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Category	Median (range)	95% CI	Median (range)
Normal	100 (50-150)	100	100 (50-150)
Mildly elevated	150 (100-200)	150	150 (100-200)
Severely elevated	200 (150-250)	200	200 (150-250)
Very severely elevated	250 (200-300)	250	250 (200-300)
Extremely elevated	300 (250-350)	300	300 (250-350)

N Engl J Med 2009;360:2503-2515. Pope J.H., Aufderheide T.P., Ruthazer R., et al. Ont Health Technol Assess Ser 2010;10:1-61. "Added value of coronary artery calcium score as an adjunct to gated SPECT for the evaluation of coronary artery disease in an intermediate-risk population". Furthermore, if ST depression is identified on the initial ECG, management should follow the NSTE-ACS guidelines (1).3.A normal ECG may be associated with left circumflex or right coronary artery occlusions and posterior wall ischemia, which is often "electrically silent"; therefore, right-sided ECG leads should be considered when such lesions are suspected (2-5).Recommendation for Chest RadiographyCORLORecommendation1C-EOL.In patients presenting with acute chest pain, a chest radiograph is useful to evaluate for other potential cardiac, pulmonary, and thoracic causes of symptoms.SynopsisChest radiographs are rapid, noninvasive tests that can be used to screen for several disorders that may present with chest pain. Sicari R., Nihoyannopoulos P., Evangelista A., et al. CCTA without stenosis or plaque has a low CAD event rate. Rui P., Kang K., Ashman J.J. "National Hospital Ambulatory Medical Care Survey: 2016 Emergency Department Summary Tables". In these patients with prior CABG and high-risk imaging features, referral for ICA is reasonable provided that these patients are amenable to and are candidates for coronary revascularization (1-7). *Known CAD means prior MI, revascularization, known obstructive CAD, nonobstructive CAD. In a prospective trial of 1941 patients (39% women) with suspected ACS examining the diagnostic value of high-sensitivity cardiac troponin (cTn), chest pain was reported in 92% of women and 91% of men (5). Formal translation services such as those provided through institutions and virtual translation are recommended.Recommendation for Patient-Centric ConsiderationsCORLORecommendation1C-LD1.In patients with acute chest pain, it is recommended that 9-1-1 be activated by patients or bystanders to initiate transport to the closest ED by emergency medical services (EMS) (1).SynopsisAlthough chest pain remains one of the most common reasons that patients seek evaluation, among both sexes, there is a tendency for some patients to minimize perceived risk for cardiac disease, resulting in potentially avoidable delays in care (1). Marcos-Garcés V., Gavara J., Monmeneu J.V., et al. "Percutaneous coronary intervention in stable angina (ORBITA): a double-blind, randomised controlled trial". PLoS One 2014;9:e104722. Disparities in the management of chest pain among diverse populations contribute to worse outcomes, including the greater incidence of MI and fatal coronary events (1).2.In patients of various racial and ethnic subgroups presenting with suspected ACS in whom English may not be their primary language, adequately addressing language barriers with the use of language translation is vital to obtain an accurate and complete history. "A randomized trial of a 1-hour troponin T protocol in suspected acute coronary syndromes: the Rapid Assessment of Possible Acute Coronary Syndrome in the emergency department with high-sensitivity Troponin T Study (RAPID-TnT)". In a secondary analysis, there was an interaction between the baseline stress echocardiographic wall motion score and the efficacy of PCI for improved angina at 6 weeks of follow-up (69). J Am Coll Cardiol Img 2014;7:593-604. J Cardiovasc Magn Reson 2010;12:29. Mahmarian J.J., Dakik H.A., Filipchuk N.C., et al. There are also disparities in the management of patients of South Asian descent who present with ACS, with the diagnosis often missed or delayed, resulting in poor outcomes (8-11). J Nucl Cardiol 2011;18:230-237. Chang S.A., Choi S.I., Choi E.K., et al. Additional hazardous actions include increased myocardial contractility, cardiac arrhythmias, myocardial toxicity directly or through augmented adrenergic stimulation, increased platelet aggregability, endothelial dysfunction, and hypertensive vascular catastrophes (aortic dissection, cerebrovascular hemorrhage) (4-6).Methamphetamine has also been shown to lead to myocardial ischemia from mechanisms similar to cocaine. Bittencourt M.S., Hulten E., Polonsky T.S., et al. Peacock W.F., Baumann B.M., Bruton D., et al. J Am Coll Cardiol 2011;57:700-706. "Update on prevention of cardiovascular disease in adults with type 2 diabetes mellitus in light of recent evidence: a scientific statement from the American Heart Association and the American Diabetes Association". JAMA Cardiol 2020;5:1-14. "Are discrepancies in waiting time for chest pain at emergency departments between African Americans and Whites improving over time?". Additional analyses from the SCOT-HEART and PROMISE trials reveal that high-risk atherosclerotic plaque features are associated with an elevated MACE risk among patients with nonobstructive CAD (4,5). 28. Vardhanabhuti V., Nicol E., Morgan-Hughes G., et al. Siontis G.C., Mavridis D., Greenwood J.P., et al. Wang X., Bhatt D.L. "COVID-19: an unintended force for medical revolution?". Gastroesophageal reflux disease is the most likely cause for recurring unexplained chest pain of esophageal origin (3). Comprehensive disclosure information for the Joint Committee is also available online.In developing recommendations, the writing committee uses evidence-based methodologies that are based on all available data (4,5). J Am Coll Cardiol 2011;58:e44-122. Circulation 1999;100:2140-2145. The sensitivity and negative predictive values are greater with hs-cTn compared with previous generation assays (17,21,24,25). Among women with no obstructive CAD, epicardial vasoconstriction was also significantly associated with higher rates of hospitalization for angina (p=0.0002) (2). Hess E.P., Perry J.J., Ladouceur P., et al. The final evidence tables are included in the Online Data Supplement and summarize the evidence used by the writing committee to formulate recommendations. Gaur S., Orehus K.A., Dey D., et al. "Effect of high-intensity interval versus continuous exercise training on functional capacity and quality of life in patients with coronary artery disease: a randomized clinical trial". Women commonly presented with chest pain symptoms similar to men but also had a greater prevalence of other symptoms such as palpitations, jaw and neck pain, as well as back pain. "Redefining Primary Care for the 21st Century. Current observations in the United States include:■Typical exertional angina prevalence is generally low (75 years of age, with stable symptoms suggestive of CAD, are more likely to have a positive noninvasive test and more coronary artery calcification than younger people. Initial Evaluation2.1. History1. Tex Heart Inst J 1993;20:170-179. Twerenbold R., Costabel J.P., Nestelberger T., et al. 10. "Usefulness of synthesized 18-lead electrocardiography in the diagnosis of ST-elevation myocardial infarction: a pilot study". 4.1.4. Acute Chest Pain in Patients With Prior Coronary Artery Bypass Graft (CABG) Surgery1. Candidates for exercise ECG are those: a) without disabling comorbidity (e.g., frailty, marked obesity [body mass index >40 kg/m2], peripheral artery disease, chronic obstructive pulmonary disease, or orthopedic limitations) and capable of performing activities of daily living or able to achieve ≥5 metabolic equivalents of exercise (METs) (2); and b) without rest ST-T abnormalities (e.g., >0.5-mm ST depression, left ventricular hypertrophy, paced rhythm, left bundle branch block, Wolff-Parkinson-White pattern, or digitalis use). AMI in patients undergoing dialysis is less frequently associated with chest pain than in patients who are not on dialysis, but warning signs may include diaphoresis or dyspnea (3). Fleisher, MD, FACC, FAHA#Federico Gentile, MD, FACC#Zachary D. "1-Year outcomes of angina management guided by Circulation 1999;100:2140-2145. The sensitivity and negative predictive values are greater with hs-cTn compared with previous generation assays (17,21,24,25). Among women with no obstructive CAD, epicardial vasoconstriction was also significantly associated with higher rates of hospitalization for angina (p=0.0002) (2). Hess E.P., Perry J.J., Ladouceur P., et al. 5.2. Patients With Known CAD Presenting With Stable Chest Pain1. "Finding What Works in Health Care: Standards for Systematic Reviews. Lopez L., Wilper A.P., Cervantes M.C., et al. Br Med J (Clin Res Ed) 1983;287:1505-1508. Although previous guidelines supported direct referral to ICA among patients with stable chest pain, contemporary randomized trials support that candidates for elective coronary angiography may be safely triaged using CCTA (1,84) or noninvasive stress testing (34,35).Patient characteristics and existing contraindications for a given test modality (Tables 5 and 6) should be considered when choosing a diagnostic test. Bosner S., Becker A., Haasenritter J., et al. "2015 ACC/AHA/SCAI focused update on primary percutaneous coronary intervention for patients with ST-elevation myocardial infarction: an update of the 2011 ACCF/AHA/SCAI guideline for percutaneous coronary intervention and the 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction". Am Heart J 2018;196:49-55. 47. 105. Recently, Williams et al reported that a low attenuation plaque burden was associated with a >6-fold increase in incident MI for patients with nonobstructive CAD (4).2.Controlled clinical trials reveal that FFR-CT improves diagnostic accuracy over and above obstructive CAD on CCTA when compared with invasive FFR (12,13). Blood 1997;89:1787-1792. In these patients, performing an ICA is reasonable when the angiographic findings have a high likelihood of impacting therapeutic decisions (8).Recommendation for Evaluation of Patients With Acute Chest Pain Receiving DialysisReferenced studies that support the recommendation are summarized in Online Data Supplement 20.CORLORecommendation1B-NR1.In patients who experience acute unexplained chest pain while undergoing dialysis, transfer by EMS to an acute care setting is recommended (1-5).SynopsisIn 2015, there were nearly 500,000 people in the United States who received maintenance dialysis to treat end-stage renal disease (1). Circulation 1999;100:2140-2145. The sensitivity and negative predictive values are greater with hs-cTn compared with previous generation assays (17,21,24,25). Among women with no obstructive CAD, epicardial vasoconstriction was also significantly associated with higher rates of hospitalization for angina (p=0.0002) (2). Hess E.P., Perry J.J., Ladouceur P., et al. half will ultimately be found to have a noncardiac cause (6). Instead, chest pain should be described as cardiac, possibly cardiac, or noncardiac because these terms are more specific to the potential underlying diagnosis.SynopsisChest pain is one of the most common reasons that people seek medical care. Eur Heart J 2020;41:2144-2145. 50. Psychological causes are usually diagnoses of exclusion but merit consideration in the right context.Table 9 Differential Diagnosis of Noncardiac Chest PainRespiratory Pulmonary embolism Pneumothorax/hemothorax Pneumomediastinum Pneumonia Bronchitis Pleural irritation MalignancyGastrointestinal Cholecystitis Pancreatitis Hiatal hernia Gastroesophageal reflux disease/gastritis/esophagitis Peptic ulcer disease Esophageal spasm DyspepsiaChest wall Costochondritis Chest wall trauma or inflammation Herpes zoster (shingles) Cervical radiculopathy Breast disease Rib fracture Musculoskeletal injury/spasmPsychological Panic disorder Anxiety Clinical depression Somatization disorder HypochondriaOther Hyperventilation syndrome Carbon monoxide poisoning Sarcoidosis Lead poisoning Prolapsed intervertebral disc Thoracic outlet syndrome Adverse effect of certain medications (e.g., 5-fluorouracil) Sickle cell crisisRecommendation-Specific Supportive Text1.If acute myocardial injury is ruled out, alternative diagnoses merit consideration in patients with persistent or recurrent symptoms. Ladapo J.A., Hoffmann U., Lee K.L., et al. Platt O.S., Brambilla D.J., Rosse W.F., et al. Lancet 2018;391:31-40. Women were more likely to report ≥3 associated symptoms than men (e.g., epigastric symptoms, palpitations, and pain or discomfort in the jaw, neck, arms, or between the shoulder blades; 61.9% of women versus 54.8% of men; p4 billion people) has access to the Internet and social media, respectively, making it easier to share research and best practices and/or use technology such as telehealth to provide care quickly and efficiently and at a lower cost (7).The ACC's NCD Academy is one example of how we're already making strides in this area. Circulation 2020;142:S380-S604. Jensen M.D., Ryan D.H., Arovian C.M., et al. 5.3.2. Exercise Electrocardiographic Cost-Value Considerations1. J Nucl Cardiol 2007;14:669-679. King-Shier K., Quan H., Kapral M.K., et al. "MR-IMPACT II: Magnetic resonance imaging for myocardial perfusion assessment in coronary artery disease trial: perfusion-cardiac magnetic resonance vs. Einstein A.J. "Effects of radiation exposure from cardiac imaging: how good are the data?". Derived from a nationally representative sample from the National Hospital Ambulatory Health Care Survey reflecting an estimated 78 million ED visits in the United States over a 10-year period, these findings have been unchanged over time (5). "Changes in medical therapy and lifestyle after anatomical or functional testing for coronary artery disease". 77. Hillis L.D., Smith P.K., Anderson J.L., et al. J Am Coll Cardiol 2016;67:1759-1768. Matetzky S., Freimark D., Feinberg M.S., et al. Circ Cardiovasc Imaging 2017;10:e006246. The cardiovascular profession's natural tendency to innovate and our early work to collaborate across specialties with surgeons places us in a unique position to both convene stakeholders and to help develop and implement solutions. In a recent systematic review, the evidence supports that stress echocardiography or stress MPI are cost-effective for those patients at intermediate pretest risk (5). Parsonage W.A., Milburn T., Ashover S., et al. Available at: . Mayo Clin Proc 1993;68:642-651. 14. Randomized trials have compared the effectiveness of rest/stress MPI with other noninvasive tests, such as CMR (105) and CCTA, revealing similar 1- to 3-year outcomes. "2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society". "Automated pixel-wise quantitative myocardial perfusion mapping by CMR to detect obstructive coronary artery disease and coronary microvascular dysfunction: validation against invasive coronary physiology". If we remain laser focused on building digital platforms for delivering high-quality, low-cost, personalized care, we can build a health care future that enhances, not exacerbates, our ability to provide equitable care to patients regardless of their geography or income status U.S. Senator Ron Wyden from Oregon has said: "Fixing health care and fixing the economy are two sides of the same coin" (8). Clinically stable patients presenting with chest pain should be included in decision-making; information about risk of adverse events, radiation exposure, costs, and alternative options should be provided to facilitate the discussion.5.Testing Not Needed Routinely for Low-Risk Patients. Ruigomez A., Rodriguez A., Wallander M.A., et al. In patients with known nonobstructive CAD (i.e., a luminal stenosis 1% to 49% on CCTA or ICA or calcified plaque on chest CT), repeat CCTA is recommended unless there is a large enough plaque burden where ischemia is suspected. Although TTE does provide information, for patients with acute chest pain, visualization of left and right ventricular function and regional wall motion abnormalities allows for the assessment of CAD risk and may help to guide clinical decision-making. Cooperative Study of Sickle Cell Disease". "Prognostic value of "routine" cardiac stress imaging 5 years after percutaneous coronary intervention: the prospective long-term observational BASKET (Basel Stent Kosteneffektivitats Trial) LATE IMAGING study". Eur Heart J Cardiovasc Imaging 2015;16:441-448. O'ConnorUniversity of Virginia—Professor and Chair, Department of Emergency MedicineNoneNoneNoneNoneNoneNoneMichael A. Nephrol Dial Transplant 1999;14:221-223. Of note, chest pain is broadly defined to also include referred pain in the shoulders, arms, jaw, neck, and upper abdomen. Ghadri J.R., Pashenkonttil A.P., Nkoulou R.N., et al. The annual incidence is 2 to 4 cases/100,000, with higher prevalence with genetic conditions that weaken the aortic wall (2). Measurement of D-dimers, using age- and sex-specific cutoffs, may be useful in patients at low to intermediate pretest probability; those with negative D-dimers can probably be discharged without further testing, whereas those with positive values should be considered for CTA (2).Recommendations for Acute Chest Pain With Suspected MyopericarditisReferenced studies that support the recommendations are summarized in Online Data Supplement 24.CORLORecommendations1B-NR1.In patients with acute chest pain and myocardial injury who have nonobstructive coronary arteries on anatomic testing, CMR with gadolinium contrast is effective to distinguish myopericarditis from other causes, including myocardial infarction and nonobstructive coronary arteries (MINOCA) (1-6).1B-NR2.In patients with acute chest pain with suspected acute myopericarditis, CMR is useful if there is diagnostic uncertainty, or to determine the presence and extent of myocardial and pericardial inflammation and fibrosis (7-12).1C-E03.In patients with acute chest pain and suspected myopericarditis, TTE is effective to determine the presence of ventricular wall motion abnormalities, pericardial effusion, valvular abnormalities, or restrictive physiology.2Bc-LD4.In patients with acute chest pain with suspected acute pericarditis, noncontrast or contrast cardiac CT scanning may be reasonable to determine the presence and degree of pericardial thickening (7,8,13).SynopsisPericarditis and myocarditis share overlapping common causes and likely form a continuum (8). "Comparison of the short-term survival benefit associated with revascularization compared with medical therapy in patients with no prior coronary artery disease undergoing stress myocardial perfusion single photon emission computed tomography". Accessed November 9, 2020. "ACC/AHA Guidelines for exercise testing. 2016. Mozaffarian D., Benjamin E.J., Go A.S., et al. Kisely S.R., Campbell L.A., Yelland M.J., et al. For these older patients, when compared with anatomic noninvasive testing for obstructive CAD with cardiac CT, a positive stress test result was associated with increased risk of cardiovascular death or MI (4).Recommendation-Specific Supportive Text1.Patients >75 years of age may have symptoms of shortness of breath, syncope, mental impairment, or abdominal pain, or experienced an unexplained fall. Health Technol Assess 2004;8:iii: 1-158. Maron D.J., Hochman J.S., Reynolds H.R., et al. Vogiatzis I., Koulouris E., Ioannidis A., et al. Fanaroff A.C., Rymer J.A., Goldstein S.A., et al. 23. Available at: . "Unexplained chest pain in the ED: could it be panic?". J Am Coll Cardiol 2007;49:863-871. J Am Coll Cardiol 1996;28:616-626. Cardiac Testing General Considerations1. "Methamphetamine use and emergency department utilization: 20 Years Later". Assessment of long-term outcomes, patient-centered metrics, and cost will be integrated into these studies to enhance the evidence base for care of patients presenting with chest pain with greater precision.American College of CardiologyDipti N. Page 4 JACC Journals › JACC › Archives › Vol. DeVault K.R., Castell D.O. "Guidelines for the diagnosis and treatment of gastroesophageal reflux disease. Ikonomidou, MD, PhD, FAHA#José A. J Am Coll Cardiol 2015;66:337-346. Int J Cardiol 2019;277:266-271. 4.1.3. High-Risk Patients With Acute Chest Pain1. HF extensive plaque is present a high-quality CCTA is unlikely to be achieved, and stress testing is preferred.Obstructive CAD includes prior coronary artery bypass graft/percutaneous coronary intervention. Acad Emerg Med 2009;16:495-499. Diercks D.B., Mumma B.E., Frank Peacock W., et al. Circulation 2018;138:e1-e34. hs-cTn assays may be used to guide disposition by repeat sampling at 1, 2, or 3 hours from ED arrival using the pattern of rise or fall (i.e., delta) and the repeat value itself, based on assay-specific diagnostic thresholds (37-43). 45. "A brief cognitive-behavioral intervention for patients with noncardiac chest pain". J Am Coll Cardiol 2018;72:584-586. 62. Prespecified substudies from therapeutic strategy trials for SHHD also evaluated the role of rest/stress nuclear MPI to assess residual ischemia severity among patients with known CAD who were treated with medical therapy alone or when combined with revascularization (1,2,14-18).Clinical trials of CMR have included subgroups with obstructive CAD, including 76% and 49% in the MR-IMPACT and MR-IMPACT2 studies, respectively, showing generally comparable diagnostic accuracy to stress SPECT MPI (23,24). The close association of this symptom with psychological syndromes such as anxiety, panic attack, depression, somatoform disorder, and cardiophobia suggests that there may be a psychogenic origin in many patients. "A multinational study to establish the value of early adenosine technetium-99m sestamibi myocardial perfusion imaging in identifying a low-risk group for early hospital discharge after acute myocardial infarction". Rui P., Kang K. Prognosis worsens for patients by the extent and severity of inducible wall motion abnormalities on stress echocardiography (66,67). "Validation of high-sensitivity troponin I in a 2-hour diagnostic strategy to assess 30-day outcomes in emergency department patients with possible acute coronary syndrome". J Am Coll Cardiol 2014;64:684-692. Risk scores are essential when conventional cTn assays are used. "Application of high-sensitivity troponin in suspected myocardial infarction". BMJ Open 2017;7:e013653. J Am Coll Cardiol 2015;66:1918-1933. Overall, 1-year costs were significantly lower in the CAC tiered testing protocol (16% cost savings; p

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