Clinical pathways never replace clinical judgement. Care outlined in this pathway must be altered if not clinically appropriate for the individual patient. Document all variances in patient notes.

### POSSIBLE CARDIAC CHEST PAIN CLINICAL PATHWAY

#### POSSIBLE CARDIAC CHEST PAIN

and / or

OTHER SYMPTOMS of MYOCARDIAL ISCHAEMIA

(e.g. diaphoresis, sudden orthopaed, syncope, dyspnoea, epigastric discomfort, jaw pain, arm pain)

Consider:

Atypical Presentations

(e.g. diabetes, renal failure, female, elderly or Aboriginal / Torres Strait Islander)

#### TRIAGE CATEGORY 2

Always consider other critical causes

(e.g. Aortic Dissection, Pulmonary Embolism)

Do not use this pathway if a non-ACS cause for chest pain can be diagnosed.

#### General management:

- Aspirin
- Nitrates – S/I or IVI
- IV access
- Pathology, including Troponin, on admission
- Pain relief
- Continuous Cardiac Monitoring
- Oxygen if SpO2 <93% or evidence of shock
- Chest X-ray
- Repeat ECG if recurrent chest pain
- Frequent observations

#### ST-ELEVATION OR (presumed new) LBBB

1. **Confirm Indications for Reperfusion**
   - Chest pain >30 min and <12 hours
   - Persistent ST-elevation ≥1 mm in 2 contiguous limb leads or persistent ST-elevation ≥2 mm in 2 contiguous chest leads or new or presumed new LBBB
   - Myocardial infarct likely from history

2. **Choose Reperfusion Method**
   - **Primary PCI**
     - If possible within 90 mins of first medical contact, urgently contact the on-call interventional cardiologist*
     - Notify Retrieval Services Queensland (1300 799 127) or Queensland Ambulance Service for immediate transfer to interventional cardiac facility*
   - OR
     - Transfer to on-site Cardiac Catheter Lab as directed
   - Thrombolise (if appropriate) within 30 mins of first medical contact

3. **Administer Antithrombotic Therapy**
   - Confirm administration or give:
     - Aspirin 300 mg (soluble)
     - Ticagrelor 180 mg (or alternative if advised by interventional cardiologist)
     - Enoxaparin OR Unfractionated Heparin (confirm with interventional cardiologist)

####Possible:

**NON ST-ELEVATION ACUTE CORONARY SYNDROME (NSTEMI)**

**RISK STRATIFY ACS**

Medical staff to complete Risk Stratification on reverse of this form

### Signature Log

Every person documenting in this pathway must supply a sample of their initials and signature below

<table>
<thead>
<tr>
<th>Initials</th>
<th>Signature</th>
<th>Print name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

*Follow local referral and / or transfer processes*
Possible Cardiac Chest Pain Clinical Pathway  
(For use in non-ACRE facilities only)

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**Clinical Pathway**

1. **EMERGENCY DEPARTMENT**
   - **Do not use this pathway if a non-ACS cause for chest pain can be diagnosed. Manage as per diagnosis.**

2. **HIGH RISK FEATURES - Clinical features consistent with ACS and any of the following:**
   - Repetitive or prolonged (>10 mins) ongoing chest pain or discomfort
   - Elevated Troponin
   - Persistent or dynamic ECG changes of ST-segment depression ≥0.5mm or new T-wave inversion ≥2mm
   - Transient ST-segment elevation ≥0.5mm in more than two contiguous leads
   - Haemodynamic compromise - systolic blood pressure <90mmHg, cool peripheries, diaphoresis, Killip Class >1, and/or new-onset mitral regurgitation
   - Sustained ventricular tachycardia
   - Syncpe
   - Left ventricular systolic dysfunction (left ventricular ejection fraction <0.40), and/or clinical evidence of heart failure
   - Prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery

3. **INTERMEDIATE / LOW RISK FEATURES**
   - **Clinical features consistent with ACS and any of the following:**
     - Resolved chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (>10 mins)
     - Age ≥65 years
     - Diabetes with typical or atypical symptoms of ACS
     - Chronic kidney disease (GFR <60 mL / minute) with typical or atypical symptoms of ACS
     - Known Coronary Artery Disease (CAD) or previous Myocardial Infarction (MI)
     - Two or more of the following risk factors: known hypertension, family history, active smoking or hyperlipidaemia
     - Prior regular aspirin use
     - Recent onset of crescendo or unstable angina symptoms

4. **HIGH RISK NSTEACS**
   - **YES TO ANY**
     - Commence ACS pathway
     - Continuous cardiac monitoring
     - Admit to appropriate cardiac monitored unit (e.g., CCU / HDU)
     - As soon as identified, contact Cardiology referral service to consider next day transfer to interventional facility (immediate transfer is clinically unstable)*
     - Referral date: _____ / _____ / _____
     - Time: _____ : _____
     - Discussed with: ________________________________
     - Referral date: _____ / _____ / _____
     - Time: _____ : _____
     - (accepting Cardiologist / Cardiology Registrar)
     - Once interventional facility accepts, contact Retrieval Services QLD on 1300 799 127 or Queensland Ambulance Service to arrange transport
     - Transfer to another health care facility if required*

5. **RE-STRATIFY**
   - **NO TO ALL**
     - Admit to:
       - Regular vital observations
       - Repeat ECG and Troponin at 3–6 hours (OR 6–8 hours for point-of-care test)
     - Does not require continuous cardiac monitoring if first (0 hour) Troponin negative, ECG normal, and no further chest pain

6. **HIGH RISK**
   - **IF YES TO ANY**
     - MO review following repeat ECG and Troponin
     - Manage as HIGH risk if YES to any:
       - Positive Troponin
       - New ECG changes
       - Recurrent chest pain or develops other high risk features

7. **DISCHARGE HOME**
   - **NO TO ALL**
     - Discharge home if repeat ECG normal, Troponin negative at 3–6 hours (or 6–8 hours if using point-of-care testing), and no further chest pain

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*Follow local referral and/or transfer processes*