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Mashup Score: 55 PCR Online - Most patients with coronary heart disease are present with NSTEMI. NSTEMI management begins with proper diagnosis, timely start of proper pharmacotherapy, coronary angiography/intervention and secondary preventive care. 5 years later with the latest ESC NSTEMI guidelines that propose new 2020 guidelines that will affect or change our practice... Read the full article here on August 29, 2020. Debabrat Mukherjee, MD, FACC Authors: Colle JP, Thiele H, Barbato E, et al. Citation: 2020 ESC Guidelines for Managing Acute Coronary Syndromes in Patients, Presenting Unresistant ST-segment lifting: Task Force on The Management of Acute Coronary Syndromes in Patients, Representing Unrestricted ST-Segment of the European Heart Society Eur Heart J 2020; August 29. Epub ahead of print. Below are the key points to remember from the 2020 European Society of Cardiology (ESC) guidelines for managing acute coronary syndromes (ACS) in patients presenting without persistent ST-segment height: Pathological correlates for ACS in patients, presenting without persistent ST-segment height (NSTE-ACS) at myocardial level is cardiomyocyte necrosis, measured by the release of troponin, or, less frequently, myocardial ischemia without cell damage (unstable angina). In general, people with unstable angina have a significantly lower risk of death and benefit less from an aggressive pharmacological and invasive approach. Highly sensitive troponin (hs-Tn) measurement analysis is recommended for less sensitive, as they provide higher diagnostic accuracy at the same low cost. It should be noted that many cardiac pathologies, except myocardial infarction (MI), also lead to cardiomyocytes injury and, consequently, the rise of cardiac troponin (cTn). Other biomarkers may have clinical significance in specific clinical settings when used in combination with non-hs-cTn T/I. Creatine Kinase-myocardial band (CK-MB) shows a faster decline after MI and can provide added value for early reinfarction detection. Regular use of cTn as an additional biomarker for early IS exclusion is recommended in very rare settings where hs-cTn tests are not available. The time interval to the second cTn assessment can be reduced using hs-cTn analyses due to higher sensitivity and diagnostic accuracy to detect MI at presentation. It is recommended to use the algorithm 0 h/1 h (best option, draw blood at 0 hours and 1 h) or algorithm 0 h/2 h (second option, draw blood for 0 hours and 2 hours). The 0/1 and 0/2 h algorithm, used in conjunction with clinical and electrocardiography (ECG) results, allows suitable candidates for early discharge and outpatient treatment. Four Clinical Clinical significantly affect the concentration of hs-cTn, including age (differences between healthy very young and healthy very old people up to 300%), kidney dysfunction (differences with very high and very low estimated rate of glomerular filtration (eGFR) up to 300%), the onset of chest pain (300%) initial levels of cTn add predictive information in terms of short- and long-term mortality to clinical and ECG variables. The higher the hs-cTn level, the higher the risk of death, natriuretic peptides can provide incremental predictive information. The Use of the Academic Research Consortium for high-risk bleeding (ARC-HBR) is a pragmatic approach to assessing the risk of bleeding, which includes the most recent studies conducted in patients at high risk of bleeding who have previously been excluded from clinical trials of double antithrombotic therapy (DAPT) duration or intensity. The PRECISE-DAPT assessment can be used to guide and inform decisions on the duration of DAPT with a modest predictive value for large bleeding, but their importance in improving patient outcomes remains unclear. Clinical evaluation may indicate optional non-invasive or invasive imaging even after being excluded from MI. Cardiac Computed tomography (CCTA) may be an option in patients with a low to modest clinical likelihood of unstable angina, as conventional scans eliminate coronary heart disease (CAD). CCTA has a high negative predictive value to exclude ACS (except CAD) and predicts excellent results in patients by presenting to the emergency room with a low to intermediate probability for ACS and normal CCTA. Stress imaging with cardio-magnetic resonance imaging (SMR), stress echocardiography or nuclear imaging can also be a risk-based option. An early conventional invasive approach within 24 hours of taking is recommended for NSTEMI based on hs-cTn measurements, GRACE risk assessments and new dynamic or presumably new ST-segment changes, as it improves major adverse heart events and possibly early survival. Immediate invasive angiography is necessary in very unstable patients depending on hemodynamic condition, arrhythmia, acute heart failure or permanent chest pains. In all other clinical presentations, selective invasive can be performed in accordance with non-invasive testing or clinical risk assessment. The main technical aspects of percutaneous coronary intervention (PCI) in NSTE-ACS patients are no different from invasive evaluation and revascularization strategies for other CAD presentations. Radial access is recommended as the preferred approach in NSTE-ACS NSTE-ACS undergoes an invasive evaluation with or without PCI. Since multi-vessel disease is common in NSTE-ACS, the timing and completeness of revascularization should be decided in accordance with the functional significance of all stenosis, age, general patient condition, comorbidities and left ventricular function. IM with non-constructive coronary arteries (MINOCA) includes a heterogeneous group of underlying causes that may include both coronary and non-coronary pathological conditions, with the latter including cardiac and extracardial disorders. Consensus, myocarditis and Takotsubo syndrome are excluded. CMR is one of the key diagnostic tools, as it identifies the underlying cause of 85% of patients and subsequent appropriate treatment. Spontaneous dissection of the coronary artery (SCAD) is a non-arterosclerotic, non-traumatic or iatrogenic separation of coronary arterial tunica, secondary to vasmorum hemorrhage or intra-intimate rupture, and accounts for up to 4% of all ACS, but the incidence is reported to be much higher (22-35% ACS) in women Regular pre-treatment with P2Y12 receptor inhibitor in NSTE-ACS patients whose coronary anatomy is not known and early invasive management is not recommended, given the lack of established favors. However, this can be considered in isolated cases and in accordance with the risk of bleeding of the patient. DAPT, consisting of a powerful P2Y12 receptor inhibitor in addition to aspirin, is generally recommended for 12 months, regardless of the type of stent, if there are contraindications. However, new scenarios have been implemented. The duration of DAPT can be shortened (12 months) or modified by switching DAPT or de-escalation. These decisions depend on individual clinical judgments, due to the risk of ischemic and bleeding of the patient, the occurrence of side effects, comorbidities, comedities and the availability of appropriate drugs. In at least 6-8% of patients undergoing PCI, long-term oral anticoagulation is indicated and should be continued. In general, new oral anticoagulants (NOAK) are preferable to vitamin K vitamin K antagonists (HCA) in terms of safety when patients are eligible. Double antithrombotic therapy with NOAC in the recommended dose for stroke prevention and single anti-thrombotic therapy (preferably clopidogrel selected in the available trials) is recommended as a default strategy of up to 12 months after a short period of up to 1 week of triple antithrombotic therapy (TAT) (with NOAC and DAPT). TAT can be extended to 1 month when ischemic risk outweighs the risk of bleeding. Clinical topics: Acute coronary syndromes, anticoagulant management, heart failure and cardiomyopathy, invasive angiography and intervention, non-invasive imaging, prevention, stable coronary heart disease, anticoagulant management and ACS, acute heart failure, interventions and interventions and interventions and visualizations, angiography, computed tomography, echocardiography/ultrasound, magnetic resonance imaging, nuclear tomography, chronic angina Keywords: ESC20, ESC Congress, Acute coronary syndrome, Angina, Stable, Anticoagulants, Chest Pain, Coronary Angiography, Diagnostic Tomography, Dissection, Echocardi, Electrocardiography myocardial infarction, myocardial ischemia, myocarditis, percutaneous coronary intervention, platelet aggregation inhibitors, primary prevention, renal failure, risk assessment, stroke, thrombosis, tomography, X-ray e computing, troponin, vascular disease and login to become a professional member of the ESC Pocket Guidelines App Get all the latest ESC Pocket Guidelines, as well as interactive tools (algorithms, calculators, charts, scores ...) in your pocket. Download Clinical presentation of acute coronary syndromes (ACS) is wide. It ranges from cardiac arrest, electrical or hemodynamic instability with cardiogenic shock (CS) due to ongoing ischemia or mechanical complications, such as severe mitral regurgitation, to patients who are already painless again during presentation. The leading symptom of the diagnostic and therapeutic cascade in patients with suspected ACS is acute chest discomfort, described as pain, pressure, tightness and burning. Chest pain equivalent symptoms may include shortness of breath, epigastric pain, and pain in the left hand. For more information, read the full text and additional documents of the data. Subject (s): Guidelines version available to download Handbook doi:10.1093/eurheartj/ehaa575 Reference doi:10.1093/eurheartj/ehaa601 Reference doi:10.1093/eurheartj/eh Help TOC NSTE-ACS Pocket Guidelines Handbook ESC Pocket Guidelines App Content Table: Full Text (ESC Clinical Practice Guidelines) Preamble Introduction Definitions Universal Definition of Myocardial Infarction Unstable Angina in the Age of High Sensitivity of Cardiac Troponin Epidemiology Analysis What's New? Number and breakdown of grades of recommendations (additional data) Diagnostic Clinical presentation (Additional data) Physical examination (Additional data) Diagnostic tools Electrocardiogram Biomarkers: High Sensitivity of Cardiac Troponin Rapid Rule in and Rule- Algorithms Observe Non-Invasive Imaging Differential Diagnosis Risk Assessment and Results Electrocardiogram Indicators (Data) Biomarkers anti-thrombotic treatment antithrombot drugs and pre-treatment of Peri-interventional anticoagulant treatment anti-thrombotic treatment after intervention and supportive treatment of pharmacological treatment of ischemia (additional data) Supporting pharmacological treatment (additional data) nitrates and beta-blockers (additional data) Management of oral antithrombotic agents in patients, patients with atrial fibrillators without mechanical prosthetic heart valves or moderately-heavy mitral stenosis undergoing percutaneous coronary intervention or managed (additional data) of patients, Needing vitamin K antagonists or undergoing coronary artery bypass surgery When managing acute bleeding (additional data) General assisted measures (additional data) Bleeding events on antithrombotic agents (Additional data) Bleeding events on vitamin K antagonists (Additional data) Related to percutaneous coronary intervention (Additional data) Bleeding events associated with coronary artery bypass (Additional data) 68 Transfusion Therapy (Additional Data) Recommendations for Bleeding Management and Blood Transfusion in non-ST-segment height of acute coronary syndromes for anticoagulant patients Invasive treatments for invasive coronary angiography and revascularization of routine. Selective Invasive Approach (Additional Data) Timeline of the Invasive Strategy Pattern of Coronary Heart Disease in the non-ST-segment height of acute coronary syndrome (additional data) How to identify the culprit of the lesion? (Additional data) Spontaneous dissection of the coronary artery Fractional flow reserve, instant wave-free ratio, and Other Recreation Indicators (Additional Data) Intra-Root Imaging Conservative Treatment Patients Who Are Not Candidates for Invasive Coronary Angiography Patients with Coronary Heart Disease Are Not P approaches to Thericay Revascularization Technical Aspects Technical Aspects and Problems of Vascular Access Revascularization Strategy of coronary artery bypassion percutaneous coronary intervention against coronary surgery Treatment of patients with cardiac arrest Recommendations for coronary revascularization of myocardial infarction with non-constructive coronary arteries and alternative diagnoses Special population Heart Failure and Cardiogenic Shock Diabetes Mellitus Chronic Kidney Disease Anemia Thrombocytopenia (Additional Data) Thrombocytopenia Associated with Glycoprotein Inhibitors IIb/IIIa (Additional Data) Heparin-induced Thrombocytopenia (Additional Data) Elderly Man Frailty Sex Differences Management of non-ST-segment height of acute coronary syndrome (Additional data) Lifestyle Management (Additional data) (Дополнительные данные) Diet and alcohol (Supplementary data) Weight management (Supplementary data) Physical activity (Supplementary data) Cardiac rehabilitation (Supplementary data) Psychosocial factors (Supplementary data) Environmental factors (Supplementary data) Sexual activity (Supplementary data) Adherence and sustainability (Supplementary data) Influenza vaccination (Supplementary data) Pharmacological management (Supplementary data) Anti-ischaemic drugs Antithrombotic treatments Proton pump inhibitors (Supplementary data) Statins and other lipid-lowering agents Glucose-lowering therapy in patients with diabetes Renin-angiotensin-aldosterone system blockers (Supplementary data) Mineralocorticoid receptor antagonist therapy (Supplementary data) Antihypertensive therapy (Supplementary data) Hormone replacement therapy (Supplementary data) Quality measures Management strategy Key messages Gaps in evidence for non-ST-segment elevation acute coronary syndrome care and future research To do and not to do Supplementary data Appendix References Previous version available to download Reference European Heart Journal, doi/10.1093/eurheartj/ehv320 Reference Web Addenda - doi:10.1093/eurheartj/ehv320 Reference Q&A antithrombotic treatment NSTE-ACS GL - doi:10.1093/eurheartj/ehv407 Reference Q&A myocardial revascularization NSTE-ACS GL - doi:10.1093/eurheartj/ehv408 Reference Q&A diagnosis and risk assessment NSTE-ACS GL - doi:10.1093/eurheartj/ehv409 Справочный европейский журнал сердца (2011) 32, 2999-3054 2999-3054

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