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finally, we were unable to find a good answer to the fourth question. it is unclear whether patients with wch would benefit from monitoring bp at an earlier age. several studies have suggested that the risk of heart failure, stroke, mi and scd can be reduced if hypertension is treated earlier in life; thus, identifying patients with wch who are at risk of developing these events earlier might suggest that more aggressive management is needed, given the early risk associated with these events. wch is associated with a higher prevalence of diabetes, and wch is a known risk factor for diabetes, suggesting that follow-up of patients with wch to detect the development of diabetes might be helpful. 30.2.5.1-7 if a history of sudden death, syncope, or aborted sudden death in the patient with a known cardiac condition appears to be related to an acute reversible cause, ie, dextrocardia, ddd, or short qt syndrome, the patient should be monitored with a holter monitor for at least 24 hours. the recording of the patient's vital signs should be included in the holter monitor so that the patient's physical status can be evaluated. care should be taken to assure that arrhythmia detection and therapy will be disabled. interpretation of the findings should be within the context of the patient's other clinical data and should include an assessment of the presence and severity of any arrhythmia by the caregiver. also, the clinical history should be carefully reviewed to determine whether an association with exercise, emotional stress, or noncardiac conditions should be present. any findings of sinus bradycardia, sinus tachycardia, atrial fibrillation, atrial flutter, supraventricular tachycardia, or ventricular tachycardia should be related to the patient's clinical status and exercise tolerance s2.2-5 and not considered a sign of impending sudden death. the holter monitor should be well-tolerated and used only as indicated, with as little interference as possible and no discomfort to the patient. s2.2-7

Routine monitoring in the outpatient setting may include an ECG in the resting patient, although there is little evidence to suggest that routine 24-hour monitoring is necessary in asymptomatic patients and in those patients with stable, well-controlled diseases. High-resolution chest CT is not routinely indicated unless the patient has a recent history of abnormal imaging or abnormal pulmonary function tests. S5.1.5.3 The noninvasive, ambulatory assessment of cardiac arrhythmias includes continuous ECG monitoring (telemetry), as well as event recording, signal averaging, and other specialized tools. If continuous ECG monitoring is not available for clinical indications (e.g., deep sleep, while driving, or other normal daily activities), frequent intermittent manual ECG monitoring is needed to detect arrhythmias. The most common arrhythmias detected with invasive monitoring include sinus bradycardia, atrial arrhythmias, extrasystoles, and atrial fibrillation. Ventricular arrhythmias are rare in this setting and are usually not life-threatening. Ventricular fibrillation and tachycardia are common during arrhythmias that require electric cardioversion. In cases where mechanical defibrillation is attempted, determination of the defibrillation threshold can be accomplished by defibrillation-shock testing or by electrograms performed during open chest defibrillation. A large number of emergency department patients who present with VF also have structural heart disease, resulting in secondary causes of VF that cannot always be determined solely by means of an extensive 12-lead ECG. S5.1.3.3 5ec8ef588b

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