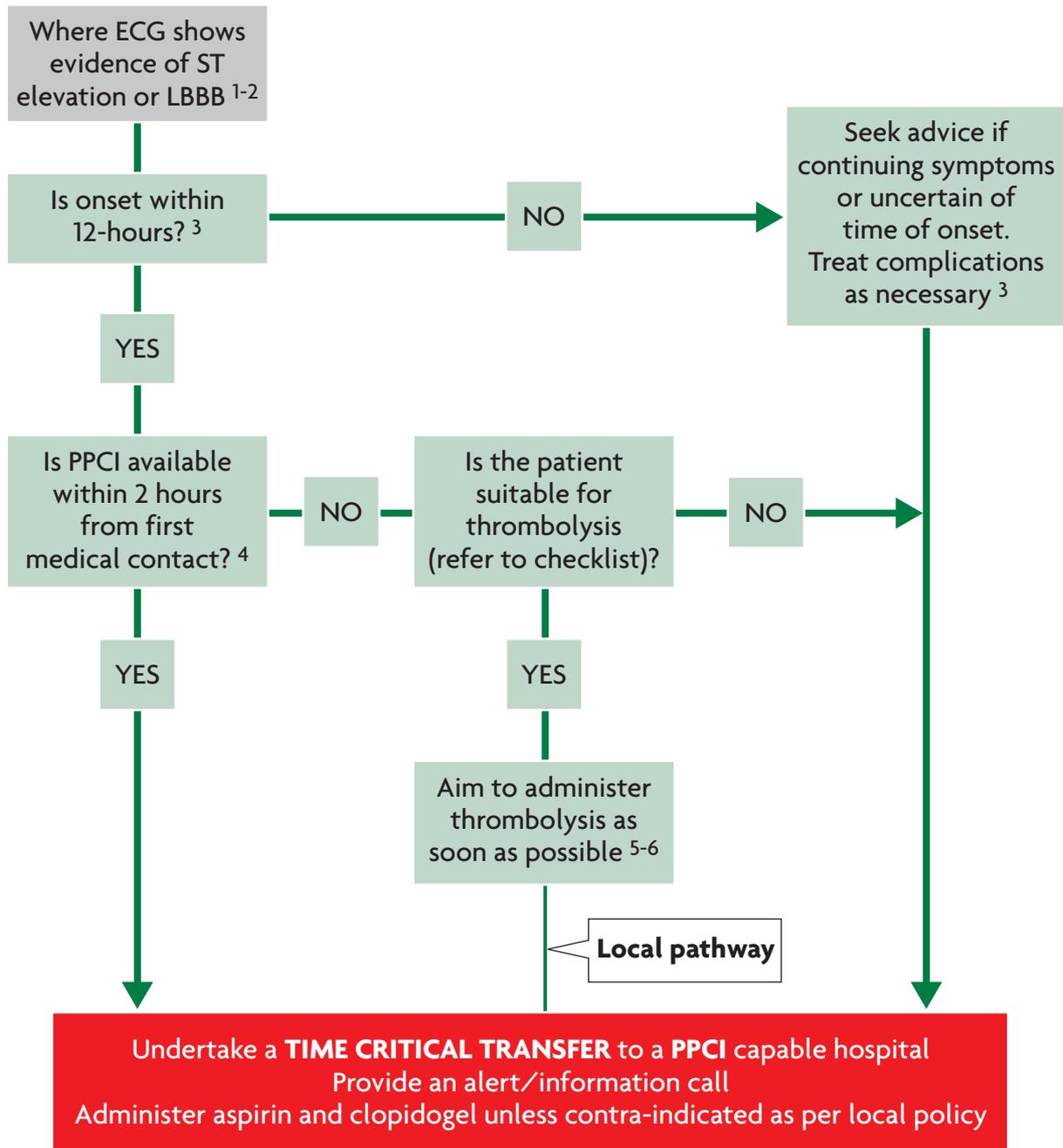


# Acute Coronary Syndrome



1. Up to a third of patients with MI will have atypical presentations such as shortness of breath or collapse, without chest pain. This is particularly so in patients with diabetes or the elderly. **Have a low threshold for performing a 12-lead ECG in any patient presenting as 'unwell'**. Seek advice in 'atypical' patients who have ST elevation or LBBB (see below) as urgent reperfusion may still be indicated.

2. ECG criteria for reperfusion include ST segment elevation ( $\geq 2\text{mm}$  in 2-standard or 2 adjacent precordial leads, not including V1) or LBBB in patients with other clinical features suggestive of ACS. Patients who have ST depression rather than elevation are a high risk group who need urgent specialist assessment. **Seek advice.**

3. If there is uncertainty about the time of symptom onset, or any ongoing chest pain/discomfort or haemodynamic upset beyond 12 hours, seek advice as urgent reperfusion may still be indicated.

4. Refer to local policies for target 'call to balloon' time.

5. Thrombolytic treatment should not be regarded as the end of the emergency care of a STEMI patient. Rapid transfer to an appropriate hospital for timely therapy to prevent re-infarction, and assessment of the need for rescue PPCI, is essential.

6. Refer to reteplase or tenecteplase guidelines for the checklist to identify eligibility for prehospital thrombolysis.

Figure 3.6 – The management of patients presenting with STEMI or LBBB.