Cardiovascular-Kidney-Metabolic (CKM) Syndrome

2026 AHA/ACC/ADA/ASN Guideline (JACC, June 2026) · retires the 2013 AHA/ACC/TOS obesity guideline

Stage decides *what & how often*

THE FIVE STAGES *bidirectional: the point is regression, not just prevention*

Stage	Definition	What it changes for you
0	No CKM risk factors. Normal weight, glucose, BP, lipids and kidney function, no subclinical or clinical CVD	Goal is keeping them here. Widest screening interval; **lifestyle counseling is the whole intervention**
1	**Excess or dysfunctional adiposity**: overweight, obesity, or abdominal obesity, may include prediabetes. **Without** Stage 2 metabolic risk factors and without subclinical CVD	First actionable stage and the most often ignored, because **the patient feels well**. Weight loss here can drive true **stage regression**
2	**Metabolic risk factors or moderate-to-high-risk CKD**: hypertension, T2DM, hypertriglyceridemia, metabolic syndrome, or CKD in moderate-to-high-risk KDIGO categories	**Screening tightens sharply** (annual lipids, glycemia, BP, and eGFR *and* UACR). Entry point for cardioprotective drug therapy
3	**Subclinical CVD or risk equivalent**: **CAC > 100**, pre-HF (**NT-proBNP ≥ 125 pg/mL** with echo dysfunction, or elevated hs-troponin), **very high-risk CKD**, or **PREVENT 10-yr CVD risk ≥ 20%**	Last stop before clinical disease. In pre-HF Stage 3, **intensive lifestyle plus intensive risk factor control is Class 1**, because clinical HF is still preventable
4	**Clinical CVD** (CHD, HF, stroke, PAD, atrial fibrillation) overlapping CKM risk factors. **4a** without kidney failure, **4b** with kidney failure	Treating the coronary disease while ignoring obesity, diabetes and albuminuria **leaves most of the modifiable risk on the table**

Stage youths under 18 as well as adults. The stages are explicitly bidirectional, which is the practical difference from a risk calculator: a score gives a probability and implies nothing can be undone, while the stage tells you what to try to reverse.

THE FOUR CKD THRESHOLDS *written in mg/g and mL/min, and easy to mix up*

Agent	Who qualifies	Why / what it prevents
RAS inhibitor (ACEi or ARB) Class 1	CKD **with T2DM**, or without T2DM but **UACR ≥ 30**, and **eGFR ≥ 30**	Lowers intraglomerular pressure and slows GFR loss. **Maximum tolerated dose is the recommendation**, not a token dose, and that is the step most often left undone
SGLT2 inhibitor Class 1	CKD **with T2DM**, or without T2DM but **UACR ≥ 200**, and **eGFR ≥ 20**	Slows GFR loss, cuts HF hospitalization and CV mortality (DAPA-CKD, EMPA-KIDNEY). **Expect an early eGFR dip and do not stop for it**: it is hemodynamic and precedes the benefit
SGLT2 inhibitor Class 2a	CKD **without T2DM**, **UACR 30 to 199**	Fills the gap below the Class 1 albuminuria threshold, where benefit is likely but the trial evidence is less direct
Finerenone (nonsteroidal MRA) Class 1	CKD **+ T2DM + UACR ≥ 30** despite ACEi/ARB and SGLT2i as tolerated, with **eGFR ≥ 25**	Targets the **residual albuminuria that persists on standard therapy** (FIDELIO-DKD). Added *despite* the other two, not instead of them. Monitor potassium

You cannot apply any of these without a UACR, because every threshold is written in mg/g. eGFR alone misses early kidney disease: albuminuria appears first and independently predicts both kidney and cardiovascular events.

TYPE 2 DIABETES *drug choice follows risk, not A1c*

Recommendation	Threshold	Why
SGLT2i or GLP-1-based therapy with proven benefit Class 1	Stage 2 to 3 with T2DM and **PREVENT 10-yr CVD ≥ 7.5%**	Benefit is **largely independent of glucose lowering**, which is why the trigger is cardiovascular risk rather than A1c
Intensified multifactorial treatment Class 1	Stage 2 to 3 with T2DM	Treating glycemia, BP, lipids and albuminuria **as a bundle** beats sequential single-target care for CVD, mortality and kidney outcomes
Metformin, added to a cardioprotective agent Class 2a	A1c **0.5% to 1% above** the individualized goal	**Note the reversal**: metformin is now what you add for glycemic control *after* the cardioprotective drug, not the mandatory first step before it
GLP-1 plus SGLT2i together Class 2b	Increased CVD risk or multiple CKM risk factors	May add benefit beyond either alone; the weak class reflects thin dedicated combination outcome data

SCREENING, SET BY STAGE *and the two numbers that replace BMI alone*

EVERY ADULT

BMI and waist circumference, both. Obesity at BMI ≥ 30; abdominal obesity at **≥ 88 cm in women, ≥ 102 cm in men**. **BMI alone misclassifies**: it misses the normal-BMI patient with central adiposity and overcalls the muscular one.

FROM STAGE 2, ANNUALLY

Lipids, glycemia, blood pressure, and **eGFR with UACR**, all Class 1. **PREVENT** risk in Stages 0 to 3: **≥ 20% 10-year risk is itself a Stage 3 criterion**, and **≥ 7.5% prioritizes** starting cardioprotective therapy.

DO NOT FORGET

FIB-4 every 1 to 2 years with diabetes or ≥ 2 risk factors: MASLD travels with this syndrome, is silent, and FIB-4 costs nothing extra. **Pre-HF biomarkers** (BNP/NT-proBNP, hs-troponin) if PREVENT-HF ≥ 5%, Class 2a. Screen for **OSA**.

WHAT CHANGED, AND WHAT GETS MISSED

- **Obesity is the entry point, and the conversation is the intervention.** Lifestyle first-line targeting **5% to 10%** of baseline weight, and counsel about that benefit **at least annually** (Class 1). That range is where blood pressure, glycemia, triglycerides and hepatic steatosis reliably improve **even if the patient stays in the obese BMI range**.
- **Two reversals worth knowing:** metformin has moved from mandatory first step to a Class 2a glycemic add-on, and **BMI alone is no longer adequate** without a waist circumference.
- **Social determinants are clinical data, not paperwork.** Food insecurity, housing instability and cost barriers predict both the development of CKM syndrome and the failure of the plan you are writing. **A GLP-1 the patient cannot afford is a failed prescription.**
- **Add finerenone despite the other two, not instead.** The commonest error is treating the four thresholds as a ladder where each replaces the last, when RAS inhibitor, SGLT2i and finerenone are meant to stack.

References: 2026 AHA/ACC/ADA/ASN CKM Syndrome Guideline (JACC, June 9 2026) and ACC Guideline-at-a-Glance · PREVENT (AHA) · DAPA-CKD · EMPA-KIDNEY · FIDELIO-DKD.

Educational aid; verify against current guidance, local formulary and patient factors.

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