SUSPECTED ACUTE CORONARY SYNDROME PATHWAY

Ref No: 2026

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Care Group	:	Unscheduled Care (Medicine)
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Initial clinical assessment: Suspected Acute Coronary Syndrome

(i.e. chest pain suggestive of cardiac ischaemia lasting longer than 15 minutes)

- **12 lead ECG**
- iv cannula – FBC / U&E / LFT / Glucose / Lipids / Troponin
- CXR
- Analgesia (GTN/opiates)

ST elevation or new onset LBBB on ECG:

- Arrange immediate transfer to Heart Attack Centre
- Aspirin 300mg *po stat*
- Ticagrelor[1,2] 180mg *po stat*

Calculate TIMI risk score (one point for each of the following):

- Age 65 years or older? ❑
- Known coronary artery disease (i.e. vessel stenosis ≥ 50%)? ❑
- Use of aspirin in the previous seven days? ❑
- Severe angina (two or more episodes within the last 24 hrs)? ❑
- ST segment change ≥ 0.5mm? ❑
- Elevated serum Troponin? *(NB result not required before medical referral)* ❑
- At least 3 risk factors for coronary artery disease? ❑
  i.e. current smoker, hypertension, family history premature IHD (<65yrs old), hypercholesterolemia, diabetes mellitus.

TIMI risk score = / 7

≥ 4 — High-risk

- Aspirin 300mg *po stat* and 75mg *od*
- Ticagrelor[1,2] 180mg *po stat* and 90mg *bd* unless previous CVA/TIA or need for oral anti-coagulant (OAC)[3] in which case use Clopidogrel[1,2] 600mg *po stat* (if not already receiving) and 75mg *od*.
- Admit to CCU

- Fondaparinux[4] 2.5mg *sc od*
- Consider Bisoprolol 1.25mg *od* if heart rate >70bpm & no contra-indications.
- Consider discussion with Heart Attack Centre or on-call Cardiologist if ongoing chest pain, haemodynamic upset, pulmonary oedema or ventricular arrhythmias.

2 - 3 — Intermediate-risk

- Aspirin 300mg *po stat* and 75mg *od*
- Admit to a monitored bed on AMU

- Fondaparinux[4] 2.5mg *sc od*
- Consider Bisoprolol 1.25mg *od* if heart rate >70bpm & no contra-indications.
- Serial ECGs and interval serum Troponin.

0 - 1 — Low-risk

- Aspirin 300mg *po stat* and 75mg *od*
- Admit to AMU bed

- Serial ECGs and interval serum Troponin.

1. Contra-indicated if previous intra-cranial haemorrhage, active pathological bleeding, current renal dialysis therapy or severe hepatic impairment.
2. Consider a proton pump inhibitor in patients at higher than average risk of gastrointestinal bleeds (i.e. history of gastrointestinal ulcer/haemorrhage, OAC therapy, chronic NSAID/ corticosteroid use or two or more of the following: age ≥65 years, dyspepsia, gastro-oesophageal reflux disease, Helicobacter pylori infection, chronic alcohol use).
3. The continued use of an OAC (i.e. Warfarin or NOAC) is recommended in patients with: paroxysmal, persistent or permanent atrial fibrillation with a CHA_2DS_2-VASC score ≥ 2; recent or a history of recurrent deep vein thrombosis or pulmonary embolism; left ventricular thrombus; mechanical heart valve.
4. Contra-indicated if eGFR <20ml/min/1.73m^2.