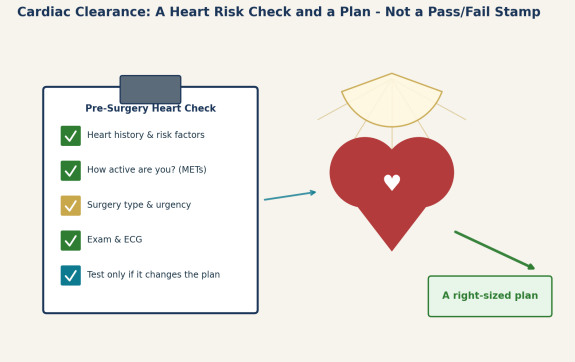
Heart Clearance Before Surgery

What It Means, When You Need Heart Tests, and How to Plan Your Medicines

Cardiac clearance is a heart risk check and a plan before non-heart surgery - not a simple pass or fail. For most healthy, active people, no extra heart test is needed.



Online: https://go.riasalimd.com/preop-cardiac-guide

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Names & Terms You Will Hear

Term	Meaning
Cardiac clearance	An everyday name for a heart evaluation before non-heart surgery. It is really a risk estimate and a plan - not a yes/no 'pass'. Your cardiologist or primary doctor estimates the chance of a heart problem around surgery and helps lower it.
Preoperative cardiac evaluation	The formal name. 'Pre-op' means before surgery. The goal is a right-sized check. We do enough to keep you safe. We skip tests that would not change the plan.
Perioperative	The whole window around surgery: before, during, and after. We manage heart risk across all three, not just on the day of surgery.
Risk assessment	We estimate your chance of a heart problem around surgery, such as a heart attack or a rhythm problem. To do this we use your history, your activity level, the type of surgery, and a focused exam and ECG.
Functional capacity	How much physical work you can do without trouble. It is one of the most useful clues we have. If you can climb two flights of stairs or walk up a hill without chest pain or being very winded, that is reassuring.
METs (metabolic equivalents)	A way to measure how hard your body is working. 1 MET is resting. Light housework is about 2 METs. Climbing two flights of stairs is about 4 METs - the level we consider 'good enough' for most surgery.
Surgical risk (of the operation)	Surgeries are grouped by how likely they are to stress the heart. Low-risk surgery (like cataract surgery or a scope) has under a 1 in 100 chance of a major heart problem. Major vessel, chest, or abdominal surgery is higher-risk.
Active (unstable) cardiac condition	A heart problem that is not stable right now. This could be a recent heart attack, new chest pain, a heart-failure flare, a dangerous rhythm, or a severe valve problem with symptoms. These usually mean pausing elective surgery to treat the heart first.

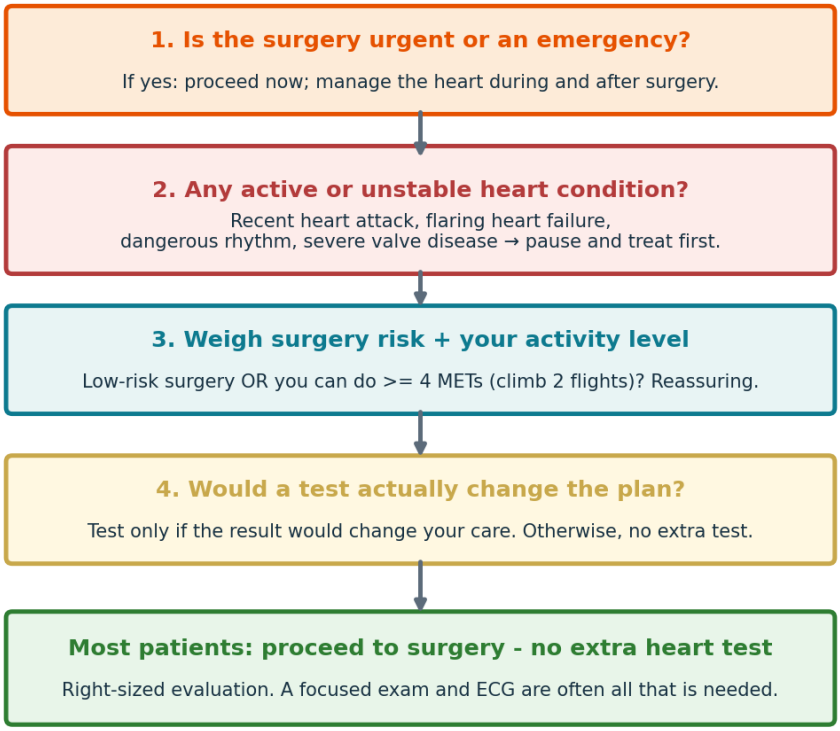
Term	Meaning
Stress test	A test that watches the heart while it works hard. Before surgery it is reserved for selected higher-risk patients - and only when the result would actually change the plan. Most people do not need one.
ECG (EKG)	A quick, painless tracing of the heart's electrical activity. A focused exam and an ECG are often all the 'testing' a low-risk patient needs.
Bridging	A short-term plan for blood thinners around surgery. Sometimes a shorter-acting shot is used while a longer-acting pill is held. Bridging is selective. Most people on a blood thinner do not need it.

The big idea. 'Cardiac clearance' is a heart risk check and a plan - not a yes/no pass. For most people who are active and whose heart is stable, the safest path is a focused exam and an ECG, with **no extra heart test**. Before low-risk surgery, routine stress tests and echoes are discouraged. They rarely change the plan. And they can lead to more testing that does not make surgery safer.

Heart Clearance Before Surgery?

- Cardiac clearance is a heart check before non-heart surgery. Despite the name, it is not a simple stamp that says 'pass' or 'fail'. It is a risk estimate plus a plan to make your surgery as safe as we can.
- The check puts together four things. We look at your heart history and risk factors. We ask how active you are. We weigh the type and urgency of the surgery. And we do a focused exam with an ECG.
- How active you are is one of the strongest clues. Can you climb two flights of stairs or walk up a hill without chest pain or being very winded? That is about 4 METs, and it is reassuring. You usually do not need extra heart testing.
- The surgery itself matters too. Low-risk surgery has under a 1 in 100 chance of a major heart problem. Cataract surgery and a colonoscopy are good examples. Major blood-vessel, chest, or belly surgery carries more risk.
- Extra tests, like a stress test or an echo, are saved for selected higher-risk patients. We add a test only when the result would change the plan. We do not order routine tests before low-risk surgery.
- Planning your medicines is part of clearance too. We decide which ones to keep, which to hold, and how to handle blood thinners. This is individualized and shared with your whole care team.
- The goal is a right-sized check. We do enough to keep you safe. We skip testing that would not change your care.

The Step-by-Step Heart Check Before Surgery



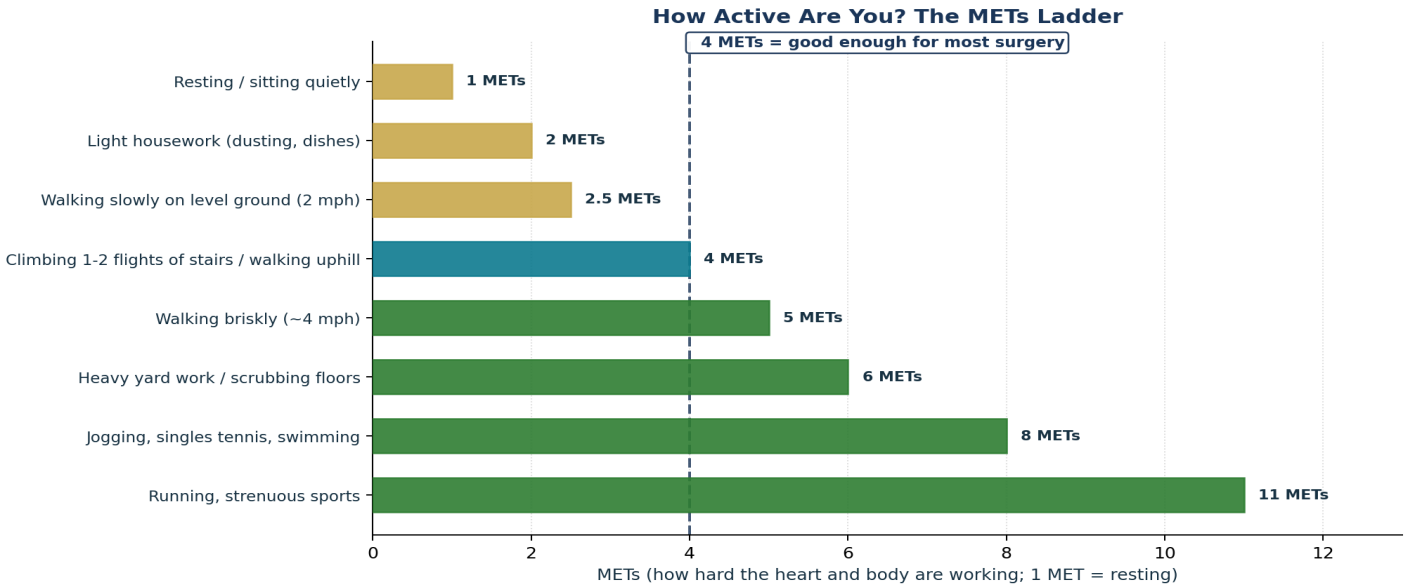
The step-by-step heart check before surgery. Urgent surgery goes ahead. An active or unstable heart condition gets treated first. For everyone else, the surgery risk and your activity level guide whether any test is needed - and a test is added only if it would change the plan.

What 'Clearance' Really Means (Risk and Plan, Not Pass/Fail)

- There is no single test that 'clears' a heart. Clearance is shorthand for: we estimated your heart risk and made a plan to lower it.
- The estimate combines your heart history, your activity level (functional capacity), the type and urgency of the surgery, and a focused exam with an ECG.
- A good evaluation can end with 'no extra testing needed' - and that is a complete, valid answer, not a shortcut.
- Clearance does not promise a perfect outcome. It means your team understands your risk and has a plan for it - before, during, and after surgery.
- It is a shared decision. You, your surgeon, anesthesia, and your heart doctor are all part of the plan.

Why It Matters

- Surgery and anesthesia put extra stress on the heart. A short, focused heart check helps spot the few people who need a closer look. It also reassures the many who do not.
- Most people who are fairly active and have a stable heart need NO extra heart testing. Knowing this avoids delays, cost, and tests that lead to more tests. None of that makes surgery safer.
- Sometimes a heart condition is active or unstable. This could be a recent heart attack, a heart-failure flare, a dangerous rhythm, or severe valve disease with symptoms. It is much safer to pause elective surgery and treat the heart first.
- Getting the medicine plan right matters as much as any test. Stopping the wrong medicine can harm you. So can stopping a blood thinner at the wrong time.
- A clear plan made ahead of time means fewer surprises on the day of surgery. It means fewer last-minute cancellations and a smoother recovery.



The METs ladder. METs measure how hard your body is working. Climbing two flights of stairs is about 4 METs - the level we consider good enough for most surgery. If you can do that without chest pain or being very winded, extra heart testing is usually not needed.

Do I Need Extra Heart Tests? (Activity Level + Surgery Risk; Less Is Often More)

- Start with two questions: how active are you, and how risky is the surgery?
- If you can do about 4 METs (climb two flights of stairs, walk up a hill) without chest pain or severe shortness of breath, your heart usually has enough reserve - extra testing is often not needed.
- For low-risk surgery (cataract surgery, a scope, a minor procedure), we skip routine stress tests and echoes even if you are less active.
- Extra testing is mainly considered when activity level is poor or unknown AND the surgery is higher-risk - and only when the result would change the plan.
- A stress test before surgery is not a routine box to check. We order one when it will genuinely change what we do - not just to have it on file.
- If a stress test is part of your plan, our Stress Test guide walks through what to expect.

The two-flights test. A simple, powerful question: **can you climb two flights of stairs without stopping for chest pain or severe shortness of breath?** That is about 4 METs of work. If the answer is yes, your heart usually has enough reserve for most surgery - and extra heart testing is often not needed.

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
Known heart disease	This includes heart-artery disease, a prior heart attack, heart failure, valve disease, or a prior stent or bypass. Each raises the chance of a heart problem around surgery. Each one shapes the plan.
Poor functional capacity	You may not be able to climb two flights of stairs or walk up a hill. That is less than about 4 METs. Or you may not know, because you are not active. Then your heart's reserve is harder to judge. A closer look may be needed for higher-risk surgery.
Higher-risk surgery	Major blood-vessel (aortic) surgery stresses the heart more. So do major chest or belly surgery and long operations. Minor or surface procedures stress the heart far less.
Other risk factors	Diabetes, kidney disease, a prior stroke, and older age each add to heart risk. Diabetes counts more if you take insulin. All of these are part of the risk estimate.
Active or unstable heart symptoms	Watch for new or worse chest pain, new shortness of breath, fainting, or a racing irregular heartbeat. Call us BEFORE the operation if any of these happen. They may change the plan.
Blood thinners and recent stents	A blood thinner, or a recent stent, needs careful timing. A drug-eluting stent usually means waiting several months for elective surgery, unless it cannot wait.

Treatment Options

- Bring a complete, up-to-date medicine list to your pre-surgery visit. Include over-the-counter drugs, supplements, inhalers, and anything you take 'as needed'. This is the single most useful thing you can do.
- Beta-blockers (like metoprolol or carvedilol): if you already take one, you usually KEEP taking it through surgery. Stopping it suddenly can be harmful. We do not start a brand-new high-dose one on the day of surgery.
- Statins (like atorvastatin or rosuvastatin): usually CONTINUED right through surgery. They help protect the heart during this stressful time.
- ACE inhibitors and ARBs (like lisinopril, losartan): often HELD on the morning of surgery because they can drop blood pressure too far during anesthesia. This is individualized - follow the team's instruction.
- Blood thinners (warfarin, or a newer agent like apixaban, rivaroxaban, dabigatran, edoxaban): the timing of stopping is individual. 'Bridging' with a shorter-acting shot is used only for selected high-risk patients. Most people do not need it.
- Antiplatelet medicines after a stent (aspirin plus clopidogrel, ticagrelor, or prasugrel): aspirin is often continued. The second one is managed with your cardiologist. Elective surgery is usually delayed after a recent stent.
- Diabetes medicines: insulin doses are usually cut on the fasting morning of surgery. SGLT2 inhibitors (empagliflozin, dapagliflozin, canagliflozin) are usually HELD 3 to 4 days before. This avoids a dangerous build-up of acid in the blood.
- Water pills (diuretics) are often held the morning of surgery. Always confirm the day-of plan with the surgery team and with us - do not guess.
- Never stop or change a heart medicine on your own. Call us if any instruction is unclear. We would much rather answer a question than fix a problem.

How Much Heart Workup? It Depends on the Surgery and Your Heart

Low-risk surgery

< 1 in 100 chance of a major heart problem

Cataract, scopes, skin, breast, many minor ops

Usually NO extra heart test

Focused exam + ECG only

Keep most heart medicines

Higher-risk surgery

Major vessel, chest, or abdominal surgery

Check activity level (METs)

Poor capacity (< 4 METs)? consider a test IF it changes the plan

Plan medicines carefully

Active / unstable heart

Recent heart attack, HF flare, bad rhythm, valve

Pause elective surgery

Treat the heart first

Cardiology involved

Re-evaluate once stable

Emergency surgery: proceed, manage heart alongside

How much heart workup depends on the surgery and your heart. Low-risk surgery rarely needs extra testing. Higher-risk surgery prompts a look at your activity level. An active or unstable heart condition means treating the heart first.

Managing Your Heart Medicines Around Surgery (Continue vs Hold or Plan)

- Continue, usually: beta-blockers and statins. They protect the heart through the stress of surgery, and stopping a beta-blocker suddenly can be harmful.
- Hold, often: ACE inhibitors and ARBs on the morning of surgery (to avoid a big blood-pressure drop), water pills on the morning of surgery, and SGLT2 diabetes medicines 3 to 4 days before.
- Blood thinners need a timed plan, not a guess - see our Blood Thinner Bridging guide. Bridging with injections is only for selected high-risk patients.
- After a stent, the timing of surgery and of antiplatelet medicines is coordinated with your cardiologist - see our Dual Antiplatelet Therapy (DAPT) guide. Elective surgery is usually delayed after a drug-eluting stent.
- For more on the heart-protective medicines themselves, see our Beta-Blockers guide and our Statins guide.
- For the blood-pressure medicines often held before surgery, see our ACE Inhibitors and ARBs guide.
- Bring a complete, current medicine list to every pre-surgery visit, and ask for the day-of plan in writing.

Never stop a heart medicine on your own. Some medicines are continued (beta-blockers, statins), some are held on a plan (ACE inhibitors/ARBs, SGLT2 diabetes medicines, some blood thinners). Guessing can cause real harm. Bring a complete medicine list and ask for the plan in writing: which to take with a sip of water on the morning of surgery, and which to hold.

Comfort Measures at Home (No Medication Needed)

These simple steps support healing and ease symptoms. Use them alongside any medication your doctor prescribes.

- Stay as active as you safely can in the weeks before surgery - it builds the very heart-and-lung reserve that makes surgery safer.
- If you smoke, stopping even a few weeks before surgery lowers heart and lung complications. We can help.
- Keep blood pressure, blood sugar, and weight as steady as possible leading up to the operation.
- Write down your questions ahead of the pre-surgery visit, and bring someone with you to help remember the plan.
- Confirm in writing which medicines to take with a small sip of water on the morning of surgery, and which to hold.
- Arrange a ride and someone to help at home for the first day or two - good recovery support lowers stress on the heart.

Risks, Benefits, and Alternatives

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

Option	Risks	Benefits	Alternatives
No extra heart testing (most low-risk patients)	Very small chance a hidden problem is missed - but for stable, active patients having low-risk surgery this chance is tiny.	Avoids delays, cost, and tests that lead to more tests; gets you to your needed surgery sooner.	A focused exam and ECG; clear instructions to call if new symptoms appear before surgery.
Stress test before surgery (selected patients)	Adds time and cost; can find borderline results that lead to more testing without changing the plan.	Useful when you have poor or unknown activity level AND higher-risk surgery, and the result would truly change care.	Sometimes a heart-imaging test or, rarely, a coronary angiogram if the picture is high-risk.
Delay elective surgery to treat the heart first	Postpones the planned operation; the original problem still needs attention.	Far safer when a heart condition is active or unstable (recent heart attack, HF flare, bad rhythm, severe valve disease).	Treat and stabilize the heart, then re-evaluate and reschedule; proceed sooner only if the surgery is urgent.
Proceed with surgery on current heart medicines	A few medicines may need a hold or a plan. These include ACE/ARB drugs, SGLT2 inhibitors, water pills, and some blood thinners. Guessing can cause harm.	Keeps protective medicines (beta-blockers, statins) on board through a stressful time.	A written, individualized day-of medicine plan agreed on by you, the surgeon, anesthesia, and us.

Your Heart Medicines Around Surgery: Continue, Hold, or Plan

Medicine	Around surgery	Why
Beta-blocker (metoprolol, carvedilol, atenolol)	Usually CONTINUE	Protects the heart; stopping suddenly is risky. We do not start a new high-dose one on the day of surgery.
Statin (atorvastatin, rosuvastatin)	Usually CONTINUE	Helps protect the heart through surgery.
ACE inhibitor / ARB (lisinopril, losartan)	Often HOLD morning of surgery	Can drop blood pressure too far during anesthesia. Individualized - follow the team's plan.
SGLT2 inhibitor (empagliflozin, dapagliflozin)	HOLD 3 to 4 days before	Can cause a dangerous build-up of acid in the blood (DKA) around surgery.
Blood thinner (warfarin, apixaban, rivaroxaban)	PLAN - timed individually	Stopped on a schedule based on the drug and your clot risk. Bridging is only for selected high-risk patients.
Antiplatelet after a stent (aspirin + clopidogrel)	PLAN with cardiology	Aspirin is often continued. The second drug is managed by your heart doctor. Elective surgery is usually delayed after a recent stent.

Common Misconceptions

Myth	Reality
'Cardiac clearance' means my heart passed a test and surgery is guaranteed safe.	There is no single pass/fail test. Clearance is a risk estimate plus a plan. It lowers risk and prepares your team - it does not promise that nothing can go wrong.
Everyone needs a stress test or an echo before surgery.	Most people do not. We skip routine stress tests and echoes for low-risk surgery, and when you are active with a stable heart. We save them for selected higher-risk cases where the result would change the plan.
More testing is always safer.	Not true. Unneeded tests find borderline results that lead to more tests, more delay, and more worry - without making the surgery safer. Right-sized testing is the safe path.
I should stop all my heart medicines before surgery to be safe.	The opposite is often true. Beta-blockers and statins are usually continued because they protect the heart. Only specific medicines are held - and only on a plan. Never stop a medicine on your own.
If I am on a blood thinner, I will always need bridging with injections.	Bridging is selective. Most people on a blood thinner do not need it. Whether to bridge depends on why you take the blood thinner and how high your clotting risk is - it is an individualized decision.
Being able to walk to the mailbox is enough activity to clear me.	It depends on the surgery. A useful benchmark is about 4 METs - climbing two flights of stairs or walking up a hill. If you cannot reach that, and the surgery is higher-risk, we may look closer.
I had a stent, so I can have surgery anytime.	Recent stents need careful timing. After a drug-eluting stent, elective surgery is usually delayed, often about 6 months. That lets the stent heal while you stay on antiplatelet medicine. We plan the timing together.

Possible Complications

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

Where / What	What Can Happen
Heart attack around surgery	The main heart risk we are trying to lower. It is uncommon, and most likely in people with known heart disease, poor functional capacity, or higher-risk surgery. The whole evaluation is built to find and reduce this risk.
Heart-failure flare	Extra fluid and stress around surgery can tip a weak heart into a flare. Spotting heart failure ahead of time - and getting it stable first - lowers this risk.
Heart-rhythm problems	New or fast irregular rhythms (like atrial fibrillation) can appear around surgery. Most are managed well; a known dangerous rhythm should be controlled before elective surgery.
Bleeding or clotting from blood-thinner timing	Stopping a blood thinner too early raises clot risk. Stopping too late, or bridging when you do not need it, raises bleeding risk. Careful, individual timing is the safeguard.
Low blood pressure during anesthesia	Some blood-pressure medicines can drop pressure too far during anesthesia. These are the ACE inhibitors and ARBs. That is why they are often held the morning of surgery.
Stent-related clot	Stopping antiplatelet medicine too soon after a recent stent can let a clot form in the stent. So elective surgery is usually delayed after a stent. The medicine plan is set with cardiology.
Over-testing harms	This is not a heart problem, but it is real. Unneeded tests cause delays, cost, and worry. They lead to follow-up tests with their own small risks. And they do not make surgery safer.

Points to Know

If you remember nothing else, remember these key points.

- Cardiac clearance is a risk check and a plan - not a yes/no pass. The goal is right-sized, not maximum, testing.
- Functional capacity is key: if you can climb two flights of stairs (about 4 METs) without chest pain or severe shortness of breath, that is reassuring.
- Most healthy, active people having low-risk surgery need NO extra heart test - a focused exam and ECG are often enough.
- Extra tests are reserved for selected higher-risk patients, and only when the result would change the plan.
- Active or unstable heart conditions (recent heart attack, HF flare, dangerous rhythm, severe valve disease) usually mean pausing elective surgery to treat the heart first.
- Usually CONTINUE beta-blockers and statins through surgery. We do not start a new high-dose beta-blocker on the day of surgery.
- Some medicines need a plan: ACE inhibitors/ARBs are often held the morning of surgery; SGLT2 diabetes medicines are usually held 3 to 4 days before; blood thinners are timed individually.
- Bring a complete medicine list and never stop a heart medicine on your own - call us if anything is unclear.

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 or worsening chest pain or pressure before your surgery - call us the same day. Severe or prolonged chest pain or pressure - call 911.
- New shortness of breath at rest, new swelling in the legs, sudden weight gain, or waking up gasping - signs of a heart-failure flare - call us before surgery.
- Fainting, or a fast and irregular heartbeat that does not settle, in the days before surgery - call us right away.
- You are not sure which medicines to take or hold on the morning of surgery - call us. Do not guess, and do not stop a medicine on your own.
- You take a blood thinner or had a recent stent and have not received clear timing instructions - call us well before the surgery date.
- A fever, productive cough, or new illness in the days before surgery - call us and the surgical team; it may change the timing.
- Sudden weakness, drooping face, or trouble speaking - call 911. (Heart and stroke risk often travel together; the emergency comes first.)

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When Surgery Should Wait - Active Heart Conditions

- A recent heart attack or new, unstable chest pain - the heart needs to settle and be treated before elective surgery.
- Heart failure that is flaring (new swelling, weight gain, breathlessness) - far safer to get it stable first.
- A dangerous or uncontrolled heart rhythm - controlled before an elective operation.
- Severe, symptomatic valve disease, such as severe aortic stenosis - see our Aortic Stenosis guide; this may need treatment before surgery.
- Emergencies are different: if surgery cannot wait, it proceeds, and the heart is managed during and after the operation.

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 - Heart Health and Surgery - Plain-language AHA overview of why a heart evaluation is done before surgery and what the team is assessing.
- Cleveland Clinic - Preoperative Cardiac Evaluation - Patient-friendly overview of risk assessment, functional capacity, and when extra testing is and is not needed.
- MedlinePlus - Surgery and Your Heart - NIH/NLM plain-language prep instructions, including medicines and questions to ask before surgery.
- Mayo Clinic - Exercise Intensity and METs - Patient-friendly guide to METs and how everyday activities compare - useful for judging your functional capacity.
- Choosing Wisely - Preoperative Testing - Why routine stress imaging and echoes are discouraged before low-risk surgery in stable patients.
- American College of Cardiology - CardioSmart - ACC's patient-facing site with simple explainers and decision aids about heart health and surgery.

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.

- 2024 AHA/ACC Guideline for Perioperative Cardiovascular Management for Noncardiac Surgery *[Guideline]*
  Primary authority for stepwise risk stratification, the >= 4 METs functional-capacity cutoff, which patients should NOT get routine testing, biomarker use, and continuing or holding cardiac medicines around surgery.
- 2022 ESC Guidelines on Cardiovascular Assessment and Management of Patients Undergoing Non-Cardiac Surgery *[Guideline]*
  European counterpart that aligns on the same directional points (>= 4 METs adequate, hold SGLT2 inhibitors, continue statins, individualized anticoagulant timing, postpone for active conditions).
- Choosing Wisely (ACC) — Avoid Routine Preoperative Cardiac Testing in Low-Risk Surgery *[Guideline]*
  Basis for the 'less is often more' message — do not order routine stress imaging, echo, or ECG before low-risk surgery in stable, asymptomatic patients.
- American Heart Association — Heart Health and Surgery (Preoperative Evaluation) *[Patient Education]*
  Frames why a heart evaluation is done before non-cardiac surgery and what the cardiologist is assessing, in plain language.
- AHA Newsroom — New Guideline on Managing Heart Risk Before, During, and After Noncardiac Surgery (2024) *[Patient Education]*
  Plain-language summary of the 2024 guideline's main patient-facing messages, including judicious, targeted testing and medication planning.
- Cleveland Clinic — Preoperative Cardiac Evaluation (Cardiac Clearance) *[Patient Education]*
  Patient-facing overview of risk assessment, functional capacity (METs), and when extra testing is or is not needed before surgery.
- Cleveland Clinic Journal of Medicine — What's New in the 2024 Perioperative Guideline *[Review]*
  Concise clinician summary of the guideline changes used to verify the >= 4 METs (DASI) cutoff, SGLT2-inhibitor hold timing, and beta-blocker / statin continuation guidance.
- MedlinePlus — Surgery and Your Heart (Getting Ready) *[Patient Education]*
  NIH/NLM plain-language prep instructions, including medication management and questions to ask before surgery.
- Mayo Clinic — METs (Metabolic Equivalents) and Exercise Intensity *[Patient Education]*
  Patient-friendly reference for the everyday-activity MET values used in the functional-capacity ladder (stairs, walking pace, housework).
- American College of Cardiology — CardioSmart: Preparing for Surgery *[Patient Education]*
  ACC patient-facing resource with simple explainers and decision aids about heart risk and surgery.

About This Guide

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Reviewer note: Reviewed against the AHA preoperative-evaluation page, Cleveland Clinic's cardiac clearance overview, and MedlinePlus 'Surgery and Your Heart'. Ours adds: a step-by-step decision flow, a METs functional-capacity ladder with a 4-MET reference line, a low/higher/unstable surgery-risk panel, a tinted medicine continue/hold/plan table, per-step subsections (what clearance means, do I need a test, planning my medicines), and direct cross-links into the stress test, blood-thinner bridging, DAPT, beta-blocker, and statin guides. Built on the 2024 AHA/ACC and 2022 ESC guidelines and Choosing Wisely.

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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