Clinical Practice Guideline For Acute Chest Pain Evaluation

This guideline is a uniform algorithm for Mercy Medical Center and Medical Associates Clinic and Health Plans.

- Non Cardiac pain
  - workup as appropriate without routine “rule out MI” protocol

- Resolve, stable, <30 minute pain (stable exertional angina-even recent new onset)
  - initiate treatment as appropriate
    - ED/Acute Care – arrange follow-up with primary care physician or cardiologist within one week.
  - outpatient workup

- Low risk for ACS* (acute coronary syndrome)
  - atypical pain & low risk clinical profile
    - normal EKG; no CHF or arrhythmia; normal CXR
    - If still having pain, consider obtaining a troponin level
    - GXT (Graded Exercise Testing) – immediately if possible or within 24 hours
      - ED/Acute Care – arrange GXT through Cardiology or Primary Care. GXT will be available at hospital at all times. (Ask Medical Associates Cardiology to perform and interpret test)
      - Early stress testing is okay but not required – can be done electively as outpatient in the office.
      - discharge if negative; further workup if indeterminate or positive

- Moderate risk for ACS* (acute coronary syndrome)
  - admit to chest pain unit* Use routine coronary orders (RCO’s) preferentially
    - MMC – observation beds will be available on CVU or equivalent setting.
    - Acute Care – notify internist on call or cardiologist you would like patient admitted on this basis and they will follow through.
    - ED – notify primary care physician, internist on call or cardiologist that you have performed initial assessment and completed observation orders. They will see patient during time frame when cardiac markers are being obtained and will assume responsibility for patient’s care.
  - give ASA – consider Lovenox
  - obtain cardiac marker panel (no other labs necessary)
  - admit if positive
- GXT if negative-radionuclide study or stress echo needed only on selected basis

- High risk for ACS* (acute coronary syndrome)
  - admit to CVU/ICU** Use routine coronary orders preferentially
  - ED/Acute Care – notify primary care physician, internist on call, or cardiologist to assume care in usual fashion
  - start treatment for ACS: ASA, beta blockers, nitrates, Lovenox or heparin. *Suggest Cardiology Consultation prior to anticoagulation/antiplatelet treatments.
  - cardiac marker panel
  - evaluate for early cath

*Risk stratification is based upon initial clinical assessment of patient’s symptoms including the character, location, radiation, duration of the symptoms; precipitating and relieving factors; and associated symptoms. Appropriate consideration must be given to the patient’s prior cardiac history/workup and risk factors. Non-low risk factors include:

- pain pattern consistent with prolonged ischemia
- known CAD
- multiple risk factors
- abnormal EKG, evidence CHF, significant arrhythmias

*Use of RCO’s may simplify the admitting process, but consideration should be taken to ensure these orders are individualized to each patient’s needs.

References: