NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CHEST PAIN PATHWAY

PRIMARY PCI SITE

Date of Presentation ☐☐/☐☐/☐☐☐☐ Time ☐☐:☐☐ Time of Symptom Onset: ☐☐:☐☐

CHEST PAIN or OTHER SYMPTOMS of MYOCARDIAL ISCHAEMIA

(eg sweating, sudden orthopnea, syncope, dyspnoea, epigastric discomfort, jaw pain, arm pain)

Be aware:
HIGH RISK ATYPICAL PRESENTATIONS
(eg diabetes, renal failure, female, elderly or Aboriginal)

TRIAGE CATEGORY 2

ECG & Vital Signs, expert interpretation within 10 minutes

General Management
- ☐ Oxygen
- ☐ Aspirin
- ☐ IV Access
- ☐ Pain Relief
- ☐ Pathology incl Troponin
- ☐ Chest X-ray

ST ELEVATION or (presumed new) LBBB

Y → **Consider Pericarditis** (sharp chest pain, respiratory or positional component) → N → Go immediately to **STEMI MANAGEMENT** (page 3)

N → **Consider Aortic Dissection** (back pain, hypertension, absent pulse, BP difference)
Consider Pulmonary Embolism (severe dyspnoea, respiratory distress, low subscript O_2 saturation)

N → **Diagnose NON ST ELEVATION ACUTE CORONARY SYNDROME (ACS)**

STRATIFY ACS RISK

HIGH RISK Any of the following	INTERMEDIATE RISK Any of the following and no high risk features	LOW RISK Any of the following and no high or intermediate risk features
☐ ACS symptoms are repetitive or prolonged (> 10 min) & still present. ☐ Syncope ☐ History of chronic left ventricular systolic dysfunction (especially if known LVEF < 40%) OR current clinical evidence of LVF. ☐ Previous PCI/CABG < 6 months ☐ Diabetes + typical ACS symptoms ☐ Chronic renal failure + typical ACS symptoms ☐ Haemodynamic compromise (sustained SBP < 90 mmHg and / or new onset mitral regurgitation) ☐ Elevated Troponin (consider haemolysis, renal failure)	☐ ACS symptoms within 48 hrs that occurred at rest, or were repetitive or prolonged (but currently resolved) ☐ Previous PCI/CABG > 6 months ☐ Known coronary heart disease- Esp if prior AMI or known coronary lesion > 50% stenosis ☐ Two or more risk factors of: Hypertension, family history, active smoking or hyperlipidaemia ☐ Chronic renal failure (especially if known GFR < 60 mL/min) + atypical ACS symptoms ☐ Diabetes + atypical ACS symptoms ☐ Age > 65 years	☐ Presentation with clinical features consistent with ACS without intermediate- risk or high-risk features.
☐ Persistent or dynamic ECG changes of ● ST depression ≥ 0.5 mm or ● new T wave inversion ≥ 2 mm ☐ Transient ST elevation (≥ 0.5 mm) in more than two contiguous leads ☐ Sustained VT	☐ ECG is not normal and has changed from previous pain free ECG but does not contain high risk changes.	☐ ECG Normal or unchanged from previous pain free ECG

All cases to be discussed with Senior Medical Officer

Recommended Management on page 2

This tool is intended as a guideline for clinicians to provide quality patient care. It is not intended, nor should it replace, individual clinical judgement. Some patients with co-morbidities or patients not suitable for invasive investigations may be appropriately managed medically.

CHEST PAIN PATHWAY PRIMARY PCI SITE

SMR080.070

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CHEST PAIN PATHWAY

PRIMARY PCI SITE

Contraindications and cautions for thrombolysis use in STEMI[1]

Absolute contraindications:

Risk of bleeding
- Active bleeding or bleeding diathesis (excluding menses)
- Significant closed head or facial trauma within 3 months
- Suspected aortic dissection (including new neurological symptoms)

Risk of intracranial haemorrhage
- Any prior intracranial haemorrhage
- Ischaemic stroke within 3 months
- Known structural cerebral vascular lesion (eg, arteriovenous malformation)
- Known malignant intracranial neoplasm (primary or metastatic)

Relative contraindications:

Risk of bleeding
- Current use of anticoagulants: the higher the international normalised ratio (INR), the higher the risk of bleeding
- Non-compressible vascular punctures
- Recent major surgery (< 3 weeks)
- Traumatic or prolonged (> 10 minutes) cardiopulmonary resuscitation
- Recent (within 4 weeks) internal bleeding (eg, gastrointestinal or urinary tract haemorrhage)
- Active peptic ulcer

Risk of intracranial haemorrhage
- History of chronic, severe, poorly controlled hypertension
- Severe uncontrolled hypertension on presentation (> 180 mmHg systolic or > 110 mmHg diastolic)
- Ischaemic stroke more than 3 months ago, dementia, or known intracranial abnormality not covered in contraindications

Other
- Pregnancy

[1] Adapted from NHF/CSANZ Guidelines for the management of acute coronary syndromes 2006

Contraindications to Exercise Testing (ACC/AHA Guidelines)[2]

Absolute
- Recurrent chest pain
- Acute myocardial infarction, within 2 days
- High-risk unstable angina
- Uncontrolled cardiac arrhythmias causing symptoms or haemodynamic compromise
- Symptomatic severe aortic stenosis
- Uncontrolled symptomatic heart failure
- Acute pulmonary embolus or pulmonary infarction
- Acute myocarditis or pericarditis
- Acute aortic dissection

Relative
- Critical left main coronary stenosis
- Moderate stenotic valvular heart disease
- Electrolyte abnormalities
- Systolic hypertension > 200 mmHg
- Diastolic hypertension > 100 mmHg
- Tachyarrhythmias or bradyarrhythmias
- New onset atrial fibrillation
- Hypertrophic cardiomyopathy and other forms of outflow obstruction
- Mental or physical impairment leading to the inability to exercise adequately
- High-degree atrioventricular block
- Resting ECG which will make EST interpretation difficult (eg LBBB, LVH with strain, Ventricular pacing, Ventricular preexcitation.)

[2] Gibbons etal, Circulation 106:1883,2002

Abbreviations:

ACS – Acute Coronary Syndrome
CABG – Coronary Artery Bypass Graft
ECG – Electrocardiogram
EST – Exercise Stress Test
FMC – First Medical Contact
GTN – Glyceryl trinitrate
LBBB – Left Bundle Branch Block
LVF – Left Ventricular Failure
LVH – Left Ventricular Hypertrophy
PCI – Percutaneous Coronary Intervention
SMO – Senior Medical officer
STEMI – ST Elevation Myocardial Infarction

BINDING MARGIN - NO WRITING

SMR080070

NSW GOVERNMENT Health

Facility:

CHEST PAIN PATHWAY

PRIMARY PCI SITE

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Recommended Further Management Refer to drug protocols &/or Therapeutic Guidelines

HIGH RISK

ADMIT or TRANSFER

- ☐ Continuous cardiac monitoring & frequent vital signs
- ☐ Repeat ECG immediately if symptoms recurs
- ☐ Repeat ECG 8 hrs post onset of symptoms
- ☐ Repeat Troponin at 8 hrs if 1st sample negative *
- ☐ ECG/Troponin review by medical officer

Antiplatelet therapy

☐ Yes
☐ No } Discuss with cardiologist /SMO

If no reason_____

_____

Betablocker

☐ Yes
☐ No

If no reason_____

_____

Anticoagulant

☐ Yes
☐ No

If no reason_____

_____

Symptomatic treatment of ongoing pain/hypertension

- ☐ IV GTN (titrate against pain & BP)
- ☐ IV Morphine
- ☐ Refer to nominated cardiologist for further management

INTERMEDIATE RISK

RESTRATIFY

- ☐ Continuous cardiac monitoring & frequent vital signs
- ☐ Repeat ECG immediately if symptoms recur
- ☐ Repeat ECG 8 hrs post onset of symptoms
- ☐ Repeat Troponin at 8 hrs if 1st sample negative *
- ☐ ECG/Troponin review by medical officer

Refer for Exercise Stress Test ** if :

- ☐ No further chest pain/symptoms **and**
- ☐ 2 negative Troponin tests **and**
- ☐ No new ECG changes and
- ☐ No contraindications to stress test (page 4)

Restratify to High Risk if:

- ☐ Recurrent ischaemic chest pain **or**
- ☐ Positive Troponin **or**
- ☐ New ECG changes **or**
- ☐ Positive stress test

Restratify to Low Risk & Discharge if:

- ☐ Negative stress test **or**
- ☐ Stress test available within 72 hrs** **and**
- ☐ No further chest pain/symptoms
- ☐ Repeat ECG & vital signs, if stable discharge

NB: ** If stress test is not available within 72 hrs of discharge, treatment plan should be guided by nominated SMO/Cardiologist

Pharmacological stress test or CT coronary angiography may be indicated

LOW RISK

DISCHARGE

- ☐ Regular vital signs
- ☐ Repeat ECG immediately if symptoms recur
- ☐ Repeat ECG 8 hrs post onset of symptoms
- ☐ Repeat Troponin at 8 hrs if 1st sample negative *
- ☐ ECG/Troponin review by medical officer

Restratify Risk if:

- ☐ Recurrent ischaemic chest pain **or**
- ☐ Positive Troponin **or**
- ☐ New ECG changes

If low Risk ACS

- ☐ Discharge
- ☐ Follow up GP/LMO within 3-5 days of D/C
- ☐ Consider Specialist follow up
- ☐ Consider discharge on Aspirin (discuss with SMO)
- ☐ Vital signs prior to discharge

If unlikely cardiac cause

Consider alternative diagnosis

Exit Pathway

***If a high sensitivity troponin assay is used, the testing interval may be reduced to 3 hours, provided the second sample is taken at least 6 hours after symptom onset.**

Medical Officer: Print name & sign_____ **Date**_____

Medical Officer Designation_____

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NH606600 - 120511

NSW GOVERNMENT Health

Facility:

CHEST PAIN PATHWAY
PRIMARY PCI SITE

STEMI MANAGEMENT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

1. CONFIRM INDICATIONS for REPERFUSION

- ☐ Chest pain > 30 min and < 12 hrs
- ☐ Persistent ST segment elevation of ≥ 1 mm in two or more contiguous limb leads or ST segment elevation of ≥ 2 mm in two contiguous chest leads or presumed new LBBB pattern
- ☐ Myocardial infarct likely from history

Time of diagnostic ECG ☐☐:☐☐

2. GENERAL MANAGEMENT

- ☐ Cardiac monitoring
- ☐ ECG
- ☐ IV Cannula X 2
- ☐ Routine bloods
- ☐ Oxygen
- ☐ Analgesia – Morphine
- ☐ Nitrates-Sublingual or IV
- ☐ CXR
- ☐ Beta Blockers

3. ADMINISTER ANTITHROMBOTIC THERAPY

Confirm administration or give:

- ☐ Aspirin 300 mg (soluble)
- ☐ Clopidogrel 300 - 600 mg (or prasugrel &/or tirofiban)
- ☐ Enoxaparin 30 mg IV then bd (or IV heparin or bivalirudin) 1 mg/kg subcut (Max 100 mg)

Refer to local protocols &/or Therapeutic Guidelines

4. CHOOSE REPERFUSION METHOD

PRIMARY PCI UNLESS

- ☐ Significant delay to availability of Cath Lab or interventional team or
- ☐ Patient does not consent to primary PCI
- ☐ History, contrast allergy
- ☐ Vascular access problems
- ☐ Discuss with Interventional cardiologist: Time ☐☐:☐☐
- ☐ Decision regarding reperfusion method: Time ☐☐:☐☐

5. TRANSFER TO CATH LAB

Discuss adjunctive treatment with Cardiologist

OR

THROMBOLYSE if appropriate

- ☐ No contraindications (see page 4)
- ☐ Tenecteplase / Reteplase

Body Weight _____kg Dose _____

Time administered ☐☐:☐☐

- ☐ Repeat ECG at 60 mins post thrombolytic
- ☐ Discuss further mx with cardiologist
- ☐ Failure to reperfuse (less than 50% reduction in ST elevation)

Consider Rescue Angioplasty

Cath Lab arrival time ☐☐:☐☐ please use 24 hr Clock

On table time ☐☐:☐☐

First device use time ☐☐:☐☐

Time to Revascularisation (TIMI 3 flow) Yes / No Time ☐☐:☐☐

☐ 0-30 mins ☐ 31-45 mins ☐ 46-60 mins ☐ 61-75 mins ☐ 76-90 mins ☐ >90 mins Reason for delay

Medical Officer: Print name & sign_____ **Date**_____

Medical Officer Designation_____

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NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CHEST PAIN PATHWAY

NON PRIMARY PCI SITE

Date of Presentation ☐☐/☐☐/☐☐☐☐ Time ☐☐:☐☐ Time of Symptom Onset: ☐☐:☐☐

CHEST PAIN or OTHER SYMPTOMS of MYOCARDIAL ISCHAEMIA

(eg sweating, sudden orthopnea, syncope, dyspnoea, epigastric discomfort, jaw pain, arm pain)

Be aware:
HIGH RISK ATYPICAL PRESENTATIONS
(eg diabetes, renal failure, female, elderly or Aboriginal)

TRIAGE CATEGORY 2

ECG & Vital Signs, expert interpretation within 10 minutes

General Management
- ☐ Oxygen
- ☐ Aspirin
- ☐ IV Access
- ☐ Pain Relief
- ☐ Pathology incl Troponin
- ☐ Chest X-ray

ST ELEVATION or (presumed new) LBBB

Y → **Consider Pericarditis** (sharp chest pain, respiratory or positional component) → N → Go immediately to **STEMI MANAGEMENT** (page 3)

N → **Consider Aortic Dissection** (back pain, hypertension, absent pulse, BP difference) **Consider Pulmonary Embolism** (severe dyspnoea, respiratory distress, low subscript O_2 saturation) → N → **Diagnose NON ST ELEVATION ACUTE CORONARY SYNDROME (ACS)** → **STRATIFY ACS RISK**

HIGH RISK Any of the following	INTERMEDIATE RISK Any of the following and no high risk features	LOW RISK Any of the following and no high or intermediate risk features
☐ ACS symptoms are repetitive or prolonged (> 10 min) & still present. ☐ Syncope ☐ History of chronic left ventricular systolic dysfunction (especially if known LVEF < 40%) OR current clinical evidence of LVF. ☐ Previous PCI/CABG < 6 months ☐ Diabetes + typical ACS symptoms ☐ Chronic renal failure + typical ACS symptoms ☐ Haemodynamic compromise (sustained SBP < 90 mmHg and / or new onset mitral regurgitation) ☐ Elevated Troponin (consider haemolysis, renal failure)	☐ ACS symptoms within 48 hrs that occurred at rest, or were repetitive or prolonged (but currently resolved) ☐ Previous PCI/CABG > 6 months ☐ Known coronary heart disease- Esp if prior AMI or known coronary lesion > 50% stenosis ☐ Two or more risk factors of: Hypertension, family history, active smoking or hyperlipidaemia ☐ Chronic renal failure (especially if known GFR < 60 mL/min) + atypical ACS symptoms ☐ Diabetes + atypical ACS symptoms ☐ Age > 65 years	☐ Presentation with clinical features consistent with ACS without intermediate- risk or high-risk features.
☐ Persistent or dynamic ECG changes of ● ST depression ≥ 0.5 mm or ● new T wave inversion ≥ 2 mm ☐ Transient ST elevation (≥ 0.5 mm) in more than two contiguous leads ☐ Sustained VT	☐ ECG is not normal and has changed from previous pain free ECG but does not contain high risk changes.	☐ ECG Normal or unchanged from previous pain free ECG

All cases to be discussed with Senior Medical Officer

Recommended Management on page 2

CHEST PAIN PATHWAY NON PRIMARY PCI SITE SMR080.071

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CHEST PAIN PATHWAY

NON PRIMARY PCI SITE

Contraindications and cautions for thrombolysis use in STEMI[1]

Absolute contraindications:

Risk of bleeding
- Active bleeding or bleeding diathesis (excluding menses)
- Significant closed head or facial trauma within 3 months
- Suspected aortic dissection (including new neurological symptoms)

Risk of intracranial haemorrhage
- Any prior intracranial haemorrhage
- Ischaemic stroke within 3 months
- Known structural cerebral vascular lesion (eg, arteriovenous malformation)
- Known malignant intracranial neoplasm (primary or metastatic)

Relative contraindications:

Risk of bleeding
- Current use of anticoagulants: the higher the international normalised ratio (INR), the higher the risk of bleeding
- Non-compressible vascular punctures
- Recent major surgery (< 3 weeks)
- Traumatic or prolonged (> 10 minutes) cardiopulmonary resuscitation
- Recent (within 4 weeks) internal bleeding (eg, gastrointestinal or urinary tract haemorrhage)
- Active peptic ulcer

Risk of intracranial haemorrhage
- History of chronic, severe, poorly controlled hypertension
- Severe uncontrolled hypertension on presentation (> 180 mmHg systolic or > 110 mmHg diastolic)
- Ischaemic stroke more than 3 months ago, dementia, or known intracranial abnormality not covered in contraindications

Other
- Pregnancy

[1] Adapted from NHF/CSANZ Guidelines for the management of acute coronary syndromes 2006

Contraindications to Exercise Testing (ACC/AHA Guidelines)[2]

Absolute
- Recurrent chest pain
- Acute myocardial infarction, within 2 days
- High-risk unstable angina
- Uncontrolled cardiac arrhythmias causing symptoms or haemodynamic compromise
- Symptomatic severe aortic stenosis
- Uncontrolled symptomatic heart failure
- Acute pulmonary embolus or pulmonary infarction
- Acute myocarditis or pericarditis
- Acute aortic dissection

Relative
- Critical left main coronary stenosis
- Moderate stenotic valvular heart disease
- Electrolyte abnormalities
- Systolic hypertension > 200 mmHg
- Diastolic hypertension > 100 mmHg
- Tachyarrhythmias or bradyarrhythmias
- New onset atrial fibrillation
- Hypertrophic cardiomyopathy and other forms of outflow obstruction
- Mental or physical impairment leading to the inability to exercise adequately
- High-degree atrioventricular block
- Resting ECG which will make EST interpretation difficult (eg LBBB, LVH with strain, Ventricular pacing, Ventricular preexcitation.)

[2] Gibbons etal, Circulation 106:1883,2002

Abbreviations:

ACS – Acute Coronary Syndrome
CABG – Coronary Artery Bypass Graft
ECG – Electrocardiogram
EST – Exercise Stress Test
FMC – First Medical Contact
GTN – Glyceryl trinitrate
LBBB – Left Bundle Branch Block
LVF – Left Ventricular Failure
LVH – Left Ventricular Hypertrophy
PCI – Percutaneous Coronary Intervention
SMO – Senior Medical officer
STEMI – ST Elevation Myocardial Infarction

SMR080071

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CHEST PAIN PATHWAY

NON PRIMARY PCI SITE

Recommended Further Management Refer to drug protocols &/or Therapeutic Guidelines

HIGH RISK
ADMIT or TRANSFER

- ☐ Continuous cardiac monitoring & frequent vital signs
- ☐ Repeat ECG immediately if symptoms recurs
- ☐ Repeat ECG 8 hrs post onset of symptoms
- ☐ Repeat Troponin at 8 hrs if 1st sample negative *
- ☐ ECG/Troponin review by medical officer

Antiplatelet therapy

☐ Yes
☐ No } Discuss with cardiologist /SMO

If no reason_____

_____

Betablocker

☐ Yes
☐ No

If no reason_____

_____

Anticoagulant

☐ YES
☐ No

If no reason_____

_____

Symptomatic treatment of ongoing pain/hypertension

- ☐ IV GTN (titrate against pain & BP)
- ☐ IV Morphine
- ☐ Refer to nominated cardiologist for further management

INTERMEDIATE RISK
RESTRATIFY

- ☐ Continuous cardiac monitoring & frequent vital signs
- ☐ Repeat ECG immediately if symptoms recur
- ☐ Repeat ECG 8 hrs post onset of symptoms
- ☐ Repeat Troponin at 8 hrs if 1st sample negative *
- ☐ ECG/Troponin review by medical officer

Refer for Exercise Stress Test ** if :

- ☐ No further chest pain/symptoms **and**
- ☐ 2 negative Troponin tests **and**
- ☐ No new ECG changes and
- ☐ No contraindications to stress test (page 4)

Restratify to High Risk if:

- ☐ Recurrent ischaemic chest pain **or**
- ☐ Positive Troponin **or**
- ☐ New ECG changes **or**
- ☐ Positive stress test

Restratify to Low Risk & Discharge if:

- ☐ Negative stress test **or**
- ☐ Stress test available within 72 hrs** **and**
- ☐ No further chest pain/symptoms
- ☐ Repeat ECG & vital signs, if stable discharge

NB: ** If stress test is not available within 72 hrs of discharge, treatment plan should be guided by nominated SMO/Cardiologist

Pharmacological stress test or CT coronary angiography may be indicated

LOW RISK
DISCHARGE

- ☐ Regular vital signs
- ☐ Repeat ECG immediately if symptoms recur
- ☐ Repeat ECG 8 hrs post onset of symptoms
- ☐ Repeat Troponin at 8 hrs if 1st sample negative *
- ☐ ECG/Troponin review by medical officer

_____

Restratify Risk if:

- ☐ Recurrent ischaemic chest pain **or**
- ☐ Positive Troponin **or**
- ☐ New ECG changes

If low Risk ACS

- ☐ Discharge
- ☐ Follow up GP/LMO within 3-5 days of D/C
- ☐ Consider Specialist follow up
- ☐ Consider discharge on Aspirin (discuss with SMO)
- ☐ Vital signs prior to discharge

If unlikely cardiac cause

Consider alternative diagnosis

Exit Pathway

***If a high sensitivity troponin assay is used, the testing interval may be reduced to 3 hours, provided the second sample is taken at least 6 hours after symptom onset**.

Medical Officer: Print name & sign_____ **Date**_____

Medical Officer Designation_____

This tool is intended as a guideline for clinicians to provide quality patient care. It is not intended, nor should it replace, individual clinical judgement. Some patients with co-morbidities or patients not suitable for invasive investigations may be appropriately managed medically.

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NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CHEST PAIN PATHWAY
NON PRIMARY PCI SITE

STEMI MANAGEMENT

1. CONFIRM INDICATIONS for REPERFUSION

- ☐ Chest pain > 30 min and < 12 hrs
- ☐ Persistent ST segment elevation ≥ 1 mm in two or more contiguous limb leads or ST segment elevation ≥ 2 mm in two contiguous chest leads or presumed new LBBB pattern
- ☐ Myocardial infarct likely from history

Time of diagnostic ECG ☐☐:☐☐

2. GENERAL MANAGEMENT

☐ Cardiac monitoring	☐ ECG	☐ IV Cannula X 2
☐ Routine bloods	☐ Oxygen	☐ Analgesia – Morphine
☐ Nitrates-Sublingual or IV	☐ CXR	☐ Beta Blockers

3. ADMINISTER ANTITHROMBOTIC THERAPY

Confirm administration or give:

☐ Aspirin	300 mg (soluble)	
☐ Clopidogrel	300 - 600 mg	(or prasugrel &/or tirofiban)
☐ Enoxaparin	30 mg IV then bd 1 mg/kg subcut	(or IV heparin or bivalirudin) (Max 100 mg)

Refer to local protocols &/or Therapeutic Guidelines

4. CHOOSE REPERFUSION METHOD

THROMBOLYSIS UNLESS

- ☐ Absolute or unacceptable relative contraindications (see page 4) **or**
- ☐ Patient does not consent to thrombolysis **or**
- ☐ Documented system for transfer to PRIMARY PCI SITE in place

☐ Discussed with cardiologist: Time ☐☐:☐☐

5. THROMBOLYSE

☐ Tenecteplase / Reteplase
Body Weight _____kg Dose _____

Time administered ☐☐:☐☐

OR

☐ **Transfer to PRIMARY PCI SITE if appropriate**
(As per table below)

Maximum Acceptable Delay from First Medical Contact (FMC):	
Time since symptom onset	**Acceptable delay from FMC to percutaneous intervention**
< 1hours	**60 minutes**
1-3 hours	**90 minutes**
3-12 hours	**120 minutes**
>12hours	**Not routinely recommended**

from NHF/CSANZ Guidelines for the management of acute coronary syndromes 2006

- ☐ Discuss further management immediately with nominated cardiologist
- ☐ Prioritise urgency of transfer with nominated cardiologist
- ☐ Organise transfer to PCI-capable hospital (as per locally agreed protocol)
- ☐ Repeat ECG at 60 mins post thrombolytic

Medical Officer: Print name & sign_____ **Date**_____

Medical Officer Designation_____

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