

Evaluation and Management of Chest Discomfort 2021

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Key points and strength of recommendation (SORT: <http://www.aafp.org/afp/2004/0201/p548.html>)

- Initial evaluation of chest pain should include evaluation of clinical stability, a concise history and physical, and a chest x-ray and electrocardiogram (ECG) unless the cause is clearly not life-threatening. (C)
- Chest pain described as exertional, radiating to one or both arms, similar to or worse than prior cardiac chest pain, or associated with nausea, vomiting, or diaphoresis indicates high risk for acute coronary syndrome. ECG identifies ST elevation myocardial infarction (STEMI), and cardiac biomarkers are essential for further evaluation of suspected chest pain in the absence of STEMI(A)
- The Wells, Geneva, Pisa, & PERC clinical prediction rules can stratify a patient's risk of pulmonary embolism. (B)
- Patients with chest pain that is stabbing, pleuritic, positional, or reproducible with palpation are at very low risk for ACS and are most likely to have chest wall pain. (A)
- Stretching exercises may help patients with persistent pain from costochondritis. (B)
- A two-week course of high-dose proton-pump inhibitor therapy can help identify patients whose chest pain may be from undiagnosed GERD. (A)
- Esophageal rupture may be suspected in patients with pain, dyspnea, and shock after forceful emesis, and prompt imaging with (CT) or esophagram is essential. (C)
- A 3-item questionnaire may identify panic disorder. (B)
- For persistent non-cardiac chest pain, cognitive-behavior therapy can improve symptoms over the short term. (B)
- Patients who have suspected tension pneumothorax and who are clinically stable should have a chest x-ray for confirmation before needle decompression is attempted. (C)
- Aortic dissection is uncommon, but patients with abrupt chest pain that is ripping, tearing, or stabbing should have CXR, CT, or MRI. (C)

Powerpoint Lecture: <https://resourcelibrary.stfm.org/viewdocument/evaluation-and-management-of-chest>

Review Articles

- Roth AR, Lazris A, Ganatra S. Overuse of Cardiac Testing. Am Fam Physician. 2018;98(10):561-563. <https://www.aafp.org/afp/2018/1115/p561.html>
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Tools (links to all are available at: <https://sites.google.com/site/clinicalcalculators/>)

- Aortic Dissection Detection Risk Score (ADD-RS): <https://www.mdcalc.com/aortic-dissection-detection-risk-score-add-rs>
- Marburg Heart Score: <https://www.mdcalc.com/marburg-heart-score-mhs>
- INTERCHEST rule: <https://www.mdcalc.com/interchest-clinical-prediction-rule-chest-pain-primary-care>
- HEART Score: <https://www.mdcalc.com/heart-score-major-cardiac-events>
- Wells PE Prediction Rule: <http://www.mdcalc.com/wells-criteria-for-pulmonary-embolism-pe/>
- Geneva PE Prediction Rule: http://www.medicalapps.ch/Geneva_Score.aspx
- Pisa PE Prediction Rule: <https://ebmcalc.com/PulmonaryEmbRiskPisaCXR.htm>
- Pulmonary embolism rule-out criteria: <https://www.mdcalc.com/perc-rule-pulmonary-embolism>

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