Suspected Acute Coronary Syndrome Protocol

HISTORY AND EXAMINATION

Protocol to be used for patients with cardiac-sounding chest pain lasting ≥ 15 minutes

12-LEAD ECG EVERY 30 MINUTES DURING PAIN, AND ONE HOUR AFTER PAIN RESOLVES, UNLESS PAIN RETURNS

Chest Pain Resolved
AND
NORMAL or non-Diagnostic ECG
(e.g. no new changes)

If TnI on admission <3ng/L

and stable presentation D/W senior

and discharge home (see overleaf for further guidance).

If TnI >3ng/L- 49ng/L on admission

Repeat TnI 2hrs after first TnI

Please see low risk chest pain pathway overleaf

ST DEPRESSION OF >0.5mm OR DEEP T WAVE INVERSION > 2mm deep

Administer Aspirin 300 mg PO +/- IV Morphine, ONDANSETRON 4mg IV

TNI on admission AND 2 hours later

TnI≥50ng/l (@0hr)

OR <u>change</u> ≥20ng/l (over 2hrs)

AND / OR

Dynamic ECG changes

High Probability ACS - Admit under medical team if pain free for Cardiology post-take ward round

<u>If ongoing cardiac chest pain, contact Cardiology SpR on # 6527 or 9227 in NBT</u>

<u>If definitive diagnosis of NSTE-ACS</u>, unless contraindicated, prescribe:

- Clopidogrel 600mg PO (Loading dose)
  - Then 75mg PO, OD
- Fondaparinux 2.5mg[†] s/c, OD
- Bisoprolol 1.25mg PO, OD
- Atorvastatin 80mg PO, OD
- Ramipril 1.25mg PO, OD
- Aspirin 75mg PO, OD
- GTN Spray 1-2 puffs SL, PRN

STEMI

ST Elevation / DYNAMIC ECG CHANGES

- Two leads: >2mm V1-V6 **<u>or</u>**
- 1 mm other leads
- **<u>NEW</u>** LBBB and compatible history

IMMEDIATE Senior ED Review

Activate PPCI Team:

Call (0117 34) 25999 **<u>and</u>**

contact Cardiology SpR on #6527.

Administer Ticagrelor 180mg* PO

(Unless contraindicated*)

RUH EXT 4326 M-F 9am – 5pm

NBT bleep 9227 M-F 9am – 4pm

Out of hours please contact BHI on 01173425999

Transfer to Cath Lab
as soon as team ready

*Ticagrelor contraindicated if history of intracerebral haemorrhage or patient on an oral anticoagulant: give Clopidogrel 600mg loading dose instead

[†] Fondaparinux not to be administered if patient on DOAC. Please consult Trust guidelines

Other Considerations

Patients Undergoing Angiography on Oral Anticoagulation

◆ Stop anticoagulant 24hrs pre-angiography. Please refer to Clinical Guideline – DOACs (Direct Oral Anticoagulants) – DOACs – a quick guide: APIXABAN (ELIQUIS®), DABIGATRAN (PRADAXA®), EDOXABAN (LIXIANA®) & RIVAROXABAN (XARELTO®) http://nww.avon.nhs.uk/dms/download.aspx?did=18640

◆ If patient on Vitamin K antagonist (e.g., Warfarin) for mechanical valve or other indication for anticoagulation discuss with Cardiology SpR and consider commencing IV heparin as per Trust protocol

◆ Aspirin, Clopidogrel and oral anticoagulant for 1 week after PCI followed by oral anticoagulant and Clopidogrel for 12 months (ESC 2017)

◆ Lansoprazole 30mg OD whilst on triple therapy

Low Risk Chest Pain Pathway

Take Troponin I at presentation (anytime from chest pain)
Time 0 hrs

Troponin I <3ng/L

Discharge

Troponin I 3-49ng/L

Baseline TNI (Time 0) <5ng/L AND Delta <5ng/L

Repeat 2 hrs after presentation

Delta (+/-) ≥20ng/L

Treat as ACS

Baseline (Time 0) TNI ≥5ng/L OR 2hr Delta 5-19ng/L

Observation group
Repeat 6hrs after presentation

Troponin I <18ng/L on ALL values

Discharge

Troponin I ≥18ng/L AND 6hr delta <11ng/L (NPV 94%)

Senior review Consider whether discharge or further investigations (CTCA/stress testing)

Troponin I ≥50ng/L

Troponin I ≥18ng/L AND 6hr delta ≥11ng/L

Treat as ACS

If pain free and ACS Ruled Out, consider referral to rapid access chest pain clinic if stable angina suspected.
If unstable angina suspected, consider medical admission (discuss with senior ED clinician)