

SBU GUIDELINES FOR THE PHARMACOLOGICAL MANAGEMENT OF STEMI PATIENTS BASED ON ACC/AHA GUIDELINES 2009 UPDATES

STEMI	
Call Code H (444-1911)	
Oxygen	Administer oxygen by nasal prongs
Aspirin	162-325 mg should be chewed and swallowed as soon as possible in the ED. Give clopidogrel instead of aspirin in aspirin allergic patients.
Clopidogrel (Plavix®) or Prasugrel (Effient®)	At least 300 to 600 mg of clopidogrel should be given as early as possible before or at the time of primary or nonprimary PCI. May be given in ED or in Catheterization Lab. Prasugrel 60 mg may be given instead of clopidogrel in the catheterization lab in patients with clopidogrel allergy or when coronary anatomy is known.
Beta blockers	In patients with hypertension and/or tachycardia consider IV metoprolol 5 mg IV every 5 minutes for a total of 15 mg if tolerated. Contraindications: signs of heart failure, low cardiac output, risk of cardiogenic shock (age>70, SBP<120, HR>110, HR<60, late arrival), asthma, 1 st or 2 nd degree AV block
Heparin	UFH 60 units/kg IV bolus (max 4000) in ED followed by 12 units/kg/hr (max 1000). Do not delay transfer to cath lab to administer.
Nitroglycerine	Intravenous nitroglycerin is indicated in the first 48 hours after STEMI for treatment of persistent ischemia, CHF, or hypertension. SL nitroglycerine may be considered for pain control. Nitrates should not be administered to patients with systolic blood pressure less than 90 mm Hg or greater than or equal to 30 mm Hg below baseline, severe bradycardia (less than 50 bpm), tachycardia (more than 100 bpm), RV infarction, or after use of medications for erectile dysfunction.
Morphine Sulfate	In patients with pain despite treatment with nitrates, oxygen and beta blockers, morphine sulfate can be administered (2-4 mg IV with increments of 2 to 8 mg IV repeated at 5-15 minutes intervals).

SBU GUIDELINES FOR THE PHARMACOLOGICAL MANAGEMENT OF NSTEMI/UA PATIENTS BASED ON ACC/AHA GUIDELINES 2009 UPDATES

Acute Coronary Syndrome: NSTEMI/UA	
Low Risk	
<p><i>TIMI Score <3</i> <i>Negative troponin I</i> <i>Normal or unchanged ECG</i></p>	
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Intermediate Risk	
<p><i>Age >70</i> <i>T wave changes</i> <i>Previous MI or atherosclerotic disease</i> <i>New onset angina within 2 weeks</i></p>	
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Clopidogrel (Plavix®) or Prasugrel (Effient®)	At least 300 to 600 mg of clopidogrel should be given as early as possible before or at the time of primary or nonprimary PCI. May be given in ED or in Catheterization Lab. Prasugrel 60 mg may be given instead of clopidogrel in the catheterization lab in patients with clopidogrel allergy when coronary anatomy is known.
Heparin	Low molecular weight heparin (Enoxaparin) 1 mg/kg SC (Max 150 mg) in ED followed by 1 mg/kg q 12 hours OR UFH 60 units/kg IV bolus (max 5000) in ED followed by 12 units/kg/hr (max 1000)
Beta blockers	Metoprolol 50 mg orally within the first 24 hours followed by 50 mg every 6 hours. Contraindications: signs of heart failure, low cardiac output, risk of cardiogenic shock (age >70, SBP <120, HR >110, HR <60, late arrival), asthma, 1 st degree AV block.
Nitroglycerine	SL nitroglycerine may be considered for pain control. Nitrates should not be administered to patients with systolic blood pressure less than 90 mm Hg or greater than or equal to 30 mm Hg below baseline, severe bradycardia (less than 50 bpm), tachycardia (more than 100 bpm), RV infarction, or after use of medications for erectile dysfunction.
High Risk	
<p><i>TIMI Score >4</i> <i>Positive Troponin I</i> <i>New ST depressions</i> <i>Cardiogenic shock</i> <i>Signs of heart failure</i> <i>Ongoing rest pain >20 minutes</i> <i>Accelerating angina over last 48 hrs</i></p>	

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GP IIB/IIIA	Consider GP IIB/IIIA inhibitor (ReoPro®, Integrilin® or Aggrastat®) in consultation with cardiologist.