

CARDIOLOGY

Guidelines at a Glance



Major cardiovascular guidelines distilled to single-liner summaries
for rapid clinical reference at the bedside and in the cath lab

Dr. Ali Akram Khan, MD
Interventional & Structural Cardiologist

Chief Structural Cardiology Fellow & Junior Faculty Attending — NYU Langone Health, New York

alikhancardiology.com

@alikhnm.d · @aliakhanm.d · [linkedin.com/in/ali-khan-671132134](https://www.linkedin.com/in/ali-khan-671132134)

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These single-liner summaries capture the most practice-changing recommendation from each major cardiovascular guideline, curated and distilled by **Dr. Ali Khan, MD**. Each entry is designed for rapid clinical reference. Bold text highlights the core message. Always consult the full guideline for complete recommendations and evidence grading. *Last reviewed May 2026.*

♥ ■ Preventive Cardiology & Risk Reduction

2018	<p>ACC/AHA Blood Cholesterol Full ■</p> <p>High-intensity statin for ASCVD. If LDL ≥ 70 on max statin: add ezetimibe, then PCSK9 inhibitor. Coronary calcium score breaks ties in borderline-risk patients.</p> <p>AHA · ACC · AACVPR · NLA</p>
2017	<p>ACC/AHA Hypertension Full ■</p> <p>BP $\geq 130/80$ = Stage 1 HTN. Target $<130/80$ in CVD or high-risk. Lifestyle first for low-risk Stage 1; pharmacotherapy for Stage 2 or high-risk Stage 1.</p> <p>ACC · AHA · Multi-Society</p>
2019	<p>ACC/AHA Primary Prevention Full ■</p> <p>Aspirin no longer routine for primary prevention age >70 or high bleeding risk. Statins + BP control + lifestyle are the pillars.</p> <p>ACC · AHA</p>
2023	<p>ACC/AHA Chronic Coronary Disease Full ■</p> <p>OMT is cornerstone. Revascularize for symptoms despite OMT or high-risk anatomy. Routine PCI for stable CCD without ischemia does NOT improve outcomes (ISCHEMIA).</p> <p>ACC · AHA · NLA · PCNA</p>
2023	<p>ACC/AHA Peripheral Artery Disease Full ■</p> <p>All PAD: statin + antiplatelet + smoking cessation. Supervised exercise therapy before revascularization for claudication. Endovascular preferred for most CLTI with favorable anatomy.</p> <p>ACC · AHA · SCAI · SVS · Multi-Society</p>
2022	<p>ACC/AHA Aortic Disease Full ■</p> <p>Repair ascending ≥ 5.5cm (≥ 5.0cm in bicuspid/CTD). Type A dissection = surgical emergency. Type B uncomplicated = medical. Type B + malperfusion = TEVAR.</p> <p>ACC · AHA · Multi-Society</p>

■ Coronary Artery Disease & Acute Coronary Syndromes

2025	<p>ACC/AHA/SCAI Unified ACS Guideline [NEW] Full ■</p> <p>Do NOT pre-load P2Y12 in NSTEMI — 40% go to CABG. Complete revascularization preferred in stable multivessel STEMI. IVUS/OCT Class I for complex lesions.</p> <p>ACC · AHA · ACEP · NAEMSP · SCAI</p>
2021	<p>ACC/AHA/SCAI Revascularization Full ■</p> <p>CABG preferred for LM + multivessel + high SYNTAX or diabetes. FFR/iFR-guided PCI Class I. IVUS/OCT guidance improves outcomes in complex PCI — use routinely.</p> <p>ACC · AHA · SCAI</p>
2022	<p>ACC/AHA Chest Pain Evaluation Full ■</p> <p>0/1-hour hs-troponin safely rules in/out NSTEMI. CCTA preferred for low-intermediate pretest probability. HEART score guides ED disposition.</p> <p>ACC · AHA · Multi-Society</p>

2016	<p>ACC/AHA DAPT Duration Full ■</p> <p>Post-DES: ≥6 months stable CAD, ≥12 months ACS. Prolonged DAPT reduces MI but increases bleeding — individualize with DAPT score. Partially updated by 2025 ACS guideline.</p> <p>ACC · AHA</p>
Updated	<p>SCAI High-Risk PCI Requirements Full ■</p> <p>Unprotected LM + last-vessel PCI require on-site cardiac surgery and MCS availability. Prophylactic Impella before balloon inflations — not rescue after collapse.</p> <p>SCAI</p>

♥ Heart Failure, Cardiomyopathy & Cardiogenic Shock

2022	<p>AHA/ACC/HFSA Heart Failure Full ■</p> <p>The 'Fantastic Four' for HFrEF: ARNI + beta-blocker + MRA + SGLT2i — all Class I, start together. SGLT2i Class I for HFmrEF; Class IIa for HFpEF. ICD for EF ≤35% after ≥3 months GDMT.</p> <p>AHA · ACC · HFSA</p>
2022/25	<p>SCAI/ACC Cardiogenic Shock Full ■</p> <p>SCAI stages A–E — reassess every 6–12 hours. Stage C+ requires RHC + MCS consideration. Impella supported by DanGer Shock for AMI-CS. VA-ECMO for biventricular failure — always plan LV venting.</p> <p>SCAI · ACC 2025</p>
2020	<p>AHA/ACC Hypertrophic Cardiomyopathy Full ■</p> <p>Annual SCD risk calc; ICD for prior arrest, sustained VT, or ≥2 risk factors. Mavacamten approved for obstructive HCM on max beta-blocker. Septal reduction for drug-refractory LVOTO.</p> <p>AHA · ACC</p>
2023	<p>ACC Expert Consensus Cardiac Amyloidosis Full ■</p> <p>Tc-PYP grade 2–3 + negative immunofixation = ATTR-CM without biopsy. Tafamidis reduces mortality; acoramidis approved 2024. Diagnose early — treatment most effective before advanced remodeling.</p> <p>ACC</p>
2022	<p>ACC/AHA Cardio-Oncology Full ■</p> <p>Baseline echo before anthracyclines + trastuzumab. EF drop ≥10% to <53% = cardiotoxicity — hold and optimize GDMT. ICI myocarditis = medical emergency requiring high-dose steroids.</p> <p>ACC · AHA · Multi-Society</p>

■ Arrhythmias & Electrophysiology

2023	<p>ACC/AHA/HRS Atrial Fibrillation Full ■</p> <p>Early rhythm control reduces CV outcomes (EAST-AFNET 4). Ablation Class IIa first-line for paroxysmal/early persistent AF. DOACs preferred; anticoagulate CHA₂DS₂-VASc ≥2 (men) ≥3 (women).</p> <p>ACC · AHA · ACCP · HRS</p>
2017	<p>AHA/ACC/HRS VT & SCD Prevention Full ■</p> <p>ICD for EF ≤35% NYHA II–III on GDMT. Catheter ablation preferred over escalating AADs for recurrent VT in ischemic cardiomyopathy (VANISH2 2024 confirmed). Avoid AADs without ICD in high-risk structural disease.</p> <p>AHA · ACC · HRS</p>
2018	<p>ACC/AHA/HRS Bradycardia & Conduction Full ■</p> <p>PPM for symptomatic SND or AV block. His/LBBP preferred over RV apical pacing to prevent pacing-induced cardiomyopathy. Upgrade in RV-paced patients with new EF decline.</p> <p>ACC · AHA · HRS</p>

2017	<p>ACC/AHA/HRS Syncope</p> <p>High-risk features (structural HD, abnormal ECG, exertional, family SCD) demand urgent workup. Implantable loop recorder is the diagnostic tool for unexplained recurrent syncope after standard evaluation.</p> <p>ACC · AHA · HRS</p>	Full ■
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◆ Valvular Heart Disease & Structural Cardiology

2021	<p>ACC/AHA Valvular Heart Disease</p> <p>TAVR preferred for AS >80 or high/intermediate risk; shared decision for low-risk. TEER (MitraClip) for primary MR with high surgical risk or suitable anatomy. Heart team documentation mandatory.</p> <p>ACC · AHA</p>	Full ■
2024	<p>ACC/AHA Focused Update VHD [NEW]</p> <p>TTVR (Evoque/TriClip) now incorporated for severe TR with high surgical risk. Expanded TAVR indications in younger/low-risk. Transcatheter MVIV for bioprosthetic dysfunction.</p> <p>ACC · AHA 2024</p>	Full ■
2023	<p>SCAI/ACC/AHA LAA Occlusion</p> <p>LAA closure reasonable alternative to OAC in AF with high bleeding risk (Class IIb). CHAMPION-AF 2026 may upgrade this recommendation. Post-procedure: DAPT 45 days → aspirin long-term.</p> <p>SCAI · HRS · ACC · AHA</p>	Full ■
2025	<p>ACC/AHA/SCAI ACHD — PFO & ASD [NEW]</p> <p>PFO closure Class IIa for cryptogenic stroke <60 with high-risk PFO (large shunt, ASA). ASD closure for Qp:Qs >1.5 or RV volume overload. Screen first-degree relatives for heritable aortopathy.</p> <p>ACC · AHA · HRS · ISACHD · SCAI</p>	Full ■
2019	<p>AHA/ACC Infective Endocarditis</p> <p>Modified Duke criteria; blood cultures x3 before antibiotics. Surgery within 7 days for HF, uncontrolled infection, or vegetation >10mm. TTE first; TEE for prosthetic valve or non-diagnostic TTE.</p> <p>AHA · ACC</p>	Full ■

■ PE, VTE & Pulmonary Hypertension

2023	<p>ASH/ISTH VTE — PE & DVT</p> <p>DOACs preferred over warfarin for most PE/DVT. Intermediate-high-risk PE: anticoagulation first; catheter-directed thrombolysis only for hemodynamic deterioration. HI-PEITHO 2026 will define CDT role in submassive PE.</p> <p>ASH · ISTH · ESC</p>	Full ■
2019	<p>AHA/ACC Pulmonary Hypertension</p> <p>New PH threshold: mPAP >20 mmHg on RHC. Group 1 PAH: upfront combination therapy (PDE5i + ERA); triple therapy in high-risk. Always exclude Group 2 (left heart) before PAH-specific therapy.</p> <p>AHA · ACC · CHEST</p>	Full ■

■ Echocardiography, Nuclear & Cardiac Imaging

2016	<p>ASE/EACVI Diastolic Function</p> <p>Grade II/III if ≥3 of 4 abnormal: e/e' >14, septal e' <7 cm/s, TR Vmax >2.8 m/s, LA Vol >34 mL/m². Indeterminate (2 of 4) → exercise stress echo. LVEDP elevation required to diagnose HFpEF.</p> <p>ASE · EACVI</p>	Full ■
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2022	<p>ASE/EACVI Valvular Regurgitation Grading Full ■</p> <p>Severe MR: EROA ≥ 0.40 cm², RVol ≥ 60 mL. Severe TR: VC >7mm, EROA ≥ 0.40 cm². PISA alone insufficient for torrential TR — integrate hepatic vein reversal, RV size, quantitative parameters.</p> <p>ASE · EACVI</p>
2025	<p>ASE Standardized Echo Reporting [NEW] Full ■</p> <p>Structured reporting with mandatory elements for quality metrics. GLS (global longitudinal strain) now incorporated as standard metric. Updated normal reference ranges throughout.</p> <p>ASE</p>
2024	<p>ASNC Cardiac Amyloid Nuclear (Tc-PYP) [NEW] Full ■</p> <p>Tc-PYP grade 2–3 + negative immunofixation = ATTR-CM without biopsy. H/CL >1.5 at 1 hour confirms uptake. Any monoclonal protein = AL possible → biopsy required.</p> <p>ASNC</p>
2023	<p>ACC Multi-Society AUC Noninvasive Testing Full ■</p> <p>CCTA preferred for low-intermediate pretest probability stable chest pain without known CAD. Functional testing for known CAD or high pretest probability. CAC score for borderline 10-year risk.</p> <p>ACC · AHA · ASE · ASNC · SCCT · SCMR</p>
2021	<p>SCCT CT Planning for Structural Interventions Full ■</p> <p>Pre-TAVR CT mandatory: annular area sizing, coronary heights (<10mm = high risk), calcium distribution, ilio-femoral access. Pre-TEER/TTVR: leaflet morphology, coaptation gap, annular dimensions.</p> <p>SCCT</p>

⊕ **Pericardial Disease, Special Topics & Cath Lab Safety**

2015	<p>ESC Pericardial Diseases Full ■</p> <p>Acute pericarditis: NSAIDs + colchicine (reduces recurrence 50%). Tamponade = pericardiocentesis. Constrictive pericarditis: pericardiectomy for chronic refractory cases. Avoid colchicine post-MI — use aspirin.</p> <p>ESC</p>
Updated	<p>SCAI Radiation Safety in the Cath Lab Full ■</p> <p>ALARA: maximize distance, minimize fluoro time, collimate aggressively. Leaded glasses reduce lens dose 95%; ceiling shields cut head/neck dose 90%. Check DAP after every case — career cumulative dose matters.</p> <p>SCAI · HRS · ACR</p>

Connect with Dr. Ali Khan, MD

Interventional & Structural Cardiologist · NYU Langone Health · New York

■ Website	alikhancardiology.com
■ TikTok	@alikhannm.d
■ Instagram	@aliakhanm.d
■ Threads	@aliakhanm.d
■ X / Twitter	@_khanAli90
■ LinkedIn	linkedin.com/in/ali-khan-671132134
■ Google Scholar	Ali Khan MD Publications
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■ Linktree	linktr.ee/alikhannmd

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