neocs
Northeast Ohio Cardiovascular Specialists

SUMMA
Physicians
Cardiology

UA/NSTEMI

Call RMH Cardiology on call

Super Stat: EKG, pCXR, CMP, CBC, PT/PTT, Cardiac enzymes/Troponin
Aspirin 325 mg chewed
Plavix 300 mg if intolerant to ASA
Lovenox 1 mg/kg SC or Heparin Bolus and Drip
Consider Integrelin bolus and drip in higher risk patients (coordinate with RMH Cardiologist)
Consider Plavix 300 mg if unlikely to need CABG in higher risk patients (work with RMH Cardiologist)
SLNTG Q5' x 3 if stable, hold for SBP < 100
IV NTG 10 – 100 mcg/min titrated to keep SBP 100-115 (in higher risk patients)
Lopressor 5 mg IV Q5' x 3 if stable, hold for HR < 60, SBP < 100, if in CHF
Lipitor 80 mg PO

Higher Risk Patients (more likely to have a true ACS) ***(May be managed by Cardiology)***

Higher TIMI (3+)/GRACE (>130) risk score, accelerating sxs, >20 min CP, risk factors, EKG/TnI abnl
Ischemic EKG or symptoms, hemodynamic changes, h/o CAD/DM, borderline or positive cardiac enzymes
Tend to use Integrelin and/or Plavix
If ongoing ischemic symptoms or hemodynamic or rhythm instability, call RMH cardiologist for consideration of urgent cath.
For improved symptoms, Admit to CCU for further therapy and risk stratification with serial cardiac enzymes,
echo, EKGs, Lipids/LDL, CBC, MI education, and likely early (but not urgent) cardiac cath.
Tend to add ace-inhibitor or ARB and continue statin, beta-blocker, ASA, anticoagulation, and IV NTG
At discharge, tend to continue ASA, Plavix, beta-blocker, Ace-inhibitor, statin.

Lower Risk Patients (not as likely to have a true ACS) ***(May be managed by PCP with possibly consult to cardiology)***

Lower TIMI (<3)/GRACE(<130) risk score
Nondiagnostic EKG, Normal initial cardiac enzymes
Tend to not use Plavix or Integrelin
Tend to use NTP instead of IV NTG; may not anticoagulate.
Admit to SDU or possibly CCU for further risk stratification with serial cardiac enzymes, stress test, echo, EKGs, Lipids/LDL, CBC.

Revision 5/20/08