

Pictorial review with representative cases of CAD-RADS 2.0 classification in stable coronary artery disease

Revisión pictórica con casos representativos de la clasificación CAD-RADS 2.0 en enfermedad coronaria estable

Alejandro Zuluaga Santamaría[1]
Natalia Aldana Sepúlveda[1]
Sara Pareja Mejía[2]
Catalina Mejía Soto[2]
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Summary

Background: The Coronary Artery Disease Reporting and Data System (CAD-RADS) is a structured reporting framework designed to standardize coronary computed tomography angiography (CCTA) interpretations. A lack of standardized reporting can impede interdisciplinary communication and contribute to variability in clinical management. The implementation of CAD-RADS 2.0 contributes to standardizing CCTA reporting, reducing variability in interpretation and improving interdisciplinary communication, facilitating more accurate management of coronary artery disease. ***Objective:*** To describe and illustrate with our own cases the CAD-RADS 2.0 Reporting System to facilitate the understanding and application of this classification. ***Methods:*** A retrospective filtered search was conducted in our institution's archive for patients who underwent CCTA between June 2, 2023, and March 26, 2024. Two cardiac imaging radiologists with more than 15 years of experience reviewed the CCTA reports, the CAD-RADS 2.0 classification, and images for each patient in the archive, selecting by consensus the cases characteristic of each CAD-RADS 2.0 category to illustrate the application of this reporting system in a representative manner. ***Results:*** Representative cases from the different categories of the updated CAD-RADS 2.0 classification were selected. Illustrations were included to facilitate the understanding of coronary anatomy and the characteristics of the different coronary lesions. ***Conclusion:*** The pictorial review provides a comprehensive and educational resource for understanding and applying the CAD-RADS 2.0 report system, combining a complete description of its categories and modifiers with high-quality images obtained through the clinical use of a state-of-the-art 320 detector row CT scanner in our Colombian population.

Resumen

Introducción: El sistema CAD-RADS (Coronary Artery Disease Reporting and Data System) es una herramienta de clasificación estructurada diseñada para los informes de la angiotomografía coronaria contrastada (ATCC). La falta de uniformidad en la interpretación y reporte de los resultados de la ATCC puede dificultar la comunicación interdisciplinaria y generar variabilidad en el manejo clínico. La implementación del CAD-RADS 2.0 contribuye a estandarizar el informe de la ATCC, pues reduce la variabilidad en la interpretación y mejora la comunicación interdisciplinaria, lo que facilita un manejo más preciso de la enfermedad arterial coronaria. ***Objetivo:*** Describir e ilustrar con casos propios el sistema de reporte CAD-RADS 2.0 para facilitar el entendimiento y la aplicación de esta clasificación. ***Metodología:*** En el archivo de la institución donde se llevó a cabo el estudio se hizo una búsqueda filtrada retrospectiva de pacientes a quienes se les practicó ATCC entre el 2 de junio de 2023 y el 26 de marzo de 2024; dos radiólogos de imagen cardiaca con más de 15 años de experiencia revisaron en el archivo los informes de las ATCC, la clasificación CAD-RADS 2.0 y las imágenes de cada paciente, y seleccionaron por consenso los casos característicos de cada categoría CAD-RADS 2.0 para ilustrar de una manera representativa la aplicación de este sistema de reporte. ***Resultados:*** Se seleccionaron casos propios representativos de las diferentes categorías de la nueva clasificación de CAD-RADS 2.0. Se incluyeron ilustraciones que facilitan la comprensión de la anatomía coronaria y las características de las diferentes lesiones coronarias. ***Conclusión:*** La revisión pictórica aporta un recurso integral y didáctico para la comprensión y aplicación del sistema CAD-RADS 2, combinando una descripción completa de sus categorías y modificadores con imágenes de alta calidad obtenidas mediante la utilización clínica de un tomógrafo de última generación de 320 filas de detectores, en la población colombiana.

[1]Cardiovascular radiologist, Cedimed. Medellín, Colombia.

[2]Radiologist, UPB-Cedimed. Medellín, Colombia. Department of Radiology, Cedimed. Medellín, Colombia

Introduction

CAD-RADS (Coronary Artery Disease Reporting and Data System) is a structured radiology reporting system used to describe contrast-enhanced computed tomography coronary angiography (CCTA). This system was first introduced in 2016 by Cury et al. and represented the first attempt to provide simple, concise information and an accurate classification of coronary artery disease (1). In 2022, the first version was updated to include additional features of new techniques, such as plaque burden and ischemia, and to incorporate evidence from recent clinical trials as well as new clinical practice guidelines (2).

The main objectives of CAD-RADS are to standardize reports of CCTA results to facilitate the communication of test results to referring physicians and, in the latest update, to provide suggestions for patient management (2, 3).

Standardizing reporting will benefit education, research, peer review, and quality control, and may ultimately lead to improved quality of care (4).

CAD-RADS can be used to interpret imaging studies of both patients with stable chest pain and patients with acute chest pain; in this case series, the authors focused on the utility of CAD-RADS 2.0 in interpreting CT chest studies of patients with stable chest pain.

Clinical value

Numerous studies have shown that the CAD-RADS classification accurately predicts major adverse cardiovascular events (unstable angina, myocardial infarction, or death) in patients with stable chest pain, with superior performance compared to traditional risk factors, other risk stratification scores, the coronary artery calcium (CAC) score, and the Society of Cardiovascular Computed Tomography (SCCT) coronary stenosis scoring system. CAD-RADS has also been shown to correlate with the degree of stenosis measured by invasive coronary angiography (ICA) with high diagnostic accuracy. Recent publications have highlighted that the adoption of CAD-RADS in clinical practice results in reduced rates of follow-up diagnostic testing and referrals to cardiology for patients with non-obstructive coronary artery disease and has a favorable impact on the initiation of appropriate preventive medical therapy. Finally, recent studies have validated the performance of deep learning algorithms for evaluating the CAD-RADS classification in CCTA (2).

Methodology

A retrospective filtered search was conducted in the database of the institution where the study was conducted to identify patients who underwent CCTA between June 2, 2023, and March 26, 2024. Two cardiac radiologists with more than 15 years of experience reviewed the CCTA reports, CAD-RADS 2.0 classifications, and images for each patient in the database to select, by consensus, cases characteristic of each CAD-RADS 2.0 category in order to provide a representative illustration of the application of this reporting system. During this period, 395 CCTA studies were performed; patients had an average age of 59.5 years (range 17–89 years): 165 women with an average age of 61.7 years (range 25–89 years) and 230 men with an average age of 57.8 years (range 17–85 years). The CAD-RADS 2.0 categories had the following percentages: 0 (25.09%), 0/E (8.61%), 1 (24.3%), 2 (17.72%), 3 (14.68%), 4 (7.09%), and 5 (2.53%).

Segmental Anatomy of the Coronary Arteries

A standardized approach to coronary segmentation improves the description and communication of findings. The AHA standard segmentation, first proposed in 1975, has stood the test of time and has been used in numerous long-term outcome studies linking the location of stenosis to major adverse coronary events.

This model has been adapted for the CCTA with minimal modifications for greater clarity (5).

Figure 1 shows a version of this modified standard model (5).

The three coronary arteries are subdivided into different coronary segments.

The original 1975 model features 15 segments (6):

Right coronary artery (RCA)
- Proximal segment: 1
- Middle segment: 2
- Distal segment: 3
- Posterior descending artery (PDA): 4 Left main coronary artery (trunk): 5

Left Anterior Descending Artery (LADA):
- Proximal segment: 6
- Medial segment: 7
- Apical segment: 8
- First diagonal branch (D1): 9
- Second diagonal branch (D2): 10

Circumflex Artery (CX)
- Proximal segment of the CX: 11
- Obtusomarginal branch (OM): 12
- Distal segment of the CX: 13
- Left posterolateral branch (PL): 14
- Posterior descending artery (PD): 15

The model proposed by Leipsic et al. in 2014 (5) differs from the standard 1975 AHA segmentation (6) in the following ways:

- A right posterolateral branch (RPL) is defined, arising from the right coronary artery, and is designated as segment 16.
- A new branch, the ramus intermedius, has been added and is designated as segment 17.
- A left posterolateral branch (LPL) is defined, originating from the circumflex artery, and is designated as segment 18.

CAD-RADS Reporting System: Categories

The CAD-RADS reporting system includes a protocol that involves determining the severity of stenosis and the plaque burden (atheromatous burden), as well as incorporating modifiers that include associated techniques for assessing ischemia, such as computed

tomography perfusion (CTP) or computed tomography fractional flow reserve (FFR-CT).

Severity of the stenosis

To classify the severity of stenosis, a system originally developed by the Society for Cardiovascular Computed Tomography is used, in which the degree of stenosis is classified based on the percentage, and a CAD-RADS (2) category is then applied (Table 1, Figure 2).

Table 1. Severity of Stenosis

Degree of Stenosis (%)	Terminology
0	No visible stenosis
1-24	Minimal stenosis
25-49	Mild stenosis
50-69	Moderate stenosis
70-99	Severe stenosis
100	Occlusion

Source: adapted from Cury (2).

Plaque buildup (atheromatous plaque)

Plaque burden is classified into four categories, which can be determined using three systems: the calcium score, the segmental involvement score, and a visual assessment (2) (Table 2).

Table 2. Atheromatous Plaque Burden

	Plaque Burde	Calcium Score	SIS*	Visual
P1	Mild	1-100	≤2	1–2 vessels with mild burden
P2	Moderate	101-300	3-4	1–2 vessels with moderate burden or 3 vessels with mild burden
P3	Severe	301-999	5-7	3 vessels with moderate burden or 1 vessel with severe burden
P4	Extensive	>1000	>8	2–3 vessels with severe burden

* Segment Involvement Score.

Source: adapted from Cury (2).

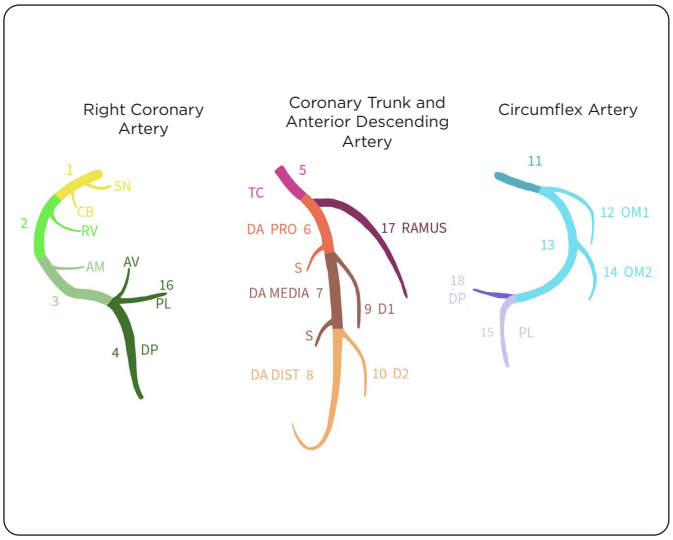


Figure 1. Segmental anatomy of the coronary arteries. SN: sinus node; CB: conal branch; AV: atrioventricular node branch; AM: acute marginal artery; CT: coronary trunk; ADA: anterior descending artery; DA: diagonal artery; PDA: posterior descending artery; OMA: obtuse marginal artery; PLA: posterolateral artery.
Source: Prepared by Dr. Catalina Mejía Soto.

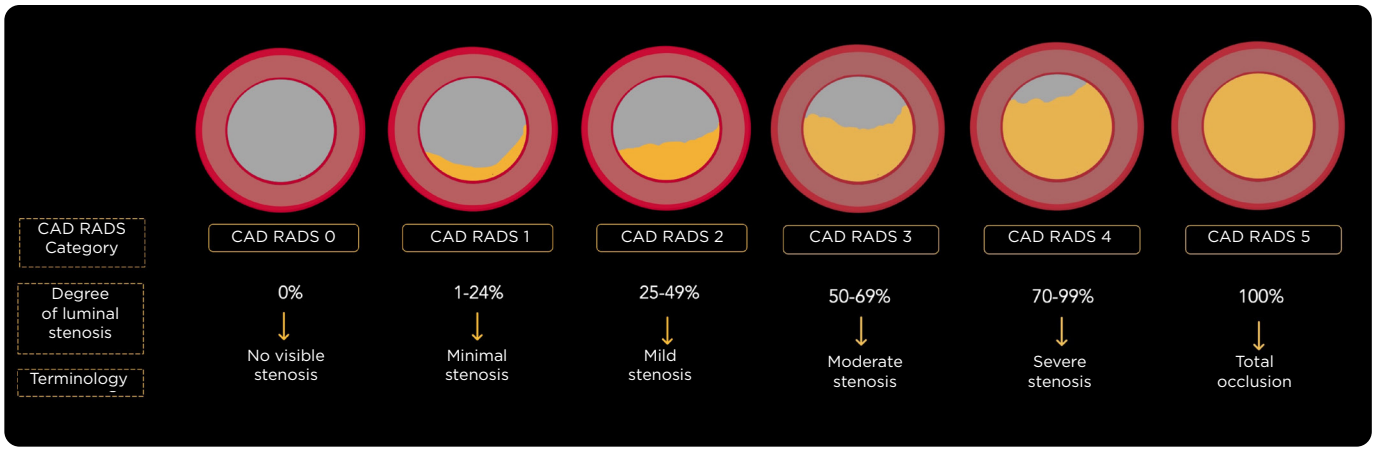


Figure 2. Diagram of the severity of stenosis.
Source: Prepared by Dr. Catalina Mejía Soto.

Calcium Score

The calcium *score* is an accurate and reproducible method for quantifying the amount of calcified plaque present in an artery. When the calcium score is measured in conjunction with an ATCC examination, the score is typically quantified using the Agatston method, which can identify the total amount of calcified plaque (Table 2). It is important to note that the calcium score should not be used in isolation and must be combined with at least one qualitative assessment of the total plaque burden—both calcified and non-calcified—to ensure that non-calcified plaque is also taken into account. Therefore, the plaque burden and the "P" category based on the calcium score will remain the same—if no non-calcified plaques are observed—or may increase after incorporating information on the total non-calcified plaque burden (2) (Figure 3).

Segment Involvement Score (SIS)

This score is calculated by assigning a score of 1 for each coronary segment with any detectable plaque—calcified or noncalcified. Several studies have shown that a higher SIS is associated with higher rates of cardiovascular death or myocardial infarction (Figure 1) (2).

Visual estimate

This method is based on a qualitative estimate of the amount of calcified and non-calcified coronary plaque in each coronary artery (Table 2) (2) (Figures 4–10).

Modifiers

The CAD-RADS categories can be supplemented with modifiers (2): Modifier N (non-diagnostic); Modifier S (stent); Modifier G (graft); Modifier HRP (high-risk plaque); Modifier I (ischemia); Modifier E (exceptions), which are described below.

- **Modifier N:** the study is not fully evaluable or is not diagnostic
  A study may not be fully diagnostic due to motion artifacts, calcium deposits, metallic artifacts, or other types of artifacts. N can be used as a modifier or as a CAD-RADS category, depending on the context:

  - ***As a modifier:*** if the CAD-RADS stenosis grade is 3, 4, or 5—that is, if there is one diagnostic segment with ≥50% stenosis and one or more non-diagnostic segments—the study can be interpreted with confidence, since the management strategy is determined by the stenosis grade of the diagnostic segment (≥50%) and not by the presence of the non-diagnostic segment. These patients require additional functional or anatomical evaluation (the type of follow-up test is determined based on the category of the detected stenosis: 3, 4, or 5).

  - ***As a category:*** if there is a non-evaluable segment (N) and the rest of the coronary tree contains no atheromatous plaques or plaques with stenosis of less than 50% (categories 0, 1, and 2), this implies that further testing is required due to the impossibility of a complete assessment of the coronary arteries; therefore, the test is not diagnostic. In these cases, the N should be placed at the beginning of CAD-RADS as a category and not as a modifier (2) (Figure 11).

- **Modifier S:** indicates at least one coronary stent anywhere in the coronary system (2) (Figure 12).

- **Modifier G:** indicates at least one coronary bypass or graft (2) (Figure 13).

- **Modifier HRP:** indicates high-risk characteristics. There are four characteristics: positive remodeling, low-attenuation plaque (less than 30 HU), punctate or mottled calcification, and the "bowtie" sign (Figure 5). If a plaque has two or more high-risk characteristics, the HRP modifier must be added, and these characteristics must be described in the report. These findings are associated with histological features of a more advanced atherosclerotic plaque that has the potential for rupture or thrombosis and, therefore, poses a greater risk to patients (2) (Figures 14 and 15).

- **Modifier I:** ischemia; indicates that the patient has undergone a FFR-CT (computed tomography fractional flow reserve) or CT-P stress (computed tomography myocardial perfusion) test (2).

- **FFR-CT**: enables the calculation of pressure throughout the coronary tree by integrating machine learning for anatomical data extraction and computational fluid dynamics (2). FFR-CT is calculated using the conventional ATCC protocol without the need to modify parameters, without contrast or additional radiation, and without vasodilators.

- **CTP:** A complete protocol requires image acquisition at rest and under stress (using pharmacological vasodilators, without physical stress or dobutamine)

- **Modifier E:** Exceptions include any non-atherosclerotic coronary abnormality, including, but not limited to, congenital anomalies of the origin, termination, or course of the coronary arteries; dissection; aneurysms or pseudoaneurysms; vasculitis; fistulas; and extrinsic compression.

These exceptions are much less common than atherosclerosis as a cause of stenosis or obstruction (2) (Figures 16–18).

Discussion

Since its introduction in 2016 and its update in 2022 (1,2), the CAD-RADS system has proven to be an essential tool in standardizing CCTA reports for patients with suspected or diagnosed coronary artery disease (3). The importance of CAD-RADS lies in its ability to classify the degree of stenosis and plaque burden in the coronary arteries in a structured and uniform manner, with the aim of establishing an effective framework for communication between those responsible for interpreting the studies and the treating physicians.

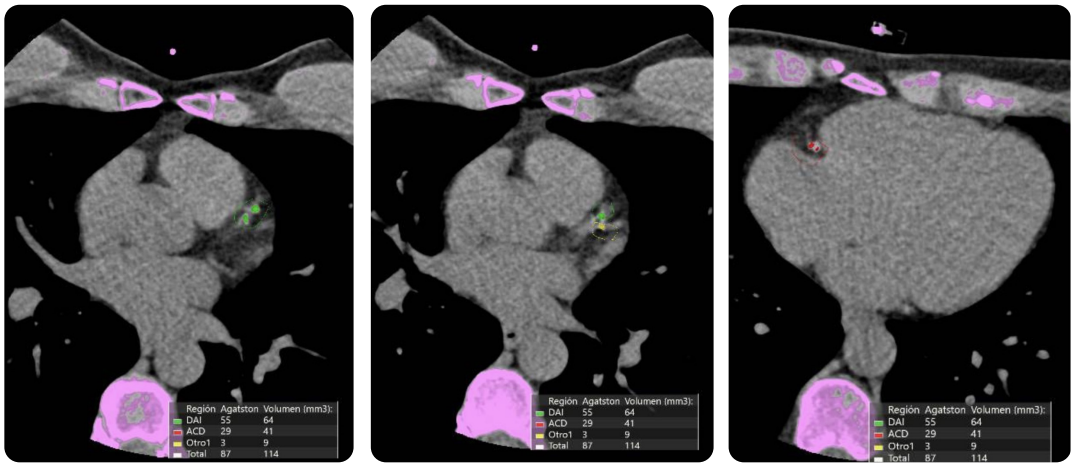


Figure 3. A 54-year-old female patient being evaluated for chest pain with a family history of coronary artery disease. Agatston index calcium score of 87, due to calcified plaques in the proximal segment of the left anterior descending artery (LADA), the first diagonal artery, and the mid-segment of the right coronary artery, placing the patient in the 90th percentile or higher for her age and sex group.

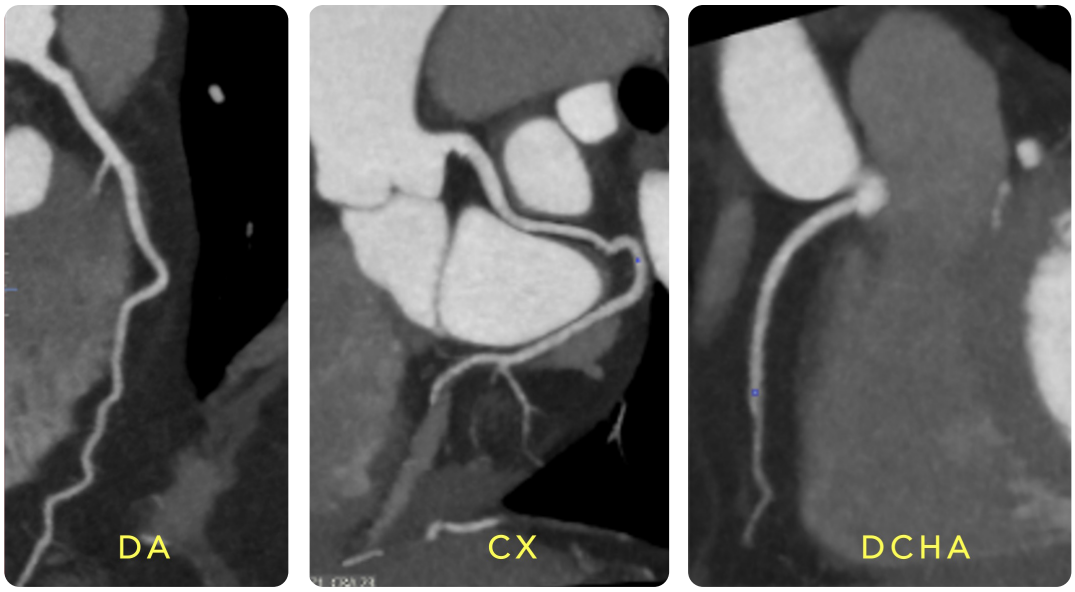


Figure 4. A 67-year-old female patient with a personal history of dyslipidemia and statin intolerance. A total Agatston calcium score of 0 was obtained. Curved multiplanar reconstructions: No atheromatous plaques or stenotic segments were identified in the coronary arteries. CAD-RADS 2.0: 0. This patient has left coronary dominance as an anatomical variant.

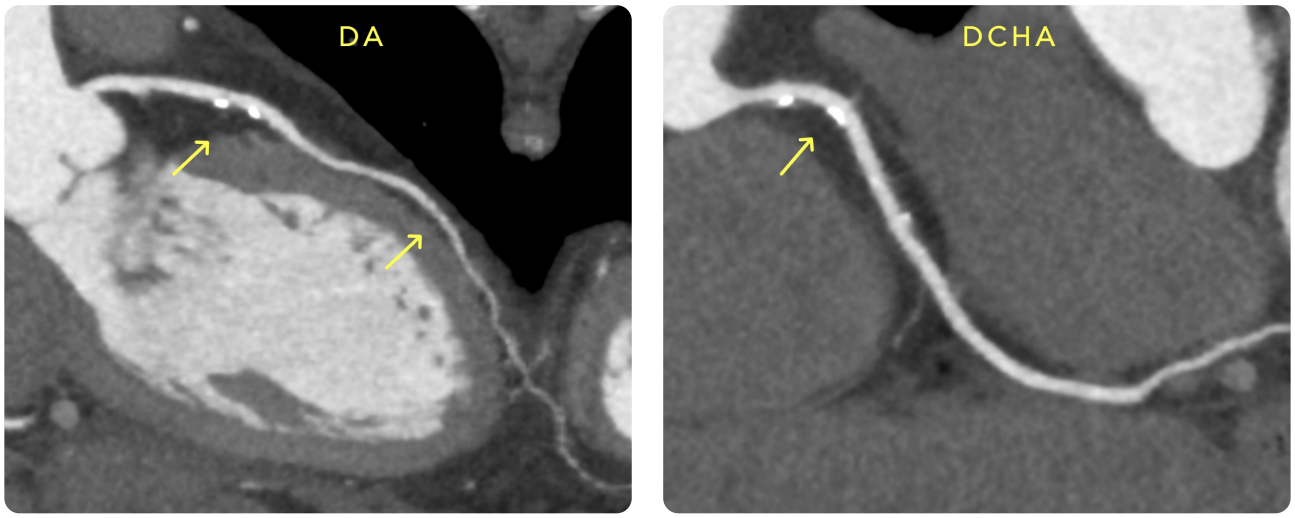


Figure 5. A 67-year-old female patient with a personal history of hypertension. Curved multiplanar reconstructions: Partially calcified plaques in the proximal and mid segments of the left anterior descending artery (LADA) and in the proximal and mid segments of the left circumflex artery (LCxA) with positive remodeling and no other high-risk features, resulting in stenosis of less than 24% (minimal). CAD-RADS 2.0: 1/P2.

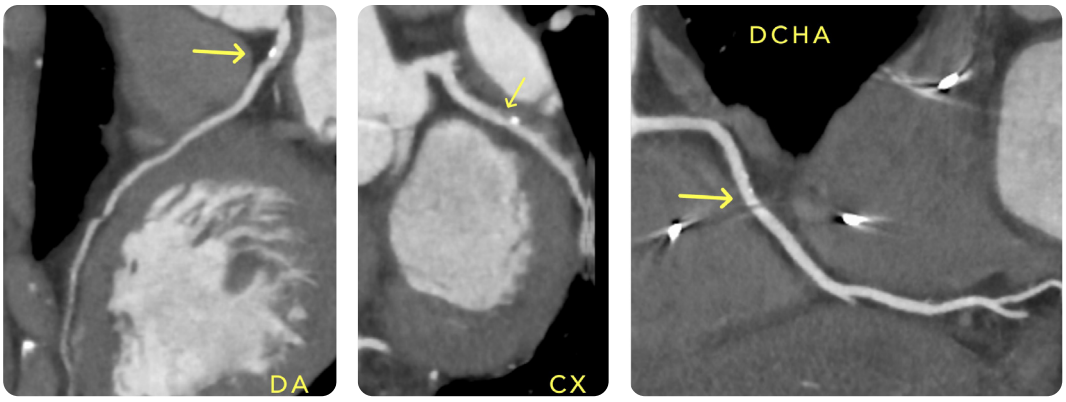


Figure 6. A 68-year-old male patient who requires evaluation for coronary artery disease. Curved multiplanar reconstructions: partially calcified plaque in the mid-segment of the left circumflex artery (LCX) causing 25–49% (mild) stenosis of the lumen, and calcified plaque in the proximal segment of the right anterior descending artery (RADA) and in the proximal and mid-segments of the right circumflex artery (RCX), causing less than 24% (minimal) stenosis. CAD-RADS 2.0: 2/P2.

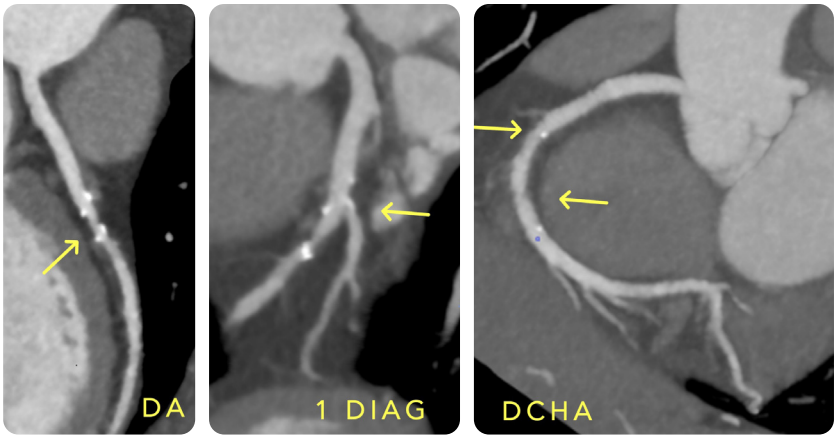
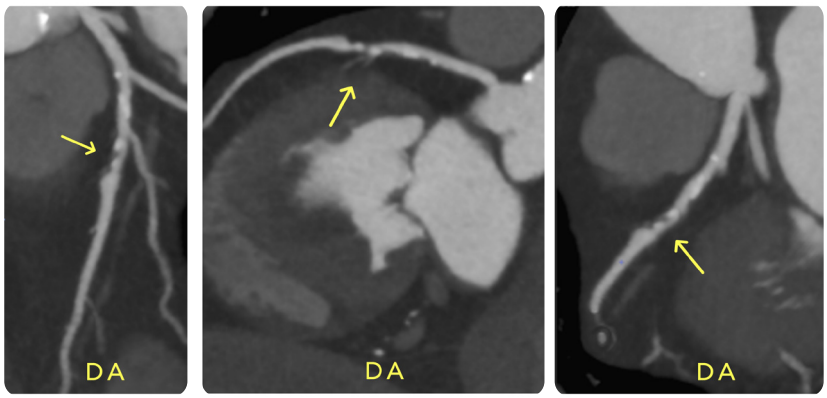


Figure 7. A 54-year-old female patient being evaluated for chest pain with a family history of coronary artery disease. Curved multiplanar reconstructions: In the middle segment of the LADA, a mixed atheromatous plaque with stenosis between 50% and 69% (moderate) is identified, along with plaques with lesser stenosis, calcified in the proximal segment of the LADA, at the origin of D1, at the junction of the middle and distal segments of the right coronary artery (RCA), and a noncalcified plaque at the junction of the middle and distal segments of the RCA. CAD-RADS 2.0: 3/P3.

Figure 8. A 67-year-old female patient with chest pain who has been under evaluation for 6 months. Personal history of asthma and ventricular arrhythmia. Curved multiplanar reconstructions: in the distal segment of the anterior descending artery immediately after the origin of D2—the middle third of the anterior descending artery—a mixed atheromatous plaque with negative remodeling is identified, causing stenosis between 70% and 99% with distal dilation. Atheromatous plaques causing stenosis of less than 24% in the mid-segments of the left anterior descending (LADA) and left circumflex (LCxA) arteries (not shown in the images). CAD-RADS 2.0: 4A/P2.



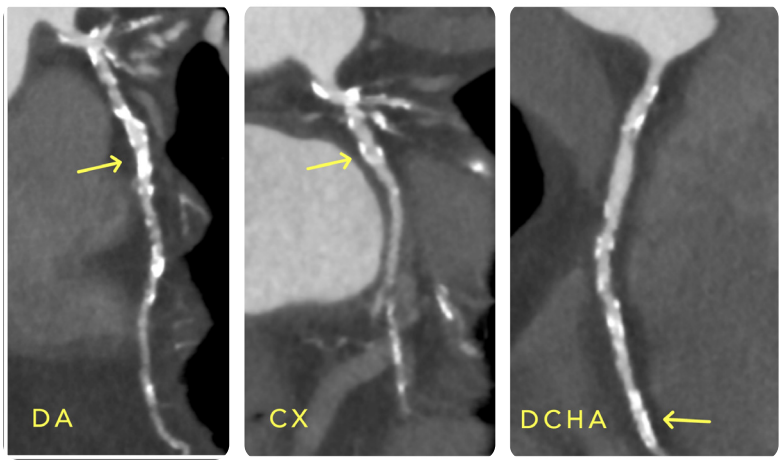


Figure 9. An 80-year-old male patient with atypical chest pain, diabetes mellitus, and hypertension. Curved multiplanar reconstructions: extensive calcified disease involving all segments of the DA, CX, and CA with 70–99% stenosis (severe). CAD-RADS 2.0: 4B/P4.

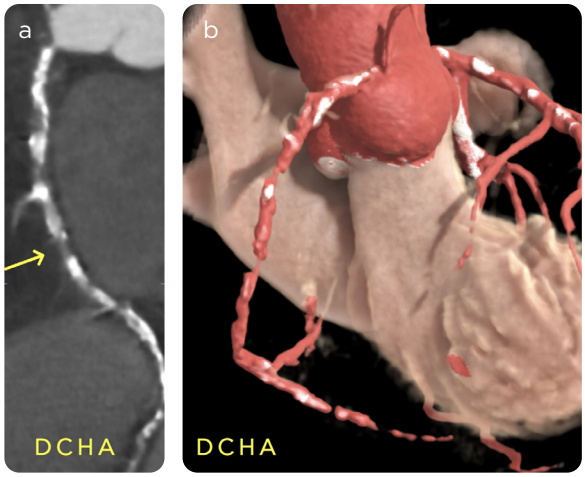


Figure 10. A 72-year-old male patient with a history of hypertension and dyslipidemia. a) Curved multiplanar reconstruction and b) textured three-dimensional volumetric reconstruction: 100% chronic occlusion in the middle segment of the CA, with distal recanalization of the lumen; plaques in the distal segment causing 50–69% stenosis (moderate) and partially calcified plaques at the origin and in the proximal segment causing 70–99% stenosis (severe). Calcified atheromatous plaques in all three segments of the right coronary artery (RCA) and in the middle and distal segments of the left circumflex artery (LCxA), causing 70–99% (severe) stenosis (not shown in the images). CAD-RADS 2.0: 5/P4.

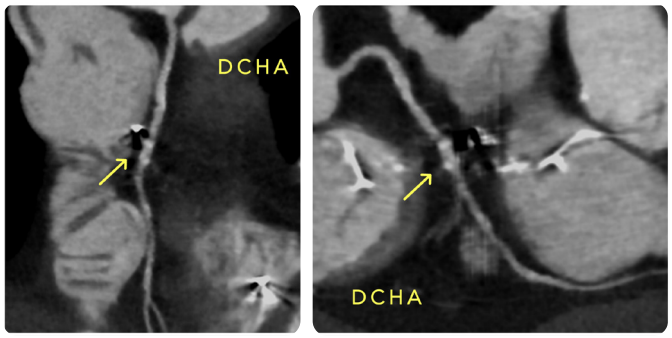


Figure 11. An 85-year-old female patient with a pacemaker. Curved multiplanar reconstructions: multiple calcified atheromatous plaques in the three main coronary arteries, causing stenosis of 50–69% (moderate) in the left anterior descending artery (LADA), less than 24% (minimal) in the left circumflex artery (LCxA), and 25–49% (mild) in the left circumflex artery (LCxA). The mid-segment of the left circumflex artery (LCA) is not evaluable due to motion artifacts and metallic artifacts caused by the pacemaker electrodes. CAD-RADS 2.0: 3/P4/N.

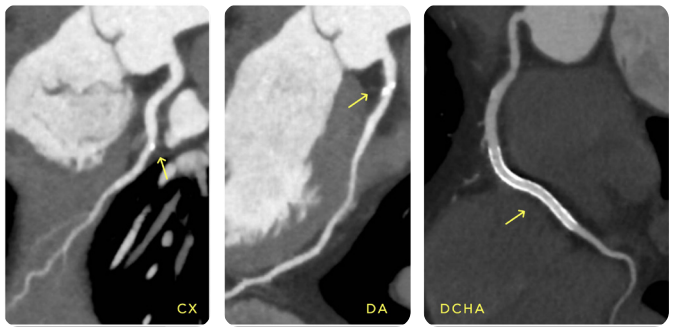
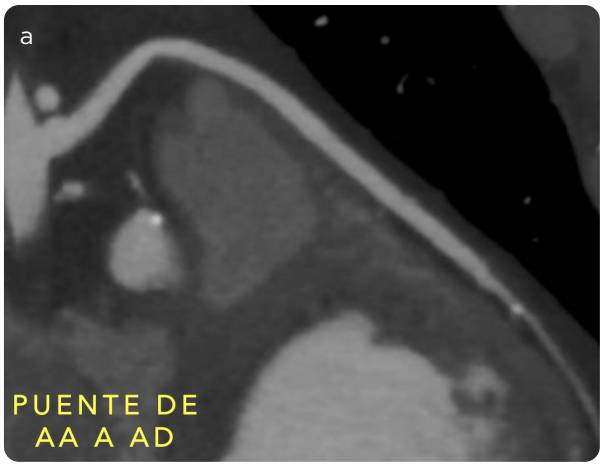
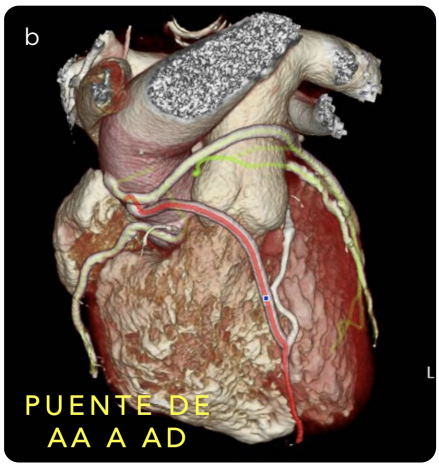


Figure 12. A 68-year-old male patient with ischemic heart disease. Curved multiplanar reconstructions: calcified plaques in the mid segments of the CD artery and partially calcified plaques in the proximal segment of the DA artery causing 25–49% stenosis (mild), and plaques in the CX artery with stenosis of less than 25% (minimal). Permeable stent in the distal segment of the CD artery. CAD-RADS 2.0: 2/P2/S.





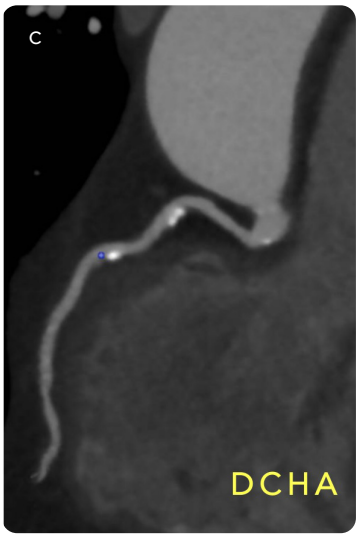


Figure 13. An 80-year-old male patient with a personal history of coronary artery bypass grafting and angina-like back pain. a and c) Curved multiplanar reconstructions and b) three-dimensional volumetric reconstruction: venous coronary bypass with a proximal anastomosis to the ascending aorta and a distal anastomosis at the junction of the middle and distal segments of the right coronary artery (RCA), which is patent with no stenosis, and a patent distal recipient vessel. In the DA distal to the bypass, calcified atheromatous plaque with stenosis between 25% and 49% (moderate). In the proximal segment of the CD, calcified atheromatous plaques with stenosis between 25% and 49% (moderate) are observed. CADRADS 2.0: 2/P2/G.

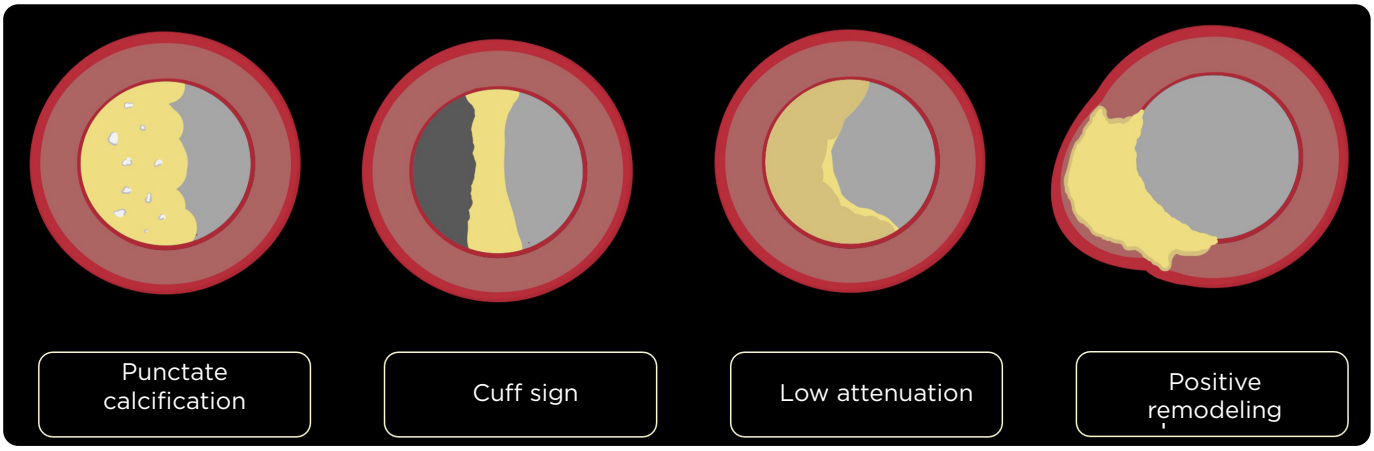


Figure 14. Characteristics of high-risk plaques.
Source: Prepared by Dr. Catalina Mejía Soto.

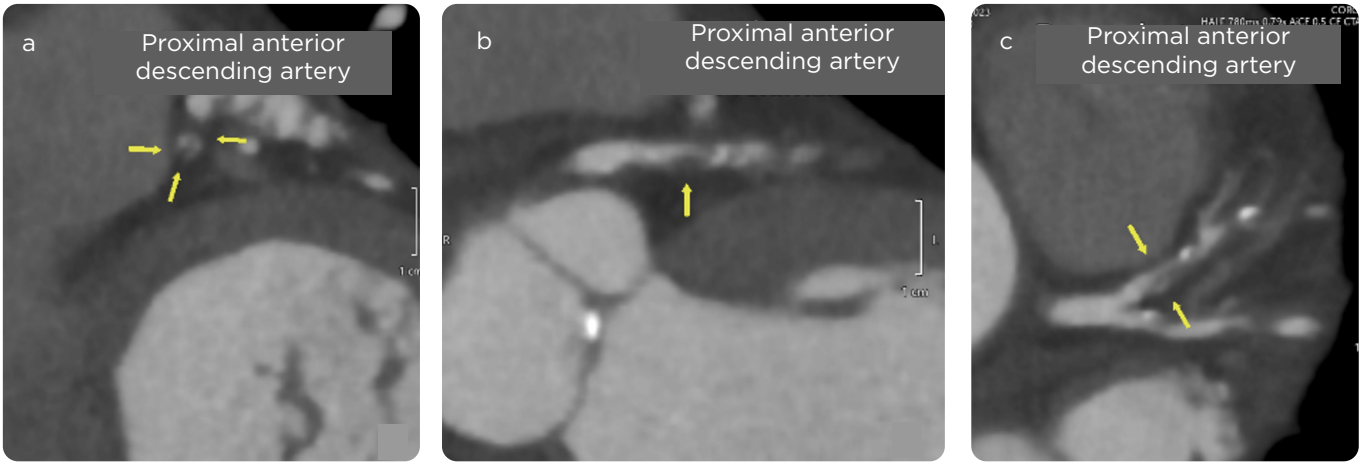


Figure 15. A 64-year-old male patient with chest pain undergoing evaluation. Multiplanar reconstructions. In the proximal segment of the left anterior descending (LAD) coronary artery: a complex mixed atheromatous plaque measuring 11.5 mm in length and causing 70–99% stenosis (severe); this plaque exhibits high-risk CT features consistent with a) the "necktie" sign, b) positive remodeling and some areas of marked hypodensity, and c) punctate calcifications. Additionally, calcified plaques are present in the middle and distal segments of the DA, at the origin of the CX, in the intermediate branch, and in all three segments of the CD, with stenosis ranging from 25–49% (mild). CAD-RADS 2.0: 4A/P4/HRP.

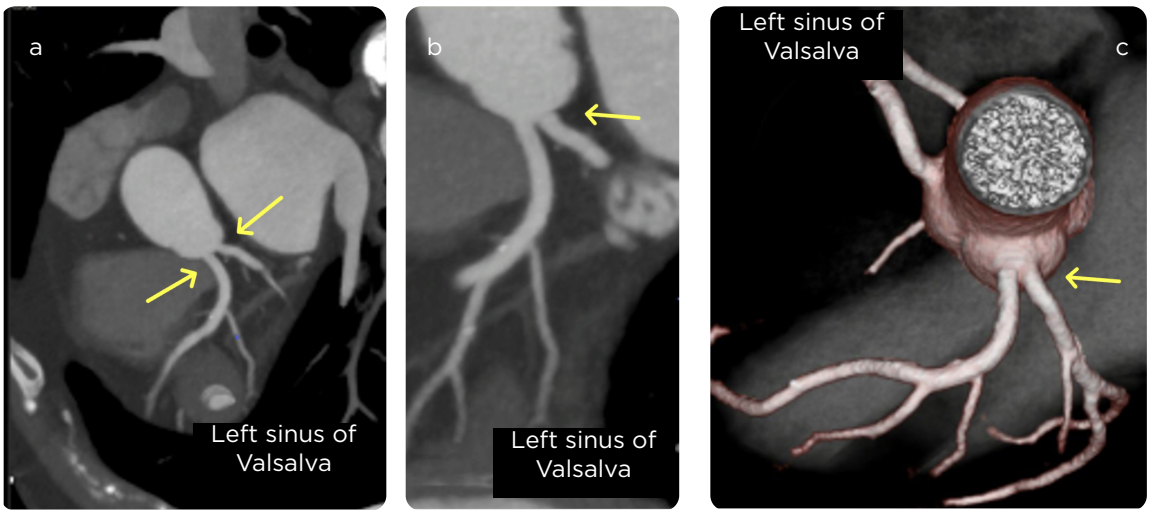


Figure 16. A 72-year-old male patient. a and b) Multiplanar reconstructions with maximum intensity projection, and c) three-dimensional volumetric reconstruction: independent origin of the right coronary artery (RCA) and the left circumflex artery (LCxA) from the left sinus of Valsalva, with no associated abnormalities of the coronary course. Calcified plaques in D2 with stenosis between 25% and 49% (mild) and other plaques with stenosis less than 25% in the proximal and middle segments of the DA and in the middle and distal segments of the CX artery. CAD-RADS 2.0: 2/P2/E.

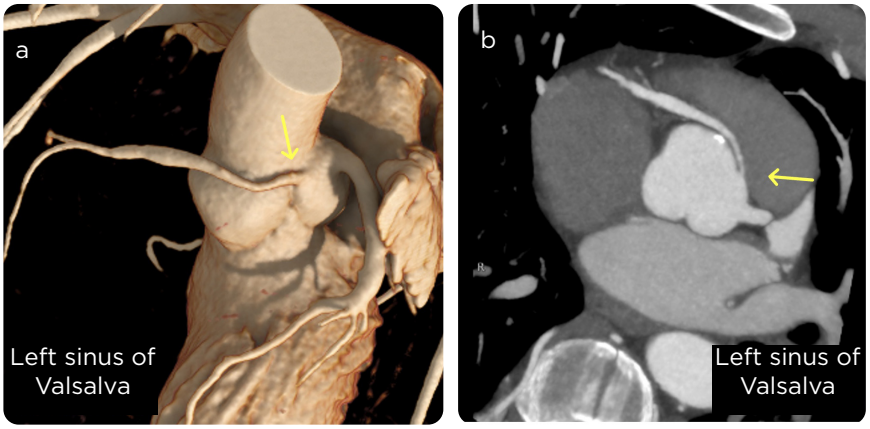


Figure 17. A 52-year-old male patient with a history of dyslipidemia and prediabetes. a) Three-dimensional volumetric reconstruction and b) multiplanar reconstruction with maximum intensity projection (MIP): anomalous origin of the right coronary artery (RCA) from the left sinus of Valsalva with an orifice separate from the left common trunk, with an inter-arterial course and a significantly reduced angle at the origin of the right coronary artery, less than 30°, all of these findings are consistent with a proximal intramural course of the right coronary artery with a malignant course. No atheromatous plaques or stenotic segments were identified in the coronary arteries. CAD-RADS 2.0: 0/E.

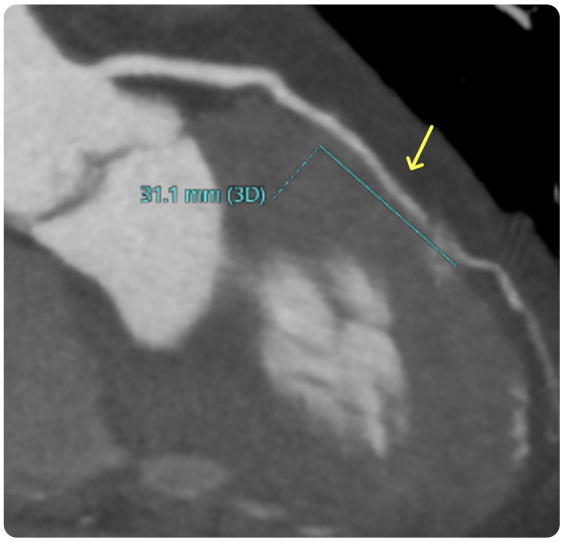


Figure 18. A 64-year-old male patient with a history of dyslipidemia and diabetes mellitus. Curved multiplanar reconstruction: no atheromatous plaques or stenotic segments were identified in the coronary arteries. In the right anterior coronary artery (RACA), distal to the origin of the diagonal branch, a long (31.1 mm in length) and superficial intramyocardial bridge is observed, with a short distal intracavitary course within the right ventricle; this latter finding has no pathological significance; however, it should be taken into account prior to any intervention in the right ventricle. CAD-RADS 2.0: 0/E.

Studies have supported the clinical value of CAD-RADS (7, 8), confirming it as a reliable predictor of adverse cardiovascular events, even outperforming other risk stratification systems such as the calcium score and the Cardiovascular Computed Tomography Society (CCTS) stenosis score. This evidence supports the hypothesis that a standardized classification based on CAD-RADS allows for a more accurate and context-specific assessment of risk than traditional risk factors. CAD-RADS not only improves the prediction of adverse events in patients with stable chest pain but also optimizes clinical management by reducing the need for additional testing and referrals to cardiology in patients with non-obstructive coronary artery disease, which benefits both the healthcare system and the patient.

CAD-RADS complements clinical judgment, which remains essential, because it does not incorporate all the individual factors that may influence treatment. This is reflected in the recommendation to interpret CAD-RADS in conjunction with the detailed information provided in the body of the report. Although CAD-RADS offers management suggestions based on the severity of stenosis and the extent of atherosclerotic burden, these recommendations should not be interpreted as prescriptive. Factors such as comorbidities, family history, and individual responses to certain treatments must be considered to ensure a personalized and effective approach for each patient. In this sense, the CAD-RADS assessment serves as a guide rather than a definitive instruction.

The introduction of modifiers—such as the presence of stents, grafts, ischemia (9, 10), and high-risk plaques—along with advances in deep learning algorithms, has expanded the applicability of CAD-RADS in increasingly complex clinical scenarios. These modifiers allow for more precise classification and provide additional context for the management of patients with specific anatomical or clinical characteristics, thereby improving diagnostic accuracy and facilitating clinical decision-making.

The growing use of advanced technologies in radiology helps improve the reproducibility and objectivity of image interpretations. However, it is essential to implement these tools with caution, as their effectiveness depends largely on the quality of the training data and current technical limitations.

Given its value in predicting events and reducing unnecessary interventions, the effective and ongoing implementation of CAD-RADS in clinical practice requires training and continuing education for cardiovascular healthcare professionals. Furthermore, it is important for future research to focus on evaluating the long-term effect of CAD-RADS 2.0 on reducing cardiovascular mortality and morbidity, as well as on exploring the inclusion of new data and parameters that could further improve its accuracy.

In summary, the CAD-RADS system represents a significant advance in the assessment of coronary artery disease using CT angiography, contributing to better standardization of reports and the optimization of clinical management. However, its effectiveness depends on its implementation as a complementary tool and on the recognition of its inherent limitations, including the need for interpretation in conjunction with clinical judgment. As technology and medical knowledge advance, CAD-RADS may continue to evolve to provide even greater value in the diagnosis and management of coronary artery disease.

This illustrative review provides a comprehensive and educational resource for understanding and applying the CAD-RADS 2.0 system, combining a complete description of its categories and modifiers with high-quality images of Colombian patients obtained using a state-of-the-art CT scanner with 320 detector rows. The inclusion of illustrative cases and the integration of the current anatomical classification of coronary segments adapted to the ATCC allow for the contextualization of the tool, enhancing its clinical and educational utility. Taken together, this material offers up-to-date, clear, and practical guidance in Colombia for the structured interpretation of the CCTA.

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Correspondence

Catalina Mejía Soto
Cedimed
Cl. 7 # 39-290, piso 3
El Poblado, Medellín, Colombia
mejiasotocatalina@gmail.com

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