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.

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.

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.

Don’t perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.
Patients with native valve disease usually have years without symptoms before the onset of deterioration. An echocardiogram is not recommended yearly unless there is a change in clinical status.

Don’t perform routine electrocardiography (ECG) screening as part of pre-operative or pre-procedural evaluations for asymptomatic patients with low perioperative risk of death or myocardial infarction.
Despite potential value in having a pre-operative ECG to identify unsuspected cardiac abnormalities or as a comparison after a perioperative event, the likelihood of benefit for patients at low risk of major cardiovascular events is very small. Low perioperative risk is defined as <1% probability of death or myocardial infarction in the 2014 ACC/AHA Guideline on Perioperative Cardiovascular Evaluation and Management of Patients Undergoing Noncardiac Surgery, which also outline evidence-based methods for perioperative risk stratification.

Unnecessary ECGs can lead to needless consults, delays and changes to operative plans, which may counterbalance any potential benefit for the patient. In the absence of scientific studies establishing the value of a pre-operative ECG in a low cardiovascular risk population, the routine ordering of pre-operative ECGs should be discouraged.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

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The American College of Cardiology (ACC) asked its standing clinical councils to recommend between three and five procedures that should not be performed or should be performed more rarely and only in specific circumstances. ACC staff took the councils’ recommendations and compared them to the ACC’s existing appropriate use criteria (AUC) and guidelines, choosing items for the five things list that had the tightest inappropriate score in the AUCs and were Class III recommendations in the guidelines. The ACC’s Advocacy Steering Committee and Clinical Quality Committee each then reviewed the five items before sending it to the ACC Executive Committee for final review and approval. ACC’s disclosure and conflict of interest policy can be found at www.cardiosource.org/RWI.

Sources


Taylor AJ, Cerqueira M, Hodgson JM, Mark D, Min J, O’Gara P, Rubin GD. ACCF/SCCT/ACR/AHA/ASE/SCAI/SIR/SNM 2010 appropriate use criteria for cardiac computed tomography: a report of the American College of Cardiology Foundation Appropriately Use Criteria Task Force, the Society of Cardiovascular Computed Tomography, the American College of Radiology, the American Heart Association, the American Society of Echocardiography, the American Society of Nuclear Cardiology, the Society for Cardiovascular Angiography and Interventions, and the Society for Cardiovascular Magnetic Resonance. J Am Coll Cardiol 2010;56:1864-94.


Taylor AJ, Cerqueira M, Hodgson JM, Mark D, Min J, O’Gara P, Rubin GD. ACCF/SCCT/ACR/AHA/ASE/SCAI/SIR/SNM 2010 appropriate use criteria for cardiac computed tomography: a report of the American College of Cardiology Foundation Appropriately Use Criteria Task Force, the Society of Cardiovascular Computed Tomography, the American College of Radiology, the American Heart Association, the American Society of Echocardiography, the American Society of Nuclear Cardiology, the Society for Cardiovascular Angiography and Interventions, and the Society for Cardiovascular Magnetic Resonance. J Am Coll Cardiol 2010;56:1864-94.


