ED / AMU ACS Pathway

First take a good history. Be wary that some patients with negative troponins give a history of Unstable Angina and therefore require admission.

When is the ACS pathway used?

The ACS pathway is for patients where coronary ischemia is in your differential. It is **not** a blanket pathway for chest pain of unknown cause.

Patients presenting >8hrs post chest pain *NEW*

If an initial trop is taken >8 hours post chest pain, and patients have no new ECG ischaemia, and no history of unstable angina, there is no compulsion to repeat a second troponin.

ACS Treatment

If patients are diagnosed with an MI (trop positive with consistent symptoms/signs) the standard ACS treatment regimen includes **Aspirin 300mg** stat, **Ticagrelor 180mg** stat and Fondaparinux 2.5mg sc stat.

If a patient is **anticoagulated** with a NOAC, or with Warfarin (with a therapeutic INR), there is no need to give LMWH (Fondaparinux), but use clopidogrel instead of ticagrelor.

Direct admissions to CCU

Patients with ST Elevation (if not accepted for primary PCI) or those with CP + new ST Depression should be discussed with a local Cardiologist and **come directly to CCU**.

As it is difficult to be prescriptive for every other circumstance, a discussion with a senior / cardiologist may be worthwhile in order to best place your patient within the hospital. Factors that should make you think about a senior discussion are included on the pathway.

Patients where MI is excluded

If patients do exit the pathway (no new symptoms, no new ECG ischemia and troponins that meet the exit criteria to exclude an MI), two other important possibilities still require consideration:

1) Is the history in keeping with **unstable angina?** (This is still an ACS). If so the patient will require an acute inpatient admission with telemetry and IP cardiology review.
2) Is the chest pain due to a significant **alternative diagnosis?** If so this still needs to be actively considered/ investigated/ treated.

ED / AMU ACS Pathway

Cardiac CP /
Symptoms consistent with ischaemia

Non diagnostic ECG

1 **Trop ≥2 hrs** from symptom onset

<5

30% of patients

Some patients potentially dischargeable – see below

≥5 & **≤39** (F) or **≤58** (M)
Admit CDU / Ambulatory

initial trop
>39 (F) or **>58** (M)

Treat as ACS
Admit AMU

NEW Ischaemia ST↓ T↓
OR a history of UA

1 **Do baseline Trop**
Give ACS meds
Telemetry
Repeat ECG within 30 mins
Admit AMU / CCU
CCU if cardiac CP + ST↓
(plus see box below)

2 **repeat trop @ 6hrs**
(from initial trop)

STEMI/New LBBB

ACS Meds.
Follow 1'PCI pathway
–> DW LGI
If not accepted DW local Cardio Cons ? **local PCI / Thrombolysis**
→ **CCU**
Prognostic trop @ 6 hours

High Risk – Will definitely need admission

Units: ng/l

2 **Repeat trop @ 6hrs**
(from initial trop)

Consider CCU (Dw Cardiology Cons/Reg +/- Cardiac nurse) if:

- Strong Cardiac history
- Refractory CP/ ischaemia
- Acute Pulmonary oedema
- Significant arrhythmia

≤39 (F) or ≤58 (M)

>39 (F) or >58 (M)

CDU / Ambulatory

MI ruled out

Consider MI if suggested clinically

AMU

Note it is still important to take a good history here. A small number may still have **Unstable Angina**

Trust Guideline for the management of Acute Coronary Syndromes in adults using High Sensitive Troponin: Roll-out 8th May 2019
Prepared by Dr Alexander Hashimi
ACS Guideline Team: Dr Sarah Hoye, Dr Karthik Viswanathan, Dr Huw Masson, Dr Karen Mitchell, Alison Eales, Dr Alexander Hashimi
Consensus by wider Cardiology Consultant group sought. Review date June 2022