

where there were less cases of COVID-19 compared with the most affected north part.¹ The risk of mortality and complications of STEMI also increased significantly.¹ Further study is needed to evaluate whether delay in treatment also cause worse prognosis of STEMI in Taiwan. In conclusion, although there was no reduction of STEMI admission in Taiwan, a significant delay for medical help was found during the COVID-19 pandemic. Further actions are necessary to avoid the negative impact of COVID-19 pandemic on care of STEMI.

Disclosures

The authors have no conflicts of interest to disclose.

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Do We Need a Modified HEART Score to Risk Stratify Chest Pain Patients in the Emergency Department?



To the Editor:—At present, History, Electrocardiogram, Age, Risk factors, and Troponin (HEART) is one of the most common scoring systems to risk stratify undifferentiated chest pain patients at Emergency Department (ED).¹ Low risk HEART scores (0-3) predict very low short-term major adverse cardiac event. We, as ED physicians, are particularly interested in recognizing the value of better directing low risk chest pain patients for their safety to discharge from ED. If patients deem to be “high” risks, such patients might need to be placed to hospital for further evaluations. However, using current HEART score might result in higher unnecessary hospital admissions among certain ED patient populations. One of the reasons is their broad definition of “high risk” items. For example, an elderly (≥ 65) patient with a history of previous myocardial infarction or cardiac atherosclerotic disease will have a HEART score of at least 4, regardless of his/her clinical presentations, EKG findings, or troponin value.

We have been expecting the modifications of HEART scoring system to better differentiate “low risk” chest pain patients and avoid unnecessary hospital admissions. The findings in the paper by Roongsritong et al. seems to help answering this question.² Specifically, authors derived a novel SVEAT score, similar to the HEART score, with better “risk” definitions. Authors emphasize the differences between stable and unstable angina clinical presentations, the importance of recent cardiovascular events, and recognize the critical new/dynamic ischemic EKG changes, which are the usual thinking on the final patient disposition by ED physicians. More importantly, using SVEAT, a 28.6% of extra “low-risk” chest pain patients, in comparison to HEART score, can be recognized.

However, some of the authors’ findings in this paper require further discussions. As mentioned in their limitation, the SVEAT scoring system is derived using clinical gestalt. With the help of statisticians, deriving a better scoring system does not seem to be challenge.³ If each “risk” is not scored based on their weight to predict major adverse cardiac event outcomes, we are expecting higher misclassification rates. On the other hand, simply reporting c-statistics/area under the receiver operating characteristic curve is not enough for determining the accuracy of the diagnostic tool, though sensitivity, specificity, positive/negative predictive value, and likelihood ratio can be further calculated based on numbers listed in the paper. It is better to report, especially the likelihood ratios, since the readers can estimate the improved post-test probability of using SVEAT score for differentiating low-risk chest pain patients at ED.⁴ The findings of this SVEAT score is promising and we expect to see the external validations of this scoring system in the future.

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Prognostic Value of Left Ventricular Global Longitudinal Strain in COVID-19



The novel severe acute respiratory syndrome coronavirus 2019 (COVID-