

Scope and Target Population:

Adults greater than age 18 years presenting with past or present symptoms of chest pain/discomfort and/or indications of acute cardiovascular syndromes.

Aims:

1. Increase the success of emergency intervention for patients with chest pain symptoms suggestive of serious illness.
2. Minimize the delay in administering fibrinolysis or angioplasty to patients with acute myocardial infarction (AMI).
3. Increase the timely initiation of treatment to reduce postinfarction mortality in patients with acute myocardial infarction.
4. Increase the percentage of patients with acute myocardial infarction using appropriate cardiac rehabilitation postdischarge.

Clinical Highlights:

- On initial contact with the health care system, high-risk patients need to be identified quickly and referred to an emergency department via the 911 system.
- Patients whose chest pain symptoms are suggestive of serious illness need immediate assessment in a monitored area of the emergency department and early therapy to include an immediate EKG, intravenous access, oxygen, aspirin and other appropriate medical therapies.
- Triage and management of patients with chest pain and unstable angina should be based on a validated risk assessment system and clinical findings.
- Patients with low-risk symptoms could be evaluated as outpatients.
- Patients with high-risk features need to be identified quickly and treatment instituted in a timely fashion.
- Thrombolysis should be instituted within 30 to 60 minutes of arrival, or angiogram/primary percutaneous coronary intervention should be performed within 90 minutes of arrival, with a target of less than 60 minutes. High-risk patients initially treated at non-PCI-capable facilities who cannot be transferred for PCI within 90 minutes should receive thrombolysis followed by as-soon-as-possible transfer to a PCI-capable facility.
- Recommend use of the following medications: P2Y12 inhibitor and aspirin (or P2Y12 inhibitor alone if aspirin allergic) at admission. Avoid P2Y12 inhibitor if cardiac surgery is anticipated. Use beta-blockers whenever possible and/or ACE inhibitors/angiotensin receptor blockers at 24 hours if stable, nitrates (when indicated), and statins whenever possible. Once the issue of surgery is clarified, consider the early use of a P2Y12 inhibitor for those in whom percutaneous coronary intervention is planned.
- Recommend appropriate use of cardiac rehabilitation postdischarge.