Queensland Government

Thrombolysis for STEMI Clinical Pathway

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Use this pathway for thrombolysing patients identified with Acute (<12hours) ST-elevation Myocardial Infarction (STEMI)
If Primary Percutaneous Coronary Intervention (pPCI) is possible within 90 mins of First Medical Contact (FMC) URGENTLY contact the on-call Interventional Cardiologist.
Clinical pathways never replace clinical judgement. Variances must be clearly documented in patient notes
Every person documenting in this clinical pathway must supply a sample of their signature page 2

Presentation time / date: ..... : .... / ..... / ..... **Symptom onset time / date:** ..... : .... / ..... / .....

1. Confirm Indications for Thrombolytic Reperfusion

- ☐ Cannot be treated with pPCI within 90 mins of FMC
- ☐ Chest pain >30min and <12 hours
- ☐ *ECG:
  - Persistent ST-elevation ≥1mm in 2 contiguous limb leads, *or*
  - Persistent ST-elevation ≥2mm in 2 contiguous chest leads, *or*
  - New or presumed new Left Bundle Branch Block (LBBB)
- ☐ Myocardial infarct likely from history

**Contact cardiology referral service if ECG interpretation advice is required*

YES TO ALL

2. Contra-indications to Thrombolysis *(answer EVERY question)*

Absolute	
Active Bleeding or bleeding diathesis (excluding menses)	☐ Y ☐ N
Suspected aortic dissection	☐ Y ☐ N
Significant closed head or facial trauma within 3 months	☐ Y ☐ N
Any prior intracranial haemorrhage	☐ Y ☐ N
Ischaemic stroke within 3 months	☐ Y ☐ N
Known cerebral vascular lesion	☐ Y ☐ N
Known malignant intracranial neoplasm	☐ Y ☐ N
Relative	
Current anticoagulants (including novel anticoagulant agents)	☐ Y ☐ N
Non-compressible vascular puncture	☐ Y ☐ N
Recent major surgery (<3 weeks)	☐ Y ☐ N
Traumatic or prolonged (>10 minutes) CPR	☐ Y ☐ N
Recent internal bleeding (within 4 weeks) / Active Peptic Ulcer	☐ Y ☐ N
Suspected Pericarditis	☐ Y ☐ N
Advanced Liver Disease / Advanced Metastatic Cancer	☐ Y ☐ N
History of chronic, severe, poorly controlled hypertension	☐ Y ☐ N
Severe uncontrolled hypertension on this presentation (systolic >180mmHg or diastolic >110mmHg)	☐ Y ☐ N
Ischaemic Stroke >3months ago / known intracranial abnormality (not discussed in Absolute Contraindications) / Dementia	☐ Y ☐ N
Pregnancy or within 1 week postpartum	☐ Y ☐ N

NO TO ANY *OR* UNSURE →

YES TO ANY *OR* UNSURE →

Urgent Consult

with
Emergency Consultant
and / or
Interventional Cardiologist
for advice / plan

(e.g. ECG interpretation, PCI availability, contraindications, advanced age, post thrombolysis referral, failed thrombolysis, shock, bleeding)

Discussed with:

.....

Facility:

.....

Referral time / date:

..... : .... / ..... / .....

Document advice / plan in clinical notes

NO CONTRA-INDICATIONS

Immediately proceed to thrombolysis (target <30 mins of FMC). Follow directions page 2.

DO NOT WRITE IN THIS BINDING MARGIN

THROMBOLYSIS FOR STEMI CLINICAL PATHWAY

v3.00 - 05/2017
Mat. No.: 10312604
SW547

Queensland Government

Thrombolysis for STEMI Clinical Pathway

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

3. General

- ☐ Informed verbal consent
- ☐ Record baseline observations: vitals, circulation, neurological
- ☐ 2 x IV access

4. Thrombolysis Medication

Confirm administration of or give:

(Record all medications prescribed in patient medication chart)

	Dose	Time
☐ Aspirin 300mg		
☐ Clopidogrel 300mg		
☐ Tenecteplase *(see weight adjusted dose guide)* • Patient weight: ..... kg		
☐ Enoxaparin *(see dose guide)* ***OR*** ☐ Unfractionated Heparin • Consider with severe renal failure (eGFR <30mL / min) • IV bolus 60 units / kg (max 4000 units) • Then infusion 12 units / kg / hr (maximum 1000 units / hr)		

Tenecteplase Dose Guide

Body weight (kg)	International units	mg	mL
<60	6,000	30	6
≥60 to <70	7,000	35	7
≥70 to <80	8,000	40	8
≥80 to <90	9,000	45	9
≥90	10,000	50	10

Age ≥75yr

Administration of half the standard dose of tenecteplase might be considered in reducing the risk of intracranial bleeding. Consult with Interventional Cardiologist for advice / plan.

Enoxaparin Dose Guide

Refer to the *Queensland Ambulance Service (QAS) Clinical Practice Procedures: Drug Administration / Priming of a Microbore Extension Set* https://www.ambulance.qld.gov.au/docs/clinical/cpp/CPP_Microbore.pdf

	Age <75yr	Age ≥75yr	Renal failure *(eGFR <30mL / min)*
Loading Dose *(omit if given pre-hospital)*	30mg IV bolus	None / Omit	Use Unfractionated Heparin
Maintenance Dose	1mg / kg SC BD begin 15 mins after bolus *(maximum 100mg for first 2 doses)*	0.75mg / kg SC BD *(maximum 75mg for first 2 doses)*	

5. Management Post Thrombolysis

- ☐ **Refer ALL thrombolysed STEMI patients for immediate transfer to Interventional Cardiac Facility** *(complete urgent consult details on page 1)*
- ☐ 12 lead ECGs reviewed at 30 mins, 60 mins and 90 mins
- ☐ If failed reperfusion (i.e. unresolved pain and ST elevation has not reduced >50% at 60 mins) for urgent consult with on-call Interventional Cardiologist *(complete referral details on page 1)*
- ☐ Continuous cardiac monitoring
- ☐ Nurse Special (1:1) for first hour post thrombolysis
- ☐ Frequent observations: vital signs, circulation and neurological

MEDEVAC checklist

- ☐ QAS / Retrieval Services QLD notified - phone: 1300 799 127
  Contact time / date: ..... : .... / ..... / ..... ETA: ..... : .....
- ☐ Patient and NOK informed
- ☐ Photocopy all ECGs and documentation

Treating Emergency Department Medical Officer

Name: .....

Time: ..... : ..... Date: ..... / ..... / ..... Signature: .....

Signature Log

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

Initials	Signature	Print name	Role	Initials	Signature	Print name	Role

DO NOT WRITE IN THIS BINDING MARGIN