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.

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 order annual electrocardiograms (ECGs) for low-risk patients without symptoms. Don’t obtain screening electrocardiogram testing in individuals who are asymptomatic and at low risk for coronary heart disease. In asymptomatic individuals at low risk for coronary heart disease (10-year risk <10%), screening for coronary heart disease with electrocardiography does not improve patient outcomes.

Don’t offer therapies on the basis of survival benefit without establishing your patient’s prognosis, preferences, and goals of care. It is often the path of least resistance to follow medical care algorithms and escalate care as patient’s require it. However, it has been consistently shown that patients value goals of care discussions to better understand prognosis and possible next therapeutic steps. These discussions enhance patient care and help avoid unnecessary interventions.
Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

**Sources**


**About the Canadian Cardiovascular Society**

The CCS mission is to promote cardiovascular health and care through knowledge translation, including dissemination of research and encouragement of best practices and professional development, as well as leadership in health policy. Its 2,000+ members include academic and community cardiologists, cardiac surgeons, pediatric cardiologists, trainees in those fields, researchers and other health care professionals working in cardiac sciences in all corners of the country.

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