Cardiac Diseases and Therapies
ACUTE CORONARY SYNDROMES

ANTITHROMBOTIC MANAGEMENT OF ACUTE CORONARY SYNDROMES
(UNSTABLE ANGINA AND NON-ST ELEVATION ACS) TREATMENT ALGORITHM

Patient presents with symptoms of cardiac ischemia within previous 24 hours:
new onset low threshold ischemia or pain at rest

Appropriate therapy depends on the assessment of Coronary Risk vs. Bleeding Risk
Note: Coronary events usually dominate bleeding events

ASSESS Coronary Risk
• Symptoms strongly suggestive of a ruptured plaque
• Transient ST segment elevation
• Elevation of initial or 8-hour Troponin
• Transient or fixed ST segment depressions
• New T wave inversion
• Hypotension or signs of heart failure
• Breakthrough ischemia while on therapy
• TIMI score ≥3

CONSIDER Bleeding Risk
• Active bleeding
• Recent trauma or surgery
• CVD – Stroke, TIA, ICH, subdural bleed
• Increased risk with increasing age, i.e. >75, >80 years
• Uncontrolled hypertension
• History of previous bleed – GI, GU, retroperitoneal
• DM
• NSAIDs, steroids, oral anticoagulants
• HAS-BLED score >3 (derived from antithrombins in Atrial Fibrillation)

ED staff in consultation with Cardiology or GIM to determine management strategy

Coronary/Bleed Risk supports early invasive therapy
• ASA 160 mg load, then 81 mg once daily
• heparin bolus and infusion

add P2Y₁₂

Coronary angiography < 6hrs, consider waiting to start P2Y₁₂ inhibitor (as per criteria below) until coronary anatomy is known*

Coronary angiography > 6hrs, consider starting P2Y₁₂ inhibitor (as per criteria below) upfront

LOW Bleeding Risk (& no stroke/TIA/ICH)
• prasugrel 60 mg load, then prasugrel 10 mg once daily
or
• ticagrelor 180 mg load, then ticagrelor 90 mg twice daily

HIGH Bleeding Risk
• clopidogrel 600 mg load, then clopidogrel 75 mg once daily
or
• None

REASSESS

Note: This flow diagram is intended as a guideline only, and cannot replace clinical judgement or patient preference.

*ACCOAST trial - increased bleeding risk when half of prasugrel loading dose (30mg) administered in emergency department prior to angiography, without increased efficacy, supports delay in administration of agent until coronary anatomy known.

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The Pharmacy & Therapeutics Committee - December 2012
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