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)



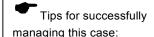
Perform simultaneously with initial assessment

Oxygen (to maintain saturation *90 - 99%)

Nitroglycerine SL or spray

Aspirin

Morphine IV if pain not relieved by 3 NTG. Only recommended if STEMI



- ් 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

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

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

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

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If suitable for revascularization PCI CABG