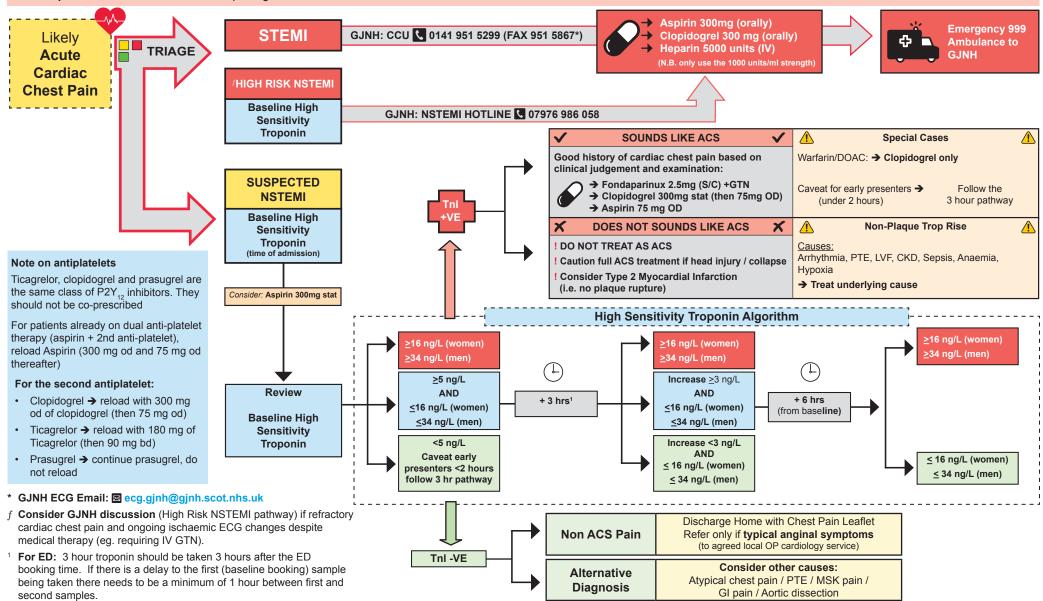
SUSPECTED ACUTE CARDIAC CHEST PAIN PROTOCOL Greater Glasgow and Clyde Patient presents with chest pain to ED/AAU Multiple other complaints No other unrelated complaints and no other acute comorbidities or multiple comorbidities Nursing assessment in triage and pain not pleuritic or pleuritic pain and not mainly epigastric or posterior or pain mainly epigastric or posterior Chest pain assessment form completed ECG and troponin within 15 minutes Usual medical management pathways by medical staff (HEART score) High risk chest pain Ischaemic ECG changes **STEMI** (for example 2mm ST depression in 2 (for example ≥2mm ST elevation in 2 adjacent leads of deep symmetrical T consecutive chest leads or >1mm in 2 adjacent limb leads or ongoing typical cardiac pain or new LBBB or >2mm ST depression V1-V3 suggestive of posterior infarct) and HEART score >5 REFER GJNH FOR CONSIDERATION OF DIRECT TRANSFER OF HIGH RISK 07976 986058 NSTEMI. **HEART SCORE < 5** Treat as STEMI Call 999 for emergency PCI transfer Refer GJNH 0141 951 5299 **\rightarrow** History suggests possible cardiac pain and non-diagnostic ECG Treat as presumed ACS Fax ECG to 0141 951 5867 Refer to cardiology Aspirin 300mg stat Clopidogrel 300mg stat Give aspirin 300mg stat Arrange CXR Clerk in and write kardex IV Heparin 5000u (if not anticoagulated) DO NOT GIVE Clopidogrel or Fondaparinux unless discussed with cardiology Troponin 6 hours post-admission (PEAK) Consider aspirin 300mg stat Review baseline troponin Arrange CXR >16 ng/L (women) <5ng/L ≥5 ng/L >34 ng/L (men) Negative MI screen discharge ≤16 ng/L (women) (caveat early plans presenters < 2 hours: ≤34 ng/L (men) Manage as ACS follow 3 hour Most patients will have: pathway) Nursing: Apply cardiac monitor A) A clear alternative diagnosis Troponin 3 hours post time booked into ED (typically musculoskeletal or GI pain) Inform senior medical staff Reassure, offer advice on Arrange for first ARU bed (if no immediate cardiology beds) management such as analgesia or Inform patient, offer to inform relatives B) Atypical chest pain. Reassure Medical: CHANGE <3 ng/L **CHANGE** ≥3 ng/L ≥16 ng/L (women) patient of very low cardiac risk. Offer Full medical review including **AND AND** ≥34 ng/L (men) routine bloods, ECG & CXR simple analgesia, advice and GP ≤16 ng/L (women) ≤16 ng/L (women) follow up if recurrence. No ETT Consider other causes of raised Tnl ≤34 ng/L (men) (PTE / LVF / arrhythmia / sepsis) Complete meds rec and kardex required. ensure not on any anticoagulants A few patients will have: Troponin 6 hours post-admission (PEAK) Rx Clopidogrel 300mg stat then 75mg C) Typical exertional cardiac pain with bd Rx Fondaparinux 2.5mg s/c stat then no previous investigations Arrange F.U. with RACPC/GP or cardiology, if appropriate. Rx PRN sublingual GTN spray ≤16 ng/L (women) ≥16 ng/L (women) ≤34 ng/L (men) ≥34 ng/L (men)

Acute Cardiac Chest Pain Guidelines



This guideline covers patients who are suspected to have acute cardiac chest pain. As of 6th November 2023, in patients with **new ACS**, clopidogrel is the first choice (not ticagrelor). Patients **post-PCI** will be commenced on prasugrel and transferred back to NHS GGC.



NHS GG&C: ACUTE CARDIAC CHEST PAIN GUIDELINES

HEART W Score Chest Pain Stratification Risk Tool

	Highly suspicious for ACS	2
History	Moderately suspicious for ACS	1
ECG	Slightly or non-suspicious for ACS	0
	Significant ST-depression / T - wave inversion	2
	Non-specific repolarisation disturbance	1
Age	Normal	0
	≥65 years	2
	45–65 years	1
Risk factors	≤45 years	0
	≥3 risk factors, or history of CVD	2
	1 or 2 risk factors	1
Transpin	No risk factors known	0
	Elevated HsTn (> 16 women, > 34 men)	1
Troponin I	≤ Normal Limit	0
TOTALS		/ 9

GUIDE: HOW TO CALCULATE THE HEART SCORE

The HEART score is a risk stratification tool first used in the Emergency Department to predict the likelihood of a major adverse cardiac event within 6 weeks following presentation with chest pain.

A score is assigned from 5 specific elements (History, ECG changes, Age, Risk factors and Troponin) to give a value between 0 and 9. Three of the elements are explained in detail below:

History - From your history characterise the patient's chest pain as typical or atypical. The following distinctions have been agreed:

- 1. Typical pain central of left-sided chest pain with radiation to the arms or throat, or associated sweating or clamminess.
- Atypical pain without chest pain or right sided chest pain or pain that radiates to the back or is worsened by inspiration/palpation.
 - **2 points**: highly suspicious chest pain (i.e. typical pain)
 - → 1 point: moderately suspicious chest pain (i.e. mixed typical/atypical features)
 - **0 point:** chest pain slightly or moderately suspicious (i.e. atypical pain only)

Electrocardiogram (12 Lead ECG) - From the 12 lead ECG:

- → 2 points: ECG shows features new/presumed new features of acute ischaemia or infarction (eg. significant ST depression, T-wave inversion)
- → 1 point: ECG is abnormal but not diagnostic of ischaemia (eg. right bundle branch block, paced rhythm) or if ECG suggests previous infarction
- 0 points: ECG is normal

Risk Factors: Count the number of risk factors for coronary artery disease:

- Diabetes mellitus
 - Current or recent (<90 days) smoker
- Hypertension (diagnosed or treated)
- Hypercholesterolaemia
- Family history of coronary artery disease Obesity (BMI > 30)
- 2 points: 3 or more risk factors or significant atherosclerotic disease (including previous coronary revascularisation, myocardial infarction, peripheral arterial disease)
- 1 point: 1-2 risk factors
- **0 point:** no risk factors

NHS Greater Glasgow and Clyde (v 2.7)