SUPPLEMENTAL MATERIAL TABLE OF CONTENTS

Appendix A: Search criteria Medline

Search terms / MESH
• Exercise test
• Bicycle ergometry test
• Electrocardiography
• Magnetic resonance imaging
• Single photon emission computed tomography
• Positron emission tomography
• Stress echocardiography
• Computed tomography
• X-ray
• Prognosis
• Coronary artery disease

Search limitations
• Language: English
• Publication dates: January 1990 – April 2015

Initial search strategy Medline

- computed tomography, x ray [MESH] AND prognosis [MESH] AND coronary artery disease (exploded)
- ((imaging, magnetic resonance[MeSH Terms]) AND prognosis[MeSH Terms]) AND coronary artery disease (exploded term).
- ((exercise test[MeSH Terms]) AND electrocardiography[MeSH Terms]) AND prognosis [MeSH Terms] AND coronary artery disease
- ((bicycle ergometry test[MeSH Terms]) AND electrocardiography[MeSH Terms]) AND prognosis [MeSH Terms] AND coronary artery disease
- ((positron emission tomography[MeSH Terms]) AND prognosis[MeSH Terms]) AND coronary artery disease
- ((single photon emission tomography[MeSH Terms]) AND prognosis[MeSH Terms]) AND coronary artery disease
- ((stress echocardiography[MeSH Terms]) AND prognosis[MeSH Terms]) AND coronary artery disease
- (prognosis [MeSH Terms] AND coronary artery disease AND stress echocardiography)

Appendix B

MOOSE Guidelines for Meta-Analyses and Systematic Reviews of Observational Studies*

Title	Identify the study as a meta-analysis (or systematic review)
Abstract	Use the journal's structured format
Introduction	**Present** ✓ • The clinical problem ✓ • The hypothesis ✓ • A statement of objectives that includes the study population, the condition of interest, the exposure or intervention, and the outcome(s) considered
Sources	**Describe** ✓ • Qualifications of searchers (eg, librarians and investigators) ✓ • Search strategy, including time period included in the synthesis and keywords ✓ • Effort to include all available studies, ~~including contact with authors~~ ✓ • Databases and registries searched ✓ • Search software used, name and version, including special features used (eg, explosion) ✓ • Use of hand searching (eg, reference lists of obtained articles) ✓ • List of citations located and those excluded, including justification ✓ • Method of addressing articles published in languages other than English ✓ • Method of handling abstracts and unpublished studies ✓ • Description of any contact with authors
Study Selection	**Describe** ✓ • Types of study designs considered ✓ • Relevance or appropriateness of studies gathered for assessing the hypothesis to be tested ✓ • Rationale for the selection and coding of data (eg, sound clinical principles or convenience) ✓ • Documentation of how data were classified and coded (eg, multiple raters, blinding, and interrater reliability) ✓ • Assessment of confounding (eg, comparability of cases and controls in studies where appropriate) ✓ • Assessment of study quality, including blinding of quality assessors; stratification or regression on possible predictors of study results ✓ • Assessment of heterogeneity ✓ • Statistical methods (eg, complete description of fixed or random effects models, justification of whether the chosen models account for predictors of study results, dose-response models, or cumulative meta-analysis) in sufficient detail to be replicated
Results	**Present** ✓ • A graph summarizing individual study estimates and the overall estimate ✓ • A table giving descriptive information for each included study ✓ • Results of sensitivity testing (eg, subgroup analysis) ✓ • Indication of statistical uncertainty of findings
Discussion	**Discuss** ✓ • Strengths and weaknesses ✓ • Potential biases in the review process (eg, publication bias) ✓ • Justification for exclusion (eg, exclusion of non–English-language citations) ✓ • Assessment of quality of included studies ✓ • Consideration of alternative explanations for observed results ✓ • Generalization of the conclusions (ie, appropriate for the data presented and within the domain of the literature review) ✓ • Guidelines for future research ✓ • Disclosure of funding source

*Modified from Stroup DF, Berlin JA, Morton SC, Olkin I, Williamson GD, Rennie D, et al. Meta-analysis of observational studies in epidemiology: a proposal for reporting. Meta-analysis Of Observational Studies in Epidemiology (MOOSE) group. JAMA 2000;283:2008–12.

Appendix C

PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	2,3
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	5
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	5
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	With the editor
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	6,7
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	6,7
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	6, Appendix 1
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	6,7, Fig. 1
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	8,9
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	8,9
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	8,9
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	8,9
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	9

PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	8,9
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	8,9
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	9, Fig 1
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	Appendix E
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	Appendix E
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	Appendix E Appendix F
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	Fig 2-3, Appendix F-G
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	Fig 2-3, Appendix F-G
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	Fig 2-3, Appendix F-G
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	11-14
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	11-14
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	11-14
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	15

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

Appendix D: Study Quality

CCTA	Representative	Patient characteristics	Outcome	Confirmation outcome	Follow up time	Follow up completeness	Total
Abidov	1	1	1	1	1	1	6
Aggarwal	0	0	1	1	1	0	3
Aldrovandi	1	1	1	1	1	0	5
Andreini	1	1	1	1	1	1	6
Carrigan	1	1	1	1	1	0	5
Chen	1	0	1	1	1	1	5
Cho	1	1	1	1	1	0	5
Chong	0	0	1	1	1	0	3
Chow	1	0	1	1	1	1	5
Christiaens	0	0	1	0	0	1	2
Danciu	1	0	1	1	1	1	5
Dedic	1	1	1	1	1	0	5
Gilard	1	1	1	0	1	1	5
Gopal	1	1	1	1	1	0	5
Grutta, la	1	1	1	1	1	0	5
Hadamitzky	1	1	1	1	1	1	6
Hansen	0	1	1	1	1	1	5
Hay	1	0	1	1	1	0	4
Hollander	0	0	1	1	1	1	4
Ko	1	0	1	1	1	1	5
Lingen	1	0	1	1	1	0	4
Min	1	0	1	1	1	0	4
Miszalski	1	0	1	1	1	1	5
Nasis	0	1	1	0	1	1	4
Noda	0	0	1	0	0	0	1
Øvrehus	1	1	1	1	1	1	6
Rubinshtein	0	1	1	1	1	0	4
Schmermund	1	1	1	1	1	1	6

Yamamoto	1	1	1	1	1	0	5
Yiu	1	1	1	1	1	0	5
CMR-perf	**Representative**	**Patient characteristics**	**Outcome**	**Confirmation outcome**	**Follow up time**	**Follow up completeness**	**Total**
Bertaso	1	0	1	1	1	0	4
Bingham	1	1	1	1	1	1	6
Bodi	1	0	1	1	1	0	4
Chen	1	0	1	1	1	1	5
Coelho-Filho	1	0	1	1	1	1	5
Doesch	1	1	1	1	1	1	6
Freed	1	0	1	1	1	0	4
Hartlage	0	1	1	1	0	0	3
Ingkanisorn	0	1	1	0	1	1	4
Lo	1	1	1	1	1	0	5
Lubbers	1	0	1	1	1	1	5
Macwar	1	0	1	1	1	0	4
Pilz	1	1	1	0	1	1	5
CMR-wm	**Representative**	**Patient characteristics**	**Outcome**	**Confirmation outcome**	**Follow up time**	**Follow up completeness**	**Total**
Bodi	1	0	1	1	1	0	4
Gebker	1	1	1	1	1	1	6
Kelle	1	1	1	1	1	1	6
Korosoglou	1	0	1	1	1	1	5
Kuijpers	1	1	1	1	1	1	6
Wallace	1	0	1	1	1	1	5
EET	**Representative**	**Patient characteristics**	**Outcome**	**Confirmation outcome**	**Follow up time**	**Follow up completeness**	**Total**
Bigi	1	0	1	1	1	1	5
Bourque	0	1	1	1	1	1	5
Bouzas-	0	1	1	1	1	1	5

Mosquera							
Calasans	1	1	1	1	1	0	5
Cannan	0	0	1	1	1	1	4
Chatziioannou	0	0	1	1	1	0	3
Cho	1	1	1	1	1	0	5
Coletta	1	0	1	1	1	1	5
Dedic	1	1	1	1	1	0	5
Houghton	1	0	1	0	1	1	4
Jeetley	0	1	1	1	0	1	4
Lichtlen	1	0	1	0	1	0	3
Marshall	0	1	1	1	1	1	5
Mulcahy	1	1	1	1	1	1	6
Niemann	1	0	1	1	1	0	4
Pontone	1	1	1	1	1	0	5
Raiker	0	0	1	1	1	1	4
Sanchis	0	0	1	1	0	0	2
Sawada	0	0	1	1	1	0	3
Vanzetto	1	0	1	1	1	1	5
Zanco	1	0	1	1	1	1	5
PET	**Representative**	**Patient characteristics**	**Outcome**	**Confirmation outcome**	**Follow up time**	**Follow up completeness**	**Total**
Chow	1	0	1	1	1	0	4
Chow	1	0	1	1	1	1	5
Dorbala	1	0	1	1	1	0	4
Tosh, van	1	1	1	1	1	0	5
SE	**Representative**	**Patient characteristics**	**Outcome**	**Confirmation outcome**	**Follow up time**	**Follow up completeness**	**Total**
Afridi	1	1	1	1	0	1	5
Almeida	1	0	1	1	1	1	5
Anthopoulos	1	0	1	1	1	0	4

Baldini	1	0	1	1	0	0	3
Bholasingh	1	0	1	1	0	1	4
Biagini	1	0	1	1	1	1	5
Bouzas-Mosquera	0	1	1	1	1	0	4
Calasans	0	1	1	1	1	0	4
Chuah	1	1	1	1	1	1	6
Chung	1	1	1	1	1	1	6
Ciaroni	1	1	1	1	1	1	6
Coletta	1	0	1	1	1	0	4
Colon	0	0	1	1	1	1	4
Cordovil	1	1	1	1	1	1	6
Cortigiani	1	0	1	1	1	1	5
Davar	1	0	1	1	1	1	5
Hartlage	0	0	1	1	0	1	3
Isma'eel	1	0	1	1	1	1	5
Ismail	1	0	1	1	1	1	5
Kamaran	1	0	1	1	0	1	4
Krivokapich	1	0	1	1	1	1	5
Krivokapich	1	0	1	1	1	1	5
Low	1	1	1	1	1	1	6
Marcovitz	1	0	1	1	1	1	5
Marwick	0	0	1	1	1	1	4
Mesa	1	1	1	1	1	1	6
Olmos	1	0	1	1	1	1	5
Pingitore	1	0	1	1	1	1	5
Sawada	1	0	1	1	1	0	4
Sawada	1	0	1	1	1	1	5
Song	1	0	1	1	1	1	5
Srivastava	1	1	1	1	1	1	6
Steinberg	1	0	1	1	1	1	5
Yao	1	0	1	1	1	1	5

Yao	1	0	1	1	1	1	5
Zagatina	1	0	1	1	1	0	4
SPECT	**Representative**	**Patient characteristics**	**Outcome**	**Confirmation outcome**	**Follow up time**	**Follow up completeness**	**Total**
Acampa	1	0	1	1	1	1	5
Akinboboye	1	0	1	1	1	0	4
Basic	1	0	1	1	1	1	5
Bom	1	1	1	1	1	0	5
Boyne	1	0	1	1	1	0	4
Bucerius	1	1	1	1	1	1	6
Calnon	1	0	1	1	1	1	5
Chatziioannou	0	1	1	1	1	0	4
Dawson	1	0	1	1	1	0	4
Dona	1	0	1	1	1	1	5
Doukky	1	1	1	1	1	1	6
Ferreira	1	0	1	1	1	1	5
Filipiak	1	0	1	1	1	1	5
Galassi	1	0	1	1	1	0	4
Gentile	1	0	1	1	1	1	5
Gibbons	0	0	1	1	1	1	4
Gibson	1	1	1	1	1	0	5
Groutars	1	0	1	1	1	1	5
Hachamovitch	1	0	1	1	1	1	5
Hage	0	0	1	1	1	0	3
Hakeem	1	1	1	1	1	0	5
Iqbal	1	1	1	1	1	1	6
Jeong	0	1	1	1	1	0	4
Kaminek	1	0	1	0	1	0	3
Klodas	0	0	1	1	1	0	3
Koehli	1	0	1	1	1	1	5
Leslie	1	0	1	1	1	0	4

Lima	1	1	1	1	1	1	6
Miernik	0	0	1	0	1	1	3
Mouden	0	1	1	1	1	1	5
Nabi	0	0	1	1	0	1	3
Nishimura	1	0	1	1	1	1	5
Olmos	1	0	1	1	1	1	5
Otsuka	1	0	1	0	1	1	4
Pazhenkottil	1	0	1	1	1	0	4
Petix	1	0	1	1	1	1	5
Raziei	1	0	1	1	1	0	4
Romero	1	0	1	1	1	0	4
Schinkel	1	0	1	1	1	1	5
Schinkel	1	0	1	1	1	1	5
Sharma	0	1	1	1	1	1	5
Shimoni	0	0	1	1	1	1	4
Simonsen	1	1	1	1	1	1	6
Soman	1	0	1	1	1	1	5
Stratmann	1	0	1	1	1	1	5
Stratmann	1	1	1	1	1	1	6
Sugihara	1	0	1	0	1	1	4
Travin	1	0	1	1	1	1	5
Travin	1	1	1	1	1	1	6
Uebleis	1	1	1	1	1	1	6
Uthamalingam	0	1	1	1	1	1	5
Vanzetto	1	0	1	1	1	1	5
Wolak	1	1	1	1	1	0	5
Yang	1	1	1	1	1	1	6
Zanco	1	0	1	0	1	1	4

Appendix E

eTable 1a. Coronary Computed Tomographic Angiography (CCTA) – patient and study characteristics

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Scanner	Definition neg. test	Quality assessment
Abidov(1)	2009	PS	Suspected CAD	199	1 (0.5)	54 (NS)	107 (54)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	6
Aggarwal(2) $	2011	PS	Suspected or known CAD	111	13 (10)	51 (NS)	47 (42)	NS	NS	NS	16-slice	<50% stenosis	3
Aldrovandi(3)	2012	RS	Suspected or known CAD	767	NS	62 (11)	496 (65)	217 (28)	151 (20)	172 (22)	64-slice	<50% stenosis	5
Andreini(4)	2012	PS	Suspected CAD	1196	38 (3)	62 (11)	782 (62)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	6
Carrigan(5)	2009	RS	Suspected CAD	227	NS	54 (12)	139 (61)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	5
Chen(6)	2014	PS	Suspected or known CAD	151	0 (0)	56 (48-63)	91 (60)	17 (11)	NS	17 (11)	320-row	<50% stenosis	5
Cho(7)	2012	RS	Suspected CAD	2977	NS	58 (10)	1476 (50)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	5
Chong(8) $	2012	RS	NS	70	NS	52 (NS)	40 (57)	NS	NS	NS	16/64-slice	<50% stenosis	3
Chow(9)	2010	PS	NS	2076	96 (4)	58 (12)	1087 (52)	NS	NS	0 (0)	64-slice	<50% stenosis	5
Christiaens(10) $	2012	PS	Suspected or known CAD	175	0 (0)	60 (8)	124 (71)	NS	2 (1)	12 (7)	64-slice	<50% stenosis	2
Danciu(11)	2007	PS	Suspected or known CAD	421	0 (0)	64 (12)	266 (63)	145 (34)	NS	NS	64-slice	<50% stenosis	5
Dedic(12)	2011	PS	Suspected CAD	409	47 (10)	58 (NS)	217 (53)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	5
Gilard(13)	2007	PS	Suspected CAD	141	0 (0)	59 (12)	88 (62)	0 (0)	0 (0)	0 (0)	16-slice	<50% stenosis	5
Gopal(14)	2009	PS	Suspected CAD	493	NS	58 (15)	347 (70)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	5
Grutta, la(15)	2011	PS	Suspected CAD	125	NS	57 (10)	82 (66)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	5
Hadamitzky(16)	2013	RS	Suspected CAD	1584	36 (2)	58 (11)	1091 (69)	0 (0)	0 (0)	0 (0)	16 / 64-slice	<50% stenosis	6
Hansen(17) $	2010	PS	Suspected CAD	89	0 (0)	56 (9)	56 (63)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	5
Hay(18)	2010	RS	Suspected CAD	138	NS	57 (NS)	73 (53)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	4
Hollander(19) $	2009	PS	Suspected or known CAD	481	0 (0)	46 (9)	193 (40)	NS	2 (0.2)	NS	64-slice	<50% stenosis	4
Ko(20)	2014	RS	Suspected or known CAD	115	1 (1)	64 (10)	76 (66)	48 (42)	11 (10)	NS	320-row	<50% stenosis	5
Lingen, van(21)	2008	RS	Suspected or known CAD	178	NS	56 (NS)	76 (43)	NS	NS	NS	16-slice	<50% stenosis	4

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Scanner	Definition	Quality assessment
Min(22)	2010	PS	Suspected or known CAD	172	NS	63 (12)	98 (57)	42 (24)	NS	NS	64-slice	<50% stenosis	4
Miszalski-Jamka(23)	2012	NS	Suspected CAD	494	10 (2)	58 (10)	259 (52)	0 (0)	0 (0)	0 (0)	16 / 64-slice	<50% stenosis	5
Nasis(24) $	2011	PS	Suspected CAD	203	0 (0)	55 (11)	123 (60)	0 (0)	0 (0)	0 (0)	320-row	<50% stenosis	4
Noda(25) $	2008	PS	Suspected CAD	26	NS	65 (NS)&	12 (43)&	0 (0)	0 (0)	0 (0)	16-slice	<50% stenosis	1
Øvrehus(26)	2011	PS	Suspected CAD	1055	0 (0)	55 (NS)	464 (44)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	6
Rubinshtein(27) $	2013	PS	Suspected CAD	334	NS	57 (13)	189 (57)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	4
Schmermund (28)	2010	RS	Suspected CAD	670	36 (5)	59 (11)	409 (58)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	6
Yamamoto(29)	2013	NS	Suspected CAD	511	NS	66 (11)	325 (64)	0 (0)	0 (0)	0 (0)	64-slice	<50% stenosis	5
Yiu(30)	2012	RS	Suspected CAD	2432	NS	57 (12)	1364 (56)	0 (0)	0 (0)	0 (0)	64-slice 320-row	<50% stenosis	5

CAD=coronary artery disease, MI=myocardial infarction, N=number of patients, NS=not specified, PS=prospective, Revasc=revascularization, RS=retrospective, SD=standard deviation.
$ Specific study population.

eTable 1b. Coronary Computed Tomographic Angiography (CCTA) – absolute number of adverse cardiovascular events

		Negative test (i.e. <50% stenosis)						Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Abidov(1)	2.3 (0.7)	163	0 / 0	0	3	NS	0 (0.0%)	199	0	0.0%
Aggarwal(2)	2.8 (0.3)	92	NS / 1	0	0	NS	1 (0.4%)	111	1	0.3%
Aldrovandi(3)	1.7 (0.3)	501	2 / 1	3	11*	0	4 (0.5%)	767	16	1.2%
Andreini(4)	4.3 (1.8)	744	NS / NS	NS	NS	NS	23 (0.7%)	1196	125	2.4%
Carrigan(5)	2.3 (0.8)	172	NS / NS	NS	NS	NS	1 (0.3%)	227	4	0.8%
Chen(6)	1.2 (0.3)	106	NS / 0	1	NS	0	1 (0.8%)			
Cho(7)	3.3 (2.3-4.6)	2568	NS / 1	2	16	3	3 (0.0%)	2977	9	0.1%
Chong(8)	4.6 (0.6)	70	1 / 0	1	0	NS	1 (0.3%)			
Chow(9)	1.3 (0.7)	1457	10 / 4	5	NS	NS	9 (0.5%)	2076	34	1.3%
Christiaens(10)	0.5 (0.2)	136	0 / 0	0	0	NS	0 (0.0%)	175	0	0.0%
Danciu(11)	1.3 (0.3)	237	0 / 0	0	NS	NS	0 (0.0%)	421	2	0.4%
Dedic(12)	2.6 (NS)	277	NS / 1	2	3	3	3 (0.4%)	409	10	0.9%
Gilard(13)	1.2 (NS)	141	0 / 0	1	NS	NS	1 (0.6%)			
Gopal(14)	3.3 (0.8)	361	0 / 0	0	0	NS	0 (0.0%)	493	21	1.3%
Grutta, la(15)	2.0 (NS)	90	NS / 0	0	5*	NS	0 (0.0%)	125	2	0.8%
Hadamitzky(16)	5.5 (5.1-6.2)	1258	NS / NS	NS	NS	NS	15 (0.2%)	1584	25	0.3%
Hansen(17)	1.0 (0.2)	74	0 / 0	0	0	NS	0 (0.0%)	89	0	0.0%
Hay(18)	1.7 (NS–NS)	116	0 / 0	0	0	0	0 (0.0%)	138	0	0.0%
Hollander(19)	1.0 (0.0)	481	1 / 0	0	0	NS	0 (0.0%)			
Ko(20)	1.5 (1.1-2.3)	20	0 / 0	0	NS	NS	0 (0.0%)	115	1	0.6%

		Negative test (i.e. <50% stenosis)						Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Lingen, van(21)	1.0 (NS)	178	0 / 0	0	2	0	0 (0.0%)			
Min(22)	1.8 (0.4)	109	0 / 0	1	0	1	1 (0.5%)	172	1	0.3%
Miszalski-Jamka(23)	3.6 (0.9)	355	NS / NS	NS	31	NS	9 (0.7%)	494	17	1.0%
Nasis(24)	1.2 (NS)	168	0 / 0	0	0	0	0 (0.0%)	203	0	0.0%
Noda(25)	0.8 (0.6)	8	NS / 0	0	0	0	0 (0.0%)	26	1	4.8%
Øvrehus(26)	1.5 (1.2–2.1)	843	2 / 0	3	2	NS	3 (0.2%)	1055	7	0.4%
Rubinshtein(27) $	6.1 (1.0)	334	NS / 10	3	NS	NS	13 (0.6%)			
Schmermund(28)	3.2 (NS)	705	9 / 0	2	13	NS	2 (0.1%)			
Yamamoto(29)	3.3 (1.2)	372	NS / 0	2	5	4	2 (0.2%)	453	9	0.6%
Yiu(30)	2.2 (1.3–3.1)	1752	NS / NS	NS	NS	NS	NS (0.5%)	2432	58	1.1%

AER=annual event rate, MI=myocardial infarction, N=number of patients, NS=not specified, Revasc=revascularization, SD=standard deviation, UAP=unstable angina pectoris.

* Represents (possible) early revascularizations.

eTable 2a. Cardiovascular Magnetic Resonance (CMR) perfusion – patient and study characteristics

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Tesla	Stressor (%)	Definition 'no ischemia'	Quality assessment
Bertaso(31)	2012	PS	Suspected or known CAD	362	NS	62 (12)	211 (58)	157 (43)	NS	NS	1.5	Adenosine	Qualitative (no reversible defect)	4
Bingham(32)	2011	PS	Suspected or known CAD	908	24 (3)	65 (NS)	532 (59)	449 (49)	317 (35)	433 (48)	1.5	Adenosine	Semi-quantitative (no fixed / reversible defect)	6
Bodi(33)	2012	PS	Suspected or known CAD	1722	NS	64 (11)	1071 (62)	NS	389 (23)	363 (21)	1.5	Dipyridamole	Semi-quantitative (no fixed / reversible defect)	4
Chen(6)	2014	PS	Suspected or known CAD	151	0 (0)	56 (48-63)	91 (60)	17 (11)	NS	17 (11)	1.5	Regadenoson / dipyridamole	Qualitative (no reversible defect)	5
Coelho-Filho(34)	2011	PS	Suspected or known CAD	405	0 (0)	57 (14)	237 (59)	NS	82 (20)	98 (24)	1.5	Adenosine (92%) / dipyridamole (8%)	Semi-quantitative (no reversible defect)	5
Doesch(35)	2009	PS	Known CAD	81	0 (0)	64 (NS)	67 (83)	81 (100)	24 (30)	28 (35)	1.5	Adenosine	Qualitative (no reversible defect)	6
Freed(36)	2013	PS	Suspected or known CAD	149	16 (10)	56 (15)	83 (56)	45 (30)	NS	NS	1.5	Regadenoson	Qualitative (no reversible defect)	4
Hartlage(37) $	2011	RS	Suspected CAD	89	NS	56 (12)	29 (33)	0 (0)	0 (0)	0 (0)	1.5	Adenosine	Qualitative (no reversible defect)	3
Ingkanisorn(38) $	2006	PS	Suspected or known CAD	135	2 (1)	56 (14)	75 (56)	23 (17)	9 (7)	16 (12)	1.5	Adenosine	Qualitative (no fixed / reversible defect)	4
Lo(39)	2011	RS	Suspected or known CAD	203	NS	62 (12)	119 (59)	32 (16)	20 (10)	32 (16)	1.5	Adenosine	Qualitative (no reversible defect)	5
Lubbers(40)	2012	PS	NS	125	3 (2)†	61 (11)	NS (54)	NS	0 (0)	NS	1.5	Adenosine	Qualitative (no fixed / reversible defect)	5
Macwar(41)	2013	RS	Suspected or known CAD	564	NS	62 (13)	325 (58)	293 (52)	NS	NS	1.5	Adenosine	Qualitative (no reversible defect)	4
Pilz(42)	2008	PS	Suspected CAD	218	0 (0)	63 (13)	122 (56)	0 (0)	0 (0)	0 (0)	1.5	Adenosine	Qualitative (no fixed / reversible defect)	5

CAD=coronary artery disease, MI=myocardial infarction, N=number of patients, NS=not specified, PS=prospective, Revasc=revascularization, RS=retrospective, SD=standard deviation.

† Based on entire population (and not just the population that was followed up).

$ Specific study population.

eTable 2b. Cardiovascular Magnetic Resonance (CMR) perfusion – absolute number of adverse cardiovascular events

			Negative test					Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Bertaso(31)	1.8 (1.5–2.1)	272	NS / 1	1	14	NS	2 (0.4%)	362	5	0.8%
Bingham(32)	2.6 (1.2)	610	NS / NS	NS	NS	NS	NS (0.8%)	908	35	1.5%
Bodi(33)	1.1 (0.9)	1010	NS / 7	10	NS	NS	17 (1.5%)	1722	61	3.2%
Chen(6)	1.2 (0.3)	108	0 / 0	0	2	NS	0 (0.0%)			
Coelho-Filho(34)	2.5 (NS–NS)	296	NS / NS	NS	NS	NS	NS (0.7%)	405	38	3.8%
Doesch(35)	2.5 (0.7)	36	0 / 0	0	2	0	0 (0.0%)	81	8	4.0%
Freed(36)	2.0 (0.8)	106	0 / 0	0	0	5	0 (0.0%)	149	2	0.7%
Hartlage(37)	0.8 (NS–NS)	82	0 / 0	0	0	0	0 (0.0%)	89	0	0.0%
Ingkanisorn(38)	1.3 (NS–NS)	107	0 / 0	0	0	NS	0 (0.0%)			
Lo(39)	3.2 (1.6)	160	NS / NS	NS	NS	NS	NS (1.0%)	203	15	2.3%
Lubbers(40)	1.8 (NS–NS)	125	NS / 0	1	3	0	1 (0.4%)			
Macwar(41)	4.0 (1.8)	264	NS / 0	0	8	NS	0 (0.0%)	504	23	1.1%
Pilz(42)	1.0 (0.0)	218	0 / 0	0	2	0	0 (0.0%)			

AER=annual event rate, MI=myocardial infarction, N=number of patients, NS=not specified, Revasc=revascularization, SD=standard deviation, UAP=unstable angina pectoris.

eTable 3a. Cardiovascular Magnetic Resonance (CMR) wall motion – patient and study characteristics

Author (ref. #)	Year	Design	Selection	N	Lost to follow up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Tesla	Stressor	Definition 'no ischemia'	Quality assessment
Bodi(43)	2012	PS	Suspected or known CAD	1722	NS	64 (11)	1071 (62)	NS	389 (23)	363 (21)	1.5	Dipyridamole	Qualitative (no reversible WMA)	4
Gebker(44)	2011	PS	Suspected or known CAD	1532	43 (3)	63 (NS)	1031 (67)	737 (48)	481 (31)	874 (57)	1.5	Dobutamine (+ atropine)	Semi-quantitative (no reversible WMA)	6
Kelle(45)	2011	PS	Suspected or known CAD	1017	94 (6)†	61 (11)	689 (68)	529 (52)	251 (25)	435 (43)	1.5	Dobutamine (+ atropine)	Qualitative (no reversible WMA)	6
Korosoglou(46)	2010	PS	Suspected or known CAD	1493	17 (1)	65 (13)	1110 (74)	816 (55)	NS	779 (52)	1.5	Dobutamine (+ atropine)	Semi-quantitative (no reversible WMA)	5
Kuijpers(47)	2004	PS	Suspected or known CAD	214	2 (1)	63 (NS)	179 (84)	77 (36)	74 (35)	40 (19)	1.0	Dobutamine	Qualitative (no reversible WMA)	6
Wallace(48)	2009	PS	Suspected or known CAD	221	0 (0)	63 (12)	0 (0)	NS	62 (28)	81 (37)	1.5	Dobutamine (+ atropine)	Qualitative (no reversible WMA)	5

CAD=coronary artery disease, MI=myocardial infarction, N=number of patients, NS=not specified, PS=prospective, Revasc=revascularization, RS=retrospective, SD=standard deviation, WMA=wall motion abnormalities.

† Based on entire population (and not just the population that was followed up).

eTable 3b. Cardiovascular Magnetic Resonance (CMR) wall motion – absolute number of adverse cardiovascular events

		Negative test						Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Bodi(43)	1.1 (0.9)	1529	NS / 19	16	NS	NS	35 (2.1%)	1722	61	3.2%
Gebker(44)	2.1 (0.8)	923	NS / 3	5	46	NS	8 (0.4%)	1532	30	0.9%
Kelle(45)	3.7 (2.0)	716	NS / NS	NS	NS	NS	NS (1.1%)	1017	46	1.2%
Korosoglou(46)	2.0 (1.0)	1193	NS / 1	4	15	NS	5 (0.2%)	1493	53	1.8%
Kuijpers(47)	2.0 (0.9)	214	NS / 1	3	11	NS	4 (0.9%)			
Wallace(48)	6.2 (1.6)	161	NS / 6	9	27	24	15 (1.5%)	221	40	2.9%

AER=annual event rate, MI=myocardial infarction, N=number of patients, NS=not specified, Revasc=revascularization, SD=standard deviation, UAP=unstable angina pectoris.

eTable 4a. Exercise electrocardiography – patient and study characteristics

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Cut off value ST-depression	Quality assessment
Bigi(49)	2007	PS	Suspected or known CAD	700	8 (1)	59 (53-64)	595 (85)	510 (72)	NS	NS	≥1.0 mm	5
Bourque(50) $	2011	PS	Suspected or known CAD	463	46 (9)	54 (NS)	332 (72)	105 (23)	67 (15)	89 (19)	≥1.0 mm	5
Bouzas-Mosquera(51) $	2009	PS	Suspected or known CAD	4004	NS	60 (13)	2358 (59)	1153 (29)	871 (22)	611 (15)	≥1.0 mm	5
Calasans(52)	2013	NS	Suspected CAD	397	NS	57 (11)	175 (44)	0 (0)	0 (0)	0 (0)	≥1.0 mm	5
Cannan(53) $	1992	NS	Suspected CAD	87	1 (1)	57 (NS-NS)	65 (75)	0 (0)	NS	0 (0)	≥1.0 mm	4
Chatziioannou(54) $	1999	RS	Suspected or known CAD	369	NS	54 (10)&	337 (87)†	224 (61)	NS (21)	NS	≥1.0 mm	3
Cho(7)	2012	RS	Suspected CAD	2977	NS	58 (10)	1476 (50)	0 (0)	0 (0)	0 (0)	≥1.0 mm	5
Coletta(55)	1995	PS	Suspected or known CAD	204	0 (0)	58 (7)&	216 (81)†	NS	137 (51)†	17 (6)†	≥1.0 mm	5
Dedic(12)	2011	PS	Suspected CAD	409	44 (10)	56 (10)	244 (52)	0 (0)	0 (0)	0 (0)	≥1.0 mm	5
Houghton(56)	1990	RS	Suspected or known CAD	64	2 (3)	51 (NS)	0 (0)	15 (23)	0 (0)	NS	≥1.0 mm	4
Jeetley(57) $	2006	PS	Suspected or known CAD	154	3 (2)	60 (13)	87 (56)	48 (31)	27 (18)	49 (32)	≥1.0 mm	4
Lichtlen(58)	1995	PS	Suspected CAD	176	NS	48 (21-68)	115 (65)	0 (0)	NS	NS	≥1.0 mm	3
Marshall(59) $	2010	RS	Suspected or known CAD	498	18 (3)	53 (10)	379 (73)	181 (35)	65 (13)	117 (23)	≥2.0 mm	5
Mulcahy(60)	1991	PS	Known CAD	172	0 (0)	58 (NS)	148 (86)	172 (100)	75 (44)	23 (13)	≥1.0 mm	6
Niemann(61)	2004	RS	Suspected or known CAD	2763	NS	56 (NS)	1777 (64)	NS	771 (28)	NS	NS	4
Pontone(62)	2013	PS	Suspected CAD	681	NS	61 (10)	461 (68)	0 (0)	0 (0)	0 (0)	>1.0 mm	5
Raiker(63) $	1994	NS	Suspected or known CAD	207	1 (0.5)	59 (11)	108 (52)	42 (20)	10 (5)	NS	≥2.0 mm	4
Sanchis(64) $	2005	PS	Suspected or known CAD	283	NS	64 (12)†	407 (67)†	269 (44)†	NS	NS	≥1.0 mm	2
Sawada(65) $	1990	RS	Suspected CAD	148	22 (13)	53 (11)	77 (52)	0 (0)	0 (0)	0 (0)	≥1.0 mm	3
Vanzetto(66)	1999	NS	Suspected or known CAD	1137	45 (4)	55 (9)	857 (75)	NS	270 (24)	239 (21)	≥1.0 mm	5
Zanco(67)	1995	PS	Suspected or known CAD	147	29 (7)	53 (9)	121 (82)	NS	61 (41)	NS	≥1.0 mm	5

CAD=coronary artery disease, MI=myocardial infarction, N=number of patients, NS=not specified, PS=prospective, Revasc=revascularization, RS=retrospective, SD=standard deviation, UAP=unstable angina pectoris.

† Based on entire population (and not just the population that was followed up).

$ Specific study population.

eTable 4b. Exercise electrocardiography – absolute number of adverse cardiovascular events

			Negative test					Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Bigi(49)	3.1 (2.0–4.3)	700	22 / 18	40	103	NS	58 (2.7%)			
Bourque(50)	2.2 (0.5)	417	12 / 1	3	1	NS	4 (0.4%)	463	4	0.4%
Bouzas-Mosquera(51)	4.5 (3.4)	4004	313 / 63	120	197	NS	183 (1.0%)			
Calasans(52)	6.3 (1.4)	397	13 / 3	13	NS	NS	16 (0.6%)			
Cannan(53)	1.8 (NS–NS)	68	0 / 0	0	NS	NS	0 (0.0%)	87	0	0.0%
Chatziioannou(54)	1.5 (0.2)	288	NS / NS	NS	14	NS	2 (0.5%)	369	5	0.9%
Cho(7)	3.3 (2.3-4.6)	2489	NS / 1	3	48	2	4 (0.0%)	2977	9	0.1%
Coletta(55)	1.3 (0.7)	109	0 / 0	1	NS	NS	1 (0.7%)	204	11	4.1%
Dedic(12)	2.6 (2.1–3.2)	172	NS / 0	1	6	3	1 (0.2%)	409	10	0.9%
Houghton(56)	3.2 (NS)	36	3 / 2	0	NS	NS	2 (1.7%)	64	4	2.0%
Jeetley(57)	0.7 (0.4)	39	0 / 0	0	2*	NS	0 (0.0%)			
Lichtlen(58)	12.4 (NS–NS)	75	10 / 3	4	NS	8	7 (0.8%)	154	6	0.3%
Marshall(59)	4.1 (NS)	367	NS / 2	4	NS	NS	6 (0.4%)	498	7	0.3%
Mulcahy(60)	2.0 (NS)	68	NS / 0	5	3	2	5 (3.7%)	172	9	2.6%
Niemann(61)	5.2 (NS)	1560	106 / 41	98	226*	NS	139 (1.7%)	2579	324	2.4%
Pontone(62)	3.7 (1.0)	262	NS / 0	20	45	NS	20 (2.1%)	681	73	2.9%
Raiker(63)	1.1 (0.2)	66	NS / 0	0	1	NS	0 (0.0%)	207	1	0.4%
Sanchis(64)	0.5 (0.0)	161	0 / 0	0	NS	NS	0 (0.0%)	283	3	2.1%
Sawada(65)	2.4 (0.7)	79	0 / 0	1	2	NS	1 (0.5%)	148	2	0.6%
Vanzetto(66)	6.0 (1.5)	601	NS / 16	19	NS	NS	35 (1.0%)	1137	103	1.5%

		Negative test						Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Zanco(67)	3.6 (NS)	63	NS / 3	2	NS	6	5 (2.2%)	147	9	1.7%

AER=annual event rate, MI=myocardial infarction, N=number of patients, NS=not specified, Revasc=revascularization, SD=standard deviation, UAP=unstable angina pectoris. * Represents (possible) early revascularizations.

eTable 5a. Positron Emission Tomography (PET) – patient and study characteristics

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Tracer	Stressor (%)	Definition 'no ischemia'	Quality assessment
Chow(68)	2005	RS	Suspected or known CAD	629	NS (NS)	59 (NS)	178 (28)	NS	59 (9)	96 (15)	Rb-82	Dipyridamole	Qualitative (no fixed / reversible defect)	4
Chow(69)	2009	PS	Suspected or known CAD	109	3 (2)	61 (NS)	77 (71)	NS	50 (46)	54 (50)	Rb-82 / N-13	Treadmill exercise (64) / dobutamine (36)	Semi-quantitative (SSS < 4)	5
Dorbala(70)	2009	PS	Suspected or known CAD	1432	NS (NS)	63 (NS)	NS (48)	NS (31)	NS (NS)	NS (NS)	Rb-82	Dipyridamole (85) / adenosine (15) /	Semi-quantitative (0% of LV)	4
Tosh, van(71)	2011	PS	Suspected CAD	457	NS	63 (12)	0 (0)	0 (0)	0 (0)	0 (0)	Rb-82	Dipyridamole (NS) / dobutamine (NS)	Semi-quantitative (SSS = 0)	5

CAD=coronary artery disease, MI=myocardial infarction, N=number of patients, NS=not specified, PS=prospective, Revasc=revascularization, RS=retrospective, SD=standard deviation, SSS=summed stress score.

eTable 5b. Positron Emission Tomography (PET) – absolute number of adverse cardiovascular events

		Negative test						Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Chow(68)	2.3 (1.1)	629	NS / 0	1	13	NS	1 (0.1%)			
Chow(69)	2.3 (1.6)	46	NS / 0	0	1	NS	0 (0.0%)	124	6	2.1%
Dorbala(70)	1.7 (0.7)	664	39 / 2	6	NS	NS	8 (0.7%)	1432	83	3.4%
Tosh, van(71)	3.3 (1.6)	457	11 / 2	3	4	NS	5 (0.3%)			

AER=annual event rate, MI=myocardial infarction, N=number of patients, NS=not specified, Revasc=revascularization, SD=standard deviation, UAP=unstable angina pectoris.

eTable 6a. Stress echocardiography – patient and study characteristics

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Stressor (%)	Definition 'no ischemia'	Quality assessment
Afridi(72)	1994	RS	Suspected or known CAD	77	0 (0)	62 (9)	76 (99)	41 (53)	22 (29)	28 (36)	Dobutamine	Qualitative (no reversible WMA)	5
Almeida(73)	2011	PS	Suspected CAD	147	0 (0)	62 (NS)	0 (0)	0 (0)	10 (7)	17 (12)	Dipyridamole	Semi-quantitative (no reversible WMA)	5
Anthopoulos(74)	1996	PS	Suspected or known CAD	120	NS	75 (3)	72 (60)	NS	48 (40)	NS	Dobutamine	Semi-quantitative (no reversible WMA)	4
Baldini(75)	2006	PS	Suspected or known CAD	112	NS	62 (NS)	80 (71)	NS	0 (0)	NS	Dipyridamole (+ atropine)	Semi-quantitative (no reversible WMA)	3
Bholasingh(76)	2003	PS	Suspected or known CAD	377	0 (0)	56 (12)	237 (58)	77 (20)	59 (16)	NS	Dobutamine (+ atropine)	Semi-quantitative (no reversible WMA)	4
Biagini(77) $	2005	NS	Suspected or known CAD	1434	16 (1)	73 (5)	965 (67)	NS	NS	NS	Dobutamine (+ atropine)	Semi-quantitative (no reversible WMA)	5
Bouzas-Mosquera(51) $	2009	PS	Suspected or known CAD	4004	NS	60 (13)	2358 (59)	1153 (29)	871 (22)	611 (15)	Treadmill exercise	Semi-quantitative (no reversible WMA)	4
Calasans(52) $	2013	NS	Suspected CAD	397	NS	57 (11)	175 (44)	0 (0)	0 (0)	0 (0)	Treadmill exercise	Semi-quantitative (no reversible WMA)	4
Chuah(78)	1998	PS	Suspected or known CAD	860	3 (0.3)	70 (10)	479 (56)	390 (45)	NS (31)	NS (24)	Dobutamine (+ atropine)	Semi-quantitative (no reversible WMA)	6
Chung(79)	2004	RS	Suspected or known CAD	233	19 (8)	64 (2)	108 (46)	51 (22)	0 (0)	0 (0)	Treadmill exercise (79) / Dobutamine + atropine (21)	Qualitative (no fixed / reversible WMA)	6
Ciaroni(80)	2002	NS	Suspected CAD	94	0 (0)	64 (NS)	55 (59)	0 (0)	0 (0)	0 (0)	Dobutamine	Semi-quantitative (no reversible WMA)	6
Coletta(55)	1995	PS	Suspected or known CAD	268	29 (11)	58 (7)	216 (81)	NS	137 (51)	17 (6)	Dipyridamole	Semi-quantitative (no reversible WMA)	4
Colon(81) $	1998	PS	Suspected CAD	108	0 (0)	54 (12)	54 (50)	0 (0)	NS	NS	Treadmill exercise (72) / Dobutamine + atropine (28)	Qualitative (no reversible WMA)	4
Cordovil(82)	2004	NS	Suspected or known CAD	300	0 (0)	61 (NS)	0 (0)	120 (40)	70 (23)	46 (15)	Dobutamine (+ atropine)	Semi-quantitative (no reversible WMA)	6
Cortigiani(83)	2001	RS	Suspected or known CAD	1733	0 (0)	63 (NS)	941 (54)	NS	587 (34)	0 (0)	Dipyridamole (58) / Dobutamine (42)	Semi-quantitative (no reversible WMA)	5
Davar(84)	1999	NS	Suspected or known CAD	72	0 (0)	60 (11)	0 (0)	NS	NS	NS	Dobutamine (+ atropine)	Qualitative (no reversible WMA)	5
Hartlage(37) $	2011	RS	Suspected CAD	166	0 (0)	54 (13)	37 (22)	0 (0)	0 (0)	0 (0)	Dobutamine + handgrip exercise (+ atropine)	Qualitative (no reversible WMA)	3
Isma'eel(85)	2009	PS	Suspected or known CAD	45	4 (8)	68 (6)&	0 (0)	NS	NS (22)†	NS (18)†	Dobutamine	NS (no reversible WMA)	5

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Stressor (%)	Definition 'no ischemia'	Quality assessment
Ismail(86)	1995	RS	Suspected or known CAD	115	0 (0)	53 (11)	42 (37)	NS	NS	NS	Bicycle exercise	Qualitative (no fixed / reversible WMA)	5
Kamaran(87)	1995	RS	Suspected or known CAD	210	0 (0)	60 (NS)	84 (40)	NS	55 (26)	NS	Dobutamine	Qualitative (no reversible WMA)	4
Krivokapich(88)	1993	RS	Suspected or known CAD	360	0 (0)	62 (13)	237 (66)	NS	127 (35)	64 (18)	Treadmill exercise	Semi-quantitative (no reversible WMA)	5
Krivokapich(89)	1999	PS	Suspected or known CAD	558	0 (0)	67 (12)	220 (39)	NS	154 (28)	129 (23)	Dobutamine (+ atropine)	Semi-quantitative (no reversible WMA)	5
Low(90)	2004	NS	Suspected CAD	122	0 (0)	60 (11)	75 (62)	0 (0)	0 (0)	0 (0)	Dobutamine (+ atropine)	NS (no fixed / reversible WMA)	6
Marcovitz(91)	1996	RS	Suspected or known CAD	291	NS (6)	63 (12)	146 (50)	NS	NS	NS	Dobutamine	Qualitative (no reversible WMA)	5
Marwick(92) $	1998	NS	Suspected or known CAD	191	2 (1)	63 (13)	120 (62)	59 (31)	NS	NS	Dobutamine (+ atropine)	Qualitative (no fixed / reversible WMA)	4
Mesa(93)	1999	RS	Suspected or known CAD	100	0 (0)	60 (13)	0 (0)	22 (22)	1 (1)	10 (10)	Dobutamine (+ atropine)	Qualitative (no reversible WMA)	6
Olmos(94)	1998	PS	Suspected or known CAD	225	23 (9)	56 (12)†	189 (76)†	NS	86 (35)†	57 (23)†	Treadmill exercise	Semi-quantitative (no fixed / reversible WMA)	5
Pingitore(95)	1999	PS	Suspected or known CAD	460	23 (4)†	60 (10)	379 (82)	NS	279 (61)	NS	Dipyridamole (+ atropine)	Semi-quantitative (no reversible WMA)	5
Sawada(65)	1990	RS	Suspected CAD	148	22 (13)	53 (11)	77 (52)	0 (0)	0 (0)	0 (0)	Treadmill exercise	Qualitative (no fixed / reversible WMA)	4
Sawada(96)	2009	PS	Suspected or known CAD	318	6 (2)	59 (12)	153 (47)	NS	94 (29)	16 (5)	Dobutamine	Semi-quantitative (no reversible WMA)	5
Song(97)	2002	RS	Suspected or known CAD	650	42 (6)	54 (10)	427 (66)	NS	NS	0 (0)	Ergonovine	Semi-quantitative (no reversible WMA)	5
Srivastava(98)	2008	RS	Suspected or known CAD	727	0 (0)	71 (NS)	299 (41)	218 (30)	158 (22)	151 (21)	Dobutamine (+ atropine)	Semi-quantitative (no fixed and no reversible WMA)	6
Steinberg(99)	1997	PS	Suspected or known CAD	120	0 (0)	67 (10)	119 (99)	NS	27 (23)	4 (3)	Dobutamine	Qualitative (no reversible WMA)	5
Yao(100)	2003	PS	Suspected or known CAD	1500	NS (2)	59 (13)	762 (51)	NS	248 (17)	260 (17)	Dobutamine + atropine (66) / Treadmill exercise (34)	Semi-quantitative (no fixed / reversible WMA)	5
Yao(101)	2010	RS	Suspected or known CAD	3121	0 (0)	60 (13)	1494 (48)	NS	510 (16)	348 (11)	Dobutamine + atropine (59) / Treadmill exercise (41)	Semi-quantitative (no fixed / reversible WMA)	5

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Stressor (%)	Definition 'no ischemia'	Quality assessment
Zagatina(102)	2013	RS	Suspected or known CAD	323	NS	54 (8)	247 (76)	255 (79)	159 (49)	NS	Bicycle exercise	Semi-quantitative (no fixed / reversible WMA)	4

CAD=coronary artery disease, MI=myocardial infarction, N=number of patients, NS=not specified, PS=prospective, Revasc=revascularization, RS=retrospective, SD=standard deviation, WMA=wall motion abnormalites.

† Based on entire population (and not just the population that was followed up).

$ Specific study population.

eTable 6b. Stress echocardiography – absolute number of adverse cardiovascular events

		Negative test						Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Afridi(72)	0.8 (NS)	67	NS / NS	NS	NS	NS	3 (5.6%)	77	7	11.4%
Almeida(73)	1.3 (NS)	128	0 / 0	0	NS	NS	0 (0.0%)	147	0	0.0%
Anthopoulos(74)	1.2 (0.6)	38	NS / 0	0	NS	NS	0 (0.0%)	120	13	9.0%
Baldini(75)	0.8 (0.6)	27	NS / 0	2	NS	NS	2 (9.3%)	112	28	31.3%
Bholasingh(76)	0.5 (NS)	351	NS / 1	0	7	6	1 (0.6%)	377	4	2.1%
Biagini(77) $	6.5 (NS)	759	NS / NS	NS	NS	NS	92 (1.9%)	1434	294	3.2%
Bouzas-Mosquera(51)	4.5 (3.4)	3335	NS / NS	NS	NS	NS	NS (0.8%)	4004	183	1.0%
Calasans(52)	6.3 (1.4)	329	NS / NS	NS	NS	NS	11 (0.5%)	397	16	0.6%
Chuah(78)	2.0 (0.8)	539	NS / 30	12	NS	NS	42 (3.9%)	860	86	5.0%
Chung(79)	2.7 (1.1)	233	NS / 4	1	7	NS	5 (0.8%)			
Ciaroni(80)	5.3 (0.6)	71	NS / 0	0	1	1	0 (0.0%)	94	6	1.2%
Coletta(55)	1.3 (0.7)	222	NS / 2	2	NS	6	4 (1.4%)	268	15	4.3%
Colon(81)	1.1 (0.6)	100	NS / 0	0	NS	NS	0 (0.0%)	108	0	0.0%
Cordovil(82)	2.3 (NS)	205	NS / 2	3	7	NS	5 (1.1%)	300	15	2.2%
Cortigiani(83)	2.8 (NS)	1273	NS / 19	41	56	NS	60 (1.7%)	1733	113	2.3%
Davar(84)	1.1 (NS)	72	0 / 0	0	0	0	0 (0.0%)			
Hartlage(37)	0.9 (0.1–1.6)	164	0 / 0	1	0	1	1 (0.7%)	166	1	0.7%
Isma'eel(85)	2.0 (0)	35	2 / 1	2	6	2	3 (4.3%)	45	4	4.4%
Ismail(86)	1.9 (NS)	115	NS / 0	3	1	1	3 (1.4%)			
Kamaran(87)	0.7 (NS–NS)	147	5 / 1	0	6	NS	1 (1.0%)	210	30	20.4%

		Negative test						Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Krivokapich(88)	1.0 (NS)	295	NS / 2	7	25*	NS	9 (3.1%)	360	16	4.4%
Krivokapich(89)	1.0 (NS)	422	NS / 13	14	26	NS	27 (6.4%)	558	52	9.3%
Low(90)	4.1 (1.6)	122	NS / 1	3	5	NS	4 (0.8%)			
Marcovitz(91)	1.3 (0.3)	148	15 / 5	3	NS	NS	8 (4.2%)	291	29	7.7%
Marwick(92) $	3.2 (1.2)	51	NS / 2	1	1	NS	3 (1.8)	191	24	3.9%
Mesa(93)	2.0 (0.9)	100	6 / 0	0	2	NS	0 (0.0%)	NS	NS	
Olmos(94)	3.7 (2.0)	117	NS / 1	3	5	3	4 (0.9%)	225	15	1.8%
Pingitore(95)	3.2 (1.8)	253	NS / 6	13	22	NS	19 (2.3%)	460	40	2.7%
Sawada(65)	2.4 (0.7)	148	NS / 0	2	4	NS	2 (0.6%)			
Sawada(96)	5.3 (3.1)	206	NS / NS	NS	NS	NS	56 (5.1%)	318	107	6.3%
Song(97)	3.8 (1.9)	413	NS / 3	4	3*	4	7 (0.4%)	650	19	0.8%
Srivastava(98)	3.3 (1.5)	727	NS / 12	52	NS	NS	64 (2.7%)			
Steinberg(99)	5.0 (NS)	42	4 / 0	2	12*	NS	2 (1.0%)	120	12	2.0%
Yao(100)	2.7 (1.0)	1075	NS / NS	NS	NS	NS	NS (0.9%)	1500	74	1.8%
Yao(101)	2.8 (1.1)	2072	NS / NS	NS	NS	NS	NS (0.8%)	3121	161	1.8%
Zagatina(102)	5.2 (0.2)	105	NS / 1	5	3*	NS	6 (1.1%)	323	48	2.9%

AER=annual event rate, MI=myocardial infarction, N=number of patients, NS=not specified, Revasc=revascularization, SD=standard deviation, UAP=unstable angina pectoris.

* Represents (possible) early revascularizations.

$ Specific study population.

eTable 7a. Single-photon Emission Computed Tomography (SPECT) – patient and study characteristics

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Tracer	Stressor (%)	Definition 'no ischemia'	Quality assessment
Acampa(103)	2014	RS	Suspected or known CAD	828	44 (5)	60 (NS)	470 (57)	NS	160 (19)	239 (29)	Tc-99m MIBI	Treadmill exercise (59) / Dipyridamole (41)	Semi-quantitative (SSS < 3)	5
Akinboboye(104)	2001	RS	Suspected or known CAD	529	NS	57 (16)	NS (29)	NS	NS (11)	0 (0)	Thallium-201	Treadmill exercise (73) / Dipyridamole (29) / Dobutamine (9)	NS (included only 'normal' scans)	4
Basic(105)	2006	PS	Suspected or known CAD	51	0 (0)	60 (11)	34 (67)	26 (51)	4 (8)	NS	Tc-99m MIBI	Dipyridamole	Semi-quantitative (included only 'normal perfusion')	5
Bom(106)	2014	NS	Suspected CAD	762	NS	63 (12)	319 (42)	0 (0)	0 (0)	0 (0)	Tc-99m Tetrofosmin	Adenosine (80) / Adenosine + exercise (16) / Dobutamine (2) / Dobutamine + atropine (1)	Qualitative (no fixed / reversible defect)	5
Bucerius(107)	2009	RS	Suspected or known CAD	90	1 (1)	75 (4)	54 (60)	46 (51)	21 (23)	33 (37)	Tc-99m MIBI	Bicycle exercise	Semi-quantitative (SDS < 2)	6
Boyne(108)	1997	PS	Suspected or known CAD	229	26 (10)	58 (12)	114 (50)	NS	54 (27)	NS	Tc-99m MIBI	Exercise	Qualitative and quantitative (no fixed / reversible defect)	4
Calnon(109)	2001	NS	Suspected or known CAD	308	3 (1)	62 (NS)	142 (46)	NS	93 (31)	50 (16)	Tc-99m MIBI	Dobutamine	NS ('normal' scans)	5
Chatziioannou(54) $	1999	RS	Suspected or known CAD	388	NS	54 (10)	337 (87)	224 (58)	67 (17)	155 (40)	Tc-99m MIBI	Treadmill exercise	Qualitative (no fixed / reversible defect)	4
Dawson(110)	2009	PS	Suspected or known CAD	261	NS	64 (NS)	131 (50)	134 (52)	99 (38)	NS	Tc-99m MIBI	Dipyridamole	Qualitative (no fixed / reversible defect)	4
Dona(111)	2011	PS	Suspected or known CAD	114	3 (5)	67 (NS)	67 (59)	NS	NS	43 (38)	Tc-99m MIBI	Bicycle exercise / Dipyridamole	Semi-quantitative (SDS ≤1)	5
Doukky(112)	2013	PS	Suspected or known CAD	1236	14 (1)	58 (12)	642 (52)	79 (6)	10 (1)	74 (6)	Tc-99m MIBI	Treadmill exercise / Adenosine (+ low-level exercise)	Semi-quantitative (SSS = 0)	6
Ferreira(113)	2013	RS	Suspected or known CAD	790	67 (8)	63 (12)	378 (48)	190 (24)	NS	157 (20)	Tc-99m Tetrofosmin	Adenosine (68) / Exercise (32)	Semi-quantitative (SSS ≤1)	5
Filipiak-Strzecka(114)	2013	RS	Suspected or known CAD	732	0 (0)	57 (9)	299 (41)	NS	109 (15)	75 (10)	Tc-99m MIBI	Treadmill exercise	Qualitative (no reversible defect)	5

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Tracer	Stressor (%)	Definition 'no ischemia'	Quality assessment
Galassi(115)	2001	NS	Suspected or known CAD	459	56 (11)	58 (10)	357 (78)	NS	252 (55)	40 (9)	Tc-99m Tetrofosmin	Treadmill exercise	Semi-quantitative (SSS = 0)	4
Gentile(116)	2001	PS	Suspected CAD	124	8 (6)	71 (NS)&	90 (68)&	0 (0)	0 (0)	0 (0)	Thallium-201	Bicycle exercise (89) / Dipyridamole (18)	Qualitative (no reversible defect)	5
Gibbons(117) $	1999	RS	Suspected or known CAD	4473	176 (4)	61 (11)	2046 (46)	NS	241 (5)	0 (0)	Thallium-201 / Tc-99m MIBI	Treadmill exercise	NS (included only 'normal stress scans')	4
Gibson(118)	2002	PS	Suspected CAD	652	77 (11)	52 (13)	224 (34)	0 (0)	0 (0)	0 (0)	Tc-99m MIBI	Treadmill exercise (93) / Dipyridamole (7)	NS (no fixed / reversible defect)	5
Groutars(119)	2002	PS	Suspected or known CAD	597	13 (2)	62 (11)	348 (58)	NS	193 (32)	178 (30)	Rest Thallium 201 / stress Tc-99m Tetrofosmin	Adenosine (58) / Bicycle exercise (42)	Semi-quantitative (SSS < 4)	5
Hachamovitch(120)	1997	RS	Suspected or known CAD	1079	71 (6)&	70 (NS)	542 (50)	NS	346 (32)	362 (34)	Rest Thallium-201 / stress Tc-99m MIBI	Adenosine	Semi-quantitative (SSS < 4)	5
Hage(121) $	2006	NS	NS	65	NS	66 (13)	13 (20)	NS	0 (0)	0 (0)	Tc-99m MIBI / Tetrofosmin	Adenosine	Qualitative (included only 'normal' scans)	3
Hakeem(122)	2008	NS	Suspected or known CAD	1084	NS	63 (10)	1029 (95)	417 (40)	194 (19)	328 (31)	Tc-99m MIBI / Tetrofosmin	Adenosine (68) / Treadmill exercise (32)	Semi-quantitative (SSS < 4)	5
Iqbal(123)	2012	RS	Suspected or known CAD	2000	0 (0)	59 (12)	900 (45)	481 (24)	133 (7)	362 (18)	Tc-99m MIBI	Adenosine (50) / Regadenoson (50)	NS (included only 'normal perfusion pattern')	6
Jeong(124) $	2013	RS	Suspected CAD	337	42 (11)	61 (9)	184 (50)	0 (0)	0 (0)	0 (0)	Thallium-201 rest / Tc99m MIBI stress	Dipyridamole	NS (included only 'normal perfusion')	4
Kaminek(125)	2002	NS	Suspected or known CAD	149	NS	54 (9)	114 (77)	NS	73 (49)	NS	Thallium-201	Bicycle exercise	Qualitative (no reversible defect)	3
Klodas(126) $	2003	NS	Suspected or known CAD	49	NS	67 (10)	6 (12)	NS	1 (2)	5 (10)	Thallium-201 / Tc-99m MIBI	Dipyridamole (51) / Adenosine (49)	NS (included only 'normal' scans)	3
Koehli(127)	2006	RS	Suspected or known CAD	200	5 (3)	65 (10)	114 (57)	50 (25)	NS	NS	Rest Thallium-201 / stress Tc-99m MIBI	Bicycle exercise (41) / Dipyridamole (53) / Dobutamine +atropine (3) / Adenosine (5)	Semi-quantitative (no fixed / reversible defect)	5

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Tracer	Stressor (%)	Definition 'no ischemia'	Quality assessment
Leslie(128)	2005	RS	NS	718	NS	60 (11)	NS	NS	NS (26)	NS	Tc-99m MIBI	Treadmill exercise (77) / Dipyridamole (15) / Dipyridamole + exercise (7)	Qualitative (no reversible defect)	4
Lima(129)	2004	RS	Suspected CAD	321	7 (2)	79 (3)	121 (38)	0 (0)	0 (0)	0 (0)	Tc-99m MIBI	Dipyridamole (50) / Treadmill exercise (50)	Semi-quantitative (no reversible defect)	6
Miernik(130) $	2012	PS	Suspected or known	115	0 (0)	58 (9)	0 (0)	NS	0 (0)	0 (0)	Tc-99m MIBI	Treadmill exercise	Quantitative (<10% reversible perfusion defect)	3
Mouden(131) $	2014	RS	Suspected CAD	282	0 (0)	69 (9)	177 (63)	0 (0)	0 (0)	0 (0)	Tc-99m Tetrofosmin	Adenosine (+ low-level exercise) (95) / Dobutamine (5)	Semi-quantitative (no reversible defect)	5
Nabi(132) $	2012	PS	Suspected or known CAD	1561	15 (1)	56 (14)	663 (42)	189 (12)	NS	NS	NS (Tc-99m)	Adenosine (92) / Treadmill exercise (8) / Dobutamine (0.2)	Quantitative (no fixed or reversible defect)	3
Nishimura(133)	2008	PS	Suspected or known CAD	4031	223 (5)	66 (10)	2580 (64)	NS	1172 (29)	1436 (36)	Tc-99m Tetrofosmin	Exercise (69) / Dipyridamole (15) / Adenosine (14)	Semi-quantitative (SSS < 4)	5
Olmos(94)	1998	PS	Suspected or known CAD	225	23 (9)	56 (12)&	189 (76)&	NS	86 (35)&	57 (23)&	Thallium-201	Treadmill exercise	Semi-quantitative (no reversible defect)	5
Otsuka(134)	2014	PS	NS	543	24 (4)	65 (NS)	334 (62)	NS	0 (0)	0 (0)	Thallium-201	Bicycle exercise	Qualitative ('without any perfusion abnormalities)	4
Pazhenkottil(135)	2011	RS	Suspected or known CAD	876	NS	65 (11)	558 (64)	343 (39)	NS	NS	Tc-99m Tetrofosmin	Adenosine	Semi-quantitative (SSS < 1)	4
Petix(136)	2005	PS	Suspected or known CAD	333	4 (0.0)	63 (10)	217 (65)	NS	126 (38)	87 (26)	Tc-99m MIBI	Bicycle exercise (75) / Dipyridamole (25)	Semi-quantitative (SSS < 4)	5
Raziei(137)	2011	PS	Suspected or known CAD	1047	NS	60 (12)	248 (24)	NS	9 (1)	0 (0)	Tc-99m MIBI	Dipyridamole (63) / Treadmill exercise (37) / Dobutamine (0.4)	NS (included only 'normal' scans)	4
Romero-Farina(138)	2015	NS	Suspected or known CAD	2922	NS	63 (13)	1275 (44)	508 (17)	NS	NS	Tc-99m Tetrofosmin	Exercise (70) (+ dipyridamole (16))/Dipyridamole (14)	Semi-quantitative (no fixed / reversible defect)	4
Sharma(139) $	2010	RS	Suspected CAD	76	4 (5%)	66 (9)	10 (13)	0 (0)	0 (0)	0 (0)	Thallium-201 / Tc-99m MIBI	Adenosine	Semi-quantitative (included only 'normal' MPI)	5

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Tracer	Stressor (%)	Definition 'no ischemia'	Quality assessment
Schinkel(140)	2002	PS	Suspected or known CAD	473	3 (1)&	61 (12)	273 (58)	NS	210 (44)	167 (35)	Tc-99m MIBI	Dobutamine (+atropine)	Semi-quantitative (no fixed / reversible defect)	5
Schinkel(141)	2002	PS	Suspected or known CAD	693	2 (0.3)&	60 (10)	419 (60)	NS	194 (28)	211 (30)	Tc-99m Tetrofosmin	Dobutamine (+atropine)	Semi-quantitative (no fixed / reversible defect)	5
Shimoni(142) $	2010	PS	Suspected or known CAD	53	0 (0)	75 (7)&	43 (74)&	NS	17 (29)&	23 (40)&	Thallium-201	Dipyridamole	NS (no fixed / reversible defect)	4
Simonsen(143)	2013	NS	Suspected or known CAD	2157	7 (0.3)	61 (0)	1152 (53)	720 (33)	394 (18)	619 (29)	Tc-99m MIBI	Exercise / Adenosine / Dipyridamole / Dobutamine	Semi-quantitative (SSS < 4)	6
Soman(144)	1999	RS	Suspected or known CAD	435	35 (8)	57 (10)	NS (56)	28 (6)&	NS	24 (5)&	Tc-99m MIBI	Treadmill exercise (90) / Dipyridamole (10)	NS (included only 'normal' scans)	5
Stratmann(145)	1994	RS	Suspected or known CAD	534	20 (3)	65 (9)	519 (97)	NS	197 (37)	107 (20)	Tc-99m MIBI	Dipyridamole	Qualitative (no reversible defect)	5
Stratmann(146)	1994	RS	Suspected or known CAD	521	10 (2)	59 (NS)	511 (98)	190 (36)	184 (35)	132 (25)	Tc-99m MIBI	Treadmill exercise	Qualitative (no reversible defect)	6
Sugihara(147)	1998	PS	Suspected or known CAD	182	0 (0)	68 (11)	105 (58)	NS	NS	NS	Tc-99m MIBI	Treadmill exercise	Qualitative (no reversible defect)	4
Travin(148)	1997	PS	Suspected or known CAD	2228	149 (6)	63 (NS)	1226 (52)	NS	711 (30)	308 (13)	Tc-99m MIBI	Treadmill exercise (64) / Dipyridamole (43)	Semi-quantitative (no fixed / reversible defect)	5
Travin(149)	2004	RS	Suspected or known CAD	3207	332 (9)	62 (13)	1620 (51)	937 (29)	777 (24)	789 (25)	Tc-99m MIBI	Treadmill exercise (59)/Dipyridamole (36)/Dobutamine (5)/Adenosine(<1)	Semi-quantitative (SSS = 0)	6
Uebleis(150)	2009	PS	Known CAD	260	1 (0.4)	60 (10)	174 (67)	260 (100)	57 (22)	89 (34)	Tc-99m MIBI	Bicycle (62) / Pharmacological stress (38)	Semi-quantitative (SDS < 5)	6
Uthamalingam (151) $	2013	NS	Suspected CAD	43	0 (0)	73 (9)	10 (23)	0 (0)	0 (0)	0 (0)	Tc-99m MIBI	Regadenoson	NS (included only 'normal' scans)	5
Vanzetto(66)	1999	RS	Suspected or known CAD	1137	45 (4)	55 (9)	857 (75)	NS	270 (24)	239 (21)	Thallium-201	Bicycle exercise	Qualitative (no fixed / reversible defect)	5
Wolak(152)	2014	RS	Suspected CAD	11,812	NS	61 (NS)	4928 (42)	0 (0)	0 (0)	0 (0)	Thallium-201 / Tc-99m MIBI	Treadmill exercise / Dipyridamole / Dobutamine	Quantitative (perfusion defect <5%)	5

Author (ref. #)	Year	Design	Selection	N	Lost to follow-up, N (%)	Mean age, y (SD)	Male, N (%)	History of CAD, N (%)	History of MI, N (%)	History of revasc, N (%)	Tracer	Stressor (%)	Definition 'no ischemia'	Quality assessment
Yang(153)	2006	RS	Suspected or known CAD	155	4 (3)	54 (NS)	117 (75)	88 (57)	0 (0)	0 (0)	Tc-99m MIBI	Bicycle exercise	Qualitative (no fixed / reversible defect)	6
Zanco(67)	1995	PS	Suspected or known CAD	147	29 (7)	53 (9)	121 (82)	NS	61 (41)	NS	Tc-99m MIBI	Bicycle exercise	Semi-quantitative (no reversible defect)	4

CAD=coronary artery disease, MI=myocardial infarction, N=number of patients, NS=not specified, PS=prospective, Revasc=revascularization, RS=retrospective, SD=standard deviation, SDS=summed difference score, SSS=summed stress score.

† Based on entire population (and not just the population that was followed up).

$ Specific study population.

eTable 7b. Single-photon Emission Computed Tomography (SPECT) – absolute number of adverse cardiovascular events

		Negative test						Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Acampa(103)	4.4 (3.7-5.3)	828	NS / 13	11	NS	NS	24 (0.7%)			
Akinboboye(104)	1.5 (0.5)	529	NS / 11	7	NS	NS	18 (2.3%)			
Basic(105)	2.4 (NS)	27	NS / 0	0	0	0	0 (0.0%)	51	2	1.6%
Bom(106)	2.0 (NS)	762	15 / 1	8	33	NS	9 (0.6%)			
Bucerius(107)	2.7 (1.1)	44	NS / 1	1	4	NS	2 (1.7%)	90	6	2.5%
Boyne(108)	1.6 (0.4)	155	0 / 0	2	NS	NS	2 (0.8%)	229	2	0.5%
Calnon(109)	1.9 (1.1)	150	20 / 2	5	0	NS	7 (2.5%)	308	33	5.6%
Chatziioannou(54)	1.5 (0.2)	231	NS / 0	0	4	NS	0 (0.0%)	388	5	0.9%
Dawson(110)	1.2 (0.4)	172	NS / 3	4	NS	NS	7 (3.4%)	261	22	7.0%
Dona(111)	1.8 (0.8)	114	NS / 1	2	15	NS	3 (1.5%)			
Doukky(112)	2.3 (0.8)	1236	18 / 5	6	23*	NS	11 (0.4%)			
Ferreira(113)	3.6 (1.1)	790	57 / 10	9	19	NS	19 (0.7%)			
Filipiak-Strzecka(114)	4.8 (0.7)	421	11 / 5	22	23	NS	27 (1.3%)	732	74	2.1%
Galassi(115)	3.2 (NS–NS)	106	0 / 0	3	6	NS	3 (0.9%)	459	35	2.4%
Gentile(116)	2.3 (NS)	19	1 / 0	0	1	NS	0 (0.0%)	124	12	4.2%
Gibbons(117)	3.0 (2.0)	4473	NS / 26	57	75	NS	83 (0.6%)			
Gibson(118)	1.9 (0.5)	652	2 / 0	1	1	2	1 (0.1%)			
Groutars(119)	1.9 (0.8)	278	NS / 2	3	NS	NS	5 (0.9%)	597	46	4.1%
Hachamovitch(120)	2.3 (0.8)	445	NS / 9	7	NS	NS	16 (1.6%)	1079	120	4.8%
Hage(121)	2.0 (0.7)	65	1 / 0	0	6	NS	0 (0.0%)			

			Negative test					Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Hakeem(122)	2.1 (NS-NS)	684	56 / 11	15	NS	NS	26 (1.8%)	1048	79	3.6%
Iqbal(123)	2.0 (0.0)	2000	NS / NS	NS	NS	NS	43 (1.1%)			
Jeong(124)	2.7 (1.0)	337	NS / NS	NS	NS	NS	6 (0.7%)			
Kaminek(125)	1.7 (0.8)	74	NS / 4	0	8*	NS	4 (3.2%)	149	21	8.3%
Klodas(126)	2.3 (1.7)	49	3 / 2	4	5	NS	6 (5.3%)			
Koehli(127)	3.0 (NS–NS)	85	NS / 0	0	2	NS	0 (0.0%)	200	14	2.3%
Leslie(128)	5.6 (1.1)	437	NS / NS	NS	NS	NS	27 (1.1%)	718	79	2.0%
Lima(129)	2.8 (1.3)	260	NS / NS	NS	NS	NS	16 (2.2%)	321	35	3.9%
Miernik(130)	3.6 (2.6)	95	NS / 0	0	0	NS	0 (0.0%)	115	0	0.0%
Mouden (131)	2.0 (0.9)	177	NS / 1	NS	35*	NS	1 (0.3%)	282	2	0.4%
Nabi(132)	0.6 (0.2)	1441	0 / 0	8	NS	NS	8 (0.9%)	1561	17	1.8%
Nishimura(133)	3.0 (0.0)	1862	NS / 11	15	NS	NS	26 (0.5%)	4031	96	0.8%
Olmos(94)	3.7 (2.0)	115	NS / 1	3	NS	NS	4 (0.9%)	225	15	1.8%
Otsuka(134)	3.4 (0.8)	543	NS / 3	9	11	NS	12 (0.6%)			
Pazhenkottil(135)	2.3 (0.6)	43	NS / 0	0	NS	NS	0 (0.0%)	876	5	0.2%
Petix(136)	1.6 (1.3)	79	NS / NS	NS	NS	NS	NS (0.9%)	333	30	5.6%
Raziei(137)	1.0 (0.0)	1047	14 / 2	1	3	NS	3 (0.3%)			
Romero-Farina(138)	5.0 (3.3)	2922	269 / NS	NS	NS	NS	81 (0.6%)			
Sharma(139)	2.0 (1.1)	76	NS / 0	0	1	NS	0 (0.0%)			
Schinkel(140)	8.0 (1.4)	161	NS / NS	NS	NS	NS	NS (1.2%)	473	101	2.7%
Schinkel(141)	3.1 (1.4)	312	NS / NS	NS	NS	NS	NS (1.5%)	693	85	4.0%
Shimoni(142)	4.3 (NS–NS)	10	NS / 2	0	0	0	2 (4.7%)			

			Negative test					Population event risk		
Author (ref. #)	**Follow-up, years (SD)**	**N**	**Death/Cardiac death**	**MI**	**Revasc**	**UAP**	**Cardiac death + MI (AER, %)**	**N**	**Cardiac death + MI**	**Cardiac death + MI (AER, %)**
Simonsen(143)	6.2 (NS)	1327	NS / NS	NS	NS	NS	54 (0.7%)	2157	182	1.4%
Soman(144)	2.5 (1.3)	435	NS / 2	0	5	NS	2 (0.2%)			
Stratmann(145)	1.1 (0.4)	372	NS / NS	NS	NS	NS	30 (7.3%)	534	58	9.9%
Stratmann(146)	1.1 (0.4)	321	NS / NS	NS	NS	NS	8 (2.3%)	521	24	4.2%
Sugihara(147)	1.1 (0.6)	157	NS / 1	0	3	4	1 (0.6%)	182	3	1.5%
Travin(148)	1.3 (0.7)	987	NS / NS	NS	NS	NS	15 (1.2%)	2086	85	3.1%
Travin(149)	2.2 (1.3)	1970	NS / 40	23	NS	NS	63 (1.5%)	3207	180	2.6%
Uebleis(150)	5.4 (2.9–8.2)	174	NS / NS	NS	NS	NS	18 (1.9%)	260	23	1.6%
Uthamaligam(151)	1.2 (0.6)	43	2 / 1	0	5*	NS	1 (1.9%)			
Vanzetto(66)	6.0 (1.5)	388	NS / 7	6	NS	NS	13 (0.6%)	1137	103	1.5%
Wolak(152)	6.0 (2.7)	11,812	945 / 146	359	NS	NS	505 (0.7%)			
Yang(153)	4.2 (1.6)	155	NS / 0	3	7	NS	3 (0.5%)			
Zanco(67)	3.6 (NS)	74	NS / 1	2	NS	NS	3 (1.1%)	147	9	1.7%

AER=annual event rate, MI=myocardial infarction, N=number of patients, NS=not specified, Revasc=revascularization, SD=standard deviation, UAP=unstable angina pectoris.

* Represents (possible) early revascularizations.

Table: Annualized event rate of cardiac death and myocardial infarction in studies comparing two modalities.

Author (ref. #)	Modality	Cardiac death + MI (AER, %)	Total n	Death/ cardiac death	MI	Revasc	UAP
Chen(6)	**CCTA**	0.8%	106	NS/0	1	NS	0
	CMRp	0.0%	108	0/0	0	2	NS
Cho(7)	**CCTA**	0.0%	2568	NS/1	2	16	3
	EET	0.0%	2489	NS/1	3	48	2
Dedic(12)	**CCTA**	0.4%	277	NS/1	2	3	3
	EET	0.2%	172	NS/0	1	6	3
Bouzas	**EET**	1.0%	4004	313/63	120	197	NS
Mosquera(51)	**SE**	0.8%	3335	NS/NS	NS	NS	NS
Calasans(52)	**EET**	0.6%	397	13//3	13	NS	NS
	SE	0.5%	329	NS/NS	NS	NS	NS
Coletta(55)	**EET**	0.7%	109	0/0	1	NS	NS
	SE	1.4%	222	NS/2	2	NS	6
Sawada(65)	**EET**	0.5%	79	0/0	1	2	NS
	SE	0.6%	148	NS/0	2	4	NS
Hartlage(37)	**CMRp**	0.0%	82	0/0	0	0	0
	SE	0.7%	164	0/0	1	0	1
Chatziinoannou(54)	**EET**	0.5%	288	NS/NS	NS	14	NS
	SPECT	0.0%	231	NS/0	0	4	NS
Vanzetto(66)	**EET**	1.0%	601	NS/16	19	NS	NS
	SPECT	0.6%	388	NS/7	6	NS	NS
Zanco(67)	**EET**	2.2%	63	NS/3	2	NS	6
	SPECT	1.1%	74	NS/1	2	NS	NS
Olmos(94)	**SE**	0.9%	117	NS/1	3	5	3
	SPECT	0.9%	115	NS/1	3	NS	NS

AER=annual event rate, MI=myocardial infarction, N=number of patients, NS=not specified, Revasc=revascularization, UAP=unstable angina pectoris.

REFERENCES

1. Abidov A, Gallagher MJ, Chinnaiyan KM, Mehta LS, Wegner JH, Raff GL. Clinical effectiveness of coronary computed tomographic angiography in the triage of patients to cardiac catheterization and revascularization after inconclusive stress testing: results of a 2-year prospective trial. J Nucl Cardiol 2009;16:701-13.
2. Aggarwal NR, Knickelbine T, Tande A, Stoltzfus L, Lesser JR, Schwartz RS. Noncalcified plaque: relationship between results of multislice computed tomography, risk factors, and late clinical outcome. Catheterization and cardiovascular interventions : official journal of the Society for Cardiac Angiography & Interventions 2011;78:1116-24.
3. Aldrovandi A, Maffei E, Seitun S et al. Major adverse cardiac events and the severity of coronary atherosclerosis assessed by computed tomography coronary angiography in an outpatient population with suspected or known coronary artery disease. J Thorac Imaging 2012;27:23-8.
4. Andreini D, Pontone G, Mushtaq S et al. A long-term prognostic value of coronary CT angiography in suspected coronary artery disease. JACC Cardiovasc Imaging 2012;5:690-701.
5. Carrigan TP, Nair D, Schoenhagen P et al. Prognostic utility of 64-slice computed tomography in patients with suspected but no documented coronary artery disease. Eur Heart J 2009;30:362-71.
6. Chen MY, Bandettini WP, Shanbhag SM et al. Concordance and diagnostic accuracy of vasodilator stress cardiac MRI and 320-detector row coronary CTA. Int J Cardiovasc Imaging 2014;30:109-19.
7. Cho I, Shim J, Chang HJ et al. Prognostic value of multidetector coronary computed tomography angiography in relation to exercise electrocardiogram in patients with suspected coronary artery disease. J Am Coll Cardiol 2012;60:2205-15.

8. Chong FY, Soon K, Brown F, Bell K, Lim YL. Negative coronary CT angiography for chest pain assessment predicts low event rate in 5 years. J Med Imaging Radiat Oncol 2012;56:55-7.

9. Chow BJ, Wells GA, Chen L et al. Prognostic value of 64-slice cardiac computed tomography severity of coronary artery disease, coronary atherosclerosis, and left ventricular ejection fraction. Journal of the American College of Cardiology 2010;55:1017-28.

10. Christiaens L, Duchat F, Boudiaf M et al. Impact of 64-slice coronary CT on the management of patients presenting with acute chest pain: results of a prospective two-centre study. Eur Radiol 2012;22:1050-8.

11. Danciu SC, Herrera CJ, Stecy PJ, Carell E, Saltiel F, Hines JL. Usefulness of multislice computed tomographic coronary angiography to identify patients with abnormal myocardial perfusion stress in whom diagnostic catheterization may be safely avoided. Am J Cardiol 2007;100:1605-8.

12. Dedic A, Genders TS, Ferket BS et al. Stable angina pectoris: head-to-head comparison of prognostic value of cardiac CT and exercise testing. Radiology 2011;261:428-36.

13. Gilard M, Le Gal G, Cornily JC et al. Midterm prognosis of patients with suspected coronary artery disease and normal multislice computed tomographic findings: a prospective management outcome study. Arch Intern Med 2007;167:1686-9.

14. Gopal A, Nasir K, Ahmadi N et al. Cardiac computed tomographic angiography in an outpatient setting: an analysis of clinical outcomes over a 40-month period. J Cardiovasc Comput Tomogr 2009;3:90-5.

15. La Grutta L, Runza G, Gentile G et al. Prognostic outcome of routine clinical noninvasive multidetector-row computed tomography coronary angiography in patients with suspected coronary artery disease: a 2-year follow-up study. Radiol Med 2011;116:521-31.

16. Hadamitzky M, Taubert S, Deseive S et al. Prognostic value of coronary computed tomography angiography during 5 years of follow-up in patients with suspected coronary artery disease. Eur Heart J 2013;34:3277-85.

17. Hansen M, Ginns J, Seneviratne S et al. The value of dual-source 64-slice CT coronary angiography in the assessment of patients presenting to an acute chest pain service. Heart Lung Circ 2010;19:213-8.

18. Hay CS, Morse RJ, Morgan-Hughes GJ, Gosling O, Shaw SR, Roobottom CA. Prognostic value of coronary multidetector CT angiography in patients with an intermediate probability of significant coronary heart disease. Br J Radiol 2010;83:327-30.

19. Hollander JE, Chang AM, Shofer FS et al. One-year outcomes following coronary computerized tomographic angiography for evaluation of emergency department patients with potential acute coronary syndrome. Acad Emerg Med 2009;16:693-8.

20. Ko BS, Wong DT, Cameron JD et al. 320-row CT coronary angiography predicts freedom from revascularisation and acts as a gatekeeper to defer invasive angiography in stable coronary artery disease: a fractional flow reserve-correlated study. Eur Radiol 2014;24:738-47.

21. Van Lingen R, Kakani N, Veitch A, Manghat NE, Roobottom CA, Morgan-Hughes GJ. Prognostic and accuracy data of multidetector CT coronary angiography in an established clinical service. Clin Radiol 2009;64:601-7.

22. Min JK, Feignoux J, Treutenaere J, Laperche T, Sablayrolles J. The prognostic value of multidetector coronary CT angiography for the prediction of major adverse cardiovascular events: a multicenter observational cohort study. Int J Cardiovasc Imaging 2010;26:721-8.

23. Miszalski-Jamka T, Klimeczek P, Banys R et al. The composition and extent of coronary artery plaque detected by multislice computed tomographic angiography provides incremental prognostic value in patients with suspected coronary artery disease. Int J Cardiovasc Imaging 2012;28:621-31.

24. Nasis A, Meredith IT, Nerlekar N et al. Acute chest pain investigation: utility of cardiac CT angiography in guiding troponin measurement. Radiology 2011;260:381-9.

25. Noda M, Takagi A, Kuwatsuru R, Mitsuhashi N, Kasanuki H. Prognostic significance of multiple-detector computed tomography in conjunction with TIMI risk score for patients with non-ST elevation acute coronary syndrome. Heart Vessels 2008;23:161-6.

26. Ovrehus KA, Botker HE, Jensen JM, Munkholm H, Johnsen SP, Norgaard BL. Influence of coronary computed tomographic angiography on patient treatment and prognosis in patients with suspected stable angina pectoris. Am J Cardiol 2011;107:1473-9.

27. Rubinshtein R, Gaspar T, Lewis BS, Prasad A, Peled N, Halon DA. Long-term prognosis and outcome in patients with a chest pain syndrome and myocardial bridging: a 64-slice coronary computed tomography angiography study. Eur Heart J Cardiovasc Imaging 2013;14:579-85.

28. Schmermund A, Elsasser A, Behl M et al. Comparison of prognostic usefulness (three years) of computed tomographic angiography versus 64-slice computed tomographic calcium scanner in subjects without significant coronary artery disease. Am J Cardiol 2010;106:1574-9.

29. Yamamoto H, Kitagawa T, Ohashi N et al. Noncalcified atherosclerotic lesions with vulnerable characteristics detected by coronary CT angiography and future coronary events. J Cardiovasc Comput Tomogr 2013;7:192-9.

30. Yiu KH, de Graaf FR, Schuijf JD et al. Age- and gender-specific differences in the prognostic value of CT coronary angiography. Heart 2012;98:232-7.

31. Bertaso AG, Richardson JD, Wong DT et al. Prognostic value of adenosine stress perfusion cardiac MRI with late gadolinium enhancement in an intermediate cardiovascular risk population. International journal of cardiology 2012.

32. Bingham SE, Hachamovitch R. Incremental prognostic significance of combined cardiac magnetic resonance imaging, adenosine stress perfusion, delayed enhancement, and left ventricular function over preimaging information for the prediction of adverse events. Circulation 2011;123:1509-18.

33. Bodi V, Sanchis J, Lopez-Lereu MP et al. Prognostic and therapeutic implications of dipyridamole stress cardiovascular magnetic resonance on the basis of the ischaemic cascade. Heart 2009;95:49-55.

34. Coelho-Filho OR, Seabra LF, Mongeon FP et al. Stress myocardial perfusion imaging by CMR provides strong prognostic value to cardiac events regardless of patient's sex. JACC Cardiovasc Imaging 2011;4:850-61.

35. Doesch C, Seeger A, Doering J et al. Risk stratification by adenosine stress cardiac magnetic resonance in patients with coronary artery stenoses of intermediate angiographic severity. JACC Cardiovasc Imaging 2009;2:424-33.

36. Freed BH, Narang A, Bhave NM et al. Prognostic value of normal regadenoson stress perfusion cardiovascular magnetic resonance. J Cardiovasc Magn Reson 2013;15:108.

37. Hartlage G, Janik M, Anadiotis A et al. Prognostic value of adenosine stress cardiovascular magnetic resonance and dobutamine stress echocardiography in patients with low-risk chest pain. Int J Cardiovasc Imaging 2011.

38. Ingkanisorn WP, Kwong RY, Bohme NS et al. Prognosis of negative adenosine stress magnetic resonance in patients presenting to an emergency department with chest pain. J Am Coll Cardiol 2006;47:1427-32.

39. Lo KY, Leung KF, Chu CM, Loke KL, Chan CK, Yue CS. Prognostic value of adenosine stress myocardial perfusion by cardiac magnetic resonance imaging in patients with known or suspected coronary artery disease. QJM 2011;104:425-32.

40. Lubbers DD, Rijlaarsdam-Hermsen D, Kuijpers D et al. Performance of adenosine "stress-only" perfusion MRI in patients without a history of myocardial infarction: a clinical outcome study. Int J Cardiovasc Imaging 2012;28:109-15.

41. Macwar RR, Williams BA, Shirani J. Prognostic value of adenosine cardiac magnetic resonance imaging in patients presenting with chest pain. Am J Cardiol 2013;112:46-50.

42. Pilz G, Jeske A, Klos M et al. Prognostic value of normal adenosine-stress cardiac magnetic resonance imaging. Am J Cardiol 2008;101:1408-12.

43. Bodi V, Husser O, Sanchis J et al. Prognostic implications of dipyridamole cardiac MR imaging: a prospective multicenter registry. Radiology 2012;262:91-100.

44. Gebker R, Jahnke C, Manka R et al. The role of dobutamine stress cardiovascular magnetic resonance in the clinical management of patients with suspected and known coronary artery disease. J Cardiovasc Magn Reson 2011;13:46.

45. Kelle S, Chiribiri A, Vierecke J et al. Long-term prognostic value of dobutamine stress CMR. JACC Cardiovasc Imaging 2011;4:161-72.

46. Korosoglou G, Elhmidi Y, Steen H et al. Prognostic value of high-dose dobutamine stress magnetic resonance imaging in 1,493 consecutive patients: assessment of myocardial wall motion and perfusion. J Am Coll Cardiol 2010;56:1225-34.

47. Kuijpers D, van Dijkman PR, Janssen CH, Vliegenthart R, Zijlstra F, Oudkerk M. Dobutamine stress MRI. Part II. Risk stratification with dobutamine cardiovascular magnetic resonance in patients suspected of myocardial ischemia. Eur Radiol 2004;14:2046-52.

48. Wallace EL, Morgan TM, Walsh TF et al. Dobutamine cardiac magnetic resonance results predict cardiac prognosis in women with known or suspected ischemic heart disease. JACC Cardiovasc Imaging 2009;2:299-307.

49. Bigi R, Cortigiani L, Gregori D, Fiorentini C. Comparison of the prognostic value of the stress-recovery index versus standard electrocardiographic criteria in patients with a negative exercise electrocardiogram. Am J Cardiol 2007;100:605-9.

50. Bourque JM, Charlton GT, Holland BH, Belyea CM, Watson DD, Beller GA. Prognosis in patients achieving >/=10 METS on exercise stress testing: was SPECT imaging useful? J Nucl Cardiol 2011;18:230-7.

51. Bouzas-Mosquera A, Peteiro J, Alvarez-Garcia N et al. Prediction of mortality and major cardiac events by exercise echocardiography in patients with normal exercise electrocardiographic testing. J Am Coll Cardiol 2009;53:1981-90.

52. Calasans FR, Santos BF, Silveira DC et al. Stress echocardiography and major cardiac events in patients with normal exercise test. Arq Bras Cardiol 2013;101:35-42.

53. Cannan CR, Miller TD, Christian TF, Bailey KR, Gibbons RJ. Prognosis with abnormal thallium images in the absence of significant coronary artery disease. Am J Cardiol 1992;70:1276-80.

54. Chatziioannou SN, Moore WH, Ford PV et al. Prognostic value of myocardial perfusion imaging in patients with high exercise tolerance. Circulation 1999;99:867-72.

55. Coletta C, Galati A, Greco G et al. Prognostic value of high dose dipyridamole echocardiography in patients with chronic coronary artery disease and preserved left ventricular function. J Am Coll Cardiol 1995;26:887-94.

56. Houghton JL, Price C, Chatterjee B, Adams KF. Short-term prognosis in females with no or insignificant coronary disease and a diagnostic exercise test. J Cardiopulmonary Rehabil 1990;10:58-64.

57. Jeetley P, Burden L, Senior R. Stress echocardiography is superior to exercise ECG in the risk stratification of patients presenting with acute chest pain with negative Troponin. Eur J Echocardiogr 2006;7:155-64.

58. Lichtlen PR, Bargheer K, Wenzlaff P. Long-term prognosis of patients with anginalike chest pain and normal coronary angiographic findings. J Am Coll Cardiol 1995;25:1013-8.

59. Marshall AJ, Hutchings F, James AJ, Kelion AD. Prognostic value of a nine-minute treadmill test in patients undergoing myocardial perfusion scintigraphy. Am J Cardiol 2010;106:1423-8.

60. Mulcahy D, Parameshwar J, Holdright D et al. Value of ambulatory ST segment monitoring in patients with chronic stable angina: does measurement of the "total ischaemic burden" assist with management? Br Heart J 1992;67:47-52.

61. Niemann T, Labouriau R, Sorensen HT, Thorsgaard N, Nielsen TT. Five-year cardiovascular and all-cause mortality, and myocardial infarction in all subjects referred for exercise testing in two Danish counties. Scand Cardiovasc J 2004;38:137-42.

62. Pontone G, Andreini D, Bartorelli AL et al. A long-term prognostic value of CT angiography and exercise ECG in patients with suspected CAD. JACC Cardiovasc Imaging 2013;6:641-50.

63. Raiker K, Sinusas AJ, Wackers FJ, Zaret BL. One-year prognosis of patients with normal planar or single-photon emission computed tomographic technetium 99m-labeled sestamibi exercise imaging. J Nucl Cardiol 1994;1:449-56.

64. Sanchis J, Bodi V, Llacer A et al. Risk stratification of patients with acute chest pain and normal troponin concentrations. Heart 2005;91:1013-8.

65. Sawada SG, Ryan T, Conley MJ, Corya BC, Feigenbaum H, Armstrong WF. Prognostic value of a normal exercise echocardiogram. Am Heart J 1990;120:49-55.

66. Vanzetto G, Ormezzano O, Fagret D, Comet M, Denis B, Machecourt J. Long-term additive prognostic value of thallium-201 myocardial perfusion imaging over clinical and exercise stress test in low to intermediate risk patients : study in 1137 patients with 6-year follow-up. Circulation 1999;100:1521-7.

67. Zanco P, Zampiero A, Favero A et al. Myocardial technetium-99m sestamibi single-photon emission tomography as a prognostic tool in coronary artery disease: multivariate analysis in a long-term prospective study. Eur J Nucl Med 1995;22:1023-8.

68. Chow BJ, Wong JW, Yoshinaga K et al. Prognostic significance of dipyridamole-induced ST depression in patients with normal 82Rb PET myocardial perfusion imaging. J Nucl Med 2005;46:1095-101.

69. Chow BJ, Al Shammeri OM, Beanlands RS et al. Prognostic value of treadmill exercise and dobutamine stress positron emission tomography. Can J Cardiol 2009;25:e220-4.

70. Dorbala S, Hachamovitch R, Curillova Z et al. Incremental prognostic value of gated Rb-82 positron emission tomography myocardial perfusion imaging over clinical variables and rest LVEF. JACC Cardiovasc Imaging 2009;2:846-54.

71. Van Tosh A, Supino PG, Nichols KJ, Garza D, Horowitz SF, Reichek N. Prognosis of a normal positron emission tomography 82Rb myocardial perfusion imaging study in women with no history of coronary disease. Cardiology 2011;117:301-6.

72. Afridi I, Quinones MA, Zoghbi WA, Cheirif J. Dobutamine stress echocardiography: sensitivity, specificity, and predictive value for future cardiac events. Am Heart J 1994;127:1510-5.

73. Almeida MC, Markman Filho B. Prognostic value of dipyridamole stress echocardiography in women. Arq Bras Cardiol 2011;96:31-7.

74. Anthopoulos LP, Bonou MS, Kardaras FG et al. Stress echocardiography in elderly patients with coronary artery disease: applicability, safety and prognostic value of dobutamine and adenosine echocardiography in elderly patients. J Am Coll Cardiol 1996;28:52-9.

75. Baldini U, Dini FL, Raugi M, Genovesi-Ebert A. Incremental prognostic value of stress echo positivity in the left anterior descending coronary artery territory. Int J Cardiol 2006;109:381-6.

76. Bholasingh R, Cornel JH, Kamp O et al. Prognostic value of predischarge dobutamine stress echocardiography in chest pain patients with a negative cardiac troponin T. J Am Coll Cardiol 2003;41:596-602.

77. Biagini E, Elhendy A, Schinkel AF et al. Long-term prediction of mortality in elderly persons by dobutamine stress echocardiography. J Gerontol A Biol Sci Med Sci 2005;60:1333-8.

78. Chuah SC, Pellikka PA, Roger VL, McCully RB, Seward JB. Role of dobutamine stress echocardiography in predicting outcome in 860 patients with known or suspected coronary artery disease. Circulation 1998;97:1474-80.

79. Chung G, Krishnamani R, Senior R. Prognostic value of normal stress echocardiogram in patients with suspected coronary artery disease--a British general hospital experience. Int J Cardiol 2004;94:181-6.

80. Ciaroni S, Bloch A, Hoffmann JL, Bettoni M, Fournet D. Prognostic value of dobutamine echocardiography in patients with intermediate coronary lesions at angiography. Echocardiography 2002;19:549-53.

81. Colon PJ, 3rd, Guarisco JS, Murgo J, Cheirif J. Utility of stress echocardiography in the triage of patients with atypical chest pain from the emergency department. The American journal of cardiology 1998;82:1282-4, A10.

82. Cordovil A, Junior WM, Andrade JL et al. Role of dobutamine-atropine stress echocardiography in prognostic evaluation of 300 women. Echocardiography 2004;21:113-8.

83. Cortigiani L, Gigli G, Vallebona A, Mariani PR, Bigi R, Desideri A. The stress echo prognostic gender gap. Eur J Echocardiogr 2001;2:132-8.

84. Davar JI, Brull DJ, Bulugahipitiya S, Coghlan JG, Lipkin DP, Evans TR. Prognostic value of negative dobutamine stress echo in women with intermediate probability of coronary artery disease. Am J Cardiol 1999;83:100-2, A8.

85. Isma'eel H, Shamseddeen W, El Khoury M, Dimassi A, Nasrallah A, Arnaout MS. Diabetes supersedes dobutamine stress echocardiography in predicting cardiac events in female patients. Clin Exp Obstet Gynecol 2010;37:197-200.

86. Ismail G, Lo E, Sada M, Conant RD, Shapiro SM, Ginzton LE. Long-term prognosis of patients with a normal exercise echocardiogram and clinical suspicion of myocardial ischemia. Am J Cardiol 1995;75:934-6.

87. Kamaran M, Teague SM, Finkelhor RS, Dawson N, Bahler RC. Prognostic value of dobutamine stress echocardiography in patients referred because of suspected coronary artery disease. Am J Cardiol 1995;76:887-91.

88. Krivokapich J, Child JS, Gerber RS, Lem V, Moser D. Prognostic usefulness of positive or negative exercise stress echocardiography for predicting coronary events in ensuing twelve months. Am J Cardiol 1993;71:646-51.

89. Krivokapich J, Child JS, Walter DO, Garfinkel A. Prognostic value of dobutamine stress echocardiography in predicting cardiac events in patients with known or suspected coronary artery disease. J Am Coll Cardiol 1999;33:708-16.

90. Low AF, Ng WL, Lim YT, Yeo TC. The impact of diabetes mellitus on the prognostic value of a normal dobutamine stress echocardiogram in patients with intermediate to high cardiovascular risk. Singapore Med J 2004;45:161-5.

91. Marcovitz PA, Shayna V, Horn RA, Hepner A, Armstrong WF. Value of dobutamine stress echocardiography in determining the prognosis of patients with known or suspected coronary artery disease. Am J Cardiol 1996;78:404-8.

92. Marwick TH, Lauer MS, Lobo A, Nally J, Braun W. Use of dobutamine echocardiography for cardiac risk stratification of patients with chronic renal failure. J Intern Med 1998;244:155-61.

93. Mesa A, Falcone M, Hernandez A, Stainback RF, Wilansky S. Long-term prognosis in women with normal dobutamine stress echocardiography. Am J Cardiol 1999;83:1127-9, A9.

94. Olmos LI, Dakik H, Gordon R et al. Long-term prognostic value of exercise echocardiography compared with exercise 201Tl, ECG, and clinical variables in patients evaluated for coronary artery disease. Circulation 1998;98:2679-86.

95. Pingitore A, Picano E, Varga A et al. Prognostic value of pharmacological stress echocardiography in patients with known or suspected coronary artery disease: a prospective, large-scale, multicenter, head-to-head comparison between dipyridamole and dobutamine test. Echo-Persantine International Cooperative (EPIC) and Echo-Dobutamine International Cooperative (EDIC) Study Groups. Journal of the American College of Cardiology 1999;34:1769-77.

96. Sawada SG, Sayyed S, Raiesdana A, Gradus-Pizlo I, Mahenthiran J, Feigenbaum H. Clinical assessment and rest and stress echocardiography for prediction of long-term prognosis in African Americans with known or suspected coronary artery disease. Echocardiography 2009;26:558-66.

97. Song JK, Park SW, Kang DH et al. Prognostic implication of ergonovine echocardiography in patients with near normal coronary angiogram or negative stress test for significant fixed stenosis. J Am Soc Echocardiogr 2002;15:1346-52.

98. Srivastava AV, Ananthasubramaniam K, Patel SJ, Lingam N, Jacobsen G. Prognostic implications of negative dobutamine stress echocardiography in African Americans compared to Caucasians. Cardiovasc Ultrasound 2008;6:20.

99. Steinberg EH, Madmon L, Patel CP, Sedlis SP, Kronzon I, Cohen JL. Long-term prognostic significance of dobutamine echocardiography in patients with suspected coronary artery disease: results of a 5-year follow-up study. J Am Coll Cardiol 1997;29:969-73.

100. Yao SS, Qureshi E, Sherrid MV, Chaudhry FA. Practical applications in stress echocardiography: risk stratification and prognosis in patients with known or suspected ischemic heart disease. J Am Coll Cardiol 2003;42:1084-90.

101. Yao SS, Bangalore S, Chaudhry FA. Prognostic implications of stress echocardiography and impact on patient outcomes: an effective gatekeeper for coronary angiography and revascularization. J Am Soc Echocardiogr 2010;23:832-9.

102. Zagatina A, Krylova L, Vareldzhan Y, Tyurina TV, Clitsenko O, Zhuravskaya N. Comparison of 5-year outcomes for patients with coronary artery disease in groups with and without revascularization with different results of stress echocardiography. Cardiol Res 2013;4:152-158.

103. Acampa W, Petretta M, Cuocolo R, Daniele S, Cantoni V, Cuocolo A. Warranty period of normal stress myocardial perfusion imaging in diabetic patients: a propensity score analysis. J Nucl Cardiol 2013;21:50-6.

104. Akinboboye OO, Idris O, Onwuanyi A, Berekashvili K, Bergmann SR. Incidence of major cardiovascular events in black patients with normal myocardial stress perfusion study results. J Nucl Cardiol 2001;8:541-7.

105. Basic D, Siu SC, Skyba DM et al. Prognostic value of myocardial perfusion contrast echocardiography in patients with suggested or known ischemic heart disease. J Am Soc Echocardiogr 2006;19:1203-10.

106. Bom MJ, Manders JM, Uijlings R, Badings EA, Martens FM. Negative predictive value of SPECT for the occurrence of MACE in a medium-sized clinic in the Netherlands. Neth Heart J 2014;22:151-7.

107. Bucerius J, Joe AY, Herder E et al. Hemodynamic variables during stress testing can predict referral to early catheterization but failed to show a prognostic impact on emerging cardiac events in patients aged 70 years and older undergoing exercise (99m)Tc-sestamibi myocardial perfusion scintigraphy. Int J Cardiovasc Imaging 2009;25:569-79.

108. Boyne TS, Koplan BA, Parsons WJ, Smith WH, Watson DD, Beller GA. Predicting adverse outcome with exercise SPECT technetium-99m sestamibi imaging in patients with suspected or known coronary artery disease. The American journal of cardiology 1997;79:270-4.

109. Calnon DA, McGrath PD, Doss AL, Harrell FE, Jr., Watson DD, Beller GA. Prognostic value of dobutamine stress technetium-99m-sestamibi single-photon emission computed tomography myocardial perfusion imaging: stratification of a high-risk population. Journal of the American College of Cardiology 2001;38:1511-7.

110. Dawson D, Kaul S, Peters D et al. Prognostic value of dipyridamole stress myocardial contrast echocardiography: comparison with single photon emission computed tomography. J Am Soc Echocardiogr 2009;22:954-60.

111. Dona M, Massi L, Settimo L et al. Prognostic implications of post-stress ejection fraction decrease detected by gated SPECT in the absence of stress-induced perfusion abnormalities. Eur J Nucl Med Mol Imaging 2011;38:485-90.

112. Doukky R, Frogge N, Bayissa YA et al. The prognostic value of transient ischemic dilatation with otherwise normal SPECT myocardial perfusion imaging: a cautionary note in patients with diabetes and coronary artery disease. J Nucl Cardiol 2013;20:774-84.

113. Ferreira MJ, Cunha MJ, Albuquerque A et al. Prognosis of normal stress-only gated-SPECT myocardial perfusion imaging: a single center study. Int J Cardiovasc Imaging 2013;29:1639-44.

114. Filipiak-Strzecka D, Kowalczyk E, Hamala P et al. Long-term prognostic value of inducible and resting perfusion defects detected by single-photon emission computed tomography in the era of wide availability of coronary revascularization. Clin Physiol Funct Imaging 2013;33:218-23.

115. Galassi AR, Azzarelli S, Tomaselli A et al. Incremental prognostic value of technetium-99m-tetrofosmin exercise myocardial perfusion imaging for predicting outcomes in patients with suspected or known coronary artery disease. The American journal of cardiology 2001;88:101-6.

116. Gentile R, Vitarelli A, Schillaci O et al. Diagnostic accuracy and prognostic implications of stress testing for coronary artery disease in the elderly. Ital Heart J 2001;2:539-45.

117. Gibbons RJ, Hodge DO, Berman DS et al. Long-term outcome of patients with intermediate-risk exercise electrocardiograms who do not have myocardial perfusion defects on radionuclide imaging. Circulation 1999;100:2140-5.

118. Gibson PB, Demus D, Noto R, Hudson W, Johnson LL. Low event rate for stress-only perfusion imaging in patients evaluated for chest pain. Journal of the American College of Cardiology 2002;39:999-1004.

119. Groutars RG, Verzijlbergen JF, Zwinderman AH et al. Incremental prognostic value of myocardial SPET with dual-isotope rest (201)Tl/stress (99m)Tc-tetrofosmin. Eur J Nucl Med Mol Imaging 2002;29:46-52.

120. Hachamovitch R, Berman DS, Kiat H et al. Incremental prognostic value of adenosine stress myocardial perfusion single-photon emission computed tomography and impact on subsequent management in patients with or suspected of having myocardial ischemia. The American journal of cardiology 1997;80:426-33.

121. Hage FG, Heo J, Iskandrian AE. Adenosine-induced ST segment depression with normal perfusion. Cardiol J 2009;16:121-6.

122. Hakeem A, Bhatti S, Dillie KS et al. Predictive value of myocardial perfusion single-photon emission computed tomography and the impact of renal function on cardiac death. Circulation 2008;118:2540-9.

123. Iqbal FM, Hage FG, Ahmed A et al. Comparison of the prognostic value of normal regadenoson with normal adenosine myocardial perfusion imaging with propensity score matching. JACC Cardiovasc Imaging 2012;5:1014-21.

124. Jeong HJ, Lee DS, Lee HY, Choi S, Han YH, Chung JK. Prognostic Value of Normal Perfusion but Impaired Left Ventricular Function in the Diabetic Heart on Quantitative Gated Myocardial Perfusion SPECT. Nucl Med Mol Imaging 2013;47:151-7.

125. Kaminek M, Myslivecek M, Skvarilova M et al. Increased prognostic value of combined myocardial perfusion SPECT imaging and the quantification of lung Tl-201 uptake. Clin Nucl Med 2002;27:255-60.

126. Klodas E, Miller TD, Christian TF, Hodge DO, Gibbons RJ. Prognostic significance of ischemic electrocardiographic changes during vasodilator stress testing in patients with normal SPECT images. J Nucl Cardiol 2003;10:4-8.

127. Koehli M, Monbaron D, Prior JO et al. SPECT myocardial perfusion imaging: long-term prognostic value in diabetic patients with and without coronary artery disease. Nuklearmedizin 2006;45:74-81.

128. Leslie WD, Tully SA, Yogendran MS, Ward LM, Nour KA, Metge CJ. Prognostic value of automated quantification of 99mTc-sestamibi myocardial perfusion imaging. J Nucl Med 2005;46:204-11.

129. Lima RS, De Lorenzo A, Pantoja MR, Siqueira A. Incremental prognostic value of myocardial perfusion 99m-technetium-sestamibi SPECT in the elderly. International journal of cardiology 2004;93:137-43.

130. Miernik S, Kazmierczak-Dziuk A, Kaminski G, Dziuk M. The prognostic value of myocardial perfusion scintigraphy compared to coronary angiography in women with positive stress test results. Nucl Med Rev Cent East Eur 2012;15:31-8.

131. Mouden M, Ottervanger JP, Timmer JR et al. Myocardial perfusion imaging in stable symptomatic patients with extensive coronary atherosclerosis. Eur J Nucl Med Mol Imaging 2014;41:136-43.

132. Nabi F, Chang SM, Xu J, Gigliotti E, Mahmarian JJ. Assessing risk in acute chest pain: The value of stress myocardial perfusion imaging in patients admitted through the emergency department. J Nucl Cardiol 2012;19:233-43.

133. Nishimura T, Nakajima K, Kusuoka H, Yamashina A, Nishimura S. Prognostic study of risk stratification among Japanese patients with ischemic heart disease using gated myocardial perfusion SPECT: J-ACCESS study. Eur J Nucl Med Mol Imaging 2008;35:319-28.

134. Otsuka K, Fukuda S, Tanaka A et al. Prognosis of vulnerable plaque on computed tomographic coronary angiography with normal myocardial perfusion image. Eur Heart J Cardiovasc Imaging 2013;15:332-40.

135. Pazhenkottil AP, Ghadri JR, Nkoulou RN et al. Improved outcome prediction by SPECT myocardial perfusion imaging after CT attenuation correction. J Nucl Med 2011;52:196-200.

136. Petix NR, Sestini S, Coppola A et al. Prognostic value of combined perfusion and function by stress technetium-99m sestamibi gated SPECT myocardial perfusion imaging in patients with suspected or known coronary artery disease. The American journal of cardiology 2005;95:1351-7.

137. Raziei G, Tavakoli A, Seifollahi Asl S, Amoiei M, Javadi H, Assadi M. One-year prognosis of patients with normal myocardial perfusion imaging using technitium-99m sestamibi in suspected coronary artery disease: a single-center experience of 1,047 patients. Perfusion 2011;26:309-14.

138. Romero-Farina G, Candell-Riera J, Aguade-Bruix S et al. Warranty periods for normal myocardial perfusion stress SPECT. J Nucl Cardiol 2014;22:44-54.

139. Sharma J, Roncari C, Giedd KN, Fox JT, Kanei Y. Patients with adenosine-induced ST-segment depressions and normal myocardial perfusion imaging: cardiac outcomes at 24 months. J Nucl Cardiol 2010;17:874-80.

140. Schinkel AF, Elhendy A, Van Domburg RT et al. Long-term prognostic value of dobutamine stress 99mTc-sestamibi SPECT: single-center experience with 8-year follow-up. Radiology 2002;225:701-6.

141. Schinkel AF, Elhendy A, van Domburg RT, Bax JJ, Roelandt JR, Poldermans D. Prognostic value of dobutamine-atropine stress (99m)Tc-tetrofosmin myocardial perfusion SPECT in patients with known or suspected coronary artery disease. J Nucl Med 2002;43:767-72.

142. Shimoni S, Goland S, Livshitz S et al. Accuracy and long-term prognostic value of pacing stress echocardiography compared with dipyridamole tl201 emission computed tomography in patients with a permanent pacemaker and known or suspected coronary artery disease. Cardiology 2010;116:229-36.

143. Simonsen JA, Gerke O, Rask CK et al. Prognosis in patients with suspected or known ischemic heart disease and normal myocardial perfusion: long-term outcome and temporal risk variations. J Nucl Cardiol 2013;20:347-57.

144. Soman P, Parsons A, Lahiri N, Lahiri A. The prognostic value of a normal Tc-99m sestamibi SPECT study in suspected coronary artery disease. J Nucl Cardiol 1999;6:252-6.

145. Stratmann HG, Tamesis BR, Younis LT, Wittry MD, Miller DD. Prognostic value of dipyridamole technetium-99m sestamibi myocardial tomography in patients with stable chest pain who are unable to exercise. The American journal of cardiology 1994;73:647-52.

146. Stratmann HG, Williams GA, Wittry MD, Chaitman BR, Miller DD. Exercise technetium-99m sestamibi tomography for cardiac risk stratification of patients with stable chest pain. Circulation 1994;89:615-22.

147. Sugihara H, Tamaki N, Mitsunami K, Kinoshita M. Prognostic value of 1-day stress/rest electrocardiogram-gated single-photon emission computed tomography using Tc-99m-labeled methoxy-isobutyl isonitrile. Jpn Circ J 1998;62:405-8.

148. Travin MI, Duca MD, Kline GM, Herman SD, Demus DD, Heller GV. Relation of gender to physician use of test results and to the prognostic value of stress technetium 99m sestamibi myocardial single-photon emission computed tomography scintigraphy. Am Heart J 1997;134:73-82.

149. Travin MI, Heller GV, Johnson LL et al. The prognostic value of ECG-gated SPECT imaging in patients undergoing stress Tc-99m sestamibi myocardial perfusion imaging. J Nucl Cardiol 2004;11:253-62.

150. Uebleis C, Becker A, Griesshammer I et al. Stable coronary artery disease: prognostic value of myocardial perfusion SPECT in relation to coronary calcium scoring--long-term follow-up. Radiology 2009;252:682-90.

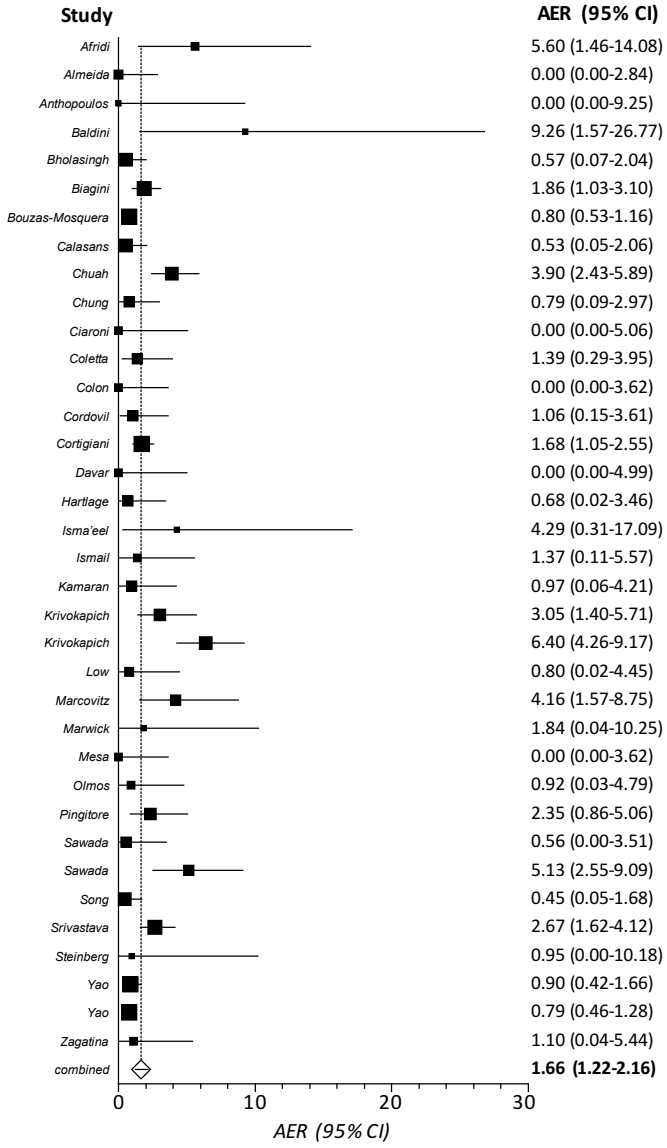
151. Uthamalingam S, Gurm GS, Ahmado I, Sidhu MS, Flynn J. Outcome of patients with regadenoson-induced ST-segment depression but normal perfusion on single-photon emission computed tomography. Angiology 2012;64:46-8.

152. Wolak A, Rafaeli E, Toledano R, Novack V, Gilutz H, Henkin Y. Attenuated predictive power of a normal myocardial perfusion scan in young smokers. Eur J Intern Med 2014;25:452-7.

153. Yang MF, Dou KF, Liu XJ, Yang YJ, He ZX. Prognostic value of normal exercise 99mTc-sestamibi myocardial tomography in patients with angiographic coronary artery disease. Nucl Med Commun 2006;27:333-8.

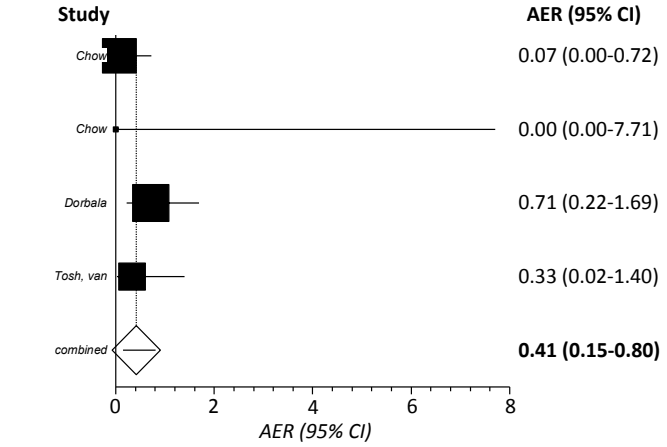
Appendix F

SE



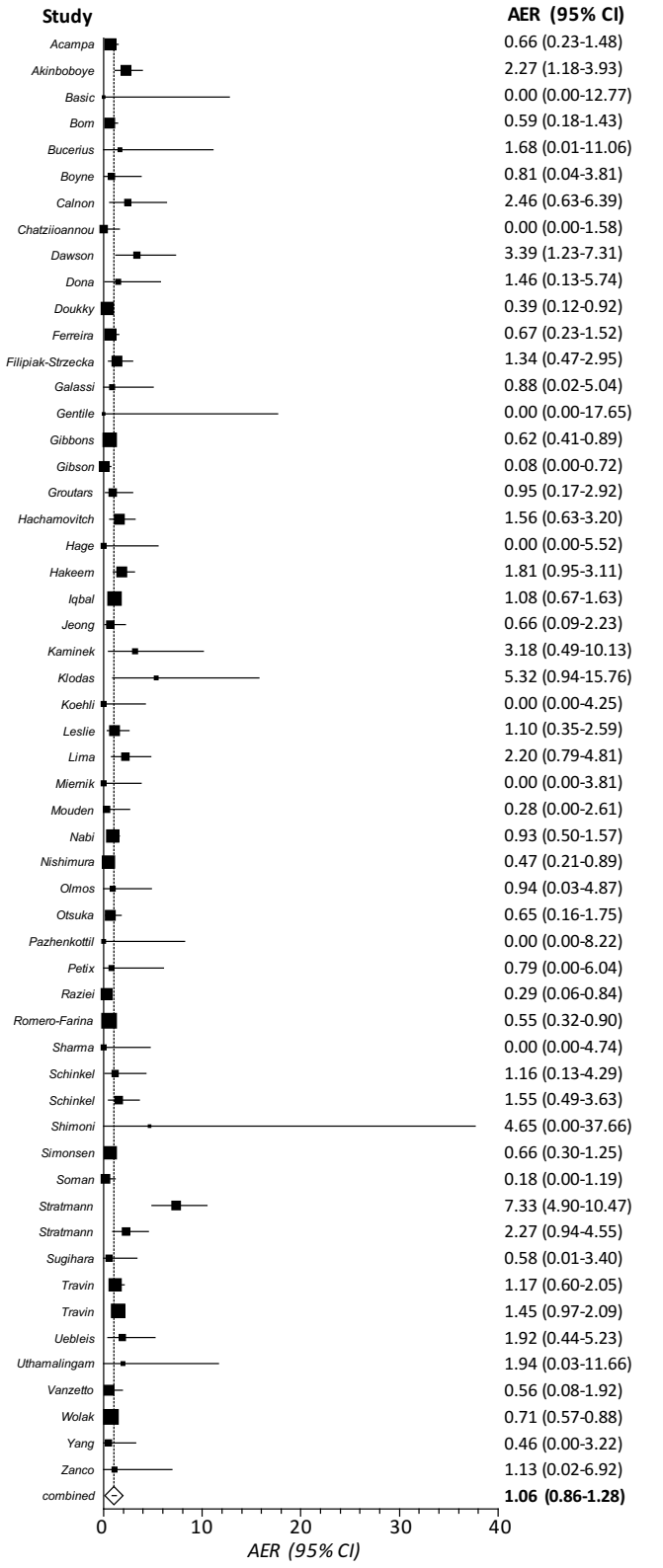
I^2 (inconsistency)	Egger's regression	*p*-value Egger test	Tau^2 statistics
72.4%	0.83	0.02	0.007016

PET



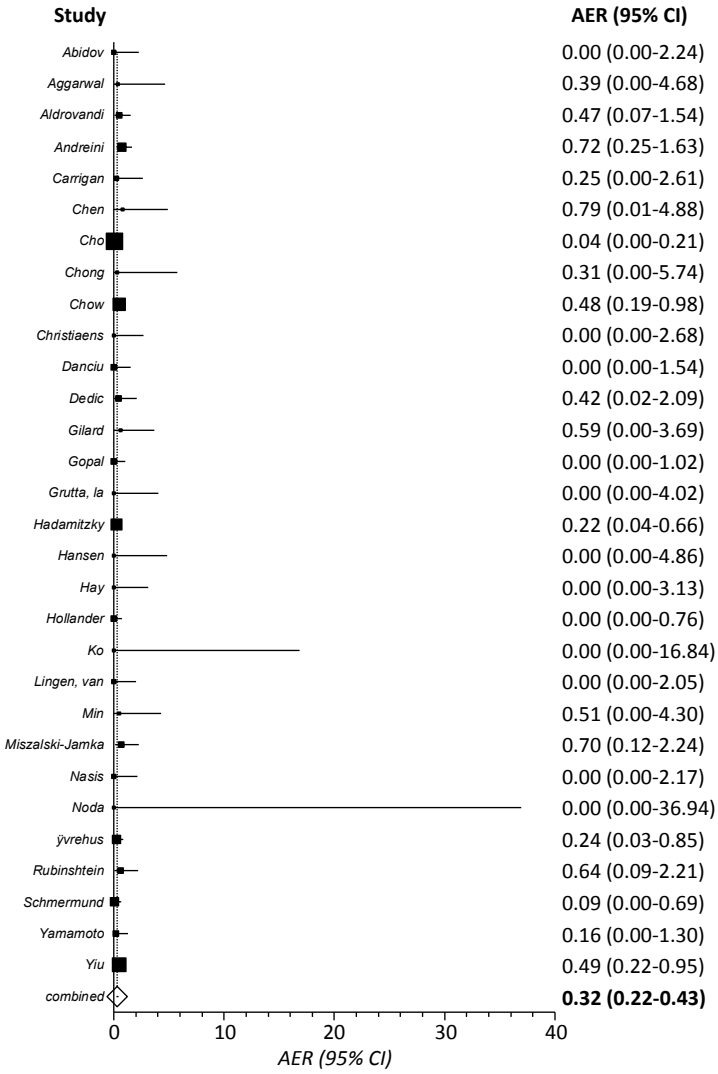
I^2 (inconsistency)	Egger's regression	*p*-value Egger test	Tau^2 statistics
13.1%	0.67	0.561	0.000373

SPECT



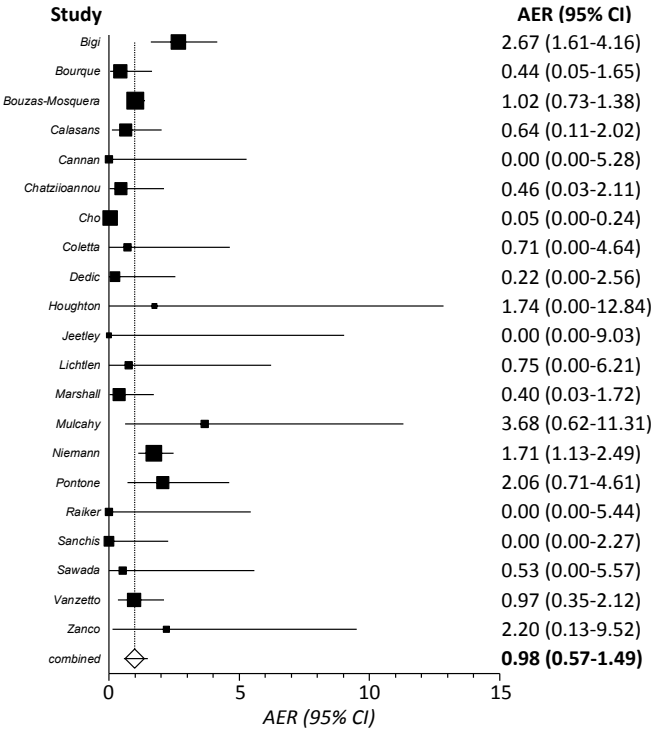
I^2 (inconsistency)	Egger's regression	*p*-value Egger test	Tau^2 statistics
65.2%	0.64	0.006	0.002655

CCTA



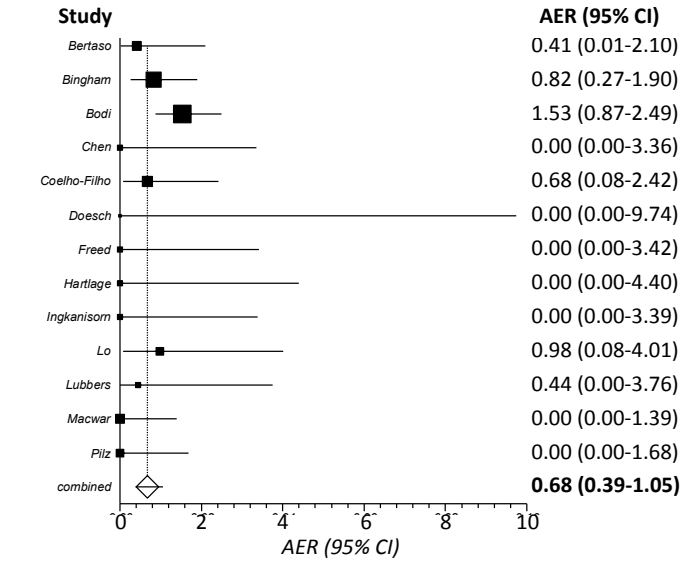
I^2 (inconsistency)	Egger's regression *p*-value	Egger test	Tau^2 statistics
9.9 %	0.44	0.02	0.00025

EET



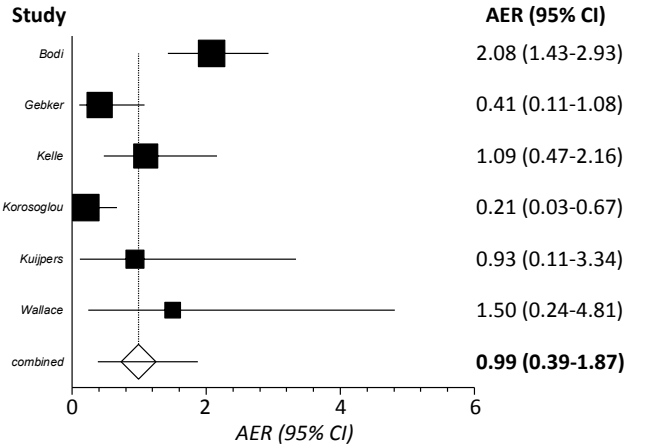
I^2 (inconsistency)	Egger's regression *p*-value	Egger test	Tau^2 statistics
76.5%	1.16	0.017	0.006604

CMR-perf



I^2 (inconsistency)	Egger's regression *p*-value	Egger test	Tau^2 statistics
19.8 %	-0.34	0.632	0.001026

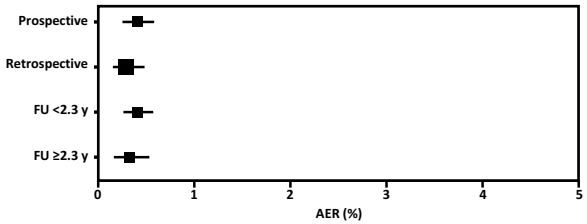
CMR-wm



I^2 (inconsistency)	Egger's regression *p*-value	Egger test	Tau^2 statistics
83.1%	2.38	0.167	0.006725

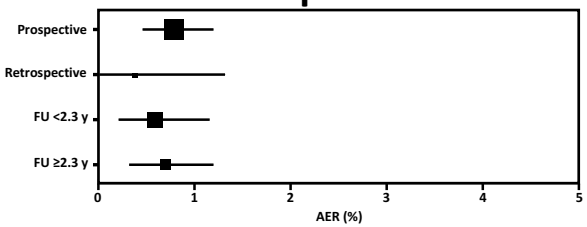
Appendix G

CCTA



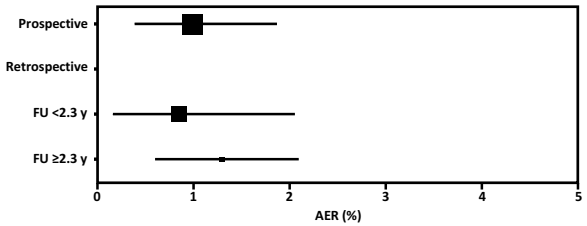
	Studies *n*	Patients *n*	AER (95% CI)	*p*-value
Prospective	18	5,821	0.40 (0.25 – 0.58)	0.325
Retrospective	10	7,340	0.26 (0.12 – 0.45)	
FU <2.3 y	17	6,417	0.40 (0.26 – 0.57)	0.578
FU ≥2.3 y	13	7,471	0.32 (0.16 – 0.53)	

CMR perfusion



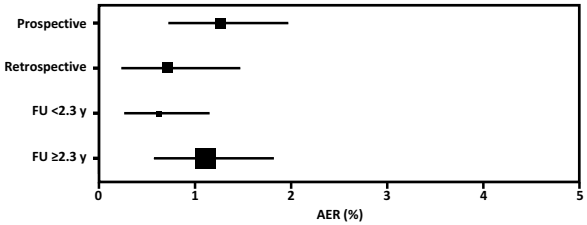
	Studies *n*	Patients *n*	AER (95% CI)	*p*-value
Prospective	10	2,888	0.79 (0.46 – 1.20)	0.455
Retrospective	3	506	0.39 (0.01 – 1.32)	
FU <2.3 y	8	2,028	0.59 (0.21 – 1.16)	0.839
FU ≥2.3 y	5	1,366	0.70 (0.32 – 1.20)	

CMR wall motion



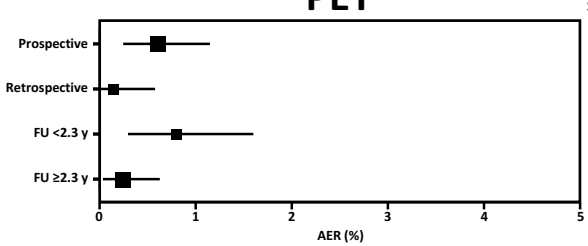
	Studies *n*	Patients *n*	AER (95% CI)	*p*-value
Prospective	6	4,736	0.99 (0.39 – 1.87)	N/A
Retrospective				
FU <2.3 y	4	3,859	0.85 (0.16 – 2.06)	0.553
FU ≥2.3 y	2	877	1.27 (0.63 – 2.11)	

EET



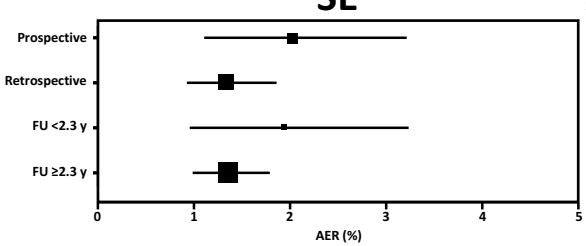
	Studies *n*	Patients *n*	AER (95% CI)	*p*-value
Prospective	11	6,070	1.28 (0.73 – 1.98)	0.265
Retrospective	6	4,819	0.76 (0.11 – 2.00)	
FU <2.3 y	8	1,216	0.64 (0.27 – 1.16)	0.381
FU ≥2.3 y	13	10,805	1.12 (0.58 – 1.83)	

PET



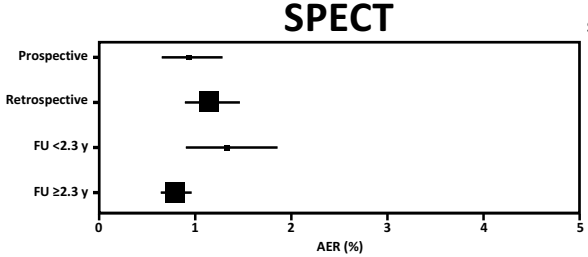
	Studies *n*	Patients *n*	AER (95% CI)	*p*-value
Prospective	3	1,167	0.62 (0.25 – 1.15)	0.231
Retrospective	1	629	0.14 (0.00 – 0.58)	
FU <2.3 y	1	664	0.78 (0.25 – 1.59)	0.257
FU ≥2.3 y	3	1,132	0.25 (0.04 – 0.63)	

SE



	Studies *n*	Patients *n*	AER (95% CI)	*p*-value
Prospective	15	6,890	2.03 (1.11 – 3.21)	0.529
Retrospective	14	6,007	1.58 (1.02 – 2.25)	
FU <2.3 y	17	2,970	2.05 (1.11 – 3.27)	0.197
FU ≥2.3 y	19	11,536	1.36 (0.99 – 1.79)	

SPECT



	Studies *n*	Patients *n*	AER (95% CI)	*p*-value
Prospective	22	9,710	0.87 (0.61 – 1.17)	0.525
Retrospective	23	26,629	1.14 (0.82 – 1.52)	
FU <2.3 y	24	12,536	1.34 (0.91 – 1.85)	0.121
FU ≥2.3 y	31	29,985	0.75 (0.62 – 0.89)	

Appendix H. Regression coefficients (B) with 95% confidence intervals from multivariable linear meta regression analysis comparing modalities with CCTA (reference category)

Modalities	All studies - unadjusted N=165 studies				Restricted to suspected CAD N=45 studies			
	N studies	Pooled AER neg. test (95% CI)	Beta	*p*-value	N studies	Pooled AER neg. test (95% CI)	Beta	*p*-value
CCTA	30	0.32 (0.22-0.43)	ref	ref	19	0.31 (0.19-0.47)	ref	ref
CMR-perf	13	0.68 (0.39-1.05)	0.035	0.276	2	0.16 (0.03-0.92)	-0.034	0.613
CMR-wm	6	0.99 (0.39-1.87)	0.078	**0.031**	0	-	-	-
EET	21	0.98 (0.57-1.49)	0.077	**0.004**	7	0.68 (0.15-1.61)	0.029	0.386
PET	4	0.41 (0.15-0.80)	0.009	0.843	1	0.43 (0.04-1.24)	0.016	0.801
SE	36	1.66 (1.22-2.16)	0.138	**<0.001**	7	0.64 (0.25-1.20)	0.043	0.268
SPECT	55	1.06 (0.86-1.28)	0.089	**<0.001**	9	0.69 (0.40-1.06)	0.053	0.068
Modalities	**Subset with total AER - unadjusted N=119 studies**				**Adjusted for total AER B: total AER (0.025, *p*<0.001) N=119 studies**			
	N studies	**Pooled AER neg. test (95% CI)**	**Beta**	***p*-value**	**N studies**	**Fitted AER neg. test (95% CI)**	**Beta**	***p*-value**
CCTA	23	0.33 (0.22-0.46)	ref	ref	23	0.56 (0.37-0.79)	ref	ref
CMR-perf	9	0.82 (0.46-1.27)	0.050	0.184	9	0.79 (0.37-1.37)	0.028	0.312
CMR-wm	5	0.97 (0.32-1.97)	0.077	0.061	5	0.96 (0.51-1.56)	0.047	0.087
EET	17	0.90 (0.44-1.52)	0.066	**0.037**	17	0.97 (0.58-1.46)	0.047	**0.040**
PET	2	0.76 (0.26-1.53)	0.051	0.484	2	0.52 (0.04-1.54)	-0.006	0.912
SE	29	1.77 (1.26-2.37)	0.145	**<0.001**	29	1.24 (0.83-1.74)	0.073	**<0.001**
SPECT	34	1.40 (1.05-1.81)	0.118	**<0.001**	34	1.14 (0.77-1.59)	0.064	**0.001**
Modalities	**Subset with total AER and % CAD - unadjusted N=71 studies**				**Adjusted for total AER and % CAD B: total AER (0.045, *p*<0.001), % CAD (0.00023, *p*=0.565) N=71 studies**			
	N studies	**Pooled AER neg. test (95% CI)**	**Beta**	***p*-value**	**N studies**	**Fitted AER neg. test (95% CI)**	**Beta**	***p*-value**
CCTA	20	0.31 (0.19-0.45)	ref	ref	20	0.77 (0.57-1.00)	ref	ref
CMR-perf	7	0.58 (0.26-1.03)	0.030	0.427	7	0.83 (0.34-1.53)	0.006	0.855
CMR-wm	3	0.55 (0.13-1.01)	0.032	0.426	3	0.71 (0.29-1.32)	-0.007	0.817
EET	13	0.69 (0.28-1.27)	0.039	0.202	13	0.90 (0.54-1.35)	0.014	0.528
PET	1	0.78 (0.25-1.59)	0.061	0.367	1	0.33 (0.01-1.09)	-0.061	0.197
SE	12	1.22 (0.61-2.03)	0.104	**0.001**	12	1.22 (0.78-1.76)	0.045	**0.048**
SPECT	15	1.29 (0.88-1.78)	0.112	**<0.001**	15	1.07 (0.66-1.56)	0.031	0.165