O que o cardiologista não deve fazer ou recomendar em pacientes com coronariopatia suspeita ou confirmada

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*Ausência de potenciais conflitos de interesse relacionados a essa apresentação

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Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.

Asymptomatic, low-risk patients account for up to 45 percent of unnecessary "screening." Testing should be performed only when the following findings are present: diabetes in patients older than 40-years-old; peripheral arterial disease; or greater than 2 percent yearly risk for coronary heart disease events.

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Don't perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.

Performing stress cardiac imaging or advanced non-invasive imaging in patients without symptoms on a serial or scheduled pattern (e.g., every one to two years or at a heart procedure anniversary) rarely results in any meaningful change in patient management. This practice may, in fact, lead to unnecessary invasive procedures and excess radiation exposure without any proven impact on patients' outcomes. An exception to this rule would be for patients more than five years after a bypass operation.

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Don't perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Non-invasive testing is not useful for patients undergoing low-risk non-cardiac surgery (e.g., cataract removal). These types of tests do not change the patient's clinical management or outcomes and will result in increased costs.

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Don't perform stenting of non-culprit lesions during percutaneous coronary intervention (PCI) for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI).

Stent placement in a noninfarct artery during primary PCI for STEMI in a hemodynamically stable patient may lead to increased mortality and complications. While potentially beneficial in patients with hemodynamic compromise, intervention beyond the culprit lesion during primary PCI has not demonstrated benefit in clinical trials to date.

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Don't use coronary artery calcium scoring for patients with known coronary artery disease (including stents and bypass grafts).

Coronary artery calcium scoring is used for evaluation of individuals without known coronary artery disease and offers limited incremental prognostic value for individuals with known coronary artery disease, such as those with stents and bypass grafts.

ABIM/SOCIETY OF CV COMPUTED TOMOGRAPHY

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Don't order coronary artery calcium scoring for preoperative evaluation for any surgery, irrespective of patient risk.

No evidence exists to support the diagnostic or prognostic potential of coronary artery calcium scoring in individuals in the preoperative setting. This practice may add costs and confound professional guideline-based evaluations.

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Don't order coronary artery calcium scoring for screening purposes on low risk asymptomatic individuals except for those with a family history of premature coronary artery disease.

Net reclassification of risk by coronary artery calcium scoring, when added to clinical risk scoring, is least effective in low risk individuals.

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Don't routinely order coronary computed tomography angiography for screening asymptomatic individuals.

Coronary computed tomography angiography findings of coronary artery disease stenosis severity rarely offer incremental discrimination over coronary artery calcium scoring in asymptomatic individuals.

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Don't use coronary computed tomography angiography in high risk* emergency department patients presenting with acute chest pain.

To date, randomized controlled trials evaluating use of coronary computed tomography angiography for individuals presenting with acute chest pain in the emergency department have been limited to low or low-intermediate risk individuals.

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Não indicar testes provocadores de isquemia em pacientes de alto risco antes de 48 de estabilização dos sintomas

Nicolau et al, Diretriz SIMI sem supra, ABC 2014;102 (supl 1):1-61

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Não indicar angiografia coronária de rotina em pacientes com comorbidades importantes ou reduzida expectativa de vida, ou ainda naqueles que, a priori, recusam perspectivas de tratamento por revascularização miocárdica

Nicolau et al, Diretriz SIMI sem supra, ABC 2014;102 (supl 1):1-61

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Não utilizar derivados di-hidropiridínicos de início de ação rápida em pacientes sem uso adequado de betabloqueadores

Nicolau et al, Diretriz SIMI sem supra, ABC 2014;102 (supl 1):1-61

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Não indicar revascularização miocárdica em pacientes com coronárias sem condições anatômicas factíveis ou com ausência de isquemia

Nicolau et al, Diretriz SIMI sem supra, ABC 2014;102 (supl 1):1-61

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Não indicar rotineiramente inibidores do complexo glicoproteico IIb/IIIa em pacientes sob uso de dupla antiagregação plaquetária antes do cateterismo

Nicolau et al, Diretriz SIMI sem supra, ABC 2014;102 (supl 1):1-61

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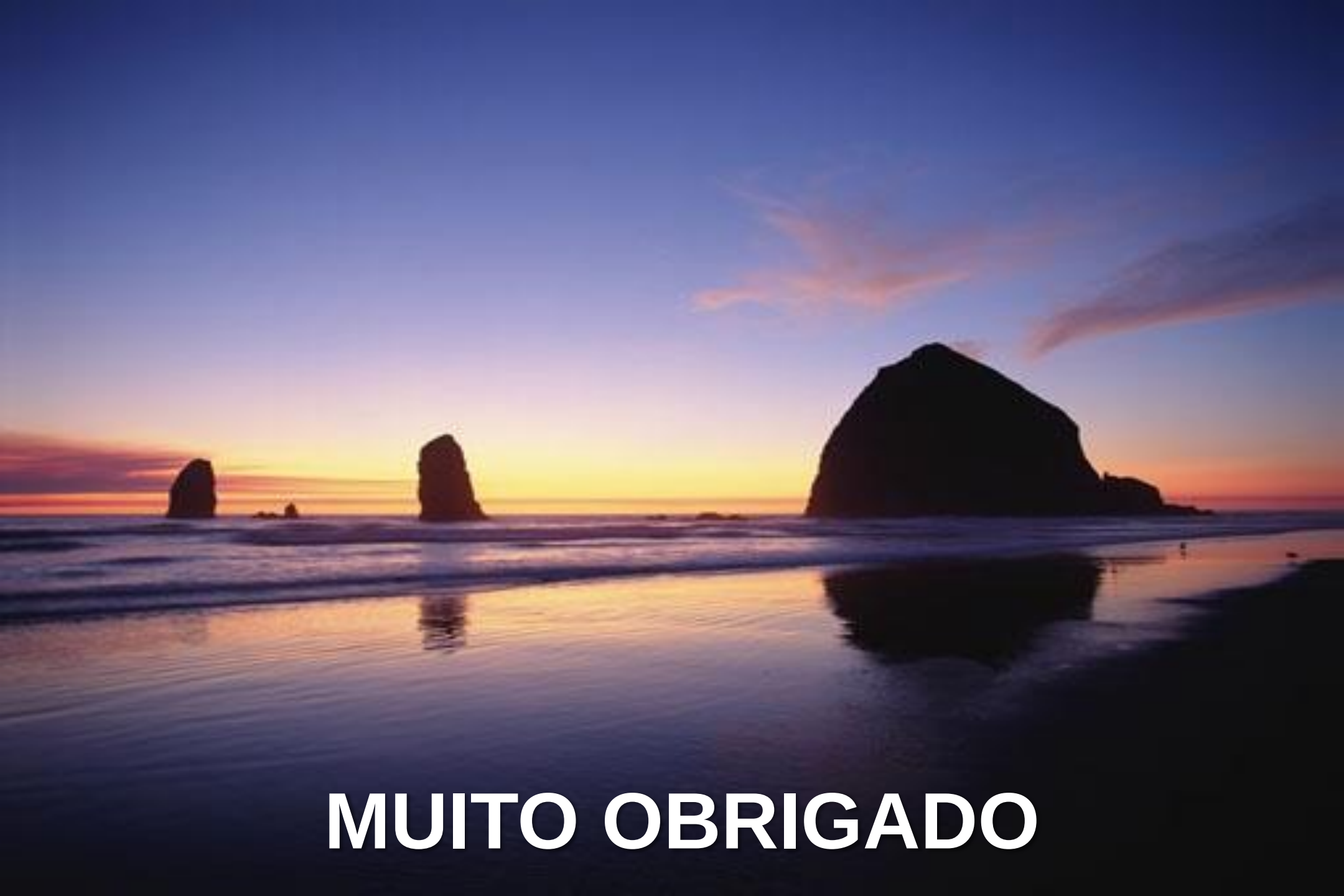
Não alternar o uso de heparina não fracionada e heparina de baixo peso molecular durante a internação

Nicolau et al, Diretriz SIMI sem supra, ABC 2014;102 (supl 1):1-61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