SUSPECTED ACUTE CARDIAC CHEST PAIN PROTOCOL

Great Western Hospitals NHS Foundation Trust

HISTORY AND EXAMINATION.

Use this protocol for patients with cardiac-sounding chest pain lasting longer than 15 minutes
ONLY PRESCRIBE ACS MEDICATION IF YOU BELIEVE THE PATIENT HAS ACS.

Oxygen (if required). Aspirin 300mg PO. GTN 2 puffs S/L (if in pain).
12 – LEAD ELECTROCARDIOGRAM - Every 15 minutes until pain free.
BLOODS: CP1 (Troponin, U&E, Lipids, LFT, Lab Glucose, CRP, FBC, Clotting Studies).
CHEST X RAY

Notes re Fondaparinux:
Do not give Fondaparinux to patients on a "Green Pathway"
If patient on Warfarin, give Aspirin and await INR. If INR <2 give Fondaparinux to patients on a "Yellow Pathway".
If patient on NOAC's, give Aspirin, withhold Fondaparinux and await senior review.
If GFR <30 or Creatinine >265, consider Unfractionated Heparin rather than Fondaparinux.

ABNORMAL ECG

- **ST Elevation**
  2 mm in V1 –V6
  1 mm in other leads
- **Left Bundle Branch Block with a good history for MI** (***People with longstanding LBBB still have MI***)

ABNORMAL / SUSPICIOUS ECG

- **ST Depression**
- **T wave inversion**
- **Transient ST Elevation**
- **LBBB – history suggestive of Unstable angina**

NORMAL ECG

TNI on admission & 6 hrs after onset of pain.

IF HISTORY STRONGLY SUGGESTIVE OF UNSTABLE ANGINA, MOVE TO YELLOW PATHWAY.

Ensure at least 2 ECGs.

If TNI positive or ECG becomes abnormal MOVE TO YELLOW PATHWAY.

In working hours, if TNI negative, pre discharge ETT on ACU.

Out of working hours, if TNI negative, low risk patients (GRACE score <1.5%) can be discharged and return for out-patient ETT on ACU.
If GRACE score >1.5%, refer to medical take.

If ETT is inappropriate, CTCA can be requested by Consultant Cardiologists or Acute Physicians.
Patient to return to ACU after the scan for result.

If ETT/CTCA negative: discharge.
If ETT/CTCA positive: move to Yellow pathway and refer to Cardiology or ACS Nurse.

GTN; Morphine 5 - 10 mg IV; Metoclopramide 10 mg IV (if required)

Glycaemic control is important. Aim for BM of 4 - 10 mmol/litre.
In confirmed ACS, if BM > 11mmol/litre use DIGAMI regimen.

Primary PCI.

In working hours onsite.
Out of working hours at BHI (See separate protocols)

If PPCI unavailable at BHI, try Oxford, then Reading.

If PPCI is unavailable or contraindicated, then consider thrombolysis.
Discuss with on call Consultant Cardiologist if required.

TNI on admission & 6 hours after onset of pain.

GRACE score (6 month prediction).

FONDAPARINUX 2.5mg s/c od.
CLOPIDOGREL 300mg PO stat (then 75mg od)
Or TICAGRELOR 180mg PO stat (then 90mg bd) if allergy to Clopidogrel.
IV NITRATE (2-10 ml/hr if pain).
METOPROLOL 25–50 mg PO TDS if not contraindicated.
STATIN.
ACE inhibitor.

If GRACE score >3% consider Tirofiban and admit to Cardiology.
Otherwise transfer to monitored bed on LAMU. Review by Cardiologist or ACS Nurse at the earliest opportunity.

The majority of these patients will require in-patient angiography.