Does stress echocardiography still have a role in Rapid Access Chest Pain Clinic post NICE CG95?

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Introduction: The 2016 NICE Clinical guideline 95 (CG95) demoted functional imaging to a second line test following Computed Tomography Coronary Angiography (CTCA). Many cardiac CT services in the UK require substantial investment and growth to implement this. Chest pain services like ours are likely to continue to use stress testing for the foreseeable future. We share service evaluation data from our department to show that a negative stress echocardiogram can continue to be used for chest pain assessment.

Methods: 1815 patients were referred to Rapid Access Chest Pain Clinic (RACPC) between June 2013 and March 2015. 802 had stress echocardiography as the initial investigation. 446 had normal resting left ventricular (LV) systolic function and a negative stress echocardiogram. At least 24 months after discharge a survey was carried out to detect Major Adverse Cardiac Events (cardiac death, myocardial infarction, admission to hospital for heart failure or angina, coronary artery disease at angiography, revascularisation by angioplasty or coronary artery bypass grafting) within two years.

Results: 351 patients were successfully followed up. The mean Diamond-Forrester (D-F) score and QRISK2 suggested a high pre-test probability (PTP) of coronary artery disease (CAD). There were 9 deaths (8 non-cardiac deaths and 1 cardiac death). MACE occurred in 4 patients with a mean time of 17.5 months (11.6 – 23.7 months). The annual event rate was 0.6%.

Conclusion: A negative stress echocardiogram can reliably reassure patients and clinicians even in high pre-test probability populations with suspected stable angina. It can continue to be used post CG95.

Introduction:

In patients with suspected stable angina, it is important to not only make a diagnosis but also to assess risk and prognosis in order to guide management. There is a wealth of evidence demonstrating the value of functional imaging, especially myocardial perfusion imaging and stress echocardiography in this setting and this underpins both European and American guidelines. Up until 2016 in the United Kingdom, functional imaging was also recommended by the National Institute of Clinical Excellence (NICE) as the initial investigation for patients presenting with suspected coronary artery disease and an
intermediate pre-test probability. As a result, functional imaging modalities have been widely utilised in clinical practice. Yet in the updated 2016 Clinical Guideline (CG95), NICE has removed the use of pre-test probability assessment and demoted functional imaging to a second line investigation behind anatomical assessment with CTCA which is recommended in all patients with suspected angina unless the test is not feasible. This is yet to be mirrored by European or American guidelines in which CTCA is recommended only as an alternative to stress testing.

In 2015 national data collected by the British Society of Cardiovascular Imaging (BSCI) showed that only 101 centres in the UK were performing CTCA\(^9\). It was estimated that the change in NICE guidance in 2016 would require a 700% national increase in CTCA delivery and the BSCI acknowledged that alternative methods of assessment such as stress echocardiography would need to be utilized for some years to come. A recent survey of UK consultant cardiologists found that only a quarter felt their practice reflected CG95\(^10\). We ourselves, are a tertiary centre with a high-volume chest pain service and a stress echo infrastructure which has been developed to meet growing demands since 2010. 3 years on from NICE CG95 2016 recommendations, our CTCA service has reached capacity and is still only able to scan the low pre-test probability patients coming through RACPC as per the 2010 recommendations of CG95. Being NICE non-compliant causes anxieties amongst both clinicians and managers but pathways cannot change without substantial investment in equipment and staffing. Like many other regions in the United Kingdom, we are likely to continue to serve our chest pain patients with functional imaging for some years to come. Here, we present data for our chest pain patients who were discharged following a negative stress echocardiogram with no knowledge of their coronary anatomy.

**Methods:**

**Patient selection**

All patients attending our RACPC between 1\(^{st}\) June 2013 and 31\(^{st}\) March 2015 were identified. Patients with a history of prior coronary artery disease were excluded. Demographic data, risk factors, symptom score and risk score including modified Diamond – Forrester\(^{11}\) and QRISK 2\(^{12}\) score were entered into the hospital electronic database prospectively at the time of assessment in RACPC. Patients who had stress echocardiography as an initial investigation were selected and any with abnormal LV systolic function at rest or ischaemia detected on stress echocardiogram were excluded. Resting
global LV systolic function was assessed visually as normal, mildly, moderately or severely reduced. Any resting wall motion abnormality was recorded. Ischaemia was defined as >1 segment of hypokinesia, akinesia or dyskinesia, or cavity dilatation during stress echocardiography. All patients with less than normal global resting function or resting wall motion abnormality were excluded. All patients with ischaemia detected on stress echocardiogram were excluded. The final selected cohort were discharged from RACPC with a diagnosis of non-cardiac chest pain. Follow up took place twenty-four months following discharge of the last patient in the cohort to determine Major Adverse Cardiovascular Events (MACE).

**Stress echocardiography**

Stress echocardiography was carried out in accordance with British Society of Echocardiography guidelines\(^{(13)}\). Exercise stress echocardiography (ESE) was performed using a semi-supine bicycle using a standard linear exercise protocol with 25 Watt load increase every 2 minutes whilst the patient maintained a steady cadence at 60-70rpm. Dobutamine stress echo (DSE) was performed using a standard 3-minute incremental protocol starting at a dose of 5mcg/kg/min up to a maximum of 40mcg/kg/min. Atropine and hand-grip augmentation was used, as required, commencing at the 30mcg/kg/min stage. Stress echocardiography was considered complete if target heart rate was reached or BSE termination criteria were met. Transpulmonary contrast agents were used if two or more myocardial segments were not well visualized at initial assessment. Standard views (A4Ch, A2Ch, A3Ch, PLAX, PSAX) were acquired. Target heart rate was calculated as 0.85 x (220 – age). Images were taken at baseline, intermediate and target heart rate for the exercise stress echo group and at baseline, low dose, intermediate and target heart rate in the dobutamine group. Images were interpreted by an experienced Imaging Consultant.

**Follow up**

The audit was considered part of service evaluation and therefore ethical approval was not required. At the time of the first clinic visit permission was sought from the patients about contact in the future. Follow up occurred at least 24 months after discharge and used several methods. The first was a standardised telephone questionnaire using contact details from the hospital electronic record or via the GP. If the patient could not be contacted, hospital and GP records were accessed. If the patient had died, medical records or post mortem reports were reviewed to establish the cause of death. All patients who could not be contacted and
had no admissions recorded in our own hospital had to be excluded from follow up because we could not assume they were event-free. In our region there were 7 other acute Trusts and 4 other cardiac catheter laboratories at the time of the study that they could have been admitted to.

The primary end point as defined by Major Adverse Cardiac Event (cardiac death, myocardial infarction, admission to hospital for heart failure or angina, coronary artery disease detected at angiography or revascularization by either angioplasty or CABG) within two years following discharge was determined. Death from any cause was also documented. If more than one event occurred, the first event was recorded as the MACE event.

Statistical analysis
Data was analysed using IBM SPSS Statistics for Mac, Version 23.0 (IBM Corporation Group). Independent t-tests were use for continuous variable and categorial variables were tested with Chi-Square test or Fisher’s Exact test as appropriate. P values <0.05 were deemed statistically significant.

Results:
1815 patients without prior coronary arterial disease were referred to our RACPC between 1st June 2013 and 31st March 2015. 802 patients were investigated by stress echocardiography as first line. 446 patients met inclusion criteria but 21% of patients were lost to follow up giving a total number of 351 patients (204 ESE and 147 DSE).

Table 1 shows the demographics of the cohort split into the two types of stress echo. Those in the DSE group were significantly older (p = 0.014), with higher QRisk2 scores, and had a higher BMI. There were also more females in this group. The mean DF score in both DSE and ESE groups correlated with a ‘high’ pretest probability. In our unit we also calculate the background QRisk2 score\(^{(12)}\). The mean score was 20.2 (±13.2) which equates to a high risk group. 52% of patients had a pretest diagnosis of typical angina as per the CG95 symptom score assessment (1= non-anginal pain, 2= atypical angina and 3= typical angina). This was significantly higher in the exercise echo group.
Total all-cause mortality was 2.6% (9 patients: 5 from DSE group, 4 from ESE group). Only one of these deaths was due to a cardiac cause. Other causes included pulmonary embolus, malignancy, pneumonia and intracerebral bleeds. MACE occurred in 4 patients consisting of 1 cardiac death, two admissions for myocardial infarction (1 ST elevation infarct with primary percutaneous coronary intervention, 1 non-ST elevation infarct requiring Coronary Artery Bypass Grafting), and 1 patient with coronary artery disease detected on elective angiography requiring revascularisation. 3 of these occurred in the ESE cohort and 1 in the DSE cohort. Mean time to MACE was 17.5 months (532.8 days +/-165.7). Table 2 shows the characteristic of patients with MACE. In our cohort, a negative stress echocardiogram correlated with an annual event rate of 0.57%. 2 other patients were also electively investigated for ongoing symptoms and were found to have normal coronary arteries at angiography.

Discussion:

Our audit has shown that a negative stress echocardiogram is associated with a very low annual event rate even in patients with a high pre-test probability. Whilst this is not a new finding, it is important in view of the 2016 NICE CG95 which recommends CTCA as the initial investigation in all patients with suspected coronary artery disease. Cardiac CT services across the UK are not able to meet this demand. The BSCI and Royal College of Radiologists latest press release in November 2018, estimated a 43% shortfall in CTCA provision\textsuperscript{(14)}. We have presented our data to demonstrate the practice in a high volume tertiary centre and reassure other practitioners who are not able to implement CG95, of the prognostic value of a negative stress echocardiogram.

Historically, a negative stress echocardiogram confers an excellent prognosis\textsuperscript{(15)(16)(17)(18)}. One study has demonstrated a 0.4% rate per person-year of cardiac death and non-fatal myocardial infarction in low PTP patients, 0.6% in intermediate patients and 0.8% in high PTP patients\textsuperscript{(19)}. Our audit included additional endpoints such as admission to hospital for heart failure or angina and the detection of significant coronary artery disease diagnosed at angiography. Even with this broader MACE definition, our data shows a low annual event rate, despite a high pretest probability cohort. The role of stress echo in assessing prognosis has been demonstrated in a similar contemporary audit where MACE was defined by cardiac death, myocardial infarction, revascularisation and cerebrovascular accident\textsuperscript{(20)}. They
demonstrated a 1% annual event rate, which may in part be explained by the inclusion of cerebrovascular accident as a primary endpoint. This study also included patients with impaired resting LV function and known coronary artery disease, which we have excluded in ours, yet multivariate analysis showed that a positive stress echo was the only predictor of MACE at 12 months.

The mean PTP in our audit, using both QRISK2 and modified D-F score reflected a high pre-test probability. It is in this group that the use of CTCA is not understood and this underpins the European and American guidelines. The 2013 European Society of Cardiology guideline recommends functional testing in patients with an intermediate risk score (15-85%) and CTCA as an alternative only in those with a PTP score 15-50% (7). The American guidelines also recommend a PTP assessment and reserve CTCA as an alternative to exercise stress testing if exercise is not possible in low to intermediate groups (8). NICE however have removed the use of PTP testing and instead recommend that assessment of likelihood of CAD is determined using symptom score (21). Those with typical or atypical symptoms should have CTCA whilst those with non-cardiac pain and a normal 12 lead ECG require no further testing. Yet 60% of recently surveyed UK Cardiologists did not agree with the removal of a PTP assessment and only 25.5% felt that their practice conformed to CG95 (10). It is not known if this is due to preference or availability of CTCA. In the same survey 71% would use CTCA for the low to intermediate probability groups and only 37% would use it for intermediate to high probability patients perhaps reflecting the lack of evidence available in this population. The large multicenter randomised trial PROMISE (Prospective Multicentre Imaging Study for the Evaluation of Chest Pain, n = 10003) (22) looked at low-intermediate PTP patients and did not find CTCA superior to functional testing, (predominantly nuclear stress testing). The large UK trial (SCOT-HEART, n = 4146) (23) did include intermediate to high PTP patients and showed the CTCA strategy to be superior to standard care but this was mainly ECG testing which has limitations and is regarded as inferior to functional imaging (24).

NICE updated the 2016 CG95 with an additional recommendation for Computed Tomography-Fractional Flow Reserve (CT-FFR) to determine the need for an invasive treatment strategy (25). At a cost of £700 per study in addition to the cost of the original CTCA compared to a stress echocardiogram tariff of £177 this does raise concerns about the cost effectiveness with this approach. In addition, the survey of UK Cardiologists (10) suggests
that when a degree of stenosis is identified, invasive angiography is the preferred downstream
test which has a high cost and a small but significant procedural risk.

It is argued that direct visualisation of coronary anatomy has prognostic implications for
primary prevention and cost effectiveness\(^{(26)}\). One of the recognised benefits of CTCA is the
identification of atherosclerosis in individuals who may have had a negative functional
imaging test. Budoff argues that clinicians may view a negative stress test as the end of the
matter and discharge patients without any primary prevention. On the other hand, detection of
atherosclerosis by CTCA prompts the clinician to commence statin and aspirin therapy as
appropriate. The mortality benefit seen from a CTCA strategy in the SCOT-HEART trial
may have been achieved by the preventative therapies recommended with the finding of
underlying atheroma. In our own institution we calculate the QRISK2 score in patients
attending RACPC and recommend primary prevention for our patients in line with NICE
guidance. 277 patients (78%) had a QRISK2 \(>10\%\) and therefore received recommendation
to commence statin therapy.

**Limitations:**

The main limitation to this audit is the proportion of patients lost to follow up (21%). The
reason for this is the method of follow up which was direct telephone communication with
patients and therefore relied on having the correct contact details on electronic records. If
patients could not be directly contacted, General Practitioners (GP) were contacted both for
up to date patient details and history of MACE. In some circumstances the patient and GP
contact details were not available, or patients had moved address or changed GP. We also
searched our Electronic Patient Record. This however would not have included all events as
patients may have attended other hospitals with MACE. In our region there were 7 other
acute Trusts and 4 other cardiac catheter laboratories at the time of the study that they could
have been admitted to. If no event was identified on our system, these patients could not be
included in the follow up.

Our audit includes a high proportion of patients undergoing dobutamine stress echo. Exercise
stress echo is recognised as being a more physiological mode of ischaemia testing and
provides additional information about exercise capacity, heart rate and blood pressure.
Exercise stress echocardiography has the added value of demonstrating left ventricular
systolic function during exercise which is one of the most important prognostic variables in
patients with coronary artery disease\textsuperscript{(27)}. In the population that we serve, we find that around 30% of patients are unable to exercise due to lung disease, arthritis and peripheral vasculopathy. In this audit, a larger proportion than would be expected (40.6%) were referred for DSE rather than ESE. This may reflect the higher proportion of females and a higher BMI in the DSE group, which is more likely to be associated with poor image quality and inability to exercise adequately on the bike.

**Conclusion:**

The purpose of this audit is to reassure clinicians and patients of the value of functional imaging in the assessment of stable chest pain post NICE 2016 CG95. The guideline recommends that CTCA is used to document coronary artery anatomy in individuals with atypical or typical symptoms and demotes functional imaging to a second line investigation. However, 3 years on from the published guideline there is still a significant short fall in CTCA provision with no prospect of meeting the sheer scale of the demand across the UK for the foreseeable future. There is no data that shows a CTCA strategy is superior to a functional imagin strategy in intermediate to high PTP patients in the assessment of stable chest pain. Moreover, stress echocardiography is radiation free, low cost, well established and easily accessible\textsuperscript{(28)}. It is our belief that stress echocardiography should and will continue to play an important role in the assessment of stable chest pain in patients attending rapid access chest pain clinics.

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**Declaration of interest:**

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

**References:**


22. Douglas PS, Hoffmann U, Lee KL, Mark DB, Al-Khalidi HR, Anstrom K, Dolor R,


**Table 1: Patient Demographics**

<table>
<thead>
<tr>
<th>Investigation</th>
<th>ESE (n=204)</th>
<th>DSE (n=147)</th>
<th>P Value</th>
<th>Total cohort (351)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yrs)</td>
<td>62.1 ± 10.4</td>
<td>65.2 ± 12.7</td>
<td>0.014</td>
<td>63.4 ± 11.5</td>
</tr>
<tr>
<td>Male</td>
<td>86 (42%)</td>
<td>45 (31%)</td>
<td>0.033</td>
<td>131 (37%)</td>
</tr>
<tr>
<td>QRISK2 (%)</td>
<td>17.9 ± 10.4</td>
<td>23.3 ± 15.8</td>
<td>&lt;0.001</td>
<td>20.2 ±13.2</td>
</tr>
<tr>
<td>All-Cause Mortality</td>
<td>4 (2%)</td>
<td>5 (3.4%)</td>
<td>0.133</td>
<td>9 (2.6%)</td>
</tr>
<tr>
<td>D-F score (%)</td>
<td>64.5 ± 28.7</td>
<td>62.8 ± 30.1</td>
<td>0.607</td>
<td>63.8 ± 28.6</td>
</tr>
<tr>
<td>BMI</td>
<td>28.3 ± 4.9</td>
<td>30.4 ± 6.9</td>
<td>0.002</td>
<td>29.1 ± 5.9</td>
</tr>
<tr>
<td><strong>Symptom score:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>45</td>
<td>66</td>
<td>&lt;0.001</td>
<td>111 (32%)</td>
</tr>
<tr>
<td>2</td>
<td>31</td>
<td>26</td>
<td>0.85</td>
<td>57 (16%)</td>
</tr>
<tr>
<td>3</td>
<td>128</td>
<td>55</td>
<td>0.005</td>
<td>183 (52%)</td>
</tr>
<tr>
<td><strong>Risk Factors:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>46 (23%)</td>
<td>32 (22%)</td>
<td>0.771</td>
<td>78 (22.2%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>82 (40%)</td>
<td>69 (47%)</td>
<td>0.230</td>
<td>151 (43%)</td>
</tr>
<tr>
<td>Smoking</td>
<td>44 (22%)</td>
<td>46 (31%)</td>
<td>0.112</td>
<td>90 (25.6%)</td>
</tr>
<tr>
<td>Hyperlipidaemia</td>
<td>23 (11%)</td>
<td>14 (10%)</td>
<td>0.725</td>
<td>37 (10.5%)</td>
</tr>
<tr>
<td>Family History</td>
<td>78 (38%)</td>
<td>52 (35%)</td>
<td>0.654</td>
<td>130 (37%)</td>
</tr>
</tbody>
</table>

QRISK2: <10% = low, 10-20% = intermediate, >20% high
Symptom Score 1 = Non Angina Pain, 2 = Atypical Pain, 3 = Typical Angina
D-F Score % likelihood CAD: <10% = very low, 10% - 29% =low, 30% - 60% = medium, 61-90% = high
### Table 2: Profile MACE and non-MACE at 24 months.

<table>
<thead>
<tr>
<th></th>
<th>Patients without MACE (n=347)</th>
<th>Patients with MACE (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (Years)</td>
<td>63.3 ± 11.5</td>
<td>66.8 ± 12.0</td>
</tr>
<tr>
<td>Gender (Male)</td>
<td>128 (37%)</td>
<td>3 (75%)</td>
</tr>
<tr>
<td>Hypertension (%)</td>
<td>43.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Diabetes (%)</td>
<td>22.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Hyperlipidaemia (%)</td>
<td>10.4</td>
<td>25.0</td>
</tr>
<tr>
<td>Family History (%)</td>
<td>36.9</td>
<td>50.0</td>
</tr>
<tr>
<td>Smoking (%)</td>
<td>25.6</td>
<td>25.0</td>
</tr>
<tr>
<td>Mean BMI</td>
<td>29.2 ± 5.9</td>
<td>27.1 ± 8.1</td>
</tr>
<tr>
<td>Mean QRISK2 (%)</td>
<td>20.2 ± 13.3</td>
<td>20.8 ± 5.3</td>
</tr>
<tr>
<td>Symptom score 3 (typical angina) (%)</td>
<td>51.9</td>
<td>75.0</td>
</tr>
<tr>
<td>DF Score</td>
<td>63.6 ± 28.7</td>
<td>82.5 ± 14.5</td>
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