1. Omit nitrates if history of recent PDE use; use NTG with caution if RV ischemia is suspected.
2. Morphine and other IV opioids may reduce absorption and/or efficacy of oral antplatelet therapy.
3. Ticagrelor exclusions include h/o major bleed or bleeding diathesis, prior CVA/TIA, known hepatic insufficiency, bradycardia (HR<50) or h/o bradydysrhythmia, active wheezing or h/o COPD.
4. UFH preferred if renal dysfunction – use ACS protocol; If LMWH, use 1mg/kg q12h.
5. Eptifibatide is contraindicated in patients on dialysis.
6. If LVEF <40, guidelines recommend carvedilol, bisoprolol, or long-acting metoprolol succinate.
7. Avoid if Cr>2, or K>5.
8. If patient is already on Clopidogrel, load with Ticagrelor 180mg PO unless contraindicated. If patient is already on Ticagrelor or Prasugrel, continue with same, no need to load again unless non-compliance is suspected.
9. If patient is on DOAC or therapeutic warfarin, do not start heparin without discussing with interventional cardiology.
10. General guidance for the use of high-sensitivity troponin-T (hs-cTnT)
   - No algorithm completely replaces clinical judgement.
   - Traditional confounders of troponin interpretation (renal failure, sepsis, etc.) also apply to hs-cTnT.
   - **RULE IN:** In patients with hs-cTnT ≥ 100ng/L or ≥ 10ng/L increase over 2 hours, acute myocardial injury is present. These patients should be admitted after discussion with the patient’s cardiologist (if any).
   - **INTERMEDIATE – HIGH PROBABILITY:** In patients with hs-cTnT (≥ 42ng/L for women or ≥ 66ng/L for men) - 3x the gender-specific upper limit of normal) or new ischemic EKG changes, acute myocardial injury is likely. These patients typically should be admitted after discussion with the patient’s cardiologist (if any).
   - **INTERMEDIATE – LOW PROBABILITY:** In patients with hs-cTnT (14-41 ng/L for women or 22-65 ng/L for men), HEART Score 0-3, and a non-ischemic EKG, discuss with the patient’s cardiologist (if any). Consider a repeat hs-cTnT in the ED 4 hours from the first. If < 12ng/L rise from 1st hs-cTnT, acute myocardial injury is unlikely (stable angina or previous MI are not excluded). In discussion with the patient’s cardiologist (if any), consider discharge with OPT ischemic workup and clinic follow up for risk factor control.
   - **RULE OUT:** In patients with HEART Score 0-3 and hs-cTnT (< 14 ng/L for women or < 22 ng/L for men) AND < 4 ng/L increase from 1st to 2nd, acute myocardial injury is very unlikely (>99% negative predictive value for MI). Consider non-ischemic causes of chest pain. Generally, these patients can be discharged safely after discussion with their cardiologist (if any), if there are no remaining indications for admission.
   - For patients not meeting the above criteria, discuss with the patient’s cardiologist (if any). Consider observation admission.
   - Coronary CT angiography or nuclear stress testing can also be obtained in the ED 8am-3pm M-F.
### STEMI and High-Risk NSTE-ACS

- **Aspirin**
  - Yes
  - No, bleeding
  - No, allergy (consider desensitization)
  - No, other (with attending cardiologist approval only)

- **P₂Y₁₂ Inhibitor**
  - Yes
  - No, bleeding
  - No, allergy (consider alternate agent)
  - No, other (with attending cardiologist approval only)

- **High-intensity Statin**
  - Atorvastatin 40-80mg or Rosuvastatin 20-40mg
  - No, allergy or prior intolerance (consider alternate agent)
  - No, other (with attending cardiologist approval only)

- **Beta-blocker**
  - Yes
  - No, bradycardia (HR<50 and no pacemaker)
  - No, hypotension
  - No, allergy (consider alternate agent)
  - No, other (with attending cardiologist approval only)

- **ACE/ARB if pt. diagnosed with MI during this admission or prior**
  - Yes
  - No, advanced renal disease
  - No, hyperkalemia
  - No, hypotension
  - No, allergy (consider alternate agent)
  - No, other (with attending cardiologist approval only)

- **Mineralocorticoid Receptor Antagonist (MRA) if LVEF <40%**
  - Yes
  - No, advanced renal disease
  - No, hyperkalemia
  - No, hypotension
  - No, allergy (consider alternate agent)
  - No, other (with attending cardiologist approval only)

- **Triple therapy (if concurrent aspirin, P₂Y₁₂ Inhibitor, and anticoagulation are needed, specify indication, planned duration, plan for discontinuation, and responsible provider) — this is rarely appropriate**

- **Echo if MI**

- **Outpatient Cardiac Rehab (phase 2) referral if MI or PCI**
  - Referred to UCM
  - Referred to outside facility (paper prescription provided stating “Cardiac rehab phase 2” with appropriate diagnosis listed)

- **Disease-Specific Education completed by nursing**

- **Nutrition education completed**

- **Smoking cessation counseling completed**

- **Meds2Beds completed**
  - Yes
  - No, patient refuses
  - No, patient does not qualify
  - No, night/weekend/holiday discharge
  - Other

- **90-day prescription of all cardiac meds provided (consider paper script for 1 year if patient does not have a pharmacy)**

- **Follow-up (Tune-up appointments) scheduled**
  - If UCM
    - Cardiology (within 7 days)
    - PCP (within 30 days)
  - If non-UCM
    - PCP (within 14 days)

- **Discharge summary completed and transmitted before patient leaves the hospital**

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### Low-Risk ACS

- **Risk-appropriate Statin therapy** ([link to ASCVD risk calculator](#))

- **Disease-Specific Education completed by nursing**

- **Nutrition education completed**

- **Smoking cessation counseling completed**

- **90-day prescription of all cardiac meds provided (consider paper script for 1 year if patient does not have a pharmacy)**

- **PCP follow up (within 14 days) scheduled**

- **Discharge summary completed and transmitted before patient leaves the hospital**

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**Pathway Owner:** Heart and Vascular Center  
**Version:** 8/01/2018  
**Questions or comments?** Email HighReliability@uchospitals.edu  
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