rhythm to exclude AF. Third, we evaluated the severity of CAD only by the number of diseased coronary arteries and did not use other risk markers. Fourth, the follow-up was performed at each center and the information of visits interval

Table 3. Cox Proportional Hazards Regression Analyses for Clinical Outcome

<table>
<thead>
<tr>
<th>Variable</th>
<th>Univariate Regression</th>
<th>Multivariate Regression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR</td>
<td>95% CI</td>
</tr>
<tr>
<td>CHADS2 score</td>
<td>1.39</td>
<td>1.25 to 1.55</td>
</tr>
<tr>
<td>Age</td>
<td>1.03</td>
<td>1.02 to 1.05</td>
</tr>
<tr>
<td>Male sex</td>
<td>0.94</td>
<td>0.90 to 0.98</td>
</tr>
<tr>
<td>BMI</td>
<td>0.99</td>
<td>0.97 to 1.01</td>
</tr>
<tr>
<td>AC</td>
<td>2.44</td>
<td>1.79 to 3.31</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.17</td>
<td>0.89 to 1.55</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.99</td>
<td>0.45 to 0.79</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>1.24</td>
<td>0.91 to 1.70</td>
</tr>
<tr>
<td>Current smoking</td>
<td>2.34</td>
<td>1.75 to 3.13</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>2.06</td>
<td>1.28 to 3.30</td>
</tr>
<tr>
<td>PAD</td>
<td>1.81</td>
<td>1.28 to 2.54</td>
</tr>
<tr>
<td>CVD</td>
<td>1.81</td>
<td>1.28 to 2.54</td>
</tr>
<tr>
<td>HF</td>
<td>3.05</td>
<td>2.23 to 4.18</td>
</tr>
<tr>
<td>Past PCI</td>
<td>0.77</td>
<td>0.55 to 1.07</td>
</tr>
<tr>
<td>Past CABG</td>
<td>1.14</td>
<td>0.62 to 2.09</td>
</tr>
<tr>
<td>Previous MI</td>
<td>0.87</td>
<td>0.61 to 1.26</td>
</tr>
<tr>
<td>1 VD</td>
<td>0.75</td>
<td>0.61 to 1.26</td>
</tr>
<tr>
<td>LMT or 3 VD</td>
<td>1.74</td>
<td>1.28 to 2.36</td>
</tr>
<tr>
<td>Statin</td>
<td>0.58</td>
<td>0.43 to 0.78</td>
</tr>
<tr>
<td>Beta-blocker</td>
<td>0.94</td>
<td>0.71 to 1.25</td>
</tr>
<tr>
<td>ACE-I/ARB</td>
<td>1.33</td>
<td>0.95 to 1.86</td>
</tr>
</tbody>
</table>

AC indicates abdominal circumference; ACE-I, angiotensin converting enzyme inhibitor; ACS, acute coronary syndrome; ARB, angiotensin receptor blocker; BMI, body mass index; CABG, coronary artery bypass graft; CKD, chronic kidney disease; CVD, cerebrovascular disease; HF, heart failure; HR, hazards ratio; LMT, left main trunk; MI, myocardial infarction; PAD, peripheral arterial disease; PCI, percutaneous coronary intervention; VD, vessel disease.

DOI: 10.1161/JAHA.117.006355

Tabata et al
ORIGINAL RESEARCH

Downloaded from http://jaha.ahajournals.org/ by guest on August 25, 2017
is lacking. This lack of information might affect the results in the present study.

Acknowledgments

The authors thank the other investigators of the KICS for their valuable contributions. We also thank Medical Secretaries, Rina Usui, Saki Ogata, Shiori Kotegawa, and Kahoru Fujisue, for collecting data.

Disclosures

None.

References

Kumamoto Intervention Conference Study (KICS) Investigators:

Shinsuke Hanatani¹, Koichiro Fujisue¹, Eiji Horio², Kenji Morihisa², Tsunenori Nishijima², Katsuo Noda², Masahide Nagano³, Takashi Fukunaga³, Eiji Taguchi³, Shinzo Miyamoto³, Tetsuji Katayama⁴, Junichi Matsubara⁴, Masakazu Matsukawa⁴, Yuji Miyao⁴, Yuji Ogura⁵, Takashi Kudo⁵, Yoshihiro Yamada⁵, Hiroki Usuku⁶, Hiromi Yoshimura⁶, Shunichiro Fuchigami⁶, Tomokazu Ikemoto⁶, Teruhiko Ito⁶, Ryusuke Tsunoda⁶, Tomoaki Uemura⁷, Hirofumi Kurokawa⁷, Hideki Maruyama⁷, Koji Sato⁸, Kenshi Yamanaga⁹, Shota Nakamura⁹, Tadasuke Chitose¹⁰, Takamichi Ono¹⁰, Koji Abe¹¹, Hideki Doi¹¹, Takashi Miyazaki¹², Mitsutoshi Miura¹², Eisaku Okuyama¹², Koichi Kikuta¹², Hiroaki Kusaka¹³, Kazumasu Kuroki¹³, Ryuichiro Fukushima¹³, Takashi Uemura¹⁴, Shinji Tayama¹⁴, Taku Rokutanda¹⁵, Yosuke Hanaoka¹⁵, Shinichi Nakamura¹⁵

Institutions:

1. Department of Cardiovascular Medicine, Graduate School of Medical Sciences, Kumamoto University, Kumamoto

2. Division of Cardiology, Kumamoto Central Hospital, Kumamoto

3. Cardiovascular Center, Kumamoto Saiseikai Hospital, Kumamoto

4. Division of Cardiology, National Hospital Organization Kumamoto Medical Center, Kumamoto

5. Division of Cardiology, Fukuoka Tokushukai Hospital, Fukuoka

6. Division of Cardiology, Kumamoto Red Cross Hospital, Kumamoto

7. Division of Cardiology, Minamata City Hospital and Medical Center, Minamata
8. Division of Cardiology, Kumamoto City Hospital, Kumamoto

9. Division of Cardiology, Amakusa Regional Medical Center, Amakusa

10. Division of Cardiology, Aroa City Hospital, Aroa

11. Division of Cardiology, Kumamoto Rosai Hospital, Yatsushiro

12. Division of Cardiology, Shinbeppu Hospital, Beppu

13. Miyazaki Prefectural Nobeoka Hospital, Nobeoka

14. Division of Cardiology, Kumamoto General Hospital, Yatsushiro

15. Division of Cardiology, Hitoyoshi General Hospital, Hitoyoshi
Prognostic Value of the CHADS₂ Score for Adverse Cardiovascular Events in Coronary Artery Disease Patients Without Atrial Fibrillation—A Multi–Center Observational Cohort Study


J Am Heart Assoc. 2017;6:e006355; originally published August 16, 2017;
doi: 10.1161/JAHA.117.006355

The Journal of the American Heart Association is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Online ISSN: 2047-9980

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://jaha.ahajournals.org/content/6/8/e006355