Supplementary Online Content

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This supplementary material has been provided by the authors to give readers additional information about their work.

eTable 1: Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

Index guideline	Index recommendation	Recommendation class and level of evidence	Revised (current) guideline	Corresponding revised (current) recommendation(s)	Recommendation class(es) and level(s) of evidence
A. Topic: Management of Patients with Atrial Fibrillation					
2001: Guidelines for the Management of Patients with Atrial Fibrillation[18](p. 1255)	Antithrombotic Therapy in Patients with AF: The need for anticoagulation should be reevaluated at regular intervals.	Class I, LOE A	2006: Guidelines for the Management of Patients with Atrial Fibrillation[19](p. e288)	Preventing Thromboembolism: It is reasonable to reevaluate the need for anticoagulation at regular intervals.	Class IIA, LOE C
2001: Guidelines for the Management of Patients with Atrial Fibrillation[18](p. 1256)	Screening for the presence of thrombus in the LA or LAA by TEE is an alternative to routine preanticoagulation in candidates for cardioversion of AF.	Class I, LOE B	2006: Guidelines for the Management of Patients with Atrial Fibrillation[19](p. e314)	As an alternative to anticoagulation prior to cardioversion of AF, it is reasonable to perform transesophageal echocardiography (TEE) in search of thrombus in the left atrium (LA) or left atrial appendage (LAA).	Class IIA, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

2001: Guidelines for the Management of Patients with Atrial Fibrillation[18](p. 1256)	[The following recommendation applies to patients undergoing TEE prior to cardioversion] Anticoagulate patients in whom no thrombus is identified with intravenous unfractionated heparin by an initial bolus injection before cardioversion, followed by a continuous infusion in a dose adjusted to prolong the activated partial thromboplastin time at 1.5 to 2 times the reference control value.	Class I, LOE B	2006: Guidelines for the Management of Patients with Atrial Fibrillation[19](p. e314)	[The following recommendation applies to patients undergoing TEE prior to cardioversion] For patients with no identifiable thrombus, cardioversion is reasonable immediately after anticoagulation with unfractionated heparin (e.g., initiated by intravenous bolus injection and an infusion continued at a dose adjusted to prolong the activated partial thromboplastin time to 1.5 to 2 times the control value until oral anticoagulation has been established with an oral vitamin K antagonist (e.g., Warfarin) as evidenced by an INR equal to or greater than 2.0).	Class IIA, LOE B
2001: Guidelines for the Management of Patients with Atrial Fibrillation[18](p. 1256)	[The following recommendation applies to patients undergoing TEE and initial anticoagulation prior to cardioversion] Next, provide oral anticoagulation (INR 2 to 3) for a period of at least 3 to 4 weeks, as for patients undergoing elective cardioversion.	Class I, LOE B	2006: Guidelines for the Management of Patients with Atrial Fibrillation[19](p. e314)	[The following recommendation applies to patients undergoing TEE and initial anticoagulation prior to cardioversion] Thereafter, continuation of oral anticoagulation (INR 2.0 to 3.0) is reasonable for a total anticoagulation period of at least 4 wk, as for patients undergoing elective cardioversion.	Class IIA, LOE C

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2001: Guidelines for the Management of Patients with Atrial Fibrillation[18](p. 1256)	[The following recommendation applies to patients undergoing TEE and initial anticoagulation prior to and after cardioversion] Limited data are available to support the subcutaneous administration of low-molecular-weight heparin in this indication.	Class I, LOE C	2006: Guidelines for the Management of Patients with Atrial Fibrillation[19](p. e314)	[The following recommendation applies to patients undergoing TEE and initial anticoagulation prior to and after cardioversion] Limited data are available to support the subcutaneous administration of a low-molecular-weight heparin in this indication.	Class IIA, LOE C
2001: Guidelines for the Management of Patients with Atrial Fibrillation[18](p. 1256)	Antithrombotic Therapy to [The following recommendation applies to patients undergoing TEE prior to cardioversion] Treat patients in whom thrombus is identified by TEE with oral anticoagulation (INR 2 to 3) for at least 3 to 4 weeks before and after restoration of sinus rhythm.	Class I, LOE B	2006: Guidelines for the Management of Patients with Atrial Fibrillation[19](p. e314)	[The following recommendation applies to patients undergoing TEE prior to cardioversion] For patients in whom thrombus is identified by TEE, oral anticoagulation (INR 2.0 to 3.0) is reasonable for at least 3 wk prior to and 4 wk after restoration of sinus rhythm.	Class IIA, LOE C
2001: Guidelines for the Management of Patients with Atrial Fibrillation[18](p. 1257)	Management of Patients with AF and Acute Myocardial Infarction: *Intravenous administration of digitalis* or amiodarone to slow a rapid ventricular response and improve LV function. [Italics added.]	Class I, LOE C	2006: Guidelines for the Management of Patients with Atrial Fibrillation[19](p. e324)	Special Considerations: Acute Myocardial Infarction: Intravenous administration of digitalis is reasonable to slow a rapid ventricular response and improve LV function in patients with acute MI and AF associated with severe LV dysfunction and HF.	Class IIA, LOE C

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B. Topic: Perioperative Cardiovascular Evaluation for Noncardiac Surgery					
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 19)	Preoperative Noninvasive Evaluation of LV Function: Patients with current or poorly controlled HF. (If previous evaluation has documented severe left ventricular dysfunction, repeat preoperative testing may not be necessary.)	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21](p. e437)	Preoperative Noninvasive Evaluation of LV Function: It is reasonable for patients with current or prior HF with worsening dyspnea or other change in clinical status to undergo preoperative evaluation of LV function if not performed within 12 months.	Class IIA, LOE C
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 24)	Exercise or Pharmacological Stress Testing: Diagnosis of adult patients with intermediate pretest probability of CAD.	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21](p. e440)	Noninvasive stress testing may be considered for patients with at least 1 or 2 clinical risk factors and poor functional capacity (less than 4 METs) who require intermediate-risk or vascular surgery if it will change management.	Class IIB, LOE B
C. Topic: Cardiac Pacemakers and Antiarrythmia Devices					
2002: Guideline Update for Implantation of Cardiac Pacemakers and Antiarrhythmia Devices[23](p. 30)	ICD Therapy: Spontaneous sustained VT in patients without structural heart disease not amenable to other treatments.	Class I, LOE C	2008: Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities[22](p. e384)	Implantable Cardioverter Defibrillators: ICD implantation is reasonable for patients with sustained VT and normal or near-normal ventricular function.	Class IIA, LOE C

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
D. Topic: Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease					
2006: Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease[24](p. 2365)	Diabetes Management: Goal HbA1c <7% : Initiate lifestyle and pharmacotherapy to achieve near-normal HbA1c.	Class I, LOE B	2011: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease[25](p. 2460)	Type II Diabetes Mellitus Management: A target HbA1c of less than or equal to 7% may be considered.	Class IIA, LOE C
2006: Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease[24](p. 2365)	ACE Inhibitors: Consider for all other patients [i.e. those without left ventricular ejection fraction <40%, hypertension, diabetes, or chronic kidney disease.]	Class I, LOE B	2011: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease[25](p. 2461)	ACE Inhibitors: It is reasonable to use ACE inhibitors in all other patients [i.e. those without left ventricular ejection fraction <40%, hypertension, diabetes, or chronic kidney disease.]	Class IIA, LOE B
2006: Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease[24](p. 2365)	Angiotensin Receptor Blockers: Consider in other patients who are ACE inhibitor intolerant [and do not have heart failure or have had a myocardial infarction with left ventricular ejection fraction less than or equal to 40%.]	Class I, LOE B	2011: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease[25](p. 2462)	Renin-Angiotensin-Aldosterone System Blockers: It is reasonable to use ARBs in other patients who are ACE-inhibitor intolerant [and do not have heart failure or a past myocardial infarction with left ventricular ejection fraction less than or equal to 40%.]	Class IIA, LOE B

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E. Topic: Coronary Artery Bypass Graft Surgery					
2004: Guideline Update for Coronary Artery Bypass Graft Surgery[16](p. e382)	Smoking Cessation: Pharmacological therapy including nicotine replacement and bupropion should be offered to select patients indicating a willingness to quit.	Class I, LOE B	2011: Guideline for Coronary Artery Bypass Graft Surgery[26](p. e682)	Smoking Cessation: The effectiveness of pharmacological therapy for smoking cessation offered to patients before hospital discharge is uncertain.	Class IIB, LOE C
2004: Guideline Update for Coronary Artery Bypass Graft Surgery[16](p. e407)	CABG is recommended in patients with stable angina who have 2-vessel disease with significant proximal LAD stenosis and either EF less than 0.50 or demonstrable ischemia on noninvasive testing.	Class I, LOE A	2011: Guideline for Coronary Artery Bypass Graft Surgery[26](p. e670)	CABG to improve survival is reasonable in patients with mild-moderate LV systolic dysfunction (EF 35% to 50%) and significant (greater than or equal to 70% diameter stenosis) multivessel CAD or proximal LAD coronary artery stenosis, when viable myocardium is present in the region of intended revascularization.	Class IIA, LOE B
2004: Guideline Update for Coronary Artery Bypass Graft Surgery[16](p. e407)	CABG is beneficial for patients with stable angina who have 1- or 2-vessel CAD without significant proximal LAD stenosis but with a large area of viable myocardium and high-risk criteria on noninvasive testing.	Class I, LOE B	2011: Guideline for Coronary Artery Bypass Graft Surgery[26](p. e670)	CABG to improve survival is reasonable in patients with significant (greater than or equal to 70% diameter) stenoses in 2 major coronary arteries with severe or extensive myocardial ischemia (eg, high-risk criteria on stress testing, abnormal intracoronary hemodynamic evaluation, or >20% perfusion defect by myocardial perfusion stress imaging) or target vessels supplying a large area of viable myocardium.	Class IIA, LOE B

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2004: Guideline Update for Coronary Artery Bypass Graft Surgery[16](p. e411)	Coronary bypass should be performed in patients with prior CABG for disabling angina despite maximal noninvasive therapy (If angina is not typical, then objective evidence of ischemia should be obtained).	Class I, LOE B	2011: Guideline for Coronary Artery Bypass Graft Surgery[26](p. e697)	In patients with a patent LIMA to the LAD artery and ischemia in the distribution of the right or left circumflex coronary arteries, it is reasonable to recommend reoperative CABG to treat angina if GDMT has failed and the coronary stenoses are not amenable to PCI.	Class IIA, LOE B
F. Topic: Cardiovascular Disease Prevention in Women					
2007: Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women[27](p. 1486)	Diabetes mellitus: Lifestyle and pharmacotherapy should be used as indicated in women with diabetes.	Class I, LOE B	2011: Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women[28](p. 1253)	Diabetes mellitus: Lifestyle and pharmacotherapy can be useful in women with diabetes mellitus to achieve an HbA1C < 7% if this can be accomplished without significant hypoglycemia.	Class IIA, LOE B
2007: Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women[27](p. 1486)	Diabetes mellitus: [Lifestyle and pharmacotherapy should be used as indicated in women with diabetes] to achieve an HbA1C <7% if this can be accomplished without significant hypoglycemia.	Class I, LOE C	2011: Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women[28](p. 1253)	Diabetes mellitus: Lifestyle and pharmacotherapy can be useful in women with diabetes mellitus to achieve an HbA1C < 7% if this can be accomplished without significant hypoglycemia.	Class IIA, LOE B
2007: Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women[27](p. 1487)	Aspirin therapy (75 to 325 mg/d) should be used in high-risk women unless contraindicated (Criteria for high risk include…diabetes mellitus.)	Class I, LOE A	2011: Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women[28](p. 1253)	Aspirin therapy (75-325 mg/d) is reasonable in women with diabetes mellitus unless contraindicated.	Class IIA, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
G. Topic: Management of Heart Failure					
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e162)	Two-dimensional echocardiography with Doppler should be performed during initial evaluation of patients presenting with HF to assess LVEF, LV size, wall thickness, and valve function. *Radionuclide ventriculography can be performed to assess LVEF and volumes.*[Italics added]	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30](p. e257)	Noninvasive Cardiac Imaging: Radionuclide ventriculography or magnetic resonance imaging can be useful to assess LVEF and volume when echocardiography is inadequate.	Class IIA, LOE C
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e162)	Coronary arteriography should be performed in patients presenting with HF who have angina or significant ischemia unless the patient is not eligible for revascularization of any kind.	Class I, LOE B	2013: Guideline for the Management of Heart Failure[30](p. e259)	When ischemia may be contributing to HF, coronary arteriography is reasonable for patients eligible for revascularization.	Class IIA, LOE C
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e173)	Patients with Current or Prior Symptoms of HF (Stage C): Diuretics and *salt restriction are indicated* in patients with current or prior symptoms of HF and reduced LVEF who have evidence of fluid retention. [Italics added]	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30](p. e263)	Nonpharmacological Interventions: Sodium Restriction: Sodium restriction is reasonable for patients with symptomatic HF to reduce congestive symptoms.	Class IIA, LOE C
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e194)	Patients with Current or Prior Symptoms of HF (Stage C): Physicians should control ventricular rate in patients with HF and normal LVEF and atrial fibrillation.	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30](p. e274)	Pharmacological Treatment for Stage C HFpEF: Management of AF according to published clinical practice guidelines in patients with HFpEF is reasonable to improve symptomatic HF.	Class IIA, LOE C

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2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e201)	Patients with HF who have Concomitant Disorders: Physicians should prescribe anticoagulants in patients with HF who have paroxysmal or persistent atrial fibrillation or a previous thromboembolic event.	Class I, LOE A	2013: Guideline for the Management of Heart Failure[30](p. 61)	Pharmacological Treatment for Stage C HFrEF: Chronic anticoagulation is reasonable for patients with chronic HF who have permanent/ persistent/ paroxysmal AF but are without an additional risk factor for cardioembolic stroke.	Class IIA, LOE B
H. Topic: Percutaneous Coronary Intervention					
2005: Guidelines on Percutaneous Coronary Intervention[32](p. e200)	Primary PCI for patients with STEMI should be performed in facilities with onsite cardiac surgery.	Class I, LOE B	2011: Guideline for Percutaneous Coronary Intervention[31](p. e594)	Primary PCI is reasonable in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished.	Class IIA, LOE B
2005: Guidelines on Percutaneous Coronary Intervention[32](p. e218)	Patients with STEMI: PCI After Successful Fibrinolysis or for Patients Not Undergoing Primary Reperfusion: In patients whose anatomy is suitable, PCI should be performed when there is objective evidence of recurrent MI.	Class I, LOE C	2011: Guideline for Percutaneous Coronary Intervention[31](p. e599)	Delayed or Elective PCI in Patients with STEMI: PCI is reasonable in patients with STEMI and clinical evidence for fibrinolytic failure or infarct artery reocclusion.	Class IIA, LOE B
2005: Guidelines on Percutaneous Coronary Intervention[32](p. e218)	Patients with STEMI: PCI After Successful Fibrinolysis or for Patients not Undergoing Primary Reperfusion: In patients whose anatomy is suitable, PCI should be performed for moderate or severe spontaneous or provocable myocardial ischemia during recovery from STEMI.	Class I, LOE B	2011: Guideline for Percutaneous Coronary Intervention[31](p. e599)	Delayed or Elective PCI in Patients with STEMI: PCI is reasonable in patients with STEMI who demonstrate ischemia on noninvasive testing.	Class IIA, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

2005: Guidelines on Percutaneous Coronary Intervention[32](p. e221)	Percutaneous Intervention in Patients with Prior Coronary Bypass Surgery: When technically feasible, PCI should be performed in patients with early ischemia (usually within 30 days) after CABG.	Class I, LOE B	2011: Guideline for Percutaneous Coronary Intervention[31](p. e583, p. e583)	Revascularization to Improve Symptoms: PCI to improve symptoms is reasonable in patients with previous CABG, 1 or more significant (greater than or equal to 70% diameter) coronary artery stenoses associated with ischemia, and unacceptable angina despite GDMT. Revascularization to Improve Survival: Non-Left Main CAD Revascularization: The usefulness of CABG or PCI to improve survival is uncertain in patients with previous CABG and extensive anterior wall ischemia on noninvasive testing	Class IIA, LOE C Class IIB, LOE B
I. Topic: Management of Patients with Chronic Stable Angina					
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 22)	Cardiac Stress Imaging as the Initial Test for Diagnosis in Patients With Chronic Stable Angina Who Are Able to Exercise: Exercise myocardial perfusion imaging or exercise echocardiography in patients with prior revascularization (either PTCA or CABG.)	Class I, LOE B	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e375)	Stress Testing and Advanced Imaging for Initial Diagnosis in Patients with Suspected SIHD who Require Noninvasive Testing: Able to Exercise: Exercise stress with nuclear MPI or echocardiography is reasonable for patients with an intermediate to high pretest probability of obstructive IHD who have an interpretable ECG and at least moderate physical functioning or no disabling comorbidity.	Class IIA, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 33)	Noninvasive Testing: Measurement of Rest LV Function by Echocardiography or Radionuclide Angiography in Patients With Chronic Stable Angina: Echocardiography or radionuclide angiography (RNA) in patients with a history of prior MI, pathologic Q waves or symptoms or signs suggestive of heart failure to assess LV function.	Class I, LOE B	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e382)	Resting Imaging to Assess Cardiac Structure and Function: Measurement of LV function with radionuclide imaging may be considered in patients with a prior MI or pathological Q waves, provided there is no need to evaluate symptoms or signs suggestive of heart failure, complex ventricular arrhythmias, or an undiagnosed heart murmur.	Class IIB, LOE C
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 33)	Noninvasive Testing: Measurement of Rest LV Function by Echocardiography or Radionuclide Angiography in Patients With Chronic Stable Angina: Echocardiography or RNA [radionuclide imaging] in patients with complex ventricular arrhythmias to assess LV function.	Class I, LOE B	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e382)	Advanced Testing: Resting and Stress Noninvasive Testing: Resting Imaging to Assess Cardiac Structure and Function: Measurement of LV function with radionuclide imaging may be considered in patients with a prior MI or pathological Q waves, provided there is no need to evaluate symptoms or signs suggestive of heart failure, complex ventricular arrhythmias, or an undiagnosed heart murmur.	Class IIB, LOE C

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 77)	Revascularization With PCI (or Other Catheter-Based Techniques) and CABG in Patients With Stable Angina: Percutaneous coronary intervention for patients with two- or three-vessel disease with significant proximal LAD CAD, who have anatomy suitable for catheter based therapy and normal LV function and who do not have treated diabetes.	Class I, LOE B	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e416)	Revascularization to Improve Survival: Non-Left Main CAD Revascularization: The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease.	Class IIB, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 77)	Revascularization With PCI (or Other Catheter-Based Techniques) and CABG in Patients With Stable Angina: Percutaneous coronary intervention or CABG for patients with one- or two-vessel CAD without significant proximal LAD CAD but with a large area of viable myocardium and high-risk criteria on noninvasive testing.	Class I, LOE B	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e416, p. e416)	Revascularization to Improve Survival: Non-Left Main CAD Revascularization: CABG to improve survival is reasonable in patients with significant (>70% diameter) stenoses in 2 major coronary arteries with severe or extensive myocardial ischemia (e.g., high-risk criteria on stress testing, abnormal intracoronary hemodynamic evaluation, or >20% perfusion defect by myocardial perfusion stress imaging) or target vessels supplying a large area of viable myocardium. Revascularization to Improve Survival: Non-Left Main CAD Revascularization: The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease.	Class IIA, LOE B Class IIB, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 77)	Revascularization With PCI (or Other Catheter-Based Techniques) and CABG in Patients With Stable Angina: In patients with prior PCI, CABG or PCI for recurrent stenosis associated with a large area of viable myocardium or high-risk criteria on noninvasive testing.	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e416, p. e416)	Revascularization to Improve Survival: Non-Left Main CAD Revascularization: CABG to improve survival is reasonable in patients with significant (>70% diameter) stenoses in 2 major coronary arteries with severe or extensive myocardial ischemia (e.g., high-risk criteria on stress testing, abnormal intracoronary hemodynamic evaluation, or >20% perfusion defect by myocardial perfusion stress imaging) or target vessels supplying a large area of viable myocardium. Revascularization to Improve Survival: Non-Left Main CAD Revascularization: The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease	Class IIA, LOE B Class IIB, LOE B

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2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 77)	Revascularization with PCI and CABG in Asymptomatic Patients: Percutaneous coronary intervention or CABG for patients with one- or two-vessel CAD without significant proximal LAD CAD but with a large area of viable myocardium and high-risk criteria on noninvasive testing.	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e416, p. e416)	Revascularization to Improve Survival: Non-Left Main CAD Revascularization: CABG to improve survival is reasonable in patients with significant (>70% diameter) stenoses in 2 major coronary arteries with severe or extensive myocardial ischemia (e.g., high-risk criteria on stress testing, abnormal intracoronary hemodynamic evaluation, or >20% perfusion defect by myocardial perfusion stress imaging) or target vessels supplying a large area of viable myocardium. Revascularization to Improve Survival: Non-Left Main CAD Revascularization: The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease.	Class IIA, LOE B Class IIB, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 77)	Revascularization with PCI and CABG in Asymptomatic Patients: In patients with prior PCI, CABG, or PCI for recurrent stenosis associated with a large area of viable myocardium or high-risk criteria on noninvasive testing.	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e416, p. e416)	Revascularization to Improve Survival: Non-Left Main CAD Revascularization: CABG to improve survival is reasonable in patients with mild-moderate LV systolic dysfunction (EF 35% to 50%) and significant (greater than or equal to 70% diameter stenosis) multivessel CAD or proximal LAD coronary artery stenosis, when viable myocardium is present in the region of intended revascularization. Revascularization to Improve Survival: Non-Left Main CAD Revascularization: The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease.	Class IIA, LOE B Class IIB, LOE B

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2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 91)	Echocardiography, Treadmill Exercise Testing, Stress Radionuclide Imaging, Stress Echocardiography Studies, and Coronary Angiography During Patient Follow-up: Stress radionuclide imaging or stress echocardiography procedures for patients who have a significant change in clinical status and required a stress imaging procedure on their initial evaluation because of equivocal or intermediate-risk treadmill results.	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e429)	Follow-Up on Noninvasive Testing Patients with Known SIHD: Exercise with nuclear MPI or echocardiography is reasonable in patients with known SIHD who have new or worsening symptoms not consistent with UA and who have a) at least moderate physical functioning and no disabling comorbidity, b) previously required imaging with exercise stress.	Class IIA, LOE B
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 91)	Echocardiography, Treadmill Exercise Testing, Stress Radionuclide Imaging, Stress Echocardiography Studies, and Coronary Angiography During Patient Follow-up: Stress radionuclide imaging or stress echocardiography procedures for patients with prior revascularization who have a significant change in clinical status.	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33](p. e429)	Follow-Up on Noninvasive Testing Patients with Known SIHD: Exercise with nuclear MPI or echocardiography is reasonable in patients with known SIHD who have new or worsening symptoms not consistent with UA and who have a) at least moderate physical functioning and no disabling comorbidity…[and] c) known multivessel disease or high risk for multivessel disease.	Class IIA, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
J. Topic: Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction					
2002: Guideline Update for the Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction[36](p. 24)	Hospital Care: Anti-Ischemic Therapy: Morphine sulfate intravenously when symptoms are not immediately relieved with NTG or when acute pulmonary congestion and/or severe agitation is present.	Class I, LOE C	2007: Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction[35](p. e183)	Anti-Ischemic Therapy: In the absence of contradictions to its use, it is reasonable to administer morphine sulfate intravenously to UA/NSTEMI patients if there is uncontrolled ischemic chest discomfort despite NTG, provided that additional therapy is used to manage the underlying ischemia.	Class IIA, LOE B
2002: Guideline Update for the Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction[36](p. 24)	Hospital Care: Anti-Ischemic Therapy: A beta-blocker, with the first dose administered intravenously if there is ongoing chest pain, followed by oral administration, in the absence of contraindications.	Class I, LOE B	2007: Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction[35](p. e183)	Anti-Ischemic Therapy: It is reasonable to administer intravenous (IV) beta blockers at the time of presentation for hypertension to UA/NSTEMI patients who do not have 1 or more of the following: 1) signs of HF, 2) evidence of a low-output state, 3) increased risk for cardiogenic shock, or 4) other relative contraindications to beta blockade (PR interval greater than 0.24 s, second or third degree heart block, active asthma, or reactive airway disease).	Class IIA, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
2002: Guideline Update for the Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction[36](p. 25)	Hospital Care: Anti-Ischemic Therapy: An ACEI when hypertension persists despite treatment with NTG and a beta-blocker in patients with LV systolic dysfunction or CHF and in ACS patients with diabetes.	Class I, LOE B	2007: Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction[35](p. e183)	Anti-Ischemic Therapy: An ACE inhibitor administered orally within the first 24 h of UA/NSTEMI can be useful in patients without pulmonary congestion or LVEF less than or equal to 0.40 in the absence of hypotension (Systolic blood pressure less than 100 mm Hg or less than 30 mm Hg below baseline) or known contraindications to that class of medications.	Class IIA, LOE B
2002: Guideline Update for the Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction[36](p. 59)	Hospital Discharge and Post-Hospital Care: Long Term Medical Therapy: Beta-blockers in the absence of contraindications.	Class I, LOE B	2007: Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction[35](p. e238)	Beta Blockers: It is reasonable to prescribe beta blockers to low-risk patients (i.e., normal LV function, revascularized, no high-risk features) recovering from UA/NSTEMI in the absence of absolute contraindications.	Class IIA, LOE B
2002: Guideline Update for the Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction[36](p. 61)	Risk Factor Modification: Specific Instructions should be given on the following: A fibrate or niacin if high-density lipoprotein (HDL) cholesterol is less than 40 mg per dL, occurring as an isolated finding or in combination with other lipid abnormalities.	Class I, LOE B	2007: Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction[35](p. e240)	Lipid Management: The following lipid management strategies can be beneficial: Nicotinic acid (niacin) and fibric acid derivatives (fenofibrate, gemifibrozil) can be useful as therapeutic options (after LDL-C - lowering therapy) for HDL-C less than 40 mg per dL.	Class IIA, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.					
2002: Guideline Update for the Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction[36](p. 64)	Diabetes Mellitus: For patients with multivessel disease, CABG with use of the internal mammary arteries is preferred over PCI in patients being treated for diabetes.	Class I, LOE B	2007: Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction[35](p. e253)	Special Groups: Diabetes Mellitus: For patients with UA/NSTEMI and multivessel disease, CABG with use of the internal mammary arteries can be beneficial over PCI in patients being treated for diabetes mellitus.	Class IIA, LOE B
K. Topic: Management of Patients with Valvular Heart Disease					
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1957)	Exercise Testing in Chronic Aortic Regurgitation: Assessment of functional capacity and symptomatic responses in patients with a history of equivocal symptoms.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e115)	Aortic Regurgitation: Diagnosis and Initial Evaluation: Exercise stress testing for chronic AR is reasonable for assessment of functional capacity and symptomatic response in patients with a history of equivocal symptoms.	Class IIA, LOE B
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1957)	Vasodilator Therapy for Chronic Aortic Regurgitation: Long-term therapy in asymptomatic patients with severe regurgitation who have LV dilatation but normal systolic function.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e115)	Aortic Regurgitation: Vasodilator therapy may be considered for long-term therapy in asymptomatic patients with severe AR who have LV dilatation but normal systolic function.	Class IIB, LOE B
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1957)	Vasodilator Therapy for Chronic Aortic Regurgitation: Long-term therapy in asymptomatic patients with hypertension and any degree of regurgitation.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e115)	Aortic Regurgitation: Medical Therapy: Vasodilator therapy is not indicated for long-term therapy in asymptomatic patients with mild to moderate AR and normal LV systolic function.	Class III, LOE B

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1957)	Vasodilator Therapy for Chronic Aortic Regurgitation: Short-term therapy to improve the hemodynamic profile of patients with severe heart failure symptoms and severe LV dysfunction before proceeding with AVR.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e115)	Aortic Regurgitation: Medical Therapy: Vasodilator therapy is reasonable for short-term therapy to improve the hemodynamic profile of patients with severe heart failure symptoms and severe LV dysfunction before proceeding with AVR.	Class IIA, LOE C
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1964)	Mitral Valve Replacement for Mitral Stenosis: Patients with moderate or severe MS (mitral valve area less than or equal to 1.5 cm^2) and NYHA functional Class III-IV symptoms who are not considered candidates for percutaneous balloon valvotomy or mitral valve repair.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e136)	Indications for Surgery for Mitral Stenosis: MV replacement is reasonable for patients with severe MS and severe pulmonary hypertension (pulmonary artery systolic pressure greater than 60) with NYHA functional class I–II symptoms who are not considered candidates for percutaneous mitral balloon valvotomy or surgical MV repair.	Class IIA, LOE C
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1957)	Echocardiography in Mitral Valve Prolapse: To exclude MVP in patients who have been given the diagnosis when there is no clinical evidence to support the diagnosis.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e115)	Mitral Valve Prolapse: Evaluation and Management of the Asymptomatic Patient: Echocardiography can effectively exclude MVP in asymptomatic patients who have been diagnosed without clinical evidence to support the diagnosis.	Class IIA, LOE C

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1972)	Echocardiography in Infective Endocarditis: Prosthetic Valves: Evaluation of bacteremia without a known source.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e162)	Transesophageal Echocardiography in Endocarditis: Transesophageal echocardiography is reasonable to diagnose possible infective endocarditis in patients with persistent staphylococcal bacteremia without a known source.	Class IIA, LOE C
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1973)	Surgery for Prosthetic Valve Endocarditis: Early prosthetic valve endocarditis (in the first two months after surgery).	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e166)	Surgery for Prosthetic Valve Endocarditis: Routine surgery is not indicated for patients with uncomplicated infective endocarditis of a prosthetic valve caused by first infection with a sensitive organism.	Class III, LOE C
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1973)	Surgery for Prosthetic Valve Endocarditis: Staphylococcal endocarditis not responding to antibiotic therapy.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e166)	Surgery for Prosthetic Valve Endocarditis: Surgery is reasonable for patients with infective endocarditis of a prosthetic valve who present with evidence of persistent bacteremia or recurrent emboli despite appropriate antibiotic treatment.	Class IIA, LOE C
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1957)	Antithrombotic Therapy in Patients with Prosthetic Heart Valves: First 3 months after valve replacement: Warfarin, INR 2.5 to 3.5.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e115)	Management of Patients with Prosthetic Heart Valves: Antithrombotic Therapy: During the first 3 months after AVR with a mechanical prosthesis, it is reasonable to give Warfarin to achieve an INR of 2.5 to 3.5.	Class IIA, LOE C

eTable 1 (continued): Downgraded and reversed Class I recommendations appearing in 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1957)	Valve Replacement with a Mechanical Prosthesis: Patients with expected long life spans.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e115)	Major Criteria for Aortic Valve Selection: Patient preference is a reasonable consideration in the selection of aortic valve operation and valve prosthesis. A mechanical prosthesis is reasonable for AVR in patients under 65 years of age who do not have a contraindication to anticoagulation.	Class IIA ,LOE C
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1957)	Valve Replacement with a Bioprosthesis: Patients greater than or equal to 65 years needing AVR who do not have risk factors for thromboembolism.	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38](p. e115)	Major Criteria for Aortic Valve Selection: A bioprosthesis is reasonable for AVR in patients aged 65 years or older without risk factors for thromboembolism.	Class IIA LOE C

Abbreviations: ACE: Angiotensin-converting enzyme; ACS: Acute coronary syndrome; AF: Atrial fibrillation; AR: Aortic regurgitation; ARB: Angiotensin receptor blockers; AVR: Aortic valve replacement; CABG: Coronary artery bypass grafting; CAD: Coronary artery disease; ECG: Electrocardiogram; EF: Ejection fraction; GDMT: Guideline-directed medical therapy; HbA1C: Hemoglobin A1C; HDL: High-density lipoprotein; HF: Heart Failure; HFpEF: Heart failure with preserved ejection fraction; HFrEF: Heart failure with reduced ejection fraction; ICD: Implantable cardioverter-defibrillator; IHD: Ischemic heart disease; INR: International normalized ratio; LA: Left atrium; LAA: Left atrial appendage; LAD: Left anterior descending artery; LDL: Low-density lipoprotein; LIMA: Left internal mammary artery; LV: Left ventricle; LVEF: Left ventricular ejection fraction; MI: Myocardial infarction; MPI: Myocardial perfusion imaging; MS: Mitral stenosis; MV: Mitral valve; MVP: Mitral valve prolapse; NTG: Nitroglycerin; NYHA: New York Heart Association; PCI: Percutaneous coronary intervention; PTCA: Percutaneous transluminal coronary angioplasty; RNA: Radionuclinde angiography; SIHD: Stable ischemic heart disease; STEMI: ST-segment elevation myocardial infarction; TEE: Transesophageal echocardiography; UA: Unstable angina; UA/NSTEMI: Unstable angina/non-ST-segment elevation myocardial infarction; VT: Ventricular tachycardia.

eTable 2: Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

Index guideline	Original recommendation	Recommendation class and level of evidence	Revised (current) guideline	Status in revised (current) guideline
A. Topic: Management of Patients with Atrial Fibrillation				
2001: Guidelines for the Management of Patients with Atrial Fibrillation[18](p. 1887)	Pharmacological Therapy to Maintain Sinus Rhythm: Base selection of pharmacological therapy to maintain sinus rhythm in patients with disabling or otherwise troublesome symptoms during AF predominantly on safety	Class I, LOE B	2006: Guidelines for the Management of Patients with Atrial Fibrillation[19]	Omitted
B. Topic: Perioperative Cardiovascular Evaluation for Noncardiac Surgery				
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 20)	Preoperative 12-Lead Rest ECG: Recent episode of chest pain or ischemic equivalent in clinically intermediate- or high-risk patients scheduled for an intermediate- or high-risk operative procedure	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 24)	Exercise or Pharmacological Stress Testing: Prognostic assessment of patients undergoing initial evaluation for suspected or proven CAD; evaluation of subjects with significant change in clinical status	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 24)	Exercise or Pharmacological Stress Testing: Demonstration of proof of myocardial ischemia before coronary revascularization	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 24)	Exercise or Pharmacological Stress Testing: Evaluation of adequacy of medical therapy; prognostic assessment after an acute coronary syndrome (if recent evaluation unavailable)	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.				
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 26)	Coronary Angiography in Perioperative Evaluation Before (or After) Noncardiac Surgery: Evidence for high risk of adverse outcome based on noninvasive test results	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 26)	Coronary Angiography in Perioperative Evaluation Before (or After) Noncardiac Surgery: Angina unresponsive to adequate medical therapy	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 26)	Coronary Angiography in Perioperative Evaluation Before (or After) Noncardiac Surgery: Unstable angina, particularly when facing intermediate-risk or high-risk noncardiac surgery	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 26)	Coronary Angiography in Perioperative Evaluation Before (or After) Noncardiac Surgery: Equivocal noninvasive test results in patients at high clinical risk undergoing high-risk surgery	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted
2002: Guideline Update on Perioperative Cardiovascular Evaluation for Noncardiac Surgery[20](p. 38)	Intraoperative Nitroglycerin: High-risk patients previously taking nitroglycerin who have active signs of myocardial ischemia without hypotension	Class I	2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery[21]	Omitted
C. Topic: Cardiac Pacemakers and Antiarrhythmia Devices				
2002: Guideline Update for Implantation of Cardiac Pacemakers and Antiarrhythmia Devices[23](p. 15)	Pacing Indications for Dilated Cardiomyopathy: Class I indications for sinus node dysfunction or AV block as previously described	Class I, LOE C	2008: Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities[22]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

D. Topic: Coronary Artery Bypass Graft Surgery				
2004: Guideline Update for Coronary Artery Bypass Graft Surgery[16](p. e347)	Morbidity Associated With CABG: Adverse Cerebral Outcomes: Significant atherosclerosis of the ascending aorta mandates a surgical approach that will minimize the possibility of arteriosclerotic emboli	Class I, LOE C	2011: Guideline for Coronary Artery Bypass Graft Surgery[26]	Omitted
2004: Guideline Update for Coronary Artery Bypass Graft Surgery[16](p. e373)	Myocardial Protection for Acutely Depressed Cardiac Function: Blood cardioplegia should be considered in patients undergoing cardiopulmonary bypass accompanying urgent/emergency CABG for acute MI or unstable angina	Class I, LOE B	2011: Guideline for Coronary Artery Bypass Graft Surgery[26]	Omitted
2004: Guideline Update for Coronary Artery Bypass Graft Surgery[16](p. e412)	Patients with Previous CABG: Coronary bypass should be performed in patients with prior CABG without patent bypass grafts but with Class I indications for surgery for native-vessel CAD (significant left main coronary stenosis, left main equivalent, 3-vessel disease)	Class I, LOE B	2011: Guideline for Coronary Artery Bypass Graft Surgery[26]	Omitted
E. Topic: Cardiovascular Disease Prevention in Women				
2007: Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women[27](p. 1486)	Lipids and lipoprotein levels - optimal levels and lifestyle: If a woman is at high risk or has hypercholesterolemia, intake of saturated fat should be <7% and cholesterol intake <200 mg/d	Class I, LOE B	2011: Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women[28]	Omitted
F. Topic: Management of Heart Failure				
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e161)	Initial Clinical Assessment of Patients Presenting with HF: A careful history of current and past use of alcohol, illicit drugs, current or past standard or "alternative therapies," and chemotherapy drugs should be obtained from patients presenting with HF	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.				
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e161)	Initial Clinical Assessment of Patients Presenting with HF: In patients presenting with HF, initial assessment should be made of the patient's ability to perform routine and desired activities of daily living	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e162)	Serial Clinical Assessment of Patients Presenting with HF: Assessment should be made at each visit of the ability of a patient with HF to perform routine and desired activities of daily living	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e162)	Serial Clinical Assessment of Patients Presenting with HF: Careful history of current use of alcohol, tobacco, illicit drugs, "alternative therapies," and chemotherapy drugs, as well as diet and sodium intake, should be obtained at each visit of a patient with HF	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e169)	Patients at High Risk for Developing HF (Stage A): Thyroid disorders should be treated in accordance with contemporary guidelines in patients at high risk for developing HF	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e169)	Patients at High Risk for Developing HF (Stage A): Healthcare providers should perform periodic evaluation for signs and symptoms of HF in patients at high risk for developing HF	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e169)	Patients at High Risk for Developing HF (Stage A): In patients at high risk for developing HF who have known atherosclerotic vascular disease, healthcare providers should follow current guidelines for secondary prevention	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.				
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e169)	Patients at High Risk for Developing HF (Stage A): Healthcare providers should perform a noninvasive evaluation of LV function (i.e., LVEF) in patients with a strong family history of cardiomyopathy or in those receiving cardiotoxic interventions	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e171)	Patients with Cardiac Structural Abnormalities or Remodeling who have not Developed HF Symptoms (Stage B): All Class I recommendations for Stage A should apply to patients with cardiac structural abnormalities who have not developed HF	Class I	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e171)	Patients with Cardiac Structural Abnormalities or Remodeling who have not Developed HF Symptoms (Stage B): Patients who have not developed HF symptoms should be treated according to contemporary guidelines after an acute MI	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e171)	Patients with Cardiac Structural Abnormalities or Remodeling who have not Developed HF Symptoms (Stage B): Coronary revascularization should be recommended in appropriate patients without symptoms of HF in accordance with contemporary guidelines (see ACC/AHA Guidelines for the Management of Patients With Chronic Stable Angina)	Class I, LOE A	2013: Guideline for the Management of Heart Failure[30]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.				
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e171)	Patients with Cardiac Structural Abnormalities or Remodeling who have not Developed HF Symptoms (Stage B): Valve replacement or repair should be recommended for patients with hemodynamically significant valvular stenosis or regurgitation and no symptoms of HF in accordance with contemporary guidelines	Class I, LOE B	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e174)	Patients with Current or Prior Symptoms of HF (Stage C): Patients with Reduced LVEF: An implantable cardioverter-defibrillator is recommended as secondary prevention to prolong survival in patients with current or prior symptoms of HF and reduced LVEF who have a history of cardiac arrest, ventricular fibrillation, or hemodynamically destabilizing ventricular tachycardia	Class I, LOE A	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e196)	Patients with Refractory End-Stage HF (Stage D): Meticulous identification and control of fluid retention is recommended in patients with refractory end stage HF	Class I, LOE B	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e196)	Patients with Refractory End-Stage HF (Stage D): Referral of patients with refractory end-stage HF to an HF program with expertise in the management of refractory HF is useful	Class I, LOE A	2013: Guideline for the Management of Heart Failure[30]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e196)	Patients with Refractory End-Stage HF (Stage D): Options for end-of-life care should be discussed with the patient and family when severe symptoms in patients with refractory end-stage HF persist despite application of all recommended therapies	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e196)	Patients with Refractory End-Stage HF (Stage D): Patients with refractory end-stage HF and implantable defibrillators should receive information about the option to inactivate defibrillation	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e199)	Treatment of Special Populations: Groups of patients including : (a) high-risk ethnic minority groups (e.g., blacks); (b) groups underrepresented in clinical trials, and (c) any groups believed to be underserved should, in the absence of specific evidence to direct otherwise, have clinical screening and therapy in a manner identical to that applied to the broader population	Class I, LOE B	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e199)	Treatment of Special Populations: It is recommended that evidence-based therapy for HF be used in the elderly patient, with individualized consideration of the elderly patient's altered ability to metabolize or tolerate standard medications	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e201)	Patients with HF who have Concomitant Disorders: All other recommendations should apply to patients with concomitant disorders unless there are specific exceptions	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.				
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e201)	Patients with HF who have Concomitant Disorders: Physicians should use nitrates and beta-blockers for the treatment of angina in patients with HF	Class I, LOE B	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e201)	Patients with HF who have Concomitant Disorders: Patients with coronary artery disease and HF should be treated in accordance with recommended guidelines for chronic stable angina	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e201)	Patients with HF who have Concomitant Disorders: Physicians should prescribe antiplatelet agents for prevention of MI and death in patients with HF who have underlying coronary artery disease	Class I, LOE A	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e206)	End-of-Life Considerations: Discussion is recommended regarding the option of inactivating ICDs for patients with HF at the end of life	Class I, LOE C	2013: Guideline for the Management of Heart Failure[30]	Omitted
2005: Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult[29](p. e208)	Implementation of Practice Guidelines: Academic detailing or educational outreach visits are useful to facilitate the implementation of practice guidelines	Class I, LOE A	2013: Guideline for the Management of Heart Failure[30]	Omitted
G. Topic: Percutaneous Coronary Intervention				
2005: Guidelines on Percutaneous Coronary Intervention[32](p. e214)	PCI in Fibrinolytic-Ineligible Patients: Primary PCI should be performed in fibrinolytic-ineligible patients who present with STEMI within 12 hours of symptom onset	Class I, LOE C	2011: Guideline for Percutaneous Coronary Intervention[31]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

H. Topic: Management of Patients with Chronic Stable Angina				
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 13)	Initial Laboratory Tests for Diagnosis: Hemoglobin	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 13)	Initial Laboratory Tests for Diagnosis: Fasting glucose	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 14)	Initial Laboratory Tests for Diagnosis: Fasting lipid panel, including total cholesterol, HDL cholesterol, triglycerides, and calculated LDL cholesterol	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 15)	Noninvasive Testing: Electrocardiography, Chest X-Ray, or Electron Beam Computed Tomography in the Diagnosis of Chronic Stable Angina: Rest ECG during an episode of chest pain	Class I, LOE B	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 15)	Noninvasive Testing: Electrocardiography, Chest X-Ray, or Electron Beam Computed Tomography in the Diagnosis of Chronic Stable Angina: Chest X-ray in patients with signs or symptoms of congestive heart failure, valvular heart disease, pericardial disease, or aortic dissection/aneurysm	Class I, LOE B	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 21)	Echocardiography (Resting) for Diagnosis of Cause of Chest Pain in Patients With Suspected Chronic Stable Angina Pectoris: Patients with systolic murmur suggestive of aortic stenosis or hypertrophic cardiomyopathy	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 21)	Echocardiography (Resting) for Diagnosis of Cause of Chest Pain in Patients With Suspected Chronic Stable Angina Pectoris: Evaluation of extent (severity) of ischemia (e.g., LV segmental wall motion abnormality) when the echocardiogram can be obtained during pain or within 30 min after its abatement	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 22)	Cardiac Stress Imaging as the Initial Test for Diagnosis in Patients With Chronic Stable Angina Who Are Able to Exercise: Adenosine or dipyridamole myocardial perfusion imaging in patients with an intermediate pretest probability of CAD and one of the following baseline ECG abnormalities: a) Electronically paced ventricular rhythm.	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 22)	Stress Imaging Studies: Echocardiographic and Nuclear: Cardiac Stress Imaging as the Initial Test for Diagnosis in Patients With Chronic Stable Angina Who Are Able to Exercise: Adenosine or dipyridamole myocardial perfusion imaging in patients with an intermediate pretest probability of CAD and one of the following baseline ECG abnormalities: b) Left bundle-branch block.	Class I, LOE B	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.				
2002: Guideline Update for the Management of Patients with Chronic Stable Angina[34](p. 91)	Echocardiography, Treadmill Exercise Testing, Stress Radionuclide Imaging, Stress Echocardiography Studies, and Coronary Angiography During Patient Follow-up: Coronary angiography in patients with marked limitation of ordinary activity (CCS class III) despite maximal medical therapy	Class I, LOE C	2012: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease[33]	Omitted
I. Topic: Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction				
2002: Guideline Update for the Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction[36](p. 47)	Early Conservative versus Invasive Strategies: In the absence of these findings [UA/NSTEMI and any of the following high-risk indicators: a) Recurrent angina/ischemia at rest or with low level activities despite intensive anti-ischemic therapy; b) Elevated TnT or TnI; c) New or presumably new ST-segment depression; d) Recurrent angina/ischemia with CHF symptoms, an S3 gallop, pulmonary edema, worsening rales, or new or worsening MR; e) High-risk findings on noninvasive stress testing; f) Depressed LV systolic function (e.g., EF less than 0.40 on noninvasive study); g) Hemodynamic instability h) Sustained ventricular tachycardia i) PCI within 6 months; j) Prior CABG] either an early conservative or an early invasive strategy in hospitalized patients without contraindications for revascularization	Class I, LOE B	2007: Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction[35]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.				
2002: Guideline Update for the Management of Patients with Unstable Angina and Non- ST-Segment Myocardial Infarction[36](p. 64)	Diabetes Mellitus: Diabetes is an independent risk factor in patients with UA/NSTEMI	Class I, LOE A	2007: Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction[35]	Omitted
J. Topic: Management of Patients with Valvular Heart Disease				
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1955)	Radionuclide Angiography in Aortic Regurgitation: Serial assessment of LV volume and function at rest when serial echocardiograms are not used	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1955)	Radionuclide Angiography in Aortic Regurgitation: Assessment of LV volume and function in asymptomatic patients with moderate to severe regurgitation when echocardiographic evidence of declining LV function is suggestive but not definitive	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1955)	Radionuclide Angiography in Aortic Regurgitation: Confirmation of subnormal LV ejection fraction before recommending surgery in an asymptomatic patient with borderline echocardiographic evidence of LV dysfunction	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1955)	Radionuclide Angiography in Aortic Regurgitation: Assessment of LV volume and function in patients with moderate to severe regurgitation when clinical assessment and echocardiographic data are discordant	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1956)	Vasodilator Therapy for Chronic Aortic Regurgitation: Long-term ACE inhibitor therapy in patients with persistent LV systolic dysfunction after AVR	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1971)	Patients who Have Used Anorectic Drugs: Discontinuation of the anorectic drug(s)	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1971)	Patients who Have Used Anorectic Drugs: Cardiac physical examination	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1971)	Patients who Have Used Anorectic Drugs: Echocardiography in patients with symptoms, heart murmurs, or associated physical findings	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1971)	Patients who Have Used Anorectic Drugs: Doppler echocardiography in patients for whom cardiac auscultation cannot be performed adequately because of body habitus	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1973)	Surgery for Native Valve Endocarditis: Evidence of valve dysfunction and persistent infection after a prolonged period (7 to 10 days) of appropriate antibiotic therapy, as indicated by presence of fever, leukocytosis, and bacteremia, provided there are no noncardiac causes for infection	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1973)	Surgery for Prosthetic Valve Endocarditis: Fungal endocarditis	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1973)	Surgery for Prosthetic Valve Endocarditis: Infection with gram-negative organisms or organisms with a poor response to antibiotics	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted

eTable 2 (continued): Class I recommendations omitted between two versions of 11 ACC/AHA clinical practice guidelines. All abbreviations are defined at the end of the table.

1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1982)	Follow-up Strategy of Patients with Prosthetic Heart Valves: Radionuclide angiography or MRI to assess LV function if result of echocardiography is unsatisfactory	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted
1998: Guidelines for the Management of Patients with Valvular Heart Disease[37](p. 1968)	Recommendations for Coronary Angiography in Mitral Regurgitation: When ischemia is suspected as an etiologic factor in MR	Class I	2006: Guidelines for the Management of Patients with Valvular Heart Disease[38]	Omitted

Abbreviations: ACE: Angiotensin-converting enzyme; AF: Atrial fibrillation; AV: atrioventricular; AVR: Aortic valve replacement; CABG: Coronary artery bypass grafting; CAD: Coronary artery disease; CCS: Canadian cardiovascular society; CHF: Congestive heart failure; ECG: Electrocardiogram; EF: Ejection fraction; HDL: High-density lipoprotein; HF: Heart Failure; ICD: Implantable cardioverter-defibrillator; LDL: Low-density lipoprotein; LV: Left ventricle; LVEF: Left ventricular ejection fraction; MI: Myocardial infarction; MR: Mitral regurgitation; MRI: Magnetic resonance imaging; PCI: Percutaneous coronary intervention; STEMI: ST-segment elevation myocardial infarction; TnI: Troponin I; TnT: Troponin-T; Tn UA/NSTEMI: Unstable angina/non-ST-segment elevation myocardial infarction.