ACUTE CORONARY SYNDROMES

Assess and maintain CAB's
Administer O₂ only if needed
Assess vitals
Apply monitors
(EKG, Pulse Ox, B/P)
Targeted history/Physical exam
Establish IV access
Perform 12 LEAD ECG
(electrolytes, enzymes-troponin, coags)

Perform simultaneously with initial assessment

Oxygen (to maintain saturation *90 - 99%)
Nitroglycerine SL or spray
Aspirin
Morphine IV if pain not relieved by 3 NTG. Only recommended if STEMI

ECG + for AMI <12 hrs
(ST elevation in 2 or more related leads)

-IV Nitroglycerine (continuing ischemia, HTN, PE)
-Heparin or LMWH
-Ace inhibitors (after 6 hrs)
-B Blockers (after stable)

Immediate: Prepare patient for:
PCI (Percutaneous Coronary intervention)
#1 choice for pt, <75 yrs old;
Cath, Stent, CABG
Ideal first contact to cath time 90 min

Fibrinolytics
Ideal door or EMS to drug time 30 min

High risk Acute Coronary Syndromes

- ST depression/T wave inversion
  - High risk unstable angina
    (female, rales Hx MI, diabetes, hypotension, tachycardia, atrial fib)
    - AMI >12 hrs
    - IV Nitroglycerine
    - Heparin or LMWH
    - Antiplatelets (GPIIb/IIIa inhibitors)
    - Ace inhibitors (after 6 hours)
    - B Blockers (after stable)

As Available: Cardiac cath to evaluate OR

Nondiagnostic ECG or enzymes,
Admit to ED/chest pain unit
Serial ECGs, Serial cardiac markers

If suitable for revascularization
PCI
CABG

Tips for successfully managing this case:

- Don't forget to:
  - Use a pain scale to help your patient rate the pain
  - Perform PQRST assessment to determine if the cause of pain is likely myocardial ischemia or injury
  - Determine time of onset early
  - History/physical should include screening for Fibrinolytic contraindications
  - Assess vital signs before and after administering Nitrates
  - Obtain 12 lead EKG early
  - Administer Morphine only if Nitro fails to relieve the pain
  - Reassess vital signs and pain frequently