

ICSI instituted a new method of grading the strength of literature as low quality evidence, moderate quality evidence, and high quality evidence this year. Hence, the former classification by study design type was discontinued in this edition of the guideline. The order set was incorporated into the guideline, and its annotation content also inserted where needed.

Algorithm(s)

Renumbered algorithm steps #20 through #123 to align with this year's clarification which definitively shunts off patients with thoracic aortic dissection or other conditions to remove them from the myocardial infarction pathway to get condition-specific care.

Annotations

- 5) deleted
- 10) deleted
- 11) deleted
- 12) deleted
- 13) deleted
- 14) deleted

- 19) Title update to “Ambulance transport to emergency department; *obtain EKG en route if able, aspirin if possible*” and language added to emphasize use of electrocardiography in ambulance, and prioritizing ECG upon arrival at hospital if not possible in ambulance.

- 24) Title was changed to reflect “acute cardiovascular syndrome,” rather than the formerly restrictive term, “coronary artery disease.” Added language prompting recognition of the symptoms of aortic dissection, cardiac tamponade (and other acute cardiovascular syndromes) (Hiratzka 2010).

- 25) Title changed to aortic dissection rather than include aneurysm.

- 26) Title was shortened to “Expedited Aortic Imaging.”

- 29) Title was updated to include “for intermediate risk patients.”

The annotation now refers readers to both the earlier annotations regarding “early therapy” and “early therapy for high risk patients,” hence, it captures the new clinical guidance from the ACCF/AHA 2011 Focused Update.

- 31) Title of this risk assessment step was updated to include “consider repeat electrocardiogram if ongoing chest discomfort” to capture the possibility that ST-elevation myocardial infarction may have evolved since the initial EKG was done.

Added recommendation to repeat EKG in some cases.

In this revision, possible aortic dissection and pericarditis with tamponade have been addressed earlier in the clinical pathway, hence, references to them are now removed from this annotation.

- 33) Title was updated to include “for high risk patients.”

Added new clinical guidance for initial invasive strategies and initial (noninvasive) conservative strategies, in line with the ACCF/AHA 2011 Focused Update for Unstable Angina/ Non-STEMI. (Cited Wright 2011)

- 44) Use of “P2Y12 inhibitors” generally replaces “thienopyridines” throughout this annotation and the entire guideline.

Changed the rather equivocal reference to dosing aspirin with unfractionated heparin (UFH) and low-molecular-weight heparin (LMWH) to more definitively recommend UFH and LMWH with the addition of Xa inhibitors and the term “P2Y12 inhibitors.” (Brito, 2011)

Language was further refined throughout the annotation for the various agents, falling into classes such as anticoagulants and beta-blockers.

- 46) Title was updated to include chest pain “not related to acute cardiovascular syndrome but indicative of other serious diagnosis.”

- 52) Removed the outdated statement that percutaneous coronary angioplasty vascularization might be superior to thrombolysis.

- 53) Emphasized the use of thrombolytics being useful only if unable to get the STEMI patient to a PCI-capable facility in fewer than 90 minutes.

- 57) Added the use of P2Y12 inhibitors and ARBs in discussion of adjunctive therapy.

Added the newly FDA-approved Ticagrelor to the section on P2Y12 inhibitors.

Added the COGENT trial, and added language from the ICSI Antithrombotic Therapy Supplement about weighing risks and benefits of using clopidogrel with proton pump inhibitors (PPI). (Bhatt, 2010)

Language addressing the Heart Protection Study Collaborative Group’s study on statins was moved into the guideline from the formerly separate order set. (Cannon, 2004)

- 66) Along with clopidogrel, ticagrelor was added. Added language from the order set and its related references.

- 76) Added comment that the Phase Two cardiac rehabilitation programs today go beyond exercise to focus on risk factor modification, education and counseling. (Thomas, 2010)