TAYSIDE CARDIOLOGY MCN PRIMARY CARE CHEST PAIN REFERRAL / MANAGEMENT GUIDE (2018)

**Intermittent stable chest pain in whom stable angina is suspected**

**Typical Angina**
1. Constricting discomfort in the front of the chest, or in the neck, shoulders, jaw, or arms
2. Precipitated by physical exertion and / or stress
3. Relieved by rest or GTN within about 5 minutes.

**Atypical Angina**
Two of the three features of ‘typical angina’

**Non-anginal Chest Pain**
One or none of the features of ‘typical angina’

- 12-lead ECG
- Routine screening bloods: FBC, U&Es, Chol, TFTs, LFTs
- Start Aspirin 75mg daily
- Provide GTN spray/tabs with advice on using both in response to, and in anticipation of, presenting chest pain
- Consider commencing first line anti-anginal

Refer to RACPC

**RACPC pre-referral considerations:** Patients should have primary care investigation for other potential causes of their symptoms where their presenting pain includes the following: Sharp chest pain, described as “like a knife”; Localised left sub-mammary chest pain; Pain worse on inspiration (pleuritic); Pain worsened by twisting or turning the thorax; Pain occurring in an isolated area of the chest (pointed at with one finger); Pain made worse by manual pressure on the chest; Pain which resolves with simple analgesia; Pain present continuously for days or weeks.

**Recent / current acute chest pain or discomfort, suspected to be caused by an acute coronary syndrome ACS**

If history and clinical examination are suggestive of an ACS as the cause of their chest pain (pain suggestive of cardiac ischaemia, often with sweating/nausea, lasting longer than 15 mins):
- 12-lead ECG to differentiate STEMI from possible NSTEMI / UA
- IV access

**STEMI Pathway**
STE > 1mm in 2 or more of leads I, II, III, aVL, aVF or STE > 2mm in 2 or more contiguous leads V2-V6 or new / apparent new LBBB or True posterior MI

- 12-lead ECG to differentiate STEMI from possible NSTEMI / UA
- IV access
- Pain relief: Sublingual GTN / IV opioid eg morphine 5-10mg slow IV
- Anti-emetic: IV Metoclopramide 10mg
- Antiplatelet: Aspirin 300mg and, if ECG changes, also give Ticagrelor 180mg (or Clopidogrel 300mg in addition to aspirin if Ticagrelor not available)
- Oxygen therapy if SaO2 <94%

**NSTEMI Pathway**
Suggestive history with or without ECG changes indicative of ischaemia (e.g., ST segment depression or transient elevation or new T wave inversion) - subsequent in-patient troponin change

- If transfer delay, pre-hospital thrombolysis may be appropriate - liaise with PCI centre
- Unstable Angina
  - Suggestive history, with or without ECG changes indicative of ischaemia (e.g., ST segment depression or transient elevation or new T wave inversion) - no subsequent elevation or change in troponin

If transfer delay, pre-hospital thrombolysis may be appropriate - liaise with PCI centre

**Dial 999**
Consider Primary PCI & liaise with CCU at Ninewells (01382 740 490)

Admit PRI / Ninewells acute medical receiving

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Haemodynamically unstable patients may be redirected to A&E by SAS crew in consultation with PCI centre