

RACCOMANDAZIONI PER LE BUONE PRATICHE CLINICO ASSISTENZIALI (RBPCA) - Riconoscimento delle sindromi dell’adulto che riferisce dolore toracico e/o dispnea e/o cardiopalmo in setting ambulatoriale specialistico extraospedaliero - Tabella di estrazione e sintesi dati della revisione della letteratura

Nelle pagine successive è riportata la tabella di estrazione e sintesi dei dati raccolti mediante la scoping review eseguita per informare il documento di indirizzo su “Riconoscimento delle sindromi dell'adulto che riferisce dolore toracico e/o dispnea e/o cardiopalmo in setting ambulatoriale specialistico extraospedaliero”.

Le immagini estratte dagli articoli inclusi nella scoping review e consultate dal gruppo di sviluppo delle RBPCA sono state fornite all'ISS nelle modalità consentite dalla normativa vigente, ma non sono contenute nel documento di indirizzo.

	Primo autore	Società, Federazione, Associazione, Fondazione scientifica, Istituzione, Ente, Organizzazione di sanità pubblica, Azienda che ha prodotto, commissionato o formalmente revisionato il documento	Anno di pubblicazione	Individuato mediante la strategia definita a priori oppure quella post hoc	Tipo di documento	Obiettivi	Metodi di sviluppo	Popolazione di pazienti	Setting dello studio o setting clinico indicato per la raccolta degli elementi informativi	Sintomi della triade predefinita cui sono riferiti gli elementi informativi estratti (locazione utilizzata nella lingua del documento)	Elementi informativi verificabili nel setting ambulatoriale (valutazioni sintetiche delle prove a supporto, ove riportate)	Note contestuali del Gruppo di lavoro delle RBPCA in merito al documento
Acute Care of Patients with Moderate Respiratory Distress: Recommendations from an American College of Emergency Physicians Expert Panel	Baugh C.W.	American College of Emergency Physicians (ACEP)	2025	A-priori	Raccomandazioni	To develop a consensus-based decision tool for emergency clinicians.	An expert panel conducted a literature review to examine recent (≤ 5 years) publications and specialty-society guidelines involving the approach to respiratory distress in the emergency department. The panel participated in four virtual rounds of questioning to make recommendations using a modified Delphi rounds process to reach a consensus. The final expert panel recommendations represented consensus and majority opinions.	Pazienti in un Pronto Soccorso con moderate respiratory distress, definito come a patient who requires more than basic respiratory care or is at risk of deterioration. For example, this definition would include a patient with a respiratory rate > 24 breaths per minute, with or without hypoxia, and with the use of accessory muscles of respiration.	Emergency department.	Dispnea (moderate respiratory distress)	Elementi da Table 1a dell'articolo: History elements for patients with moderate respiratory distress: Dyspnea at rest and with ambulation; Chest pain quality, including pleuritic pain; Increased sputum production; Fever; Heart failure; Orthopnea; Paroxysmal nocturnal dyspnea; Cough; Peripheral edema; Fatigue; Altered mental status; Weakness; Smoking/vaping use; Chronic lung disease (e.g., chronic obstructive pulmonary disease, interstitial lung disease, pulmonary fibrosis);Anemia; Asthma; Increased putum/color/producton/volume; Current oxygen requirement; Prior intubation or known difficult airway; Recent travel (e.g., elevation, exposure, pulmonary embolism); Known infectious contacts; Prior personal or family history of venous thromboembolism; Terminal diagnosis/condition; Exogenous estrogen use; Hemoptysis; Hospitalizations; Trauma/surgery (e.g., fat emboli, rib fractures, pulmonary contusion, flail chest); Dysphagia/severe reflux; Environmental exposure (e.g., carbon monoxide, asbestos); Congenital anomalies (e.g., Marfan, cystic fibrosis, Ehlers-Danlos); Cancer; Inflammatory (e.g., lupus, rheumatoid arthritis); Substance use disorder; Goals of care; Pain; Anxiety; Immunosuppressed state. Elementi da Table 1b dell'articolo: Physical examination elements for the patient with moderate respiratory distress Vitals trending, including prehospital; Tachypnea; Tachycardia; Hypotension; Upper airway exam; Voice quality; Abnormal lung exam (e.g., wheezing, rhonchi, crackles); Hypoxia; Tripoding or accessory muscle use; Mental status; Abnormal skin exam (e.g., pallor or discoloration, urticarial rash); Swallow; Cough quality; Grunting, nasal flaring, or abdominal contractions; Diaphoresis; Irregular breathing pattern; Crepitus; Extremely edema. • Screening for difficult airway assessment and management: (https://www.alem.com/memorica-for-difficult-airway/) Elementi da Table 2: Diagnostic approach to the patient with moderate respiratory distress. Physical exam maneuvers: fluid status; passive leg raise-fluid responsiveness Consider Ancillary Testing: Targeted labs: Blood gas: use pulse ox and bicarb on basic metabolic panel (BMP)	
SIRMS/IC consensus document on the management of patients with acute chest pain	Esposito A.	Società Italiana di Radiologia Medica e Interventistica (SIRM); Società Italiana di Cardiologia (SIC)	2025	A-priori	Altro documento di indirizzo sviluppato mediante esercizio di consenso tra esperti	Outlining the appropriate management of patients presenting to the ED with ACP, emphasizing the timing and utility of non-invasive imaging for rapid and accurate diagnosis of cardiac or non-cardiac auses. The document aims to improve diagnostic pathways across Italian hospitals and foster cardiologist-radiologist collaboration, improving patient safety, outcomes, and resource utilization efficiency.	A writing committee composed of members and experts from both the Italian Society of Medical and Interventional Radiology (SIRM) and the Italian Society of Cardiology (SIC) produced a multidisciplinary expert consensus statement about the diagnostic approach of the acute chest pain. The proposed recommendations are described as "based on currently available evidence and the insights of experts involved in drafting the document". No formal systematic review process, Delphi methodology or evidence grading system is reported.	Patients presenting to the emergency department with acute chest pain	Emergency department.	Dolore toracico (acute chest pain)	Elementi da Figure 1 e Figure 4 dell'articolo. Initial evaluation of ACP should focus on the rapid identification and treatment of potentially life-threatening conditions such as ACS (acute coronary syndrome), AD (aortic dissection), PE (pulmonary embolism) and infarct-like myocarditis. Indicative symptoms of ACS: Chest pressure; Tightness; Heaviness; Burning; Pain also in other areas of the body (shoulder, arm, neck, back, upper abdomen, jaw); Dyspnea; Nausea; Vomiting; Sweating; Fatigue; Altered mental status Symptoms unlikely related to ACS: Hyperacute; Fleeting; Related to inspiration (pleuritic) or position; Localized to a single point Stable chest pain: Chronic; Associated with identifiable triggers (physical exertion, emotional stress) Chest pain clinical assessment: Detailed description of chest pain; Description of associated symptoms (onset, duration, location, radiation, alleviating or exacerbating factors); Complete evaluation of cardiovascular risk factors and patient's medical history; Results from previous diagnostic tests for coronary artery disease (CAD); Signs associated with high-risk of morbidity and mortality: Reduced cardiac output (tachycardia, hypotension, cold extremities, low urine output, altered mental status); Heart failure (pulmonary edema, elevated jugular venous pressure, peripheral edema); New onset of a new systolic murmur (suggestive of acute mitral regurgitation or ventricular septal defect); Signs suggesting alternative etiologies: Fever (endocarditis, pneumonia), Differential blood pressure between pulses (AD), Pulmonary abnormalities detected on auscultation or chest X-ray (pneumonia or pneumothorax), Pericardial friction rub (pericarditis), Other cardiac murmurs (aortic stenosis, endocarditis). ESC guidelines recommend an assessment of pre-test probability of CAD based on: Age; Sex; Pain characteristics (kind of pain and associated gesturing es. Levine sign)	
Brazilian Guideline for the Evaluation and Diagnosis of Chest Pain in the Emergency Department - 2025	de Barros e Silva P.G.M.	Sociedade Brasileira de Cardiologia (SBC); Federación Latinoamericana de Medicina de Emergencias (FLAME)	2025	A-priori	Linee guida	To provide practical guidance to physicians (cardiologists and non-cardiologists) and multidisciplinary teams on the initial management of patients with acute-onset chest pain (or ischemic-equivalent symptoms), in accordance with evidence-based best practices; Establish a standardized care pathway for the management of patients with suspected ACS (and relevant differential diagnoses), minimizing the time to completion of critical diagnostic and therapeutic procedures to ensure the fastest possible patient recovery; Provide guidance on the utilization of healthcare resources, with a view to delivering value in a manner adaptable to each setting of care; Provide guidance on how to collect information on care practices to inform assessment of care quality by establishing measurable time targets and goals for the best practices included in the chest pain pathway. This information is essential for identifying gaps in care and assessing the results of ongoing quality improvement efforts.	I metodi hanno previsto la formulazione di raccomandazioni alle quali è stata assegnata una classe (Classes of Recommendations; da I a III) e un livello di prove a supporto (Levels of Evidence; da A a C).	Patients with chest pain in the emergency department.	Emergency department.	Dolore toracico (chest pain); Dispnea (dyspnea, as an ischemic equivalent)	Elementi da Central Illustration, Table 12, 14, 15, 16, 17, 18, 19, 21, 22 e 23 dell'articolo.	La dispnea (dyspnea) è considerata dagli autori un "ischemic equivalent".
The Development of a Chest-Pain Protocol for Women Presenting to the Emergency Department	Jaffer S.	Canadian Women's Heart Health Alliance (CWHHA); Heart Institute Foundation, University of Ottawa	2024	A-priori	Altro documento di indirizzo sviluppato mediante esercizio di consenso tra esperti	The authors sought to develop an intersectional diagnostic algorithmic protocol through a sex and gender lens addressing the following: (i) symptoms, (ii) (a) female-specific, (b) traditional, and (c) underrecognized, female predominant, (intersectional); (iii) sex-specific thresholds for high-sensitivity cardiac troponin (hs-cTn); and (iv) unique aspects of the pathophysiological spectrum of acute coronary syndrome in women.	È stata eseguita una revisione a mezzo di ricerche della letteratura attraverso PubMed e Google Scholar e di linee guida internazionali sul dolore toracico (chest-pain), congiuntamente a un esercizio di consenso esperto. L'oggetto di studio erano le componenti previste del protocollo clinico algoritmico. In seguito è stato disegnato e presentato il protocollo.	Donne che giungono al Pronto Soccorso con dolore toracico acuto (women who present to the ED acutely with chest pain).	Emergency department.	Dolore toracico (chest pain)	Elementi da Figure 1 e Figure 3 dell'articolo.	There is no need to apply the PERC rule to those patients who are not being evaluated for PE.
2021 AHA/ACC/AASE/ CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain	Gulati M.	American Heart Association (AHA); American College of Cardiology (ACC); American Society of Echocardiography (ASE); American College of Chest Physicians (CHEST); Society for Academic Emergency Medicine (SAEM); Society of Cardiovascular Computed Tomography (SCCT); Society for Cardiovascular Magnetic Resonance (SCMR)	2021	A-priori	Linee guida	Non esplicitati. This clinical practice guideline for the evaluation and diagnosis of chest pain provides recommendations and algorithms for clinicians to assess and diagnose chest pain in adult patients.	A comprehensive literature search was conducted from November 11, 2017, to May 1, 2020, encompassing randomized and nonrandomized trials, observational studies, registries, reviews, and other evidence conducted on human subjects that were published in English from PubMed, EMBASE, the Cochrane Collaboration, Agency for Healthcare Research and Quality reports, and other relevant databases. Additional relevant studies, published through April 2021, were also considered.	Recommendations applicable to patients with or at risk of developing cardiovascular disease. Acute or stable chest pain or other ariginal equivalents, in various clinical settings.	Various clinical settings.	Dolore toracico (chest pain); Dispnea (shortness of breath, as a chest pain-equivalent symptom)	Elementi da Figure 2, Table 3, Table 4 e Figure 11 dell'articolo. Recommendations for Defining Chest Pain An initial assessment of chest pain is recommended to triage patients effectively on the basis of the likelihood that symptoms may be attributable to myocardial ischemia Chest pain should not be described as atypical, because it is not helpful in determining the cause and can be misinterpreted as benign in nature. Instead, chest pain should be described as cardiac, possibly cardiac, or noncardiac because these terms are more specific to the potential underlying diagnosis. (COR = 1; LOE = C-LD) Recommendation for History In patients with chest pain, a focused history that includes characteristics and duration of symptoms relative to presentation as well as associated features, and cardiovascular risk factor assessment should be obtained. (COR = 1; LOE = C-LD) Recommendations for a Focus on the Uniqueness of Chest Pain in Women Women who present with chest pain are at risk for underdiagnosis, and potential cardiac causes should always be considered. (COR = 1; LOE = B-NR) In women presenting with chest pain, it is recommended to obtain a history that emphasizes accompanying symptoms that are more common in women with ACS. (COR = 1; LOE = B-NR) Recommendation for Considerations for Older Patients With Chest Pain In patients with chest pain who are >75 years of age, ACS should be considered when accompanying symptoms such as shortness of breath, syncope, or acute delirium are present, or when an unexplained fall has occurred. (COR = 1; LOE = C-LD) Recommendations for Considerations for Diverse Patient Populations With Chest Pain Among patients of diverse race and ethnicity presenting with chest pain in whom English may not be their primary language, addressing language barriers with the use of formal translation services is recommended. (COR = 1; LOE = C-LD) Recommendation for Physical Examination In patients presenting with chest pain, a focused cardiovascular examination should be performed initially to aid in the diagnosis of ACS or other potentially serious causes of chest pain (e.g., aortic dissection, PE, or esophageal rupture) and to identify complications (VEDI TABLE 4). (COR = 1; LOE = C-EO) Recommendations for Setting Considerations Unless a noncardiac cause is evident, an ECG should be performed for patients seen in the of ce setting with stable chest pain; if an ECG is unavailable the patient should be referred to the ED so one can be obtained (1-5). (COR = 1; LOE = B-NR) Recommendation for Evaluation of Patients With Acute Chest Pain Receiving Dialysis In patients who experience acute unrelenting chest pain while undergoing dialysis, transfer by EMS to an acute care setting is recommended (1-5). (COR = 1; LOE = B-NR) Recommendation for Evaluation of Acute Chest Pain in Patients With Cocaine and Methamphetamine Use In patients presenting with acute chest pain, it is reasonable to consider cocaine and methamphetamine use as a cause of their symptoms. (COR = 2a; LOE = B-NR) Recommendations for Evaluation of Acute Chest Pain in Patients With Sickle Cell Disease In patients with sickle cell disease who report acute chest pain, emergency transfer by EMS to an acute care setting is recommended. (COR = 1; LOE = B-NR)	Il primo dei "Top 10 Take-Home Messages" è il seguente: Chest Pain Means More Than Pain in the Chest. Pain, pressure, tightness, or discomfort in the chest, shoulders, arms, neck, back, upper abdomen, or jaw, as well as shortness of breath and fatigue should albe considered ariginal equivalents. Come le linee guida ESC 2023 sulla gestione delle ACS, anche in queste linee guida si raccomanda di abbandonare per il dolore toracico l'uso dei descrittori "typical" e "atypical" in favore "cardiac", "possibly cardiac" e "likely non cardiac".
Diagnostic accuracy of signs and symptoms in acute coronary syndrome and acute myocardial infarction	Raat W.	n.a.	2024	A-priori	Meta-analisi	To assess the diagnostic value of thirteen signs and symptoms suggestive for AMI or ACS.	Sono stati ricercati studi che valutassero l'accuratezza diagnostica di tredici segni e sintomi di ACS e AMI. Con i dati estratti sono state eseguite due distinte meta-analisi del valore diagnostico (diagnostic meta-analysis), stimando per i segni e sintomi predefiniti misure di utilità diagnostica rispettivamente per l'ACS e per l'AMI.	Patients who reported in primary care or emergency department settings with possible ACS or AMI.	Primary care and emergency department settings.	Dolore toracico (chest pain)	The most useful signs and symptoms (highest diagnostic odds ratios) in the diagnosis of AMI were pain radiating to both arms (DOR 2.95 (95%CI 1.57-5.06)), absence of chest wall tenderness (DOR 3.51 (95%CI 1.64-6.61)), pain radiating to the right arm (DOR 5.17 (95%CI 1.77-11.9)) and sweating (DOR 6.75 (95%CI 2.51-11.4)). For ACS these were pain radiating to the right arm (DOR 3.9 (95%CI 0.7-12.6)) and absence of chest wall tenderness (DOR 7.73 (95%CI 2.19-19.8)).	Consiste in un aggiornamento di una meta-analisi precedentemente pubblicata, con l'aggiunta di dieci studi.
2026 AHA/ACC/ACCP/ACEP/CHEST/SCAI/SHMSIR/SVM/ISVN Guideline for the Evaluation and Management of Acute Pulmonary Embolism in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines	Creager M.A.	American Heart Association (AHA); American College of Cardiology (ACC); American College of Clinical Pharmacy (ACCP); American College of Emergency Physicians (ACEP); American College of Chest Physicians (CHEST); Society for Cardiovascular Angiography and Interventions (SCAI); Society of Hospital Medicine (SHM); Society of Interventional Radiology (SIR); Society of Vascular Medicine (SVM); Society of Vascular Nursing (SVN)	2026	Post-hoc	Linee guida	Non esplicitati. The guideline addresses the clinical assessment of the patient presenting with symptoms and signs of acute PE, initial laboratory testing (specifically D-dimer), and the appropriate use of imaging to diagnose acute PE.	An initial extensive evidence review was conducted from February 2024 to October 2024. Select key studies published until April 2025 were added by the guideline writing committee as appropriate. The evidence tables summarized the evidence used by the writing committee to formulate recommendations.	The focus of this clinical practice guideline is the evaluation and management of acute pulmonary embolism (PE) in the adult patient (≥18 years of age). The guideline addresses the clinical assessment of the patient presenting with symptoms and signs of acute PE, initial laboratory testing (specifically D-dimer), and the appropriate use of imaging to diagnose acute PE.	Dolore toracico (chest pain); Dispnea (dyspnea); Cardiopalmo (palpitation)	Elementi da Table 3 dell'articolo. Recommendations for Clinical Assessment: In patients presenting with symptoms suggestive of acute PE, a targeted history and comprehensive physical examination is recommended to assist in determining the clinical pretest probability of acute PE. (COR = 1; LOE = A) Prompt diagnosis of acute PE requires recognition of a patient's predisposing risk factors for venous thromboembolism (VTE). The evaluation of patients with suspected PE integrates the clinical history with physical examination findings, laboratory testing, and diagnostic imaging.11 Many symptoms of acute PE are nonspecific. 12-18 The most common symptoms of PE are pleuritic chest pain and dyspnea. Hemoptysis, syncope, and shock are less common. 17-19 Physical examination findings of tachycardia and hypotension may indicate hemodynamic compromise, and tachypnea and hypoxemia may indicate a significant degree of gas exchange perturbation. Other signs to seek are decreased lung breath sounds, a pleural friction rub, jugular venous distention, an accentuated pulmonary second heart sound, a parasternal lift, and leg swelling and tenderness suggestive of deep vein thrombosis (DVT). Clinical decision tools such as the Wells score, the Revised Geneva Score, and the Pulmonary Embolism Rule Out Criteria (PERC) are frequently used to synthesize the history and physical findings and inform a clinical pretest probability of PE (Table 3). During a targeted history and physical examination, assessment for PE risk factors should include recent surgery, hospitalization for medical therapy, immobility, pregnancy, estrogens, trauma, cancer, inflammatory disorders, and inherited and acquired thrombophilias, among others. Other risk factors, which may vary by sex, include atherosclerotic cardiovascular disease, pulmonary disease, cancer, chronic venous disease, prolonged immobility, and hormonal therapy.23 These risk factors help to inform the pretest probability of acute PE.		
2023 ESC Guidelines for the management of acute coronary syndromes: Developed by the task force on the management of acute coronary syndromes of the European Society of Cardiology (ESC)	Byrne R.	European Society of Cardiology (ESC)	2023	Post-hoc	Linee guida	Non esplicitati. Guidelines evaluate and summarize available evidence with the aim of assisting health professionals in proposing the best diagnostic or therapeutic approach for an individual patient with a given condition.	The Task Force performed a critical evaluation of diagnostic and therapeutic approaches, including assessment of the risk-benefit ratio. The strength of every recommendation and the level of evidence supporting them were weighed and scored according to predefined scales as outlined below. The Task Force followed ESC voting procedures, and all approved recommendations were subject to a vote and achieved at least 75% agreement among voting members.	Non esplicitati. Acute chest discomfort is the leading presenting symptom prompting consideration of the clinical diagnosis of ACS and the initiation of testing aligned with specific diagnostic algorithms. Chest pain-equivalent symptoms include dyspnoea, epigastric pain, and pain in the left or right arm or neck/jaw.	Non specificato. Patients with suspected ACS present in a broad range of clinical scenarios, including in the community, at the emergency department (ED), or in the inpatient setting. It is crucial to take a focused medical history and accurately characterize the presenting symptoms in order to manage the patient via the appropriate care pathway as soon as possible.	Dolore toracico (chest pain); Dispnea (dyspnoea, as a chest pain-equivalent symptom)	Prompt assessment of vital signs is recommended at first medical contact (FMC), at the same time as acquisition of an initial ECG. Focused physical examination should include checking for the presence of all major pulses, measurement of blood pressure in both arms, auscultation of the heart and lungs, and assessing for signs of HF or circulatory compromise.	Chest pain-equivalent symptoms include dyspnoea, epigastric pain, and pain in the left or right arm or neck/jaw. Come le linee guida 2021 AHA/ACC/AASE/CHEST/SAEM/SCCT/SCMR sulla diagnosi e gestione del dolore toracico, anche in queste linee guida si raccomanda di abbandonare per il dolore toracico l'uso dei descrittori "typical" e "atypical" in favore "cardiac", "possibly cardiac" e "likely non cardiac".
2023 ESC Guidelines for the management of acute coronary syndromes Supplementary data	Byrne R.	European Society of Cardiology (ESC)	2023	Post-hoc	Materiali supplementari di linee guida	n.a.	n.a.	n.a.	n.a.	Dolore toracico (chest pain); Dispnea (dyspnoea, as a chest pain-equivalent symptom)	Elementi da Figure S1 dell'articolo. Older age, male sex, family history of coronary artery disease (CAD), diabetes, hyperlipidaemia, smoking, hypertension, renal dysfunction, previous manifestation of CAD, and peripheral or carotid artery disease all increase the likelihood of ACS. Some conditions may exacerbate or precipitate ACS, including: anaemia, infection, inflammation, fever, hypertensive crisis, emotional stress, and metabolic or endocrine (in particular thyroid) disorders. Chest pain can be classified as cardiac, possible cardiac, or non-cardiac. The term cardiac is used to describe chest pain occurring because of an underlying cardiac aetiology. This includes classic chest discomfort based on quality, location, radiation, and provoking and relieving factors that make it more likely to be of cardiac ischaemic origin. The term 'possible cardiac' is used to refer to chest pain symptoms that suggest a cardiac origin. 'Non-cardiac' is a term used to refer to chest pain symptoms likely due to a non-cardiac cause in patients with persistent or recurring symptoms despite a negative stress test or anatomic cardiac evaluation, or a low-risk designation by a clinical decision pathway. Cardiac auscultation may reveal a systolic murmur due to ischaemic mitral regurgitation, which is associated with a poor prognosis. Alternatively, the murmur of aortic stenosis may be detected, which can mimic ACS presentations. A murmur consistent with aortic insufficiency should prompt consideration of acute aortic dissection associated with ACS. Physical examination may identify signs of non-coronary causes of chest pain (e.g. pulmonary embolism, acute aortic syndromes, myopericarditis, or aortic stenosis) or extracardiac pathologies (e.g. pneumothorax, pneumonia, or musculoskeletal diseases). In this setting, the presence of chest pain that can be reproduced by exerting pressure on the chest wall has a relatively high negative predictive value for ACS. According to the clinical presentation, abdominal disorders (e.g. reflux disease, oesophageal spasm, oesophagitis, gastric ulcer, cholecystitis, or pancreatitis) may also be considered in the differential diagnosis. Differences in blood pressure between the upper and lower limbs or between the arms, irregular pulse, jugular vein distension, heart murmurs, friction rub, and pain reproduced by chest or abdominal palpation are findings suggestive of alternative diagnoses. Pallor, sweating, or tremor are often signs of stress related to MI but may also point towards precipitating conditions (i.e. anaemia or thyrotoxicosis).	

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Diagnostic strategies for suspected acute aortic syndrome: systematic review, meta-analysis, decision-analytic modelling and value of information analysis	Goodacre S.	National Institute for Health and Care Research (NIHR)	2025	Post-hoc	Revisione sistematica con meta-analisi e modellazione decisionale	To estimate the accuracy of clinical scores, models or algorithms, and/or biomarkers (including D-dimer) for diagnosing AAS. To estimate the effectiveness (in terms of quality-adjusted life-year (QALY) gained), cost-effectiveness (in terms of net benefit and incremental cost per QALY gained) and practical implications (in terms of the burden of radiological investigations) of using alternative diagnostic strategies for AAS. To estimate the expected value of perfect information (EVPI) to highlight the amount healthcare decision-makers could spend on future primary research to reduce the uncertainty in diagnostic strategies for AAS.	The authors undertook a systematic review, meta-analysis, decision analysis modelling and value of information analysis. The systematic review identified studies of index tests evaluating the accuracy of clinical scores, models, algorithms or biomarkers for a reference standard diagnosis of AAS in patients attending the ED with symptoms suggesting AAS (new-onset chest, back, or abdominal pain, syncope or symptoms related to perfusion deficit). Meta-analysis was used to generate summary estimates of accuracy for AAS for index tests evaluated with sufficient data of acceptable quality. The authors then developed a decision-analytic model to estimate the cost-effectiveness and practical implications of using alternative diagnostic strategies based on index tests identified in the systematic review to select patients with suspected AAS for CTA. The model was also used to estimate the EVPI associated with future research into diagnostic strategies for suspected AAS.	Patients attending the ED with symptoms suggesting AAS (new-onset chest, back, or abdominal pain, syncope or symptoms related to perfusion deficit)	Emergency department.	Dolore toracico (chest pain)	Gli elementi dell'Aortic Dissection Detection Risk Score (ADD-RS) non vengono specificati.	
Chest Pain in Primary Care: A Systematic Review of Risk Stratification Tools to Rule Out Acute Coronary Syndrome	van den Bulk S.	n.a.	2024	Post-hoc	Revisione sistematica con meta-analisi	To assess the performance of tools for ruling out acute coronary syndrome and to provide a comprehensive review of the current evidence.	Systematic review of studies evaluating risk stratification tools for chest pain in primary care settings, both with and without troponin assays.	Adults (aged 18 years or more) with acute chest pain enrolled in primary care.	Primary care setting.	Dolore toracico (chest pain)	Elementi da Supplemental Table 1 dell'articolo - Components of risk stratification tools (nei materiali supplementari della pubblicazione): Grippeis rule: History of CAD; Male sex; Presence of radiation of pain; Presence of nausea/sweating Bruins Slot rule: History of CAD; Male sex; Presence of radiation of pain; Presence of nausea/sweating Willemsen rule: Dyspnea. Feeling of pressure on chest; Absent lateral chest pain left; repeat ECG e laboratoristici Marburg Heart score: Known clinical vascular disease (CAD, occlusive vascular disease or cerebrovascular disease); Age/sex (F≥65 years or M ≥55 years); Increased pain with exercise; Pain not reproducible by palpation; Patient assumes pain is of cardiac origin INTERCEHST: History of CAD; Age/sex (F ≥65 years or M ≥55 years); Increased pain with exercise; Pain reproducible by palpation; Physician assumes cardiac origin; Pain feels like "pressure" Gencer rule: History of CVD; Age/sex (F ≥65 years or M ≥55 years); Increased pain with exercise; Pain not reproducible by palpation; CVD risk factor (Family history of CVD, diabetes mellitus, (treated) hypertension, (treated) hyperlipidemia, smoking or obesity (body mass index ≥30)); Duration of pain 1-60min; Substernal location of pain Safety First: Sex: Age: Acute onset of chest pain < 12 hours; Pressing/heavy character of the pain; Radiation of pain; Presence of sweating; Calling at night Original HEART-score: History: Highly suspicious for ACS; Moderately suspicious; Slightly or not suspicious. ECG: non rilevante. Age: ≥65, 46-64, <45. Risk factors (Family history of CVD, diabetes mellitus, (treated) hypertension, (treated) hyperlipidemia, smoking or obesity (body mass index ≥30)); ≥3 risk factors; or previous CAD; One or two risk factors; No risk factors. Troponin: non rilevante.	
Palpitations: Evaluation, Management, and Wearable Smart Devices	Gauer R.	n.a.	2024	Post-hoc	Revisione di tipo non specificato	Non esplicitati.	A literature search was conducted in PubMed using the key terms palpitations, ambulatory electrocardiogram monitoring, arrhythmias, atrial fibrillation, atrial flutter, epidemiology, inappropriate sinus tachycardia, atrial tachycardia, atrioventricular non reentrant tachycardia, atrioventricular reentrant tachycardia, and smartwatch.	Patients who present with palpitations.		Cardiopalmo (palpitations)	Elementi da eTABLE B dell'articolo. The four independent predictors for palpitations being from cardiac origin are male sex, description of an "irregular" heartbeat, history of heart disease, and palpitations lasting longer than 5 minutes. The evaluation of a patient presenting with palpitations includes characterization of palpitations, personal medical history, history of early unexplained events (i.e., drowning, falling from a height, motor vehicle collision), family history of sudden cardiac death, social history, illicit drug use, and medication use. The clinician should determine the onset (sudden or gradual), duration (instant, paroxysmal, sustained), quality (rapid, regular, irregular), frequency (daily, weekly, monthly), triggers (activity, position, stress), and associated symptoms (chest pain, nausea, shortness of breath, presyncope, syncope) of palpitations. Asking the patient to tap the rhythm of the palpitations can be useful in identifying the rate and regularity of symptoms. Patients with chronic conditions such as cardiac disease (i.e., heart failure, ischemic heart disease, cardiac surgery, and congenital heart disease) that include implantable cardiac devices, pulmonary disease (i.e., chronic obstructive pulmonary disease [hypercarbia, hypoxia] and pulmonary hypertension), and thyroid disease are also at increased risk for palpitations. Palpitations in patients with a history of cardiac disease are attributable to arrhythmias in 91% of cases.14 Some patients with structural heart diseases (i.e., valvular disease, congenital heart disease, hypertrophic cardiomyopathy, prosthetic valves) report palpitations in the absence of arrhythmias. Low-risk features that generally do not require referral include isolated palpitations not provoked by exercise and absence of cardiac symptoms (i.e., syncope, presyncope, dyspnea, chest pain), no personal history of structural heart disease or family history of sudden cardiac death, and the presence of normal ECG findings. Hemodynamic instability in association with palpitations may indicate a potentially lethal arrhythmia or coexisting structural heart disease. Individuals who require immediate resuscitation or who have ischemic chest pain, acute hypotension, signs of heart failure, decreased level of consciousness, and ischemic ECG changes should be transferred to the emergency department with immediate cardiology referral. Clinical Findings Prompting Immediate Evaluation: Family history of sudden cardiac death or inheritable cardiac conditions Hemodynamic instability in conjunction with palpitations; Palpitations associated with exercise or syncope or presyncope; Resting tachycardia greater than 120 beats per minute; Review medications that prolong the QT interval.	
Clinical Approach to Patients with Palpitations	Giada F. & Raviela A.	n.a.	2018	Post-hoc	Revisione di tipo non specificato	Non esplicitati.	Non specificati.	Patients with palpitations.		Cardiopalmo (palpitations)	Elementi da Box 2 dell'articolo: Clinical features suggestive of palpitations of arrhythmic origin: Low probability: Absence of structural heart disease; Absence of arrhythmogenic heart disease; Normal ECG; Negative family history; Anxiety-related or extrasystolic palpitations; Young age High probability: Severe structural heart disease; Arrhythmogenic heart disease; Pathologic ECG; Family history of sudden death; Advanced age; Tachycardic palpitations; Palpitations associated with symptoms of hemodynamic impairment.	
Aortic Dissection Detection Risk Score (ADD-RS) - Rules out aortic dissection	n.a.	MDCalc ©2005-2026	n.a.	Post-hoc	Pagina web	n.a.	n.a.	Low to moderate risk patients for whom acute aortic syndromes (AAS) are in the differential diagnosis.	Non specificato.	n.a. (non esplicitato nel documento)	Any high risk condition Marfan syndrome, family history of aortic disease, known aortic valve disease, recent aortic manipulation, or known thoracic aortic aneurysm Any high risk pain feature Chest, back, or abdominal pain described as abrupt onset, severe intensity, or ripping/tearing Any high risk exam feature Evidence of perfusion deficit (pulse deficit, systolic blood pressure differential, or focal neurological deficit in conjunction with pain), new murmur of aortic insufficiency (with pain), hypotension/shock state	Lo score ADD-RS è oggetto di studio di un documento intercettato con la metodologia a-priori della scoping review ma che non rispettava i criteri di inclusione. Il documento in questione era "" di Goodacre et al. (2025). La pagina web con lo score è raggiungibile al seguente collegamento: https://www.mdcalc.com/calc/4060/aortic-dissection-detection-risk-score-add-rs
Marburg Heart Score (MHS) - Rules out coronary artery disease in primary care patients with chest pain.	n.a.	MDCalc ©2005-2026	n.a.	Post-hoc	Pagina web	n.a.	n.a.	Patients ≥35 years old presenting with chest pain in a primary care setting. Should not be used in patients with a readily apparent cause of chest pain (e.g. trauma, infection), clear anginal equivalent symptoms (e.g. jaw pain, dyspnea on exertion, arm pain), or if other testing (e.g. electrocardiography, lab testing) has suggested a clearly cardiac etiology.	Primary care setting.	Dolore toracico (chest pain)	Female ≥65 years or male ≥55 years Known CAD, cerebrovascular disease, or peripheral vascular disease Pain worse with exercise Pain reproducible with palpation Patient assumes pain is cardiac	Gli autori specificano che "[T]he Marburg Heart Score) should not be used in patients with a readily apparent cause of chest pain (e.g. trauma, infection), clear anginal equivalent symptoms (e.g. jaw pain, dyspnea on exertion, arm pain), or if other testing (e.g. electrocardiography, lab testing) has suggested a clearly cardiac etiology." Gli autori specificano: "For any primary care patient with chest pain, clinical stability can quickly be determined by evaluating the ABCs (airway, breathing, circulation). A patient who shows no signs of respiratory distress and has appropriate vital signs is unlikely to be acutely unstable and can be further evaluated in the office with appropriately targeted history, physical examination, and testing. If there is a readily apparent cause of chest pain other than CAD (e.g. trauma, infection), attention should be directed to these causes. If there are clearly anginal equivalent symptoms (e.g. jaw pain, dyspnea on exertion, arm pain), or if there are ischemic changes on EKG, then the MHS does not apply and urgent inpatient admission is warranted." La pagina web con lo score è raggiungibile al seguente collegamento: https://www.mdcalc.com/calc/4022/marburg-heart-score-mhs
INTERCHEST Clinical Prediction Rule for Chest Pain in Primary Care - Rules out coronary artery disease (CAD) in primary care patients with chest pain.	n.a.	MDCalc ©2005-2026	n.a.	Post-hoc	Pagina web	n.a.	n.a.	Patients ≥30 years old presenting with chest pain in a primary care setting. Should not be used in patients with a readily apparent cause of chest pain (e.g. trauma, infection), clear anginal equivalent symptoms (e.g. jaw pain, dyspnea on exertion, arm pain), or if other testing (e.g. electrocardiography, lab testing) has suggested a clearly cardiac etiology.	Primary care setting.	Dolore toracico (chest pain)	History of CAD Female ≥65 years or male ≥55 years Chest pain related to effort Pain reproducible by palpation Physician initially suspected a serious condition Chest discomfort feels like "pressure"	Gli autori specificano che "[T]he INTERCHEST Rule) should not be used in patients with a readily apparent cause of chest pain (e.g. trauma, infection), clear anginal equivalent symptoms (e.g. jaw pain, dyspnea on exertion, arm pain), or if other testing (e.g. electrocardiography, lab testing) has suggested a clearly cardiac etiology." Gli autori specificano: "For any primary care patient with chest pain, clinical stability can quickly be determined by evaluating the ABCs (airway, breathing, and circulation). A patient who shows no signs of respiratory distress and has appropriate vital signs is unlikely to be acutely unstable and can be further evaluated the office with appropriately targeted history, physical examination, and testing. If there is a readily apparent cause of chest pain other than CAD (e.g. trauma, infection), attention should be directed to these causes. If there are clearly anginal equivalent symptoms (e.g. jaw pain, dyspnea on exertion, arm pain), or if there are ischemic changes on the ECG, then the INTERCHEST score does not apply and urgent inpatient admission is warranted." La pagina web con lo score è raggiungibile al seguente collegamento: https://www.mdcalc.com/calc/10225/interchest-clinical-prediction-rule-chest-pain-primary-care
Wells' Criteria for Pulmonary Embolism - Objectifies risk of pulmonary embolism.	n.a.	MDCalc ©2005-2026	n.a.	Post-hoc	Pagina web	n.a.	n.a.	Pazienti per i quali vi è il sospetto clinico di embolia polmonare. This should not be applied to all patients with chest pain or shortness of breath.	Non specificato.	n.a. (non esplicitato nel documento)	Clinical signs and symptoms of DVT PE is #1 diagnosis OR equally likely Heart rate >100 Immobilization at least 3 days OR surgery in the previous 4 weeks Previous, objectively diagnosed PE or DVT Hemoptysis Malignancy w/ treatment within 6 months or palliative	Wells' is often criticized for having a "subjective" criterion in it ("PE #1 diagnosis or equally likely"). Al posto dell'elemento "malignancy", il GdL propone la locuzione "problematica oncologica". Il GdL propone di omettere dall'elenco definitivo "PE is #1 diagnosis..." e di aggiungere caratterizzazione temporale all'ematomi. La pagina web con lo score è raggiungibile al seguente collegamento: https://www.mdcalc.com/calc/115/wells-criteria-pulmonary-embolism
PERC Rule for Pulmonary Embolism - Rules out PE if no criteria are present and pre-test probability is ≤15%.	n.a.	MDCalc ©2005-2026	n.a.	Post-hoc	Pagina web	n.a.	n.a.	Patients where the diagnosis of PE is being considered, but the patient is deemed low-risk.	Non specificato.	n.a. (non esplicitato nel documento)	Age ≥50 HR ≥100 O ₂ sat on room air <95% Unilateral leg swelling Hemoptysis Recent surgery or trauma (specifica: Surgery or trauma 54 weeks ago requiring treatment with general anesthesia) Prior PE or DVT Hormone use (specifica: Oral contraceptives, hormone replacement or estrogenic hormones use in males or female patients)	La pagina web con lo score è raggiungibile al seguente collegamento: https://www.mdcalc.com/calc/347/perc-rule-pulmonary-embolism#when-to-use