

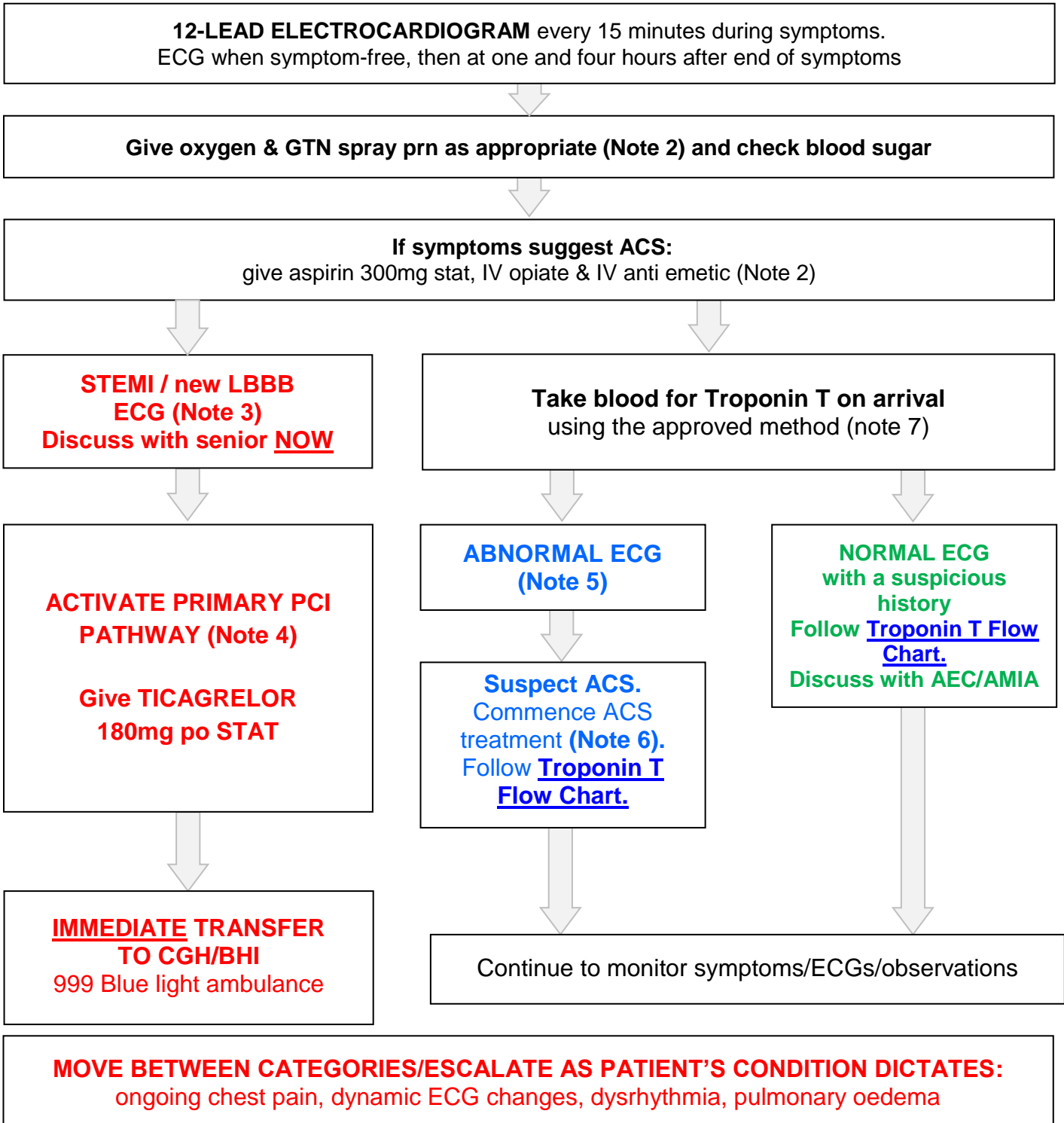
Acute Coronary Syndrome Guidelines

(Unstable angina, ST Elevation Myocardial Infarction [STEMI], Non ST Elevation Myocardial Infarction/Acute Coronary Syndrome [NSTEMI/NSTE-ACS])

and Cardiac Chest Pain Pathway

History and Examination (Note 1)

If 1st 2 ECGs show no acute changes & patient considered to be low risk, discuss with AEC/AMIA [click here](#) for AEC Low Risk Cardiac Chest Pain Pathway
If the clinical picture is suggestive of ACS, also exclude other important causes.



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Explanatory notes:

Note 1

History and Examination

Symptoms may include: Persistent or intermittent chest discomfort ie tightness, heaviness, restriction lasting for more than 15 mins.

Radiation to the jaw, throat or left arm, nausea, sweating, dyspnoea, hypotension

Increased likelihood of ACS: Diabetes, smoking, hypertension, hypercholesterolaemia, significant early family history, previous history of ischaemic heart disease, increasing age. Symptoms present as above. Recent exertional anginal symptoms.

Exclude likelihood of other significant causes of chest pain ie: acute aortic dissection pericardial effusion, pulmonary embolus.

Note 2

Current Trust recommendation:

Oxygen if indicated, according to [Trust guideline](#)

Morphine 5-10mg, slow IV then a further 5-10mg if needed.

Metoclopramide 10mg IV stat

Note 3

ST ELEVATION in 2 contiguous leads (ie same cardiac territory):

- ≥ 2 mm in chest leads (V1-6)
- ≥ 1 mm in limb/other leads
- ST depression/prominent R in V1-2

LEFT BUNDLE BRANCH BLOCK

- New or with a good history
- Discuss with senior clinician.

Note 4

ACTIVATE PPCI Pathway

Current anti platelet treatment for STEMI in this Trust is ticagrelor 180mg po STAT [Trust guideline](#)

Contact:

Hartpury Suite CGH (Mon – Fri. 8.30am – 4.30pm) ext 722995

OOH – contact Bristol Heart Institute (DW Adult Cardiology Registrar) PPCI team 0117 342 5999

Transfer: this should be an immediate emergency 999 ambulance, on blue lights & sirens.

Note 5

Abnormal ECG: ASK a senior Dr if in doubt

ST DEPRESSION

T WAVE INVERSION >2 mm deep (isolated in AVR or V1 is OK)

LVH, PACED – difficult interpretation masking abnormalities.

Note 6

Current Trust recommendations:

Aspirin 75mg od

Clopidogrel 300mg po stat then 75mg od

Fondaparinux 2.5mg s/c od [Trust guideline](#)

If eGFR <20 , use enoxaparin 1mg/kg s/c, ONCE a day, in place of fondaparinux [Trust guideline](#)

Bisoprolol 2.5mg od

Ramipril 2.5mg nocte

Atorvastatin 80mg nocte

IF symptoms persist & BP >100 systolic, add **GTN infusion** 0.1% 1-10mg/hr (1-10ml/hr) [Trust guideline](#)

IF symptoms are ongoing **AND** ECG is diagnostic **AND** Troponin T +ve, add **Tirofiban** [Trust guideline](#)

NOTE – Patients on oral anticoagulation: Switch to treatment dose dalteparin s/c od (dose as per DVT/PE treatment) to start once INR below therapeutic range or when next dose of omitted DOAC would be). If eGFR <30 , use enoxaparin 1mg/kg s/c, ONCE a day, in place of dalteparin [Trust guideline](#)

Bloods: FBC, U&E, Troponin T, Glucose, lipids.

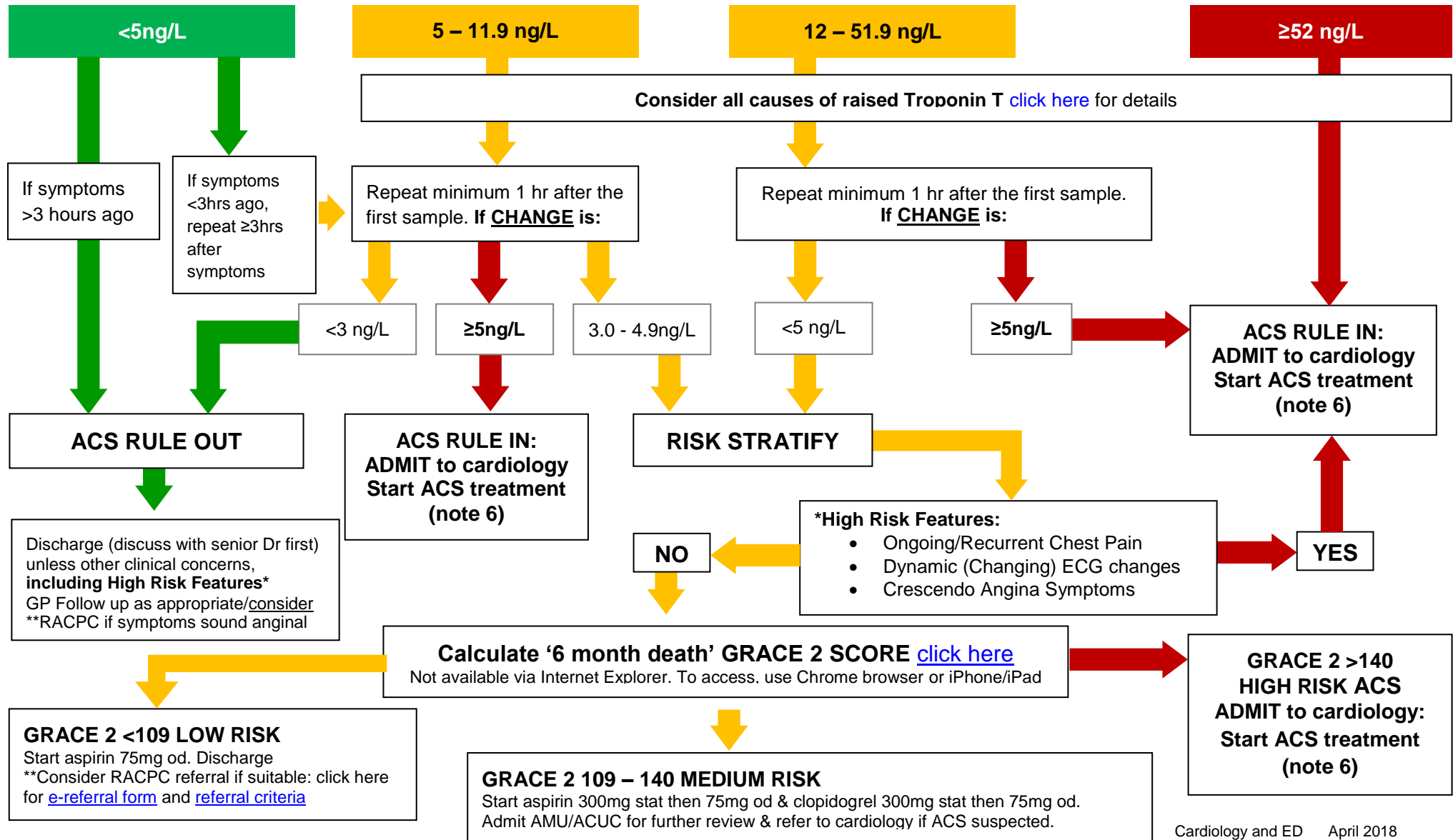
Note 7

Venepuncture: DO NOT USE A SYRINGE Use a vacutainer with a needle/butterfly or cannula into a rust bottle. Add a 'ED ACS Pathway' sticker to blood form & specify 'presentation' or 'repeat' sample with collection time.

Troponin T Interpretation Flow Chart starting from initial/presentation Troponin T result (where eGFR is >40)

UNSCHEDULED CARE ONLY

Always discuss with a senior doctor if in doubt.



Cardiology and ED April 2018