UVM Health CARDIOLOGY REFERRAL/CONSULT

All referrals must include the most recent visit note and imaging reports. Be sure imaging done outside UVMH is sent to UVMMC Film Library with reports. Below we offer guidance on popular referrals.

PALPITATIONS

Required testing: To be done PRIOR to referral.

--CMP, Magnesium, CBCD, TSH
--EKG
--Extended monitoring:

- If Daily symptoms – order Holter 24/48 h
- If Weekly symptoms – order 2-week Extended Holter
- If Monthly symptoms – order 1 month event monitor
- If Rare symptoms – recommend Pt wear EKG recording device/watch or obtain recording device such as Kardia Mobile or similar (commercially available)

Based on extended monitoring data, ROUTINE referrals accepted for:

- Sustained VT, Frequent Ventricular ectopy > 5%
- Sustained Heart Block (non-nocturnal)
- Symptomatic atrial fibrillation
- Symptomatic SVT
- Pauses > 5 sec (non-nocturnal)
- WPW pattern EKG
- Brugada type 1 pattern EKG
- Prolonged QT > 500 ms

For other abnormal rhythms, we encourage contacting On-call cardiologist for review. Referrals are not accepted when monitoring data does not show a significant arrhythmia.

CHEST PAIN

If an acute coronary syndrome is suspected, obtain EKG and emergently refer for emergency services. Otherwise,

Is the patient at low risk of coronary artery disease (i.e., man less than age 45; woman less than age 55; no known history of coronary artery disease; symptoms more likely non-anginal (non-exertional, lateral, lasting seconds, sharp, pleuritic or positional)?

- YES: ROUTINE referral.
  Required testing: EKG, lipid panel, a1c (if feasible) and blood pressure.

- NO: **Does the patient have a known history of coronary artery disease (imaging evidence of CAD; positive stress test; history of stents or CABG)?**

    - YES: URGENT referral. Ensure patient is on aspirin and high intensity statin unless contraindicated.
      Required testing: EKG, lipid panel, a1c (if feasible), CMP, blood pressure.

    - NO: **Are symptoms likely angina (chest pressure, tightness, heaviness, retrosternal, exertional/stress-related and alleviated at rest) and otherwise concerning (occurring with minimal exertion or at rest and/or multiple times per week)?**

        - YES: URGENT referral**.** Ensure patient is on aspirin and high intensity statin unless contraindicated.
          Required testing: EKG, lipid panel, a1c (if feasible), CMP, blood pressure.

        - NO: ROUTINE referral**.**
          Required testing: EKG, lipid panel, a1c (if feasible), CMP, blood pressure.

DYSPNEA

Required testing:

- CBCD, CMP
- NT-proBNP
- Echocardiogram and EKG since symptoms started
- Pulmonary function tests if history of pulmonary disease

CORONARY CALCIUM

Arterial/Coronary Calcium on Imaging: Defines the presence of atherosclerosis. The goal is to prevent a heart attack or stroke. Coronary intervention in this setting is only indicated to relieve angina symptoms. Risk factor modification is the most effective strategy for this goal:

- If the patient is physically active and is asymptomatic: Recommend lowering LDL cholesterol to about 80 mg/dL or less with statin medication and controlling blood pressure to <130 systolic.

- If the patient is symptomatic, regardless of physical activity (i.e., experiences chest, arm, or neck discomfort or dyspnea with exertion): Recommend stress testing.

- In an asymptomatic patient who is sedentary and planning to start an exercise program, stress testing should be considered.

The severity of coronary calcium is correlated with risk. Based on this information, it is reasonable to achieve more aggressive targets, such as LDL cholesterol <70 mg/dl as well as treatment with aspirin 81 mg daily in patients with moderate and severe coronary calcium.*

Treatment (such as LDL lowering) reduces risk but does not change the presence of calcification. Thus, repeating CT scans is not recommended.

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*On imaging studies that indicate a calcium score, this typically translates to a score greater than 100.