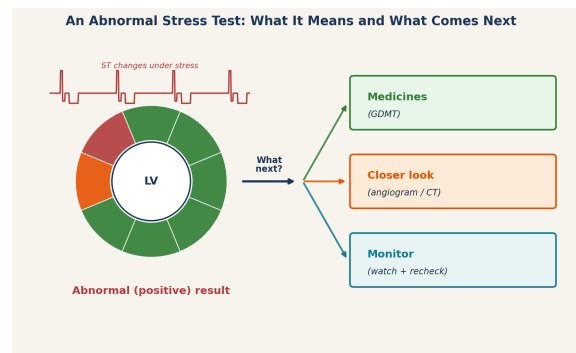


Your Stress Test Was Abnormal

What a Positive Result Means, the False-Positive Reality, and What Comes Next

An abnormal stress test is the start of a plan, not a verdict. It tells us to look closer at the blood flow to your heart - and most of the next steps are calm, routine, and in your control.



Online: <https://go.riasalimd.com/abnormal-stress-guide>

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Last Updated: August 2026



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Names & Terms You Will Hear

Term	Meaning
Abnormal stress test	A stress test that showed one or more warning signs while the heart was working hard - usually a sign that blood flow to part of the heart is limited.
Positive stress test	Another way of saying abnormal. 'Positive' means the test found something - it does not mean a heart attack. It means we should look closer.
Reversible defect (reversible ischemia)	An area of heart muscle that gets enough blood at rest but falls short under stress. The muscle is alive. It is the fingerprint of a narrowed artery we can often treat.
Fixed defect	An area of low blood flow at both rest and stress. It usually means old scar from a past heart attack. That muscle is already gone, and a stent cannot bring it back.
Ischemia	Not enough blood flow to part of the heart muscle. It is the main thing a stress test looks for. It means the muscle is starved, not yet dead.
Ischemic burden	How much of the heart muscle is short on blood under stress. A small burden is one small area. A large burden is several areas. The size helps drive the plan.
ST depression	A pattern on the ECG during exercise that suggests not enough blood flow. Measured in millimeters - 1 mm is mild; 2 mm or more is more concerning.
Perfusion defect	On a nuclear or MRI test, an area where the tracer or contrast does not reach the muscle as well. A reversible perfusion defect appears only under stress; a fixed one appears at rest too.
Wall-motion abnormality	On a stress echo, an area of the heart wall that does not squeeze well under stress. Like a perfusion defect, it points to a blood-flow problem in that region.



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Term	Meaning
False positive	A test that looks abnormal but the arteries turn out to be fine. More common in women, in people with a left bundle branch block (LBBB), and in people who were low risk to begin with.
Pretest probability	How likely heart-artery disease was BEFORE the test, based on age, sex, symptoms, and risk factors. A positive test in a low-probability person is more likely to be a false alarm.
GDMT (guideline-directed medical therapy)	The set of proven medicines we start or strengthen after an abnormal result. This means a statin, often aspirin, blood-pressure medicines, and anti-angina medicines. It is real treatment, not just waiting.
Cardiac catheterization (coronary angiogram)	A thin tube is guided to the heart arteries. Dye is injected so we can see narrowings directly. It is the most exact way to confirm and measure a blockage.
CT coronary angiography (CTA)	A CT scan that looks at the heart arteries from the outside, with no tube in the body. For many people it is a good way to confirm or rule out a blockage.
Revascularization	Opening or bypassing a blocked artery - with a stent (angioplasty) or with bypass surgery. We use it when a blockage is large and symptoms or risk call for it.

Read this first. An abnormal stress test is the start of a plan, not a verdict - and it is not a heart attack. It means we should look closer at the blood flow to your heart. Many abnormal results turn out to be false alarms, and most of the rest are handled with medicines and a calm follow-up. A few are high-risk and move quickly - and we will always tell you which kind yours is.



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Your Stress Test Was Abnormal?

- An abnormal (or 'positive') stress test means the test found a warning sign while your heart was working hard. The common signs are ECG changes (ST depression), chest symptoms brought on by exercise, a perfusion defect on a nuclear or MRI scan, or a wall that stops moving well on a stress echo.
- The main message is usually this: part of your heart muscle may not get enough blood when it is asked to work hard. We call that ischemia.
- An abnormal result is not a heart attack. It is not a diagnosis by itself. It is a reason to look closer - with your symptoms, your risk factors, and sometimes one more test.
- There are three kinds of 'abnormal' to sort out. First, reversible ischemia: low flow under stress, normal at rest - living muscle starved by a narrowed artery. Second, a fixed defect: low flow at rest and stress - old scar from a past heart attack. Third, a false positive: the test looked abnormal, but the arteries are fine.
- Telling these apart is the whole job of the visit that follows. Each one leads to a very different plan.
- Many abnormal results lead to nothing more than stronger medicines and a recheck. Some lead to a closer look at the arteries. A few - the high-risk ones - move fast. We will tell you which group you are in.



Reversible vs fixed defect. On the left, flow is normal at rest but drops under stress - living muscle starved by a narrowed artery, the kind a stent can help. On the right, flow is low at both rest and stress - old scar from a prior heart attack, which a stent cannot bring back.



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Three Kinds of 'Abnormal' - and What Each One Means

Finding	Rest flow	Stress flow	What it usually means
Reversible defect	Normal	Low	Living muscle starved by a narrowed artery - often fixable
Fixed defect	Low	Low	Old scar from a prior heart attack - treat with medicines, not a stent
False positive	Normal	Looks low	Arteries are actually fine - more common in women, LBBB, low risk



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Reversible Ischemia - the Fixable Kind

- What it is: an area of heart muscle that gets enough blood at rest but falls short under stress. The muscle is alive and starving, not dead.
- Why it happens: a narrowed artery can supply enough blood when the heart is calm. It cannot keep up when the heart is asked to work hard.
- How it looks on tests: a defect that shows up under stress and goes away at rest (nuclear, MRI), a wall that stops moving under stress (echo), or ST depression on the ECG.
- Why it matters: this is the finding a stent or bypass is built to treat. Opening the narrowed artery can ease symptoms and, in the right setting, lower risk.
- What comes next: medicines first for stable symptoms. A CT or invasive angiogram when the area is moderate or large, symptoms will not settle, or the result is high-risk.
- The good news: reversible means the muscle can still be saved. This is the kind of result where treatment has the most to offer.



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Fixed Defect - Old Scar, Not a Fresh Problem

- What it is: an area of low blood flow at BOTH rest and stress. That muscle is usually old scar from a past heart attack.
- Why it happens: when an artery was fully blocked in the past, the muscle it fed died and turned to scar. Scar does not take up the tracer and does not squeeze.
- How it looks on tests: a defect that is there at rest and does not change with stress, or a wall that does not move at rest or stress on echo.
- Why a stent does not help here: a stent opens an artery to bring blood, but dead scar cannot use it. A stent into pure scar adds risk with little to gain.
- What comes next: medicines to protect the rest of the heart, and heart-failure care if the pump is weak. A viability test (MRI or PET) can check for living muscle worth saving.
- The honest framing: a fixed defect is a record of something that already happened. The goal now is to protect what remains - not to chase scar.



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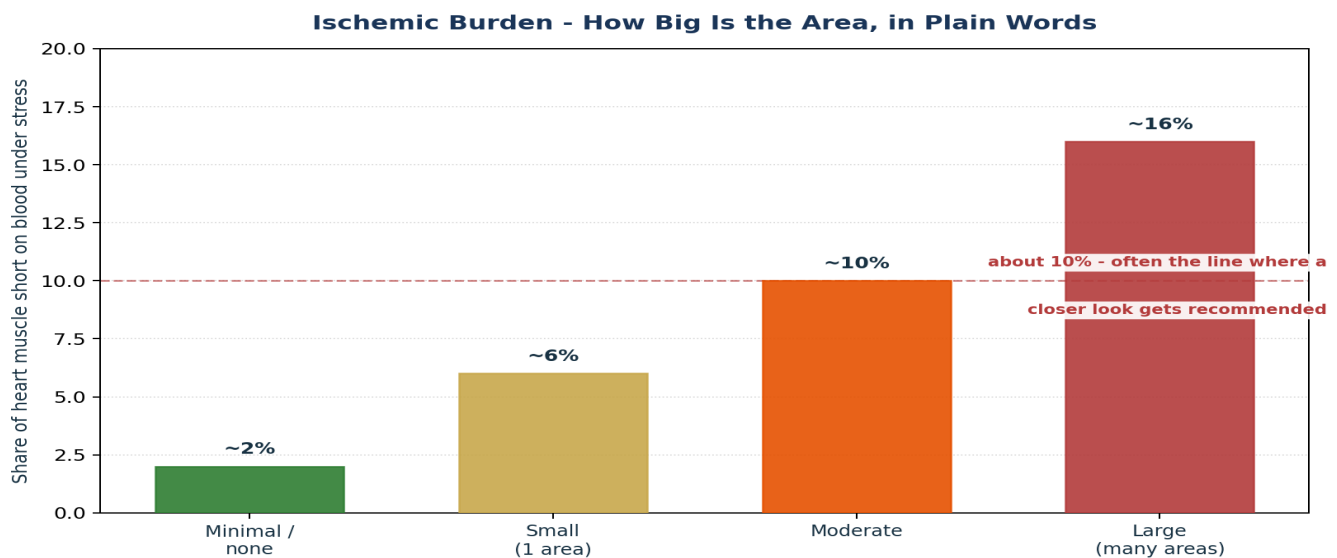
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Why It Matters

- An abnormal result matters because it can be the first clear sign of coronary artery disease. Finding it early lets us lower your risk before a heart attack, not after.
- But it matters how MUCH of the heart is involved. A small area of ischemia and a large area are very different problems with very different plans.
- It also matters the other way. Many abnormal tests are false positives. Treating a false alarm as real disease brings worry, extra tests, and risk you did not need. Sorting real from false is the point of the follow-up.
- An abnormal result changes your medicines. Even before any procedure, a statin, blood-pressure control, and often aspirin lower your risk. This is treatment that starts the day we talk.
- It also changes your urgency. Most results are routine - we plan over days to weeks. A few are high-risk and get a same-day call. We will always tell you which kind yours is, so you are never left guessing.



Ischemic burden - how big the starved area is. A small, single-area burden is usually handled with stronger medicines and a recheck. A large burden across several areas usually earns a closer look at the arteries. The percentages are illustrative thresholds, not exact cutoffs.



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Ischemic Burden - Small, Moderate, or Large

- Small burden (green to gold): roughly one small area, often a single wall. Usually handled with stronger medicines and a recheck. In a low-risk person it can also be a false alarm.
- Moderate burden (orange): a clear reversible defect in one region, often about 5 to 10% of the heart muscle. This usually earns a closer look - a CT or invasive angiogram - plus medicines.
- Large burden (red): several walls involved, often more than about 10% of the muscle. This group gains the most from finding and fixing a blockage, and it moves faster.
- Why size drives the plan: a small area at risk and a large area at risk are different problems. The bigger the starved area, the more a closer look has to offer.
- Size plus symptoms plus risk: we never read the size alone. A moderate area with bad symptoms may move faster than a large area with none. We weigh all three.
- A note on the numbers: the percentages above are rough thresholds to give you a feel for scale. Your cardiologist uses the full picture, not one cutoff.

The false-positive reality. Not every positive stress test means a blocked artery. False positives are more common in women (where exercise-ECG alone is less accurate), in people with a left bundle branch block (LBBB), and in people who were low risk to begin with. This is why we weigh how likely disease was BEFORE the test, and often confirm with a CT angiogram before any invasive step. A clean confirming test is very good news - and a real possibility.

What Your Report May Say - and the Usual Next Step

Mildly abnormal / small burden	Moderately abnormal	Strongly abnormal / high-risk	Fixed defect (old scar)
• Small, single-area defect or mild ECG changes • Good exercise capacity, few or no symptoms • Often a possible false positive in low-risk people • Usual step: strengthen medicines and recheck	• A clear reversible defect in one region • Symptoms reproduced, or moderate ST depression • Burden in the middle range (roughly 5 to 10%) • Usual step: medicines plus a CT or invasive angiogram	• ST depression of 2 mm or more at a low workload • Blood-pressure drop with exercise, or a large defect • Several walls involved, or a dangerous rhythm • Usual step: same-day call, prompt invasive angiogram	• Low flow at both rest and stress • Usually means a prior heart attack • A stent cannot bring back dead muscle • Usual step: medicines and heart-failure care if needed



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Risk Factors

Some patients are more likely to develop this condition. Knowing your risk helps your care team take extra precautions.

Risk Factor	Why It Increases Risk
What makes an abnormal result more likely to be REAL	Typical chest pain with effort. Several risk factors - diabetes, smoking, high blood pressure, high cholesterol, family history. Older age. A large or clearly reversible defect. The more of these, the more we trust the result.
What makes an abnormal result more likely to be a FALSE ALARM	Low risk to begin with - young, few risk factors, vague symptoms. A borderline ECG-only finding with no imaging. A left bundle branch block (LBBB). And, statistically, being a woman, where the exercise ECG alone misfires more often.
Why a left bundle branch block (LBBB) causes false positives	An LBBB changes how the heart muscle is activated. This can create flow patterns that look like a blockage even when the artery is open - often near the septum on a nuclear test. So when an LBBB is present, we pick a medicine-based nuclear or MRI test. We do not rely on the exercise ECG.
Why false positives are more common in women	The exercise ECG alone is less accurate in women. Part of the reason is small-vessel disease and a different baseline ECG. So for women we often add imaging - echo, nuclear, or MRI - rather than trust the ECG alone.
Reasons a result is high-risk and moves quickly	Big warning signs are: a 2 mm or more ST drop at low effort, a fall in blood pressure with exercise, a large reversible defect, or a dangerous rhythm. These get a same-day call and a faster path to an angiogram.
Reasons a result can be 'abnormal' but low-stakes	A small, single-area defect with good exercise capacity. Mild ECG changes only. A likely false alarm in a low-risk person. These are usually handled with medicines and a recheck - not a rush to the cath lab.



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Is This Result More Likely Real, or a False Alarm?

Points toward REAL disease	Points toward a FALSE alarm
Typical chest pain with effort	No symptoms, or vague ones
Many risk factors	Young, few risk factors
Large reversible defect on imaging	Borderline ECG-only finding
2 mm ST drop, BP fall, or big area	Left bundle branch block (LBBB)
Older age	Exercise-ECG alone in women



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Treatment Options

- Step one after almost every abnormal result is medicines. This is real treatment, not 'just waiting'. A statin to calm the plaque, often aspirin, blood-pressure control, and - if you have angina - anti-angina medicines like a beta-blocker, a calcium-channel blocker, or a long-acting nitrate.
- For many people with stable symptoms, strong medicines are the MAIN treatment. Large trials (ISCHEMIA, COURAGE) showed that for stable disease, medicines first does not raise the risk of death or heart attack. Rushing to a stent does not beat it.
- A closer look at the arteries comes next when the area is moderate or large, when medicines do not control symptoms, or when the result is high-risk. There are two ways to look. A CT angiogram uses no tube in the body. An invasive angiogram guides a thin tube to the heart arteries.
- A CT angiogram (CTA) is often the first closer look. It can confirm or rule out a blockage without entering the body. It is very good at saying 'the arteries are clean' when the stress test was a false alarm.
- An invasive angiogram is picked when the result is high-risk, when symptoms are severe, or when we need the most exact answer. If a tight blockage is found, it can often be fixed in the same sitting with a stent.
- If a real blockage is confirmed, the choices are a stent (angioplasty), bypass surgery, or more medicines. Complex or multi-vessel disease is decided with a Heart Team. We match the plan to your arteries and your goals.
- Sometimes the best next step is just to watch. A small area, a likely false alarm, or a fixed scar with no symptoms may call for stronger medicines and a recheck - not a procedure.
- Risk-factor care runs alongside all of this. Quit smoking. Treat diabetes. Control blood pressure and cholesterol. Join cardiac rehab. These lower your risk no matter which path your arteries lead to.



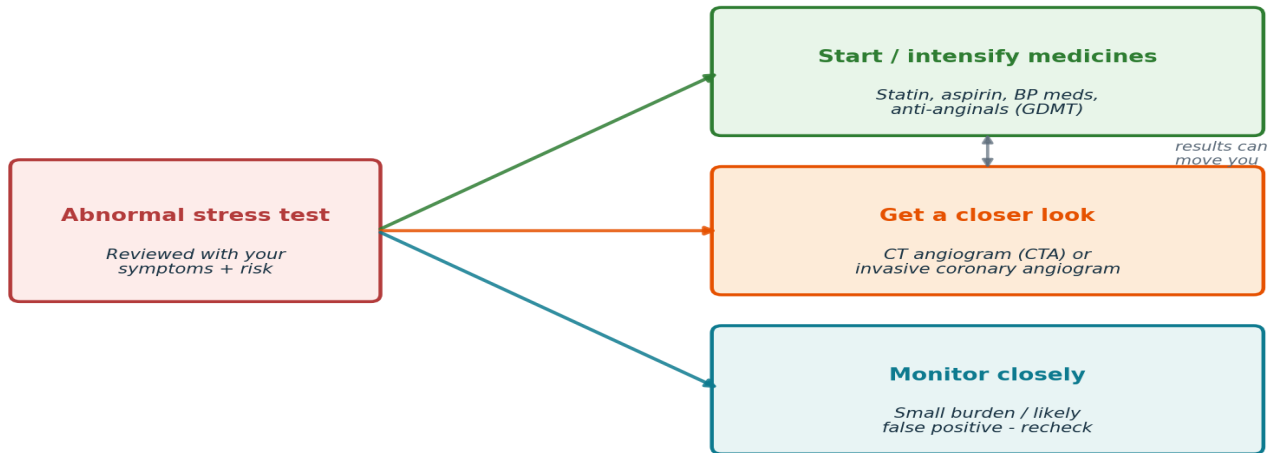
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Three Roads After an Abnormal Result - and They Connect



The three roads after an abnormal result: start or strengthen medicines (GDMT), get a closer look (CT or invasive angiogram), or monitor closely. They are not one-way - what we find on one path can move you to another.



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The Closer Look - CT Angiogram vs Invasive Angiogram

- CT angiogram (CTA): a CT scan looks at the heart arteries from the outside, with no tube in the body. It uses contrast dye and a small amount of radiation.
- CTA is excellent at ruling OUT disease. A clean CTA is very reassuring and clears a likely false alarm with no invasive step.
- Invasive angiogram: a thin tube is guided to the heart arteries and dye is injected to see narrowings directly. It is the most exact test, and a tight blockage can often be fixed with a stent in the same sitting.
- When we pick the invasive route first: high-risk results, severe symptoms that will not settle, or a strong sense that a stent will be needed.
- When we pick CTA first: lower or middle risk, a likely false alarm to rule out, or a younger person who would rather avoid a procedure.
- When neither is needed right away: a small area or a likely false alarm in a low-risk person can be handled with stronger medicines and a recheck.



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Risks, Benefits, and Alternatives

Every choice has trade-offs. Use this table to start the shared decision conversation.

Option	Risks	Benefits	Alternatives
Start with medicines (GDMT) vs go straight to an angiogram	Medicines: very low risk. The main downside is that a tight blockage causing real symptoms may take longer to fix. Angiogram: a small but real risk - about 1 to 2% for bleeding, vessel injury, a contrast issue, stroke, or heart attack.	For stable symptoms and a small or moderate area, medicines first is well supported (ISCHEMIA, COURAGE). It does not raise the risk of death or heart attack, and many people feel better with no procedure. For high-risk results or symptoms that will not settle, an earlier angiogram makes sense.	A CT angiogram is the middle ground. It confirms or rules out a blockage with no tube in the body. It is a good way to clear a likely false alarm.
CT angiogram (CTA) vs invasive coronary angiogram	CTA: contrast dye (a small kidney risk) and radiation (about 3 to 10 mSv), with no tube in the body. Invasive: the same contrast and radiation plus the small risk of the catheter - but it can treat a blockage in the same sitting.	CTA is excellent at ruling OUT disease. A clean CTA is very reassuring and is ideal when a false alarm is likely. The invasive test is best when the result is high-risk, symptoms are severe, or we expect to need a stent.	For some people, neither is needed right away. Stronger medicines and a recheck is the right call.



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Option	Risks	Benefits	Alternatives
Treating an abnormal result vs watching it	Treating - medicines, then maybe a procedure - carries the small risks above. Watching a real, large blockage risks a future heart attack if we judge the size too low.	A small area or a likely false alarm can be watched safely with strong medicines and a recheck. A moderate or large reversible area, or worse symptoms, should be looked at - not just watched.	Cardiac rehab and firm risk-factor care lower risk on every path. They are almost never the wrong choice.
Fixing a reversible defect vs leaving a fixed (scar) defect alone	Opening a reversible defect (live, starved muscle) can ease symptoms and, in the right setting, lower risk. A stent placed into pure scar (a fixed defect with no live muscle) adds procedure risk with little to gain.	Reversible ischemia is the target we treat. A fixed scar is managed with medicines, and with heart-failure care if the pump is weak - not with a stent into dead tissue.	A viability test (MRI or PET) is sometimes used to tell live muscle from scar before we decide to open an artery.

Medicines first is not 'doing nothing'. For stable symptoms, large trials (ISCHEMIA, COURAGE) showed that starting with strong medicines does not raise the risk of death or heart attack compared with rushing to a stent. A statin, blood-pressure control, and (often) aspirin start working right away. A procedure is added when the burden is large, symptoms are not controlled, or the result is high-risk - not by reflex.



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Common Misconceptions

Myth	Reality
An abnormal stress test means I am having a heart attack.	No. An abnormal result means part of the heart may be short on blood when it works hard. A heart attack is a sudden, full blockage with active damage. An abnormal test is a planning signal. Most lead to medicines and a calm follow-up, not an emergency.
A positive result means I definitely have a blocked artery.	Not always. Many positive tests are false alarms - the arteries turn out fine. This is more common in women, in people with a left bundle branch block, and in people who were low risk to start. Confirming the result is the whole point of the next step.
If my test is abnormal, I need a stent right away.	Usually not. For stable symptoms, strong medicines are the main treatment. Big trials (ISCHEMIA, COURAGE) showed that medicines first does not raise the risk of death or heart attack. Stents are saved for the right arteries and the right symptoms.
A fixed defect can be fixed with a stent.	A fixed defect is usually old scar - muscle that is already gone. A stent opens an artery, but it cannot bring dead muscle back. We treat scar with medicines, and with heart-failure care if the pump is weak. Stents aim at LIVING muscle that is starved.
An abnormal result means I should stop exercising.	Almost the opposite. After an abnormal result we adjust your medicines and risk factors. Most people should keep moving - often through cardiac rehab, a supervised program. Sitting still makes the problem worse, not better. We will tell you what is safe.



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Myth	Reality
Since my test was abnormal, the medicines will not be enough.	For many people, medicines ARE enough - and they start working on day one. A statin, blood-pressure control, and often aspirin lower risk whether or not you ever need a procedure. A procedure is added only when the area or the symptoms call for it.
A small abnormal area is just as serious as a large one.	Size matters. A small, single-area defect is a very different problem from a large one across several walls. The size of the area is one of the biggest things that drives whether you need a closer look or just stronger medicines.



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Possible Complications

Knowing what can go wrong helps you spot problems early. Most complications are uncommon, especially with treatment.

Where / What	What Can Happen
Living with the worry of an uncertain result	An abnormal result that is not yet sorted out is stressful. The fastest cure is information - a follow-up visit, a clear plan, and often a confirming test. Do not sit alone with a worrying report; call us and get the plan.
A missed real blockage (under-reacting)	Treating a real, large result as a false alarm risks a future heart attack. So we never ignore high-risk signs. A 2 mm ST drop, a blood-pressure fall, or a large reversible defect each get a prompt closer look.
Over-treating a false positive (over-reacting)	Chasing a false alarm with an angiogram you do not need adds risk and contrast for nothing. So we weigh how likely disease was to begin with. We often confirm with a CT angiogram before any invasive step.
Risks of the confirming angiogram	An invasive angiogram has a small but real risk - about 1 to 2% in all for bleeding, vessel injury, a contrast reaction, stroke, or heart attack. A CT angiogram skips the tube but still uses contrast and radiation.
Progression of untreated coronary disease	A real blockage left untreated can get worse over time - more angina, a larger area at risk, and a higher heart-attack risk. Medicines and risk-factor control slow this down on every path.
Heart muscle weakening from a large fixed defect	A large scar from a prior heart attack can weaken the pump over time. That can lead to heart failure. We manage it with heart-failure medicines and follow-up, not a stent into the scar.
Radiation and contrast from repeated testing	Repeated nuclear tests, CT scans, and angiograms add up in radiation and contrast. We pick the fewest, best tests to answer the question. We use a radiation-free option - stress echo or MRI - when it fits.



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Points to Know

If you remember nothing else, remember these key points.

- An abnormal stress test is a plan, not a verdict. It tells us to look closer at blood flow to your heart. It is not a heart attack and not a final diagnosis.
- There are three things to sort out: reversible ischemia (fixable, living muscle), a fixed defect (old scar), and a false alarm (the arteries are fine).
- False alarms are real and common - more so in women, in people with a left bundle branch block, and in people who were low risk to start.
- How much heart muscle is involved is a big driver of the plan. A small area often means medicines and a recheck. A large area usually means a closer look.
- Medicines - a statin, often aspirin, blood-pressure control, anti-angina drugs - are real treatment that starts right away. For stable disease they are often the main treatment.
- The closer look, when needed, is either a CT angiogram (no tube in the body) or an invasive angiogram (which can place a stent in the same sitting if a tight blockage is found).
- Most results are routine and handled over days to weeks. A few are high-risk and get a same-day call. We will always tell you which kind yours is.
- Bring your report and your questions to the follow-up visit, and do not skip it. The follow-up plan is the most important step.



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When to Call Us - and When to Call 911

If you are not sure, call. We would rather hear from you twice than miss a real problem.

- New chest pain or pressure that is severe, lasts more than a few minutes, or comes at rest while you wait for your follow-up - call 911. This one cannot wait.
- Chest discomfort that is new or worse than your usual pattern, but not severe - call our office the same day.
- New shortness of breath at rest, fainting, or a fast irregular heartbeat - call us the same day, or call 911 if it is severe.
- Pain spreading to the arm, jaw, neck, or back, with sweating or nausea - treat it like a possible heart attack and call 911.
- After an abnormal result, do not delay your follow-up. If new symptoms appear while you wait, call us or come to the ER. The plan can be moved up.
- Questions about your report - a word, a number, or a finding that worries you - call us. A short talk beats a worried week.
- Sudden weakness, a drooping face, or trouble speaking - call 911. (Stroke and heart-artery disease often travel together; the emergency comes first.)

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An Abnormal Result Is One Piece - Where to Read Next

- To understand the test itself - how it is done and how the result is reached: see the [Cardiac Stress Testing guide](#).
- If your abnormal test was a nuclear or PET scan: see the [Nuclear and PET Stress Test guide](#).
- For the underlying disease an abnormal result points to: see the [Coronary Artery Disease guide](#).
- For the closer look at the arteries with a thin tube: see the [Coronary Angiogram guide](#).
- For the non-invasive closer look at the arteries: see the [Coronary CT Angiography guide](#).
- If a blockage is confirmed and a stent is the plan: see the [Angioplasty and Stents guide](#).
- If the symptom that started all this was chest pain or pressure: see the [Chest Pain guide](#).



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Trusted Resources

The links below are the trusted resources Dr. Ali used to write this guide and that he recommends you visit for more information. Each is a clickable link in the digital version and a Short.io tracked URL on the printed version.

- [American Heart Association - Stress Tests](#) - Plain-language AHA overview of why a stress test is done and what an abnormal result can mean.
- [Cleveland Clinic - Exercise Stress Test](#) - Patient-friendly overview of stress-test results, false positives, and the tests that follow an abnormal result.
- [Mayo Clinic - Stress Test](#) - Symptom-focused overview of how results are interpreted and what downstream evaluation looks like.
- [NHLBI - Cardiac Stress Tests](#) - Federal NHLBI overview of what positive vs negative results mean and the next-step options.
- [MedlinePlus - Exercise Stress Test](#) - US National Library of Medicine consumer-health page on stress-test results and follow-up.
- [American College of Cardiology - CardioSmart Stress Tests](#) - ACC's patient-facing explainers and decision aids for understanding stress-test results.



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Sources Used to Build This Guide

Every recommendation in this guide is grounded in one or more of the studies, guidelines, or trusted resources below. Short links are tracked so Dr. Ali can see which references patients are reading; nothing personally identifying is captured.

- [AHA — Exercise Stress Test](#) [Patient-Education]
Stress test interpretation and next steps after an abnormal result
- [Cleveland Clinic — Exercise Stress Test](#) [Patient-Education]
What an abnormal/positive stress test means and follow-up testing
- [Mayo Clinic — Stress Test](#) [Patient-Education]
Results interpretation, false positives, and downstream evaluation
- [NHLBI — Cardiac Stress Tests](#) [Patient-Education]
Federal overview of positive vs negative results and next-step options
- [MedlinePlus — Exercise Stress Test](#) [Patient-Education]
Consumer-health page on stress-test results and follow-up
- [2021 ACC/AHA Chest Pain Guideline \(Gulati et al., Circulation 2021\)](#) [Guideline]
Framework for evaluating ischemia and choosing the test after abnormal stress results; pretest probability
- [2023 AHA/ACC Chronic Coronary Disease Guideline \(Virani et al., Circulation 2023\)](#) [Guideline]
GDMT-first management of stable disease; revascularization indications by ischemic burden and symptoms
- [ISCHEMIA Trial \(Maron, Hochman et al., NEJM 2020\)](#) [Trial]
Medicines-first vs early-invasive for stable disease with moderate/severe ischemia — the core RBA and 'medicines-first is not nothing' framing
- [COURAGE Trial \(Boden et al., NEJM 2007\)](#) [Trial]
Optimal medical therapy vs PCI in stable CAD — supports medical therapy as the main treatment for stable disease
- [ASNC Imaging Guidelines for SPECT MPI \(Henzlova et al., J Nucl Cardiol 2016\)](#) [Guideline]
SPECT/MPI protocols, reversible vs fixed defect definitions, and ischemic-burden interpretation
- [ACC CardioSmart — Stress Tests](#) [Patient-Education]
Patient-facing decision aids for understanding stress-test results and follow-up choices



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About This Guide

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Version: 2026-08-16

Reviewer note: Reviewed against the AHA stress-test page, Cleveland Clinic's exercise stress test overview, and Mayo Clinic's stress test results page. Ours adds: a reversible-vs-fixed defect diagram, an ischemic-burden chart (small vs moderate vs large area), a next-steps flow (medicines / closer look / monitor), an honest false-positive section (women, LBBB, low pretest probability), a result-category set of grade cards, an RBA table covering medicines-first vs angiogram-first (ISCHEMIA / COURAGE framing), and cross-links into the stress test, nuclear/PET, CAD, coronary angiogram, angioplasty, and chest pain guides.

Disclaimer

This guide is for educational purposes only and does not replace medical advice from your physician. Recommendations may not apply to every patient. Always follow the specific instructions of Dr. Ali and your care team. In an emergency call 911 or go to the nearest emergency department.



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