Canadian Cardiovascular Society

March 17, 2020

Guidance on ambulatory management and diagnostic testing during the COVID-19 crisis

Based on our local best practice, we are currently guided by the following principles with regards to ambulatory clinical assessment and diagnostic testing:

1. We support the principles of avoiding unnecessary contact and crowding in our workflow for patients and staff.

2. We support the planning of hospital-based and independent clinics to reduce all but urgent in-person visits and related contact and crowding by maximizing telehealth and videoconferencing.

3. Patients should be offered non “in-person” visits if care can be adequately delivered. The process and messaging should come from your local institution to ensure consistency for providers and patients/families.

4. Urgent cardiac clinical assessment using ambulatory facilities (including those external to hospital sites) is encouraged to reduce pressure on hospital-based services, particularly the emergency department. Sites are encouraged to increase Consultant availability to increase capacity for urgent assessments, which could involve recent retirees.

5. ***Suspension of elective and surveillance clinical assessment and diagnostic testing in stable and/or asymptomatic patients is strongly recommended***, pending further resolution of COVID-19 related guidance on care provision in this population from provincial and local authorities.

6. Outpatient and inpatient diagnostic testing should be guided by evaluation for urgent clinical assessment (see below).

The patient population suited to urgent assessment that may be by telephone/video or in-person should focus on:

New onset:
1. chest pain and equivalents with high-risk features
2. shortness of breath with suspected heart failure
3. sustained palpitations with high-risk features
4. suspected cardiac syncope

Worsening and refractory:
1. angina

2. heart failure
3. arrhythmias (such as unstable or rapid atrial fibrillation, ICD shock[s])

There are numerous other less common situations where urgent assessment is warranted, so clinical judgment must be exercised in the triage process of referral management. These include:

1. Left ventricular assist device (LVAD) and cardiac transplant patients, whose care should be guided by local experts

2. Congenital heart disease patients who have been referred to a new adult care provider, the transition visit may be deferred and the patient should continue to see their previous pediatric cardiologist for urgent matters

3. Suspicion of cardiac implantable device malfunction or infection, which may be clarified by remote care or require in-person evaluation

4. Non-invasive diagnostic testing suggests urgent/high-risk for cardiac events, which should be integrated with clinical status to assign urgency and need for short term care:
    a. Suspected cardiac masses, embolic stroke or infective endocarditis
    b. Significant left main or equivalent coronary artery disease on CT angiogram
    c. Large area of myocardium at risk or ischemia on MIBI/Stress Echo or cardiac MRI
    d. New significant structural abnormalities (severe left ventricular dysfunction, critical aortic stenosis, etc.)

Many speciality clinics are initiating a telephone screening physician or nurse-led consultation as a care and triage mechanism, to determine those patients best suited to in-person clinic assessment. When seeing patients that require a face-to-face visit, appropriate disinfectant and droplet precautions should be utilized. When a face-to-face appointment is required, the number of health care providers should be kept to a minimum. Subspecialty Affiliates are also communicating more detailed, patient group specific recommendations (see www.ccs.ca).

In addition, partnering with hospital emergency departments is key to enable their ability to focus on acutely ill patients. As always, these recommendations are based on the best guidance as of March 17th, and members are encouraged to work closely with local health institutions.

I am grateful to all 11 of our Affiliates as well as five national community cardiologists for their guidance in this matter.

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