Treatments and drugs for STEMI

Circulation
JOURNAL OF THE AMERICAN HEART ASSOCIATION

American Heart Association®

ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction —Executive Summary : A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction)

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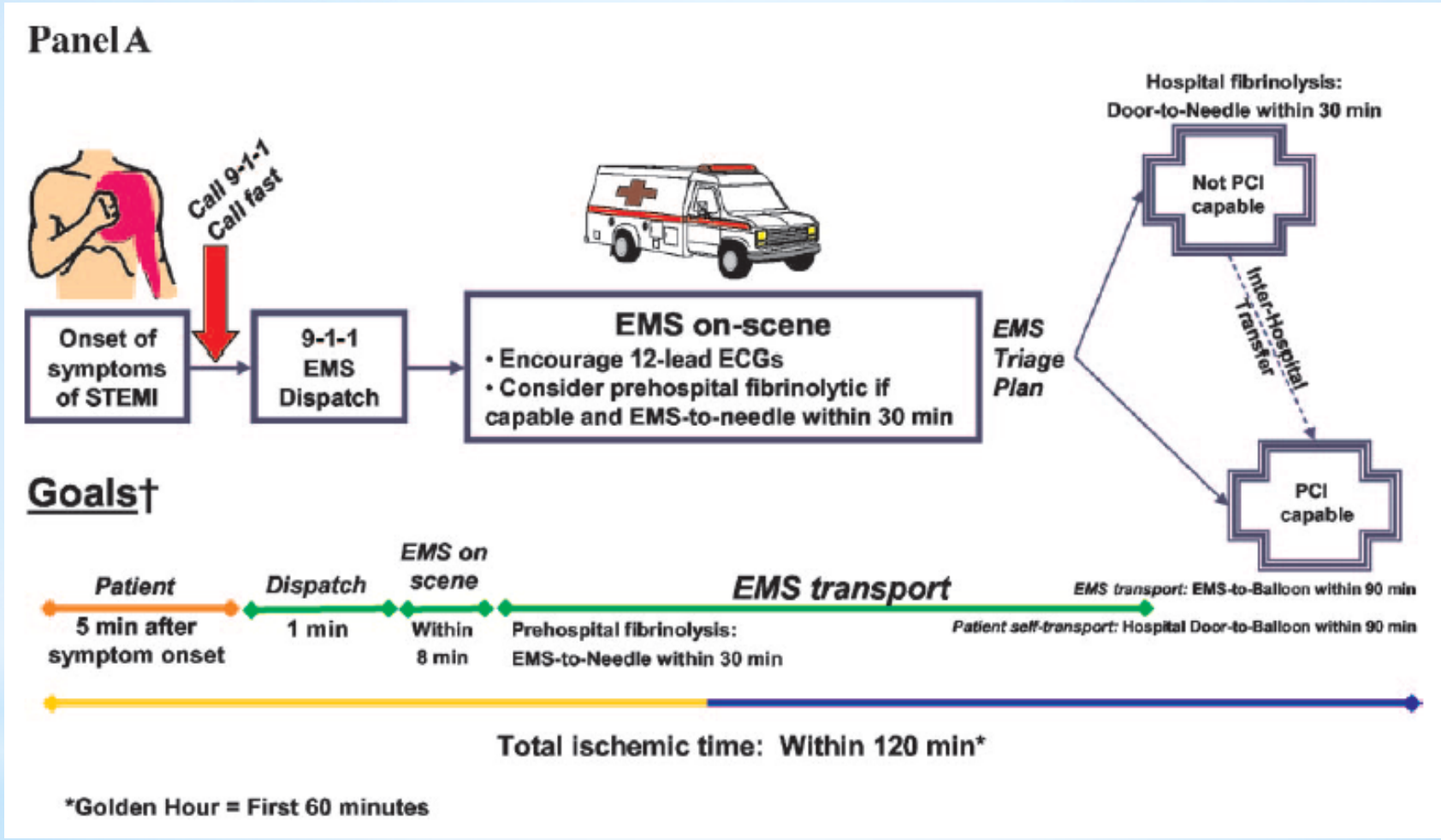
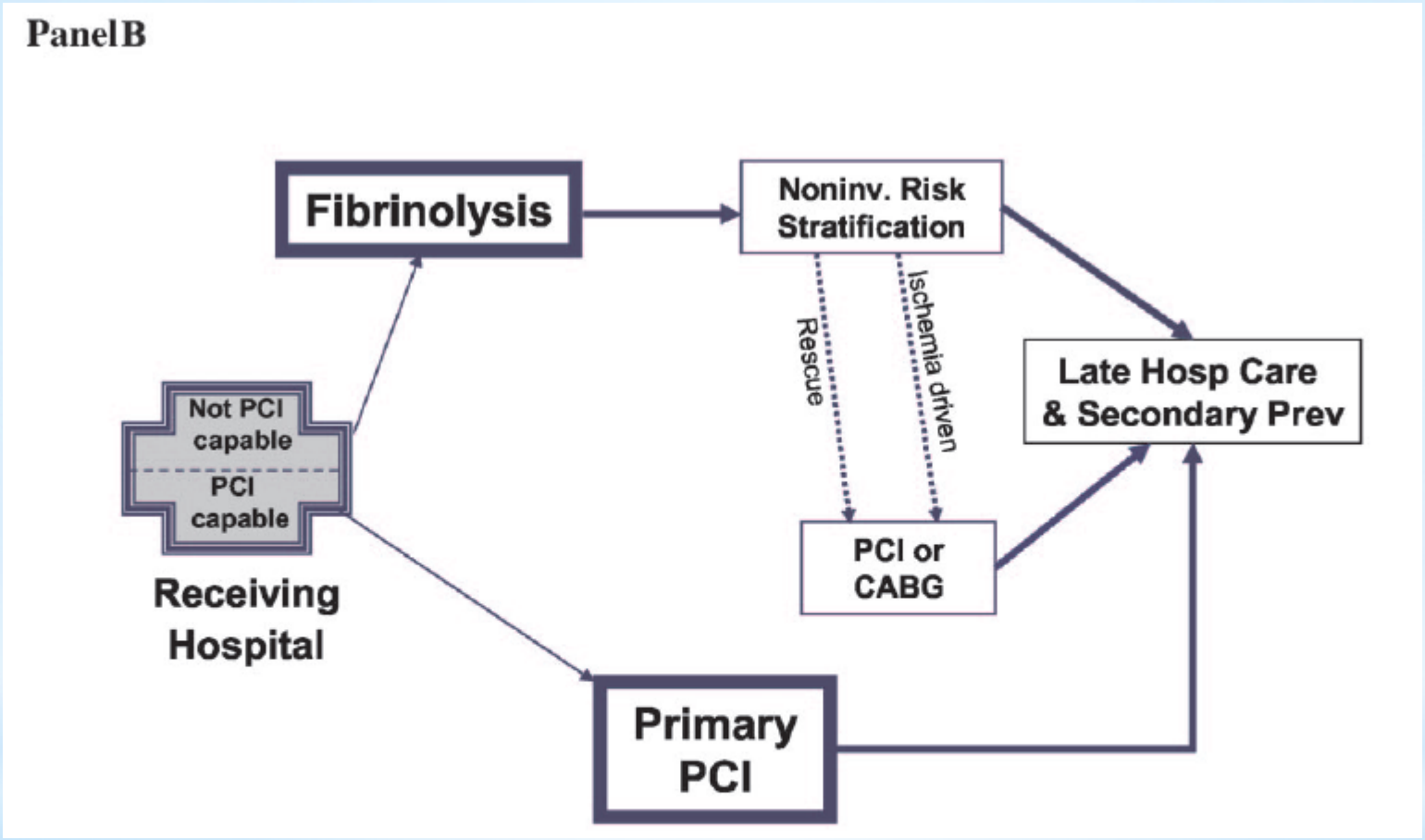
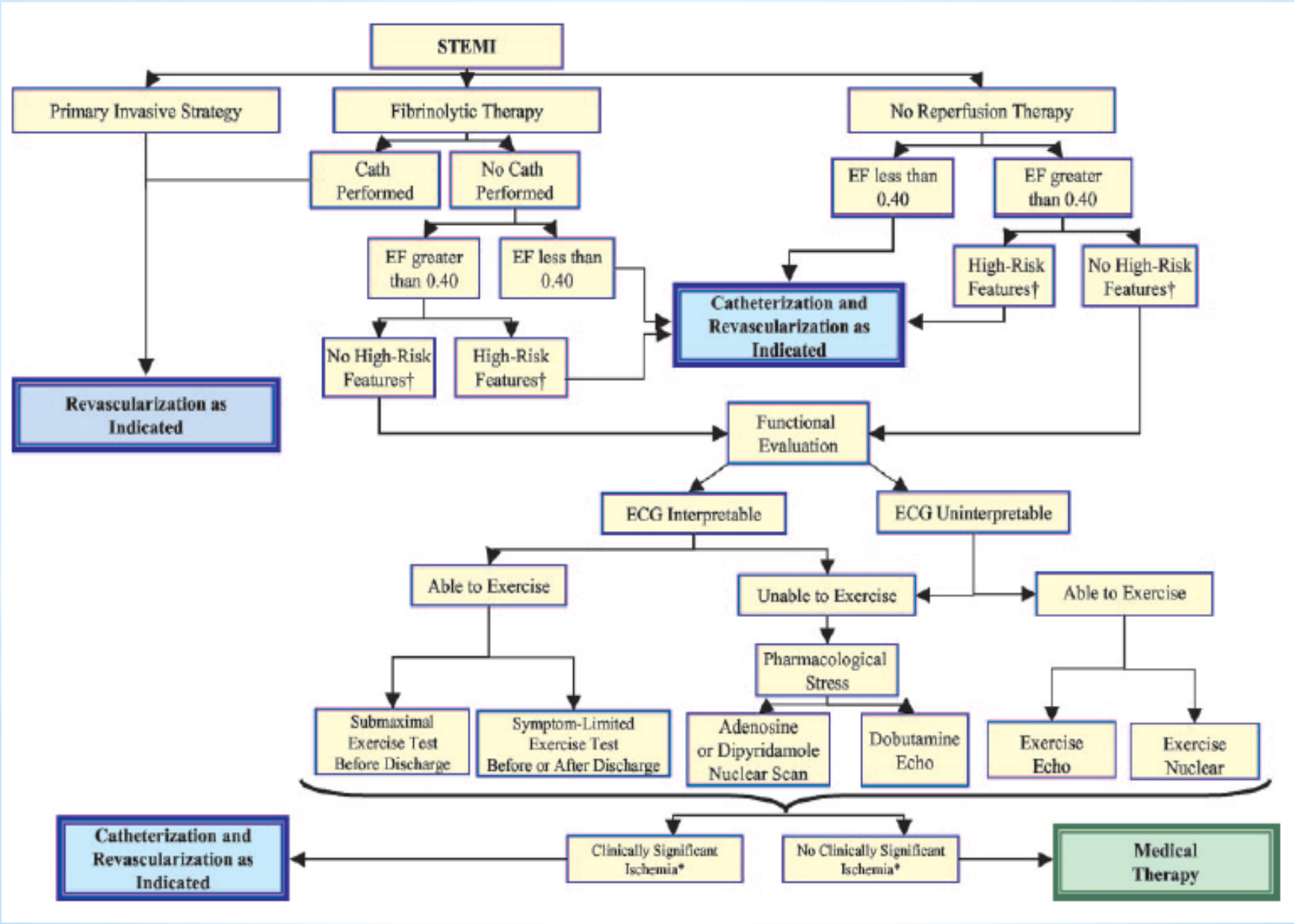
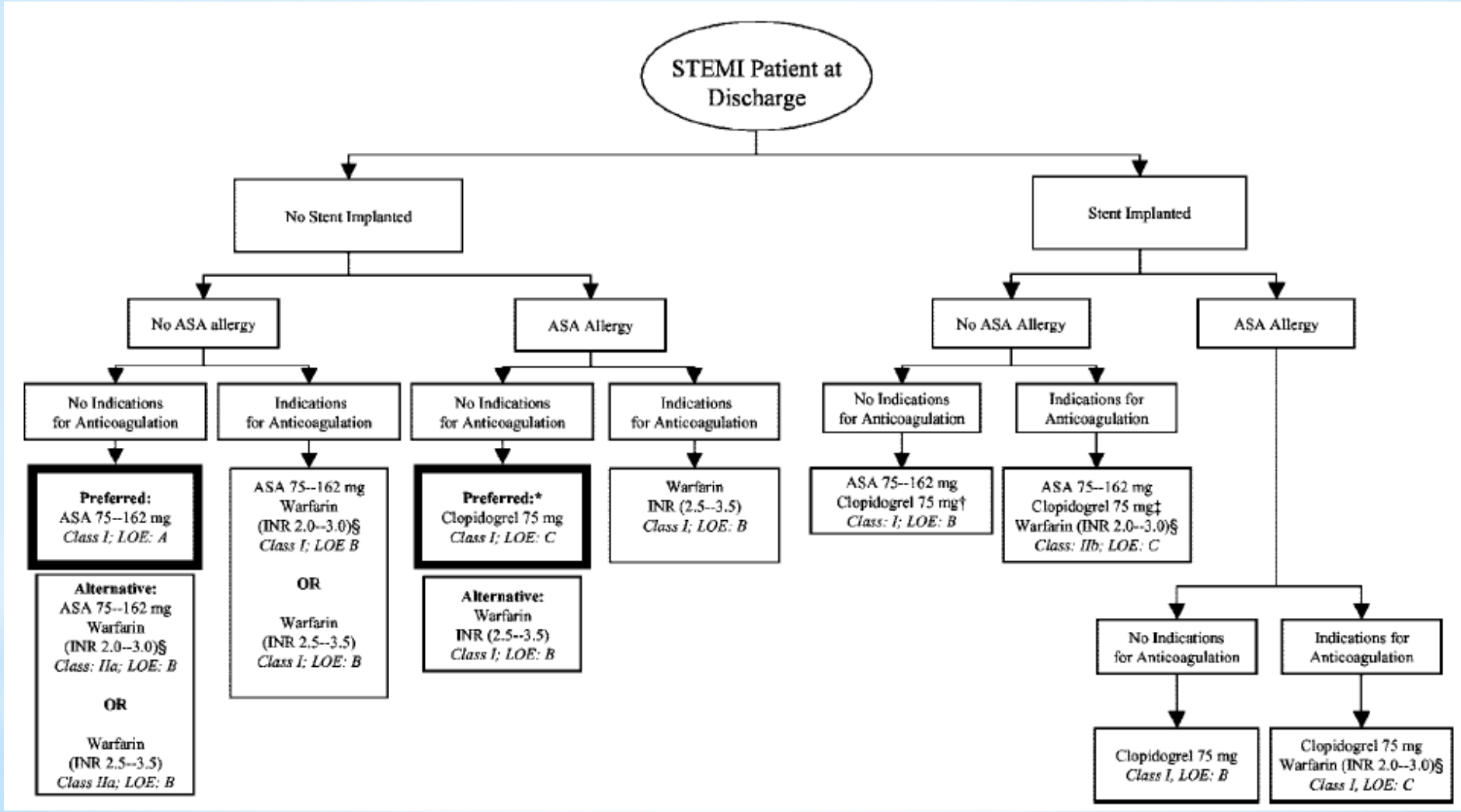

Panel A
Call 9-1-1
Call fast
Onset of symptoms of STEMI
9-1-1 EMS Dispatch
EMS on-scene
• Encourage 12-lead ECGs
• Consider prehospital fibrinolytic if capable and EMS-to-needle within 30 min
EMS Triage Plan
Hospital fibrinolysis:
Door-to-Needle within 30 min
Not PCI capable
Inter-Hospital Transfer
PCI capable
Goals†
Patient
5 min after symptom onset
Dispatch
1 min
EMS on scene
Within 8 min
EMS transport
Prehospital fibrinolysis:
EMS-to-Needle within 30 min
EMS transport: EMS-to-Balloon within 90 min
Patient self-transport: Hospital Door-to-Balloon within 90 min
Total ischemic time: Within 120 min*
*Golden Hour = First 60 minutes


Panel B
Fibrinolysis
Noninv. Risk Stratification
Rescue
Ischemia driven
Late Hosp Care & Secondary Prev
Not PCI capable
PCI capable
Receiving Hospital
PCI or CABG
Primary PCI


STEMI
Primary Invasive Strategy
Fibrinolytic Therapy
No Reperfusion Therapy
Cath Performed
No Cath Performed
EF less than 0.40
EF greater than 0.40
EF greater than 0.40
EF less than 0.40
High-Risk Features†
No High-Risk Features†
Catheterization and Revascularization as Indicated
No High-Risk Features†
High-Risk Features†
Revascularization as Indicated
Functional Evaluation
ECG Interpretable
ECG Uninterpretable
Able to Exercise
Unable to Exercise
Able to Exercise
Pharmacological Stress
Submaximal Exercise Test Before Discharge
Symptom-Limited Exercise Test Before or After Discharge
Adenosine or Dipyridamole Nuclear Scan
Dobutamine Echo
Exercise Echo
Exercise Nuclear
Catheterization and Revascularization as Indicated
Clinically Significant Ischemia*
No Clinically Significant Ischemia*
Medical Therapy


STEMI Patient at Discharge
No Stent Implanted
Stent Implanted
No ASA allergy
ASA Allergy
No ASA Allergy
ASA Allergy
No Indications for Anticoagulation
Indications for Anticoagulation
No Indications for Anticoagulation
Indications for Anticoagulation
No Indications for Anticoagulation
Indications for Anticoagulation
Preferred:
ASA 75--162 mg
Class I; LOE: A
Alternative:
ASA 75--162 mg
Warfarin
(INR 2.0--3.0)§
Class: IIa; LOE: B
OR
Warfarin
(INR 2.5--3.5)
Class IIa; LOE: B
ASA 75--162 mg
Warfarin
(INR 2.0--3.0)§
Class I; LOE B
OR
Warfarin
(INR 2.5--3.5)
Class I; LOE: B
Preferred:*
Clopidogrel 75 mg
Class I; LOE: C
Alternative:
Warfarin
INR (2.5--3.5)
Class I; LOE: B
Warfarin
INR (2.5--3.5)
Class I; LOE: B
ASA 75--162 mg
Clopidogrel 75 mg†
Class: I; LOE: B
ASA 75--162 mg
Clopidogrel 75 mg‡
Warfarin (INR 2.0--3.0)§
Class: IIb; LOE: C
No Indications for Anticoagulation
Indications for Anticoagulation
Clopidogrel 75 mg
Class I, LOE: B
Clopidogrel 75 mg
Warfarin (INR 2.0--3.0)§
Class I, LOE: C

Treatments and drugs for NSTEMI/Unstable Angina

JACC

JOURNAL of the AMERICAN COLLEGE of CARDIOLOGY

PRACTICE GUIDELINE

2011 ACCF/AHA Focused Update of the Guidelines for the Management of Patients With Unstable Angina/ Non–ST-Elevation Myocardial Infarction (Updating the 2007 Guideline)

A Report of the American College of Cardiology Foundation/ American Heart Association Task Force on Practice Guidelines

Recommendations for Warfarin Therapy

Class I

1. Use of warfarin in conjunction with aspirin and/or P2Y12 receptor inhibitor therapy is associated with an increased risk of bleeding, and patients and clinicians should watch for bleeding, especially GI, and seek medical evaluation for evidence of bleeding.

Recommendations for Warfarin Therapy

Class IIb

1. Warfarin either without (INR 2.5 to 3.5) or with low-dose aspirin (81 mg per day; INR 2.0 to 2.5) may be reasonable for patients at high coronary artery disease risk and low bleeding risk who do not require or are intolerant of P2Y12 receptor inhibitor therapy

2. Targeting oral anticoagulant therapy to a lower INR (e.g., 2.0 to 2.5) might be reasonable in patients with UA/NSTEMI managed with aspirin and a P2Y12 inhibitor.

Flowchart for Class I and Class IIa Recommendations for Initial Management of UA/NSTEMI