

Acute Coronary Syndrome

Table 3.44 – ASSESSMENT and MANAGEMENT of:

Acute Coronary Syndrome

NB A defibrillator must always be taken at the earliest opportunity to patients with symptoms suggestive of a heart attack and remain with the patient until hand-over to hospital staff.

ASSESSMENT	MANAGEMENT
<ul style="list-style-type: none">● Assess ABCD	<ul style="list-style-type: none">● If any of the following TIME CRITICAL features are present:<ul style="list-style-type: none">– major ABC problems– 12-lead ECG shows STEMI or LBBB with other clinical features suggestive of ACS– suspected acute coronary syndrome with haemodynamic instability, then:● Start correcting any ABC problems.● Undertake a time CRITICAL TRANSFER. NB For patients with STEMI undertake a direct admission to a ‘cardiac facility’ (access to cardiological advice).● Provide an alert/information call.● Continue management en-route:<ul style="list-style-type: none">– send a 12-lead ECG for expert review where possible– patients with ECG evidence of STEMI should be assessed for suitability for reperfusion treatment (Figure 3.6)– administer aspirin as soon as possible (refer to the aspirin guideline)– administer clopidogrel (refer to the clopidogrel guideline) – follow local guidelines– administer glyceryl trinitrate (GTN) for patients with ongoing ischaemic discomfort (refer to the GTN guideline).
<ul style="list-style-type: none">● Assess whether the chest pain may be cardiac	<ul style="list-style-type: none">● Pain typically comes on over seconds and minutes rather than starting abruptly – ‘classical presentation’ is detailed in Table 3.43. NB Many patients do not have ‘classical presentation’ as described above and some people, especially the elderly, and those with diabetes, may not experience pain as their chief complaint. This group have a high mortality rate.
<ul style="list-style-type: none">● Assess for accompanying features	<ul style="list-style-type: none">● Nausea and vomiting.● Marked sweating.● Breathlessness.● Pallor.● Combination of chest pain associated with haemodynamic instability.● Feelings of impending doom.● Skin that is clammy and cold to the touch. <p>NB These may not always be present.</p>
<ul style="list-style-type: none">● ECG	<ul style="list-style-type: none">● DO NOT exclude an ACS where patients have a normal resting 12-lead ECG.● Use clinical judgement as to whether a repeat 12-lead ECG is required after normal or equivocal ECG but history suggestive of ACS (continuing or worsening pain or haemodynamic instability).
<ul style="list-style-type: none">● Assess oxygen saturation	<ul style="list-style-type: none">● Closely monitor the patient’s SpO₂ but do not administer oxygen unless the patient is hypoxaemic on air (SpO₂ <94%) (refer to oxygen guidelines).
<ul style="list-style-type: none">● Undertake further assessment and management in the order appropriate to the circumstances	<ul style="list-style-type: none">● Monitor ECG for arrhythmias.● Obtain intravenous access if clinically indicated.● Monitor vital signs.● Repeat dose of GTN if chest discomfort persists.● 12-lead ECG (as above).
<ul style="list-style-type: none">● Assess patient’s pain	<ul style="list-style-type: none">● Measure and record pain score (refer to pain management guideline).● Consider analgesia (refer to pain management guideline).
<ul style="list-style-type: none">● Documentation	<ul style="list-style-type: none">● Complete documentation.^[49]
<p>Additional Information:</p> <ul style="list-style-type: none">● The treatment of patients with ACS is a rapidly developing area of practice.● National and international standards and guidelines for ACS care consistently emphasise the importance of rapid access to defibrillation and reperfusion and specialist cardiological care.● Pre-alerting the hospital can speed up appropriate treatment of STEMI patients.● Prehospital thrombolysis may be an option where PPCI is not available, but patients can subsequently be transferred to a PPCI capable hospital.	