

Top Take-Home Messages from the 2026 Guideline for Cardiovascular-Kidney-Metabolic Syndrome (CKM Syndrome)

- 1. Cardiovascular-Kidney-Metabolic Syndrome Staging:** Cardiovascular-kidney-metabolic (CKM) syndrome staging is recommended for youths and adults to prevent CKM stage progression, to tailor therapy to absolute risk, to reduce cardiovascular events and loss of kidney function across the life course, and to promote CKM stage regression through lifestyle changes and weight loss.
- 2. Quantify Risk Using the PREVENT Equations:** Individuals at risk for cardiovascular disease (CVD) (CKM syndrome stage 0–3) should have their risk quantified with the PREVENT (Predicting Risk of Cardiovascular Disease EVENTS) equations to estimate 10- and 30-year risk for atherosclerotic cardiovascular disease (ASCVD), heart failure (HF), and total CVD. PREVENT estimates inform CKM syndrome staging, with $\geq 20\%$ predicted 10-year CVD risk serving as 1 criterion for CKM syndrome Stage 3. A $\geq 7.5\%$ predicted 10-year CVD risk further informs the prioritization of pharmacotherapies for the treatment of CKM syndrome.
- 3. Routinely Assess for CKM Risk Factors:** Routine assessments for metabolic risk factors and kidney function are recommended among all adults, as well as selected assessments for pre-HF, metabolic dysfunction-associated steatotic liver disease (MASLD), and obstructive sleep apnea (OSA) in subsets of individuals.
- 4. Evaluate and Address Social Determinants of Health:** Routine assessments for social determinants of health (SDOH) that are closely linked with the development of CKM syndrome and its complications are recommended. Addressing adverse SDOH when identified is a key component of holistic care for CKM syndrome.
- 5. Emphasize Interdisciplinary Care With a CKM Coordination Point Person:** Use of interdisciplinary care models for those with overlap among the CKM conditions of type 2 diabetes (T2D), chronic kidney disease (CKD), and CVD is recommended to facilitate patient-centered care. The need for a point person is emphasized, to coordinate efforts of the CKM interdisciplinary team, to facilitate implementation of evidence-based care and guideline-directed medical therapy (GDMT), and to support patients and clinicians.
- 6. Assess and Treat Overweight and Obesity:** Assessments for overweight/obesity and abdominal adiposity with both body mass index (BMI) and waist circumference are recommended to characterize risk related to excess adiposity. Overweight and

obesity should be addressed to prevent CKM syndrome progression and to promote CKM syndrome regression. Support for lifestyle modification is emphasized, with adjunctive use of obesity pharmacotherapies and metabolic and bariatric surgery as needed to facilitate weight loss.

7. **Utilize Cardioprotective Antihyperglycemic Therapies in Diabetes:** Among patients with T2D with CVD or at increased risk for CVD, in addition to lifestyle modification, weight management, and risk factor control, utilization of cardioprotective antihyperglycemic GDMT is recommended, including sodium–glucose cotransporter-2 inhibitors (SGLT2i), glucagon–like peptide-1 (GLP-1)–based therapy, or both, to improve cardiovascular and kidney outcomes. The choice of agent should be guided by clinical comorbidities such as CKD, ASCVD, HF, obesity, severe hyperglycemia, and MASLD.
8. **Assess for CKD and Utilize Kidney Protective Agents:** Use of both estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (UACR) is recommended to characterize CKD and guide the use of kidney-protective agents to confer both cardiovascular and kidney benefits. For patients with CKD and T2D or CKD and albuminuria, renin-angiotensin system inhibitors (RASi) and SGLT2i should be used as first-line therapy. If albuminuria persists among patients with CKD and T2D, nonsteroidal mineralocorticoid receptor antagonist (nsMRA) or a GLP-1–based therapy should be added for further kidney and cardiovascular protection.
9. **Address CKM Risk Factors in Patients With ASCVD:** Management of ASCVD should emphasize CKM syndrome comorbidities, including obesity treatment through lifestyle modification, pharmacotherapy, and, when appropriate, metabolic and bariatric surgery; the use of cardioprotective antihyperglycemic agents for T2D; and the use of kidney-protective agents for CKD to reduce the risk for adverse cardiovascular events and loss of kidney function.
10. **Address CKM Risk Factors in Patients With HF:** CKM factors should be incorporated into HF management. For heart failure with reduced ejection fraction (HFrEF), emphasize the cardiovascular and kidney benefits of RASi (angiotensin receptor-neprilysin inhibitors [ARNI], angiotensin-converting enzyme inhibitors [ACEi], angiotensin II receptor blockers [ARB]) and SGLT2i as part of quadruple therapy with beta blockers and steroidal MRAs. For heart failure with mildly reduced ejection fraction (HFmrEF)/heart failure with preserved ejection fraction (HFpEF), use SGLT2i as first-line GDMT, add GLP-1–based therapies in patients with obesity or other CKM risk factors, and consider nonsteroidal MRAs in those with T2D and CKD to reduce adverse cardiovascular events and loss of kidney function.