Pathway for Acute Chest Pain thought to be due to Acute Coronary Syndrome

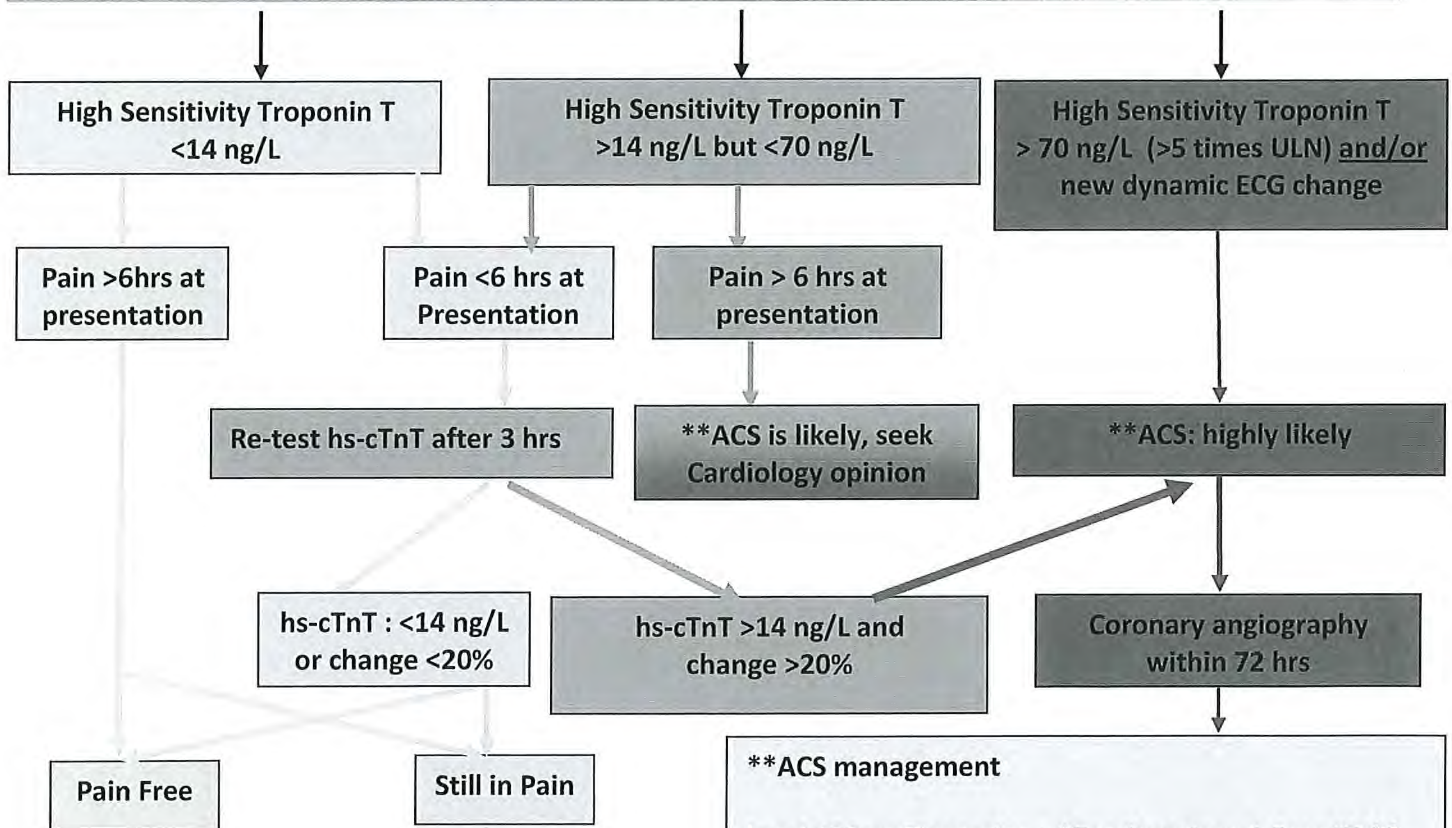
Rapid clinical assessment including history, examination and a 12 lead ECG
If ST elevation or new LBBB follow Primary Percutaneous Coronary Intervention (PPCI) pathway

If at anytime a Consultant confirms chest pain is non cardiac in origin this pathway will cease

1. Prescribe Oxygen, if saturation less than 94% on room air or 88-92% for patients known to have a type 2 respiratory failure
2. Pain relief with GTN spray; consider Morphine or Diamorphine with antiemetic cover
3. Detailed history and examination to assess for other causes including Aortic Dissection/Pulmonary Embolism
4. Serial ECGs
5. Bloods for hs-cTnT (high sensitivity troponin T), U&E, LFT, FBC, Coagulation profile

Aspirin 300mg oral and ***Fondaparinux 2.5mg sc** (if no contraindication, see ACS management box below)
* if eGFR<20 use Enoxaparin 1mg/kg daily (renal dose)

Baseline (Zero Hour) High Sensitivity Troponin T (hs-cTnT)



Check GRACE 2 score:
(web calculator/ mobile app)
For intermediate / high risk: Seek Cardiology opinion
Low risk: outpatient cardiac investigations may be considered. (refer to NICE guidance CG95,CG126)

Consider:
Further hs-cTnT after 6 hrs.

Cardiology opinion

Other causes

****ACS management**

Load 180mg Ticagrelor + *Fondaparinux 2.5mg SC (if no contraindications)
Aspirin 75mg OD + Ticagrelor 90mg BD for 12 months

If on anticoagulation: Do not stop, continue as **Triple therapy :**Aspirin +Clopidogrel + Anticoagulation
Avoid Fondaparinux and Ticagrelor if anticoagulated.
***Discuss with interventional cardiologist**

Refer to Cardiac Rehabilitation team on ICE
Consider:
Beta-blocker, ACE Inhibitor, Atorvastatin 80mg
Sliding scale insulin regimen if glucose ≥ 11.0mmol/L
Fasting lipids and glucose, CBGs for 48hrs, HbA1c

LUTON & DUNSTABLE UNIVERSITY HOSPITAL
CLINICAL EXCELLENCE, QUALITY & SAFETY

Developed by [redacted]
Next Review: April 2018