2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction

Developed in Collaboration with American College of Emergency Physicians and Society for Cardiovascular Angiography and Interventions

Citation

This slide set is adapted from the 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction (*Journal of the American College of Cardiology).* Published on December 17, 2012, available at: [INSERT assigned url address (Please note: The URL of your article is always http://content.onlinejacc.org/cgi/content/full/ + the last half of your doi (j.jacc.2011.08.023) = http://content.onlinejacc.org/cgi/content/full/j.jacc.2011.08.023)

The full-text guidelines are also available on the following Web sites: ACC (www.cardiosource.org) and AHA (my.americanheart.org)

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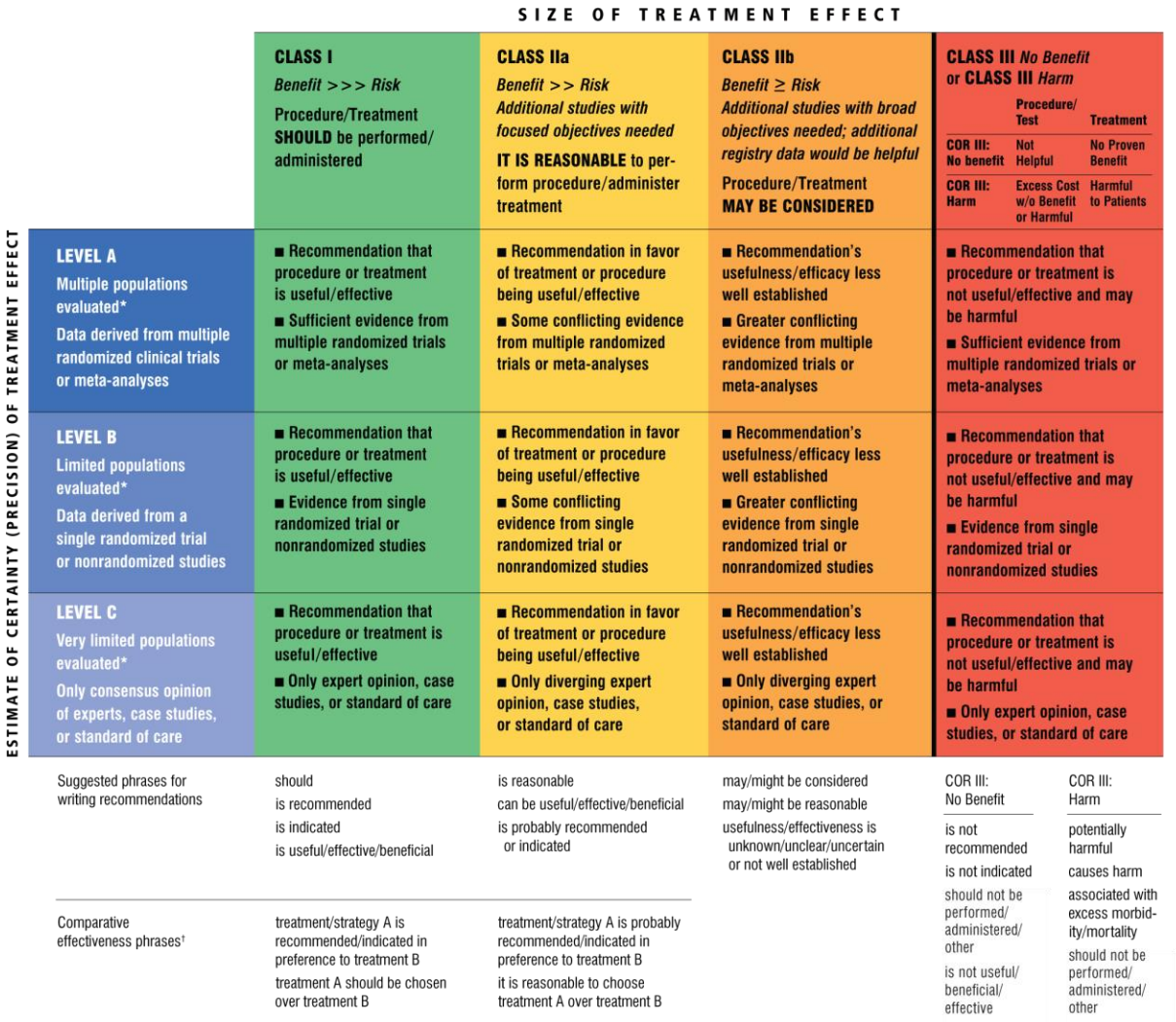
Classification of Recommendations and Levels of Evidence



SIZE OF TREATMENT EFFECT

ESTIMATE OF CERTAINTY (PRECISION) OF TREATMENT EFFECT

	CLASS I *Benefit >>> Risk* Procedure/Treatment **SHOULD** be performed/ administered	CLASS IIa *Benefit >> Risk* *Additional studies with focused objectives needed* **IT IS REASONABLE** to perform procedure/administer treatment	CLASS IIb *Benefit ≥ Risk* *Additional studies with broad objectives needed; additional registry data would be helpful* Procedure/Treatment **MAY BE CONSIDERED**	CLASS III *No Benefit* or CLASS III *Harm* Procedure/ Test / Treatment COR III: No benefit — Not Helpful — No Proven Benefit COR III: Harm — Excess Cost w/o Benefit or Harmful — Harmful to Patients
LEVEL A Multiple populations evaluated* Data derived from multiple randomized clinical trials or meta-analyses	■ Recommendation that procedure or treatment is useful/effective ■ Sufficient evidence from multiple randomized trials or meta-analyses	■ Recommendation in favor of treatment or procedure being useful/effective ■ Some conflicting evidence from multiple randomized trials or meta-analyses	■ Recommendation's usefulness/efficacy less well established ■ Greater conflicting evidence from multiple randomized trials or meta-analyses	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Sufficient evidence from multiple randomized trials or meta-analyses
LEVEL B Limited populations evaluated* Data derived from a single randomized trial or nonrandomized studies	■ Recommendation that procedure or treatment is useful/effective ■ Evidence from single randomized trial or nonrandomized studies	■ Recommendation in favor of treatment or procedure being useful/effective ■ Some conflicting evidence from single randomized trial or nonrandomized studies	■ Recommendation's usefulness/efficacy less well established ■ Greater conflicting evidence from single randomized trial or nonrandomized studies	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Evidence from single randomized trial or nonrandomized studies
LEVEL C Very limited populations evaluated* Only consensus opinion of experts, case studies, or standard of care	■ Recommendation that procedure or treatment is useful/effective ■ Only expert opinion, case studies, or standard of care	■ Recommendation in favor of treatment or procedure being useful/effective ■ Only diverging expert opinion, case studies, or standard of care	■ Recommendation's usefulness/efficacy less well established ■ Only diverging expert opinion, case studies, or standard of care	■ Recommendation that procedure or treatment is not useful/effective and may be harmful ■ Only expert opinion, case studies, or standard of care
Suggested phrases for writing recommendations	should is recommended is indicated is useful/effective/beneficial	is reasonable can be useful/effective/beneficial is probably recommended or indicated	may/might be considered may/might be reasonable usefulness/effectiveness is unknown/unclear/uncertain or not well established	COR III: No Benefit: is not recommended; is not indicated; should not be performed/ administered/ other; is not useful/ beneficial/ effective COR III: Harm: potentially harmful; causes harm; associated with excess morbidity/mortality; should not be performed/ administered/ other
Comparative effectiveness phrases†	treatment/strategy A is recommended/indicated in preference to treatment B treatment A should be chosen over treatment B	treatment/strategy A is probably recommended/indicated in preference to treatment B it is reasonable to choose treatment A over treatment B		

A recommendation with Level of Evidence B or C does not imply that the recommendation is weak. Many important clinical questions addressed in the guidelines do not lend themselves to clinical trials. Although randomized trials are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

*Data available from clinical trials or registries about the usefulness/ efficacy in different subpopulations, such as sex, age, history of diabetes, history of prior myocardial infarction, history of heart failure, and prior aspirin use.

†For comparative effectiveness recommendations (Class I and IIa; Level of Evidence A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

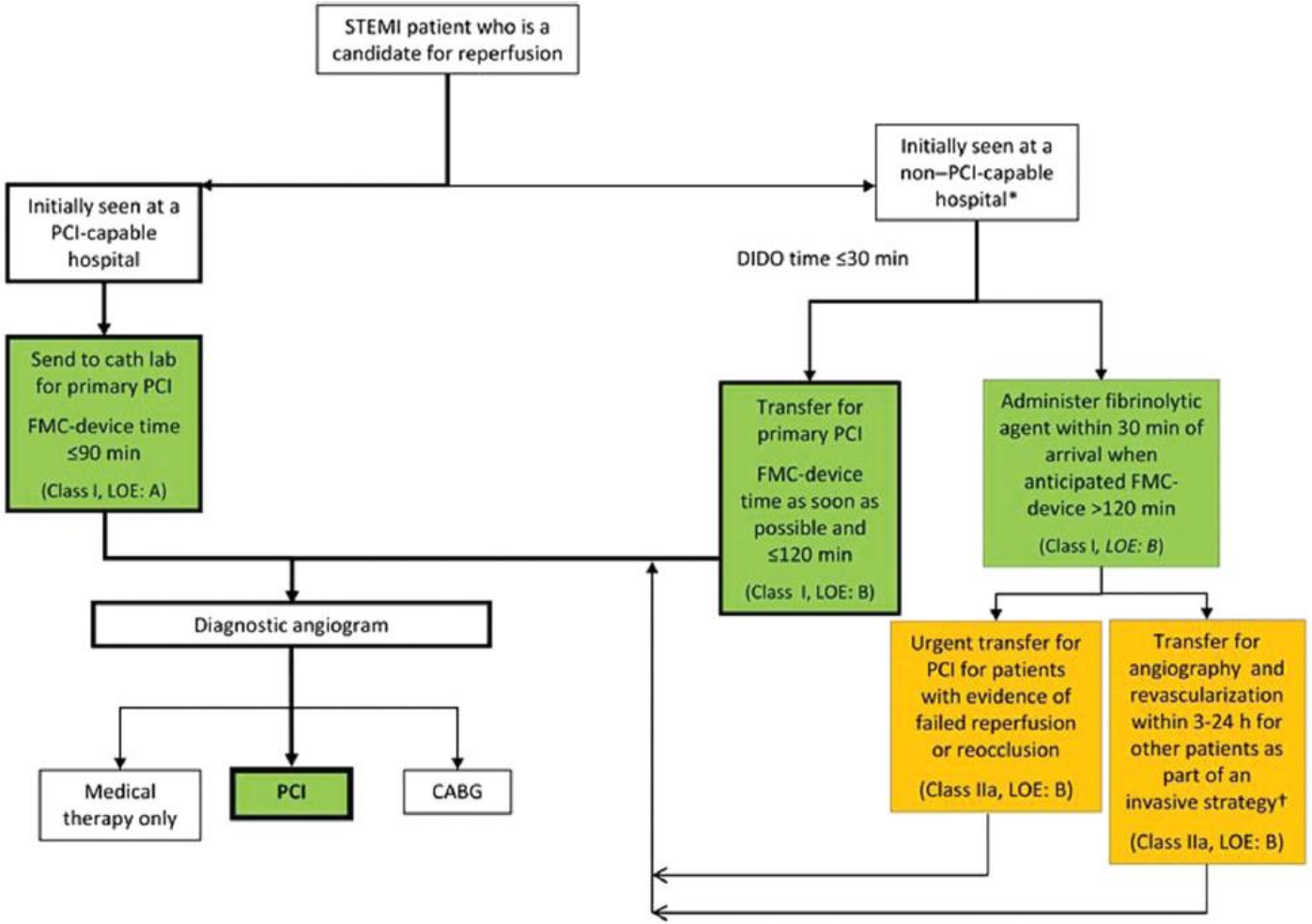
Onset of Myocardial Infarction

Community Preparedness and System Goals for Reperfusion Therapy

Onset of Myocardial Infarction

Regional Systems of STEMI Care, Reperfusion Therapy, and Time-to-Treatment Goals

Reperfusion Therapy for Patients with STEMI



*Patients with cardiogenic shock or severe heart failure initially seen at a non–PCI-capable hospital should be transferred for cardiac catheterization and revascularization as soon as possible, irrespective of time delay from MI onset (*Class I, LOE: B*). †Angiography and revascularization should not be performed within the first 2 to 3 hours after administration of fibrinolytic therapy.

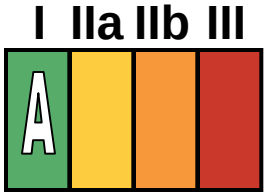
Regional Systems of STEMI Care, Reperfusion Therapy, and Time-to-Treatment Goals

All communities should create and maintain a regional system of STEMI care that includes assessment and continuous quality improvement of EMS and hospital-based activities. Performance can be facilitated by participating in programs such as Mission: Lifeline and the D2B Alliance.

Performance of a 12-lead ECG by EMS personnel at the site of FMC is recommended in patients with symptoms consistent with STEMI.

Regional Systems of STEMI Care, Reperfusion Therapy, and Time-to-Treatment Goals

Reperfusion therapy should be administered to all eligible patients with STEMI with symptom onset within the prior 12 hours.



Primary PCI is the recommended method of reperfusion when it can be performed in a timely fashion by experienced operators.

EMS transport directly to a PCI-capable hospital for primary PCI is the recommended triage strategy for patients with STEMI with an ideal FMC-to-device time system goal of 90 minutes or less.*

*The proposed time windows are system goals. For any individual patient, every effort should be made to provide reperfusion therapy as rapidly as possible.

Regional Systems of STEMI Care, Reperfusion Therapy, and Time-to-Treatment Goals

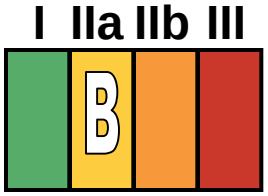
Immediate transfer to a PCI-capable hospital for primary PCI is the recommended triage strategy for patients with STEMI who initially arrive at or are transported to a non–PCI-capable hospital, with an FMC-to-device time system goal of 120 minutes or less.*

In the absence of contraindications, fibrinolytic therapy should be administered to patients with STEMI at non–PCI-capable hospitals when the anticipated FMC-to-device time at a PCI-capable hospital exceeds 120 minutes because of unavoidable delays.

*The proposed time windows are system goals. For any individual patient, every effort should be made to provide reperfusion therapy as rapidly as possible.

Regional Systems of STEMI Care, Reperfusion Therapy, and Time-to-Treatment Goals

When fibrinolytic therapy is indicated or chosen as the primary reperfusion strategy, it should be administered within 30 minutes of hospital arrival.*



Reperfusion therapy is reasonable for patients with STEMI and symptom onset within the prior 12 to 24 hours who have clinical and/or ECG evidence of ongoing ischemia. Primary PCI is the preferred strategy in this population.

*The proposed time windows are system goals. For any individual patient, every effort should be made to provide reperfusion therapy as rapidly as possible.

Onset of Myocardial Infarction

The Relationship Between Sudden Cardiac Death and STEMI

Evaluation and Management of Patients With STEMI and Out-of-Hospital Cardiac Arrest

Evaluation and Management of Patients With STEMI and Out-of-Hospital Cardiac Arrest

Therapeutic hypothermia should be started as soon as possible in comatose patients with STEMI and out-of-hospital cardiac arrest caused by VF or pulseless VT, including patients who undergo primary PCI.

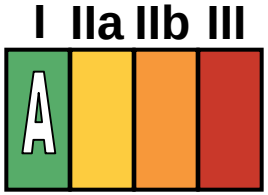
Immediate angiography and PCI when indicated should be performed in resuscitated out-of-hospital cardiac arrest patients whose initial ECG shows STEMI.

Reperfusion at a PCI-Capable Hospital

Reperfusion at a PCI-Capable Hospital

Primary PCI in STEMI

Primary PCI in STEMI

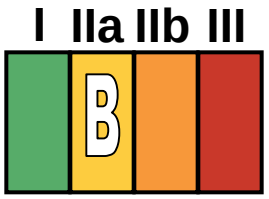


Primary PCI should be performed in patients with STEMI and ischemic symptoms of less than 12 hours' duration.

Primary PCI should be performed in patients with STEMI and ischemic symptoms of less than 12 hours' duration who have contraindications to fibrinolytic therapy, irrespective of the time delay from FMC.

Primary PCI should be performed in patients with STEMI and cardiogenic shock or acute severe HF, irrespective of time delay from MI onset.

Primary PCI in STEMI



Primary PCI is reasonable in patients with STEMI if there is clinical and/or ECG evidence of ongoing ischemia between 12 and 24 hours after symptom onset.

Harm

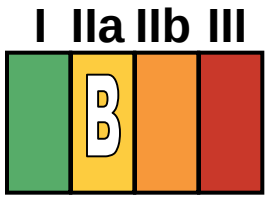
PCI should not be performed in a noninfarct artery at the time of primary PCI in patients with STEMI who are hemodynamically stable

Primary PCI in STEMI

	COR	LOE
Ischemic symptoms <12 h	I	A
Ischemic symptoms <12 h and contraindications to fibrinolytic therapy irrespective of time delay from FMC	I	B
Cardiogenic shock or acute severe HF irrespective of time delay from MI onset	I	B
Evidence of ongoing ischemia 12 to 24 h after symptom onset	IIa	B
PCI of a noninfarct artery at the time of primary PCI in patients without hemodynamic compromise	III: Harm	B

Aspiration Thrombectomy

Aspiration Thrombectomy



Manual aspiration thrombectomy is reasonable for patients undergoing primary PCI.

Use of Stents in Primary PCI

Use of Stents in Patients With STEMI

Use of Stents in Patients With STEMI

Placement of a stent (BMS or DES) is useful in primary PCI for patients with STEMI.

BMS* should be used in patients with high bleeding risk, inability to comply with 1 year of DAPT, or anticipated invasive or surgical procedures in the next year.

Harm

DES should not be used in primary PCI for patients with STEMI who are unable to tolerate or comply with a prolonged course of DAPT because of the increased risk of stent thrombosis with premature discontinuation of one or both agents.

*Balloon angioplasty without stent placement may be used in selected patients.

Adjunctive Antithrombotic Therapy for Primary PCI

Antiplatelet Therapy to Support Primary PCI for STEMI

Antiplatelet Therapy to Support Primary PCI for STEMI

Aspirin 162 to 325 mg should be given before primary PCI.

After PCI, aspirin should be continued indefinitely.

Antiplatelet Therapy to Support Primary PCI for STEMI

A loading dose of a $P2Y_{12}$ receptor inhibitor should be given as early as possible or at time of primary PCI to patients with STEMI. Options include:

- Clopidogrel 600 mg; or
- Prasugrel 60 mg; or
- Ticagrelor 180 mg

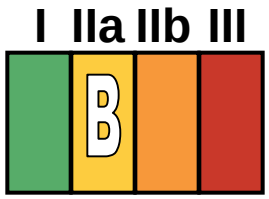
Antiplatelet Therapy to Support Primary PCI for STEMI

$P2Y_{12}$ inhibitor therapy should be given for 1 year to patients with STEMI who receive a stent (BMS or DES) during primary PCI using the following maintenance doses:

- Clopidogrel 75 mg daily; or
- Prasugrel 10 mg daily; or
- Ticagrelor 90 mg twice a day*

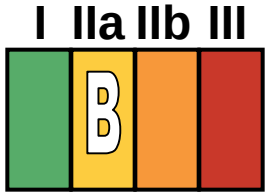
*The recommended maintenance dose of aspirin to be used with ticagrelor is 81 mg daily.

Antiplatelet Therapy to Support Primary PCI for STEMI



It is reasonable to use 81 mg of aspirin per day in preference to higher maintenance doses after primary PCI.

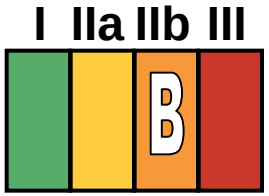
Antiplatelet Therapy to Support Primary PCI for STEMI



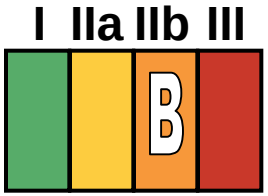
It is reasonable to start treatment with an intravenous GP IIb/IIIa receptor antagonist at the time of primary PCI (with or without stenting or clopidogrel pretreatment) in selected patients with STEMI who are receiving UFH.

- Abciximab: 0.25 mg/kg IV bolus, then 0.125 mcg/kg/min (maximum 10 mcg/min); or
- High-bolus-dose tirofiban: 25 mcg/kg IV bolus, then 0.15 mcg/kg/min; or
- Double-bolus eptifibatide: 180 mcg/kg IV bolus, then 2 mcg/kg/min; a 2nd 180-mcg/kg bolus is administered 10 min after the 1st bolus.

Antiplatelet Therapy to Support Primary PCI for STEMI



It may be reasonable to administer intravenous GP IIb/IIIa receptor antagonist in the precatheterization laboratory setting (e.g., ambulance, ED) to patients with STEMI for whom primary PCI is intended.



It may be reasonable to administer intracoronary abciximab to patients with STEMI undergoing primary PCI.

Continuation of a $P2Y_{12}$ inhibitor beyond 1 year may be considered in patients undergoing DES placement.

Antiplatelet Therapy to Support Primary PCI for STEMI

Harm

Prasugrel should not be administered to patients with a history of prior stroke or transient ischemic attack.

Anticoagulant Therapy to Support Primary PCI

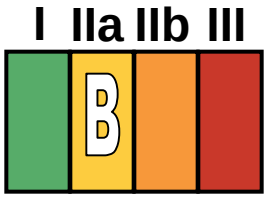
Anticoagulant Therapy to Support Primary PCI

For patients with STEMI undergoing primary PCI, the following supportive anticoagulant regimens are recommended:

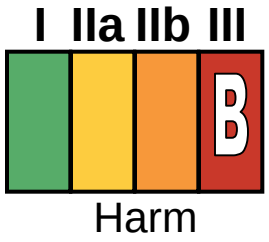
- UFH, with additional boluses administered as needed to maintain therapeutic activated clotting time levels, taking into account whether a GP IIb/IIIa receptor antagonist has been administered; or

- Bivalirudin with or without prior treatment with UFH.

Anticoagulant Therapy to Support Primary PCI



In patients with STEMI undergoing PCI who are at high risk of bleeding, it is reasonable to use bivalirudin monotherapy in preference to the combination of UFH and a GP IIb/IIIa receptor antagonist.



Fondaparinux should not be used as the sole anticoagulant to support primary PCI because of the risk of catheter thrombosis.

Adjunctive Antithrombotic Therapy to Support Reperfusion With Primary PCI

	COR	LOE
Antiplatelet therapy		
Aspirin		
• 162- to 325-mg load before procedure	I	B
• 81- to 325-mg daily maintenance dose (indefinite)*	I	A
• 81 mg daily is the preferred maintenance dose*	IIa	B
$P2Y_{12}$ inhibitors		
Loading doses		
• Clopidogrel: 600 mg as early as possible or at time of PCI	I	B
• Prasugrel: 60 mg as early as possible or at time of PCI	I	B
• Ticagrelor: 180 mg as early as possible or at time of PCI	I	B

*The recommended maintenance dose of aspirin to be used with ticagrelor is 81 mg daily.

Adjunctive Antithrombotic Therapy to Support Reperfusion With Primary PCI (cont.)

	COR	LOE
$P2Y_{12}$ inhibitors		
Maintenance doses and duration of therapy		
DES placed: Continue therapy for 1 y with:		
• Clopidogrel: 75 mg daily	I	B
• Prasugrel: 10 mg daily	I	B
• Ticagrelor: 90 mg twice a day*	I	B
BMS† placed: Continue therapy for 1 y with:		
• Clopidogrel: 75 mg daily	I	B
• Prasugrel: 10 mg daily	I	B
• Ticagrelor: 90 mg twice a day*	I	B
DES placed:		
• Clopidogrel, prasugrel, or ticagrelor* continued beyond 1 y	IIb	C
• Patients with STEMI with prior stroke or TIA: prasugrel	III: Harm	B

*The recommended maintenance dose of aspirin to be used with ticagrelor is 81 mg daily.
†Balloon angioplasty without stent placement may be used in selected patients. It might be reasonable to provide $P2Y_{12}$ inhibitor therapy to patients with STEMI undergoing balloon angioplasty alone according to the recommendations listed for BMS. (*LOE: C*).

Adjunctive Antithrombotic Therapy to Support Reperfusion With Primary PCI (cont.)

	COR	LOE
IV GP IIb/IIIa receptor antagonists in conjunction with UFH or bivalirudin in selected patients		
• Abciximab: 0.25-mg/kg IV bolus, then 0.125 mcg/kg/min (maximum 10 mcg/min)	IIa	A
• Tirofiban: (high-bolus dose): 25-mcg/kg IV bolus, then 0.15 mcg/kg/min • In patients with CrCl <30 mL/min, reduce infusion by 50%	IIa	B

• Eptifibatide: (double bolus): 180-mcg/kg IV bolus, then 2 mcg/kg/min; a second 180-mcg/kg bolus is administered 10 min after the first bolus
  • In patients with CrCl <50 mL/min, reduce infusion by 50%
  • Avoid in patients on hemodialysis
	IIa	B

• Pre–catheterization laboratory administration of IV GP IIb/IIIa receptor antagonist	IIb	B
• Intracoronary abciximab 0.25-mg/kg bolus	IIb	B

Adjunctive Antithrombotic Therapy to Support Reperfusion With Primary PCI (cont.)

	COR	LOE
Anticoagulant therapy		
• UFH:	I	C
◦ With GP IIb/IIIa receptor antagonist planned: 50- to 70-U/kg IV bolus to achieve therapeutic ACT‡		
◦ With no GP IIb/IIIa receptor antagonist planned: 70- to 100-U/kg bolus to achieve therapeutic ACT§	I	C
• Bivalirudin: 0.75-mg/kg IV bolus, then 1.75–mg/kg/h infusion with or without prior treatment with UFH. An additional bolus of 0.3 mg/kg may be given if needed.	I	B
◦ Reduce infusion to 1 mg/kg/h with estimated CrCl <30 mL/min		
◦ Preferred over UFH with GP IIb/IIIa receptor antagonist in patients at high risk of bleeding	IIa	B
• Fondaparinux: not recommended as sole anticoagulant for primary PCI	III: Harm	B

‡The recommended ACT with planned GP IIb/IIIa receptor antagonist treatment is 200 to 250 s.
§ The recommended ACT with no planned GP IIb/IIIa receptor antagonist treatment is 250 to 300 s (HemoTec device) or 300 to 350 s (Hemochron device).

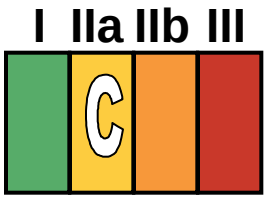
Reperfusion at a Non–PCI-Capable Hospital

Reperfusion at a Non–PCI-Capable Hospital

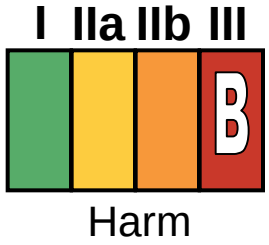
Fibrinolytic Therapy When There Is an Anticipated Delay to Performing Primary PCI Within 120 Minutes of FMC

Fibrinolytic Therapy When There Is an Anticipated Delay to Performing Primary PCI Within 120 Minutes of FMC

In the absence of contraindications, fibrinolytic therapy should be given to patients with STEMI and onset of ischemic symptoms within the previous 12 hours when it is anticipated that primary PCI cannot be performed within 120 minutes of FMC.



In the absence of contraindications and when PCI is not available, fibrinolytic therapy is reasonable for patients with STEMI if there is clinical and/or ECG evidence of ongoing ischemia within 12 to 24 hours of symptom onset and a large area of myocardium at risk or hemodynamic instability.



Fibrinolytic therapy should not be administered to patients with ST depression except when a true posterior (inferobasal) MI is suspected or when associated with ST elevation in lead aVR.

Indications for Fibrinolytic Therapy When There Is a >120-Minute Delay From FMC to Primary PCI

	COR	LOE
Ischemic symptoms <12 h	I	A
Evidence of ongoing ischemia 12 to 24 h after symptom onset and a large area of myocardium at risk or hemodynamic instability	IIa	C
ST depression, except if true posterior (inferobasal) MI is suspected or when associated with ST elevation in lead aVR	III: Harm	B

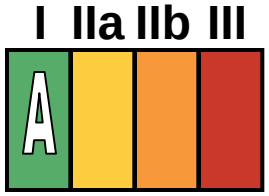
Reperfusion at a Non–PCI-Capable Hospital

Adjunctive Antithrombotic Therapy With Fibrinolysis

Adjunctive Antiplatelet Therapy With Fibrinolysis

Aspirin (162- to 325-mg loading dose) and clopidogrel (300-mg loading dose for patients ≤75 years of age, 75-mg dose for patients >75 years of age) should be administered to patients with STEMI who receive fibrinolytic therapy.

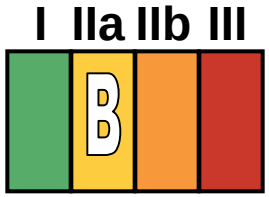
Adjunctive Antiplatelet Therapy With Fibrinolysis



In patients with STEMI who receive fibrinolytic therapy:

- aspirin should be continued indefinitely and
- clopidogrel (75 mg daily) for at least 14 days
  - and up to 1 year

Adjunctive Antiplatelet Therapy With Fibrinolysis



It is reasonable to use aspirin 81 mg per day in preference to higher maintenance doses after fibrinolytic therapy.

Reperfusion at a Non–PCI-Capable Hospital

Adjunctive Anticoagulant Therapy With Fibrinolysis

Adjunctive Anticoagulant Therapy With Fibrinolysis

Patients with STEMI undergoing reperfusion with fibrinolytic therapy should receive anticoagulant therapy for a minimum of 48 hours, and preferably for the duration of the index hospitalization, up to 8 days or until revascularization if performed. Recommended regimens include:

a. UFH administered as a weight-adjusted intravenous bolus and infusion to obtain an activated partial thromboplastin time of 1.5 to 2.0 times control, for 48 hours or until revascularization;

b. Enoxaparin administered according to age, weight, and creatinine clearance, given as an intravenous bolus, followed in 15 minutes by subcutaneous injection for the duration of the index hospitalization, up to 8 days or until revascularization; or

c. Fondaparinux administered with initial intravenous dose, followed in 24 hours by daily subcutaneous injections if the estimated creatinine clearance is greater than 30 mL/min, for the duration of the index hospitalization, up to 8 days or until revascularization.

Adjunctive Antithrombotic Therapy to Support Reperfusion With Fibrinolytic Therapy

	COR	LOE
Antiplatelet therapy		
Aspirin		
• 162- to 325-mg loading dose	I	A
• 81- to 325-mg daily maintenance dose (indefinite)	I	A
• 81 mg daily is the preferred maintenance dose	IIa	B
$P2Y_{12}$ receptor inhibitors		
• Clopidogrel:	I	A
◦ Age ≤75 y: 300-mg loading dose		
▪ Followed by 75 mg daily for at least 14 d and up to 1 y in absence of bleeding	I	A (14 d)
		C (up to 1 y)
◦ Age >75 y: no loading dose, give 75 mg	I	A
▪ Followed by 75 mg daily for at least 14 d and up to 1 y in absence of bleeding	I	A (14 d)
		C (up to 1 y)

Adjunctive Antithrombotic Therapy to Support Reperfusion With Fibrinolytic Therapy (cont.)

	COR	LOE
Anticoagulant therapy		
• UFH:	I	C
◦ Weight-based IV bolus and infusion adjusted to obtain aPTT of 1.5 to 2.0 times control for 48 h or until revascularization. IV bolus of 60 U/kg (maximum 4000 U) followed by an infusion of 12 U/kg/h (maximum 1000 U) initially, adjusted to maintain aPTT at 1.5 to 2.0 times control (approximately 50 to 70 s) for 48 h or until revascularization		
• Enoxaparin:	I	A
◦ If age <75 y: 30-mg IV bolus, followed in 15 min by 1 mg/kg subcutaneously every 12 h (maximum 100 mg for the first 2 doses)		
◦ If age ≥75 y: no bolus, 0.75 mg/kg subcutaneously every 12 h (maximum 75 mg for the first 2 doses)		
◦ Regardless of age, if CrCl <30 mL/min: 1 mg/kg subcutaneously every 24 h		
◦ Duration: For the index hospitalization, up to 8 d or until revascularization		
• Fondaparinux:	I	B
◦ Initial dose 2.5 mg IV, then 2.5 mg subcutaneously daily starting the following day, for the index hospitalization up to 8 d or until revascularization		
◦ Contraindicated if CrCl <30 mL/min		

Reperfusion at a Non–PCI-Capable Hospital

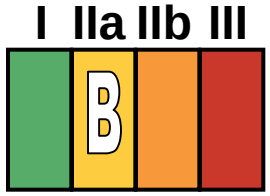
Transfer to a PCI-Capable Hospital After Fibrinolytic Therapy

Reperfusion at a Non–PCI-Capable Hospital

Transfer of Patients With STEMI to a PCI-Capable Hospital for Coronary Angiography After Fibrinolytic Therapy

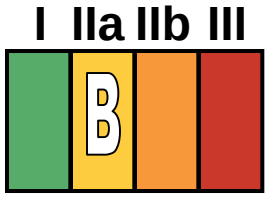
Transfer of Patients With STEMI to a PCI-Capable Hospital for Coronary Angiography After Fibrinolytic Therapy

Immediate transfer to a PCI-capable hospital for coronary angiography is recommended for suitable patients with STEMI who develop cardiogenic shock or acute severe HF, irrespective of the time delay from MI onset.



Urgent transfer to a PCI-capable hospital for coronary angiography is reasonable for patients with STEMI who demonstrate evidence of failed reperfusion or reocclusion after fibrinolytic therapy.

Transfer of Patients With STEMI to a PCI-Capable Hospital for Coronary Angiography After Fibrinolytic Therapy



Transfer to a PCI-capable hospital for coronary angiography is reasonable for patients with STEMI who have received fibrinolytic therapy even when hemodynamically stable* and with clinical evidence of successful reperfusion. Angiography can be performed as soon as logistically feasible at the receiving hospital, and ideally within 24 hours, but should not be performed within the first 2 to 3 hours after administration of fibrinolytic therapy.

*Although individual circumstances will vary, clinical stability is defined by the absence of low output, hypotension, persistent tachycardia, apparent shock, high-grade ventricular or symptomatic supraventricular tachyarrhythmias, and spontaneous recurrent ischemia.

Indications for Transfer for Angiography After Fibrinolytic Therapy

	COR	LOE
Immediate transfer for cardiogenic shock or severe acute HF irrespective of time delay from MI onset	I	B
Urgent transfer for failed reperfusion or reocclusion	IIa	B
As part of an invasive strategy in stable* patients with PCI between 3 and 24 h after successful fibrinolysis	IIa	B

*Although individual circumstances will vary, clinical stability is defined by the absence of low output, hypotension, persistent tachycardia, apparent shock, high-grade ventricular or symptomatic supraventricular tachyarrhythmias, and spontaneous recurrent ischemia.

Delayed Invasive Management

Delayed Invasive Management

Coronary Angiography in Patients Who Initially Were Managed With Fibrinolytic Therapy or Who Did Not Receive Reperfusion

Coronary Angiography in Patients Who Initially Were Managed With Fibrinolytic Therapy or Who Did Not Receive Reperfusion

Cardiac catheterization and coronary angiography with intent to perform revascularization should be performed after STEMI in patients with any of the following:

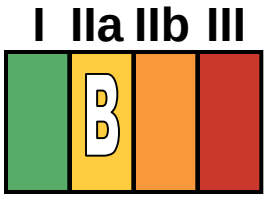
a. Cardiogenic shock or acute severe HF that develops after initial presentation;

b. Intermediate- or high-risk findings on predischarge noninvasive ischemia testing; or

c. Myocardial ischemia that is spontaneous or provoked by minimal exertion during hospitalization.

Coronary Angiography in Patients Who Initially Were Managed With Fibrinolytic Therapy or Who Did Not Receive Reperfusion

Coronary angiography with intent to perform revascularization is reasonable for patients with evidence of failed reperfusion or reocclusion after fibrinolytic therapy. Angiography can be performed as soon as logistically feasible.



Coronary angiography is reasonable before hospital discharge in stable* patients with STEMI after successful fibrinolytic therapy. Angiography can be performed as soon as logistically feasible, and ideally within 24 hours, but should not be performed within the first 2 to 3 hours after administration of fibrinolytic therapy.

*Although individual circumstances will vary, clinical stability is defined by the absence of low output, hypotension, persistent tachycardia, apparent shock, high-grade ventricular or symptomatic supraventricular tachyarrhythmias, and spontaneous recurrent ischemia.

Indications for Coronary Angiography in Patients Who Were Managed With Fibrinolytic Therapy or Who Did Not Receive Reperfusion Therapy

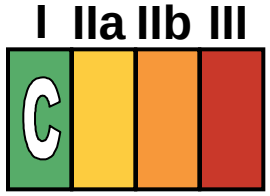
	COR	LOE
Cardiogenic shock or acute severe HF that develops after initial presentation	I	B
Intermediate- or high-risk findings on predischarge noninvasive ischemia testing	I	B
Spontaneous or easily provoked myocardial ischemia	I	C
Failed reperfusion or reocclusion after fibrinolytic therapy	IIa	B
Stable* patients after successful fibrinolysis, before discharge and ideally between 3 and 24 h	IIa	B

*Although individual circumstances will vary, clinical stability is defined by the absence of low output, hypotension, persistent tachycardia, apparent shock, high-grade ventricular or symptomatic supraventricular tachyarrhythmias, and spontaneous recurrent ischemia.

Delayed Invasive Management

PCI of an Infarct Artery in Patients Who Initially Were Managed With Fibrinolysis or Who Did Not Receive Reperfusion Therapy

PCI of an Infarct Artery in Patients Who Initially Were Managed With Fibrinolysis or Who Did Not Receive Reperfusion Therapy



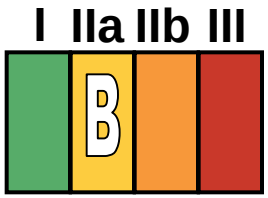
PCI of an anatomically significant stenosis in the infarct artery should be performed in patients with suitable anatomy and any of the following:

a. Cardiogenic shock or acute severe HF;

b. Intermediate- or high-risk findings on predischarge noninvasive ischemia testing; or

c. Myocardial ischemia that is spontaneous or provoked by minimal exertion during hospitalization.

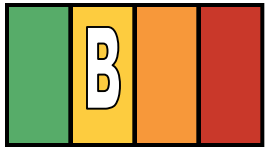
PCI of an Infarct Artery in Patients Who Initially Were Managed With Fibrinolysis or Who Did Not Receive Reperfusion Therapy



Delayed PCI is reasonable in patients with STEMI and evidence of failed reperfusion or reocclusion after fibrinolytic therapy. PCI can be performed as soon as logistically feasible at the receiving hospital.

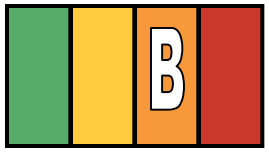
PCI of an Infarct Artery in Patients Who Initially Were Managed With Fibrinolysis or Who Did Not Receive Reperfusion Therapy

I IIa IIb III



Delayed PCI of a significant stenosis in a patent infarct artery is reasonable in stable* patients with STEMI after fibrinolytic therapy. PCI can be performed as soon as logistically feasible at the receiving hospital, and ideally within 24 hours, but should not be performed within the first 2 to 3 hours after administration of fibrinolytic therapy.

I IIa IIb III



Delayed PCI of a significant stenosis in a patent infarct artery greater than 24 hours after STEMI may be considered as part of an invasive strategy in stable* patients

*Although individual circumstances will vary, clinical stability is defined by the absence of low output, hypotension, persistent tachycardia, apparent shock, high-grade ventricular or symptomatic supraventricular tachyarrhythmias, and spontaneous recurrent ischemia.

PCI of an Infarct Artery in Patients Who Initially Were Managed With Fibrinolysis or Who Did Not Receive Reperfusion Therapy

Delayed PCI of a totally occluded infarct artery greater than 24 hours after STEMI should not be performed in asymptomatic patients with 1- or 2-vessel disease if they are hemodynamically and electrically stable and do not have evidence of severe ischemia.

Indications for PCI of an Infarct Artery in Patients Who Were Managed With Fibrinolytic Therapy or Who Did Not Receive Reperfusion Therapy

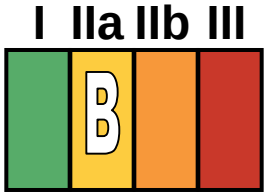
	COR	LOE
Cardiogenic shock or acute severe HF	I	B
Intermediate- or high-risk findings on predischarge noninvasive ischemia testing	I	C
Spontaneous or easily provoked myocardial ischemia	I	C
Patients with evidence of failed reperfusion or reocclusion after fibrinolytic therapy (as soon as possible)	IIa	B
Stable* patients after successful fibrinolysis, ideally between 3 and 24 h	IIa	B
Stable* patients >24 h after successful fibrinolysis	IIb	B
Delayed PCI of a totally occluded infarct artery >24 h after STEMI in stable patients	III: No Benefit	B

*Although individual circumstances will vary, clinical stability is defined by the absence of low output, hypotension, persistent tachycardia, apparent shock, high-grade ventricular or symptomatic supraventricular tachyarrhythmias, and spontaneous recurrent ischemia.

PCI of a Noninfarct Artery Before Hospital Discharge

PCI of a Noninfarct Artery Before Hospital Discharge

PCI is indicated in a noninfarct artery at a time separate from primary PCI in patients who have spontaneous symptoms of myocardial ischemia.



PCI is reasonable in a noninfarct artery at a time separate from primary PCI in patients with intermediate- or high-risk findings on noninvasive testing.

Adjunctive Antithrombotic Therapy to Support Delayed PCI After Fibrinolytic Therapy

Antiplatelet Therapy to Support PCI After Fibrinolytic Therapy

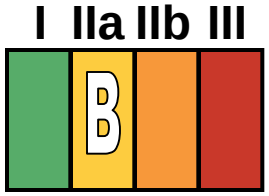
Antiplatelet Therapy to Support PCI After Fibrinolytic Therapy

After PCI, aspirin should be continued indefinitely.

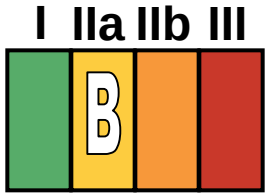
Clopidogrel should be provided as follows:

a. A 300-mg loading dose should be given before or at the time of PCI to patients who did not receive a previous loading dose and who are undergoing PCI within 24 hours of receiving fibrinolytic therapy;
b. A 600-mg loading dose should be given before or at the time of PCI to patients who did not receive a previous loading dose and who are undergoing PCI more than 24 hours after receiving fibrinolytic therapy; and
c. A dose of 75 mg daily should be given after PCI.

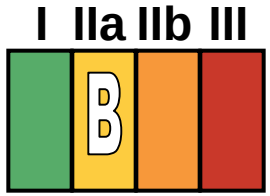
Antiplatelet Therapy to Support PCI After Fibrinolytic Therapy



After PCI, it is reasonable to use 81 mg of aspirin per day in preference to higher maintenance doses.



Prasugrel, in a 60-mg loading dose, is reasonable once the coronary anatomy is known in patients who did not receive a previous loading dose of clopidogrel at the time of administration of a fibrinolytic agent, but prasugrel should not be given sooner than 24 hours after administration of a fibrin-specific agent or 48 hours after administration of a non–fibrin-specific agent.



Prasugrel, in a 10-mg daily maintenance dose, is reasonable after PCI.

Antiplatelet Therapy to Support PCI After Fibrinolytic Therapy

Harm

Prasugrel should not be administered to patients with a history of prior stroke or transient ischemic attack.

Anticoagulant Therapy to Support PCI After Fibrinolytic Therapy

Anticoagulant Therapy to Support PCI After Fibrinolytic Therapy

For patients with STEMI undergoing PCI after receiving fibrinolytic therapy with intravenous UFH, additional boluses of intravenous UFH should be administered as needed to support the procedure, taking into account whether GP IIb/IIIa receptor antagonists have been administered.

For patients with STEMI undergoing PCI after receiving fibrinolytic therapy with enoxaparin, if the last subcutaneous dose was administered within the prior 8 hours, no additional enoxaparin should be given; if the last subcutaneous dose was administered between 8 and 12 hours earlier, enoxaparin 0.3 mg/kg IV should be given.

Anticoagulant Therapy to Support PCI After Fibrinolytic Therapy

Fondaparinux should not be used as the sole anticoagulant to support PCI. An additional anticoagulant with anti-IIa activity should be administered because of the risk of catheter thrombosis.

Adjunctive Antithrombotic Therapy to Support PCI After Fibrinolytic Therapy

	COR	LOE
Antiplatelet therapy		
Aspirin		
• 162- to 325-mg loading dose given with fibrinolytic agent (before PCI). (Section 5.1.4.1 and Table 7)	I	A
• 81- to 325-mg daily maintenance dose after PCI (indefinite)	I	A
• 81 mg daily is the preferred daily maintenance dose	IIa	B
$P2Y_{12}$ receptor inhibitors		
Loading doses		
For patients who received a loading dose of clopidogrel with fibrinolytic therapy:		
• Continue clopidogrel 75 mg daily without an additional loading dose	I	C
For patients who have not received a loading dose of clopidogrel:		
• If PCI is performed ≤24 h after fibrinolytic therapy: clopidogrel 300-mg loading dose before or at the time of PCI	I	C
• If PCI is performed >24 h after fibrinolytic therapy: clopidogrel 600-mg loading dose before or at the time of PCI	I	C
• If PCI is performed >24 h after treatment with a fibrin-specific agent or >48 h after a non–fibrin-specific agent: prasugrel 60 mg at the time of PCI	IIa	B
For patients with prior stroke/TIA: prasugrel	III: Harm	B

Adjunctive Antithrombotic Therapy to Support PCI After Fibrinolytic Therapy (cont.)

	COR	LOE
$P2Y_{12}$ receptor inhibitors		
Maintenance doses and duration of therapy		
DES placed: Continue therapy for at least 1 y with:		
• Clopidogrel: 75 mg daily	I	C
• Prasugrel: 10 mg daily	IIa	B
BMS placed: Continue therapy for at least 30 d and up to 1 y with:*		
• Clopidogrel: 75 mg daily	I	C
• Prasugrel: 10 mg daily	IIa	B

*Balloon angioplasty without stent placement may be used in selected patients. It might be reasonable to provide $P2Y_{12}$ inhibitor therapy to patients with STEMI undergoing balloon angioplasty after fibrinolysis alone according to the recommendations listed for BMS. (*Level of Evidence: C*)

Adjunctive Antithrombotic Therapy to Support PCI After Fibrinolytic Therapy (cont.)

	COR	LOE
Anticoagulant therapy		
• Continue UFH through PCI, administering additional IV boluses as needed to maintain therapeutic ACT depending on use of GP IIb/IIIa receptor antagonist†	I	C

• Continue enoxaparin through PCI:
  • No additional drug if last dose was within previous 8 h
  • 0.3-mg/kg IV bolus if last dose was 8 to 12 h earlier
	I	B

• Fondaparinux: • As sole anticoagulant for PCI	III: Harm	C

†The recommended ACT with no planned GP IIb/IIIa receptor antagonist treatment is 250–300 s (HemoTec device) or 300–350 s (Hemochron device).

CABG in Patients With STEMI

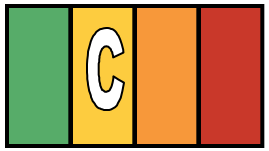
CABG in Patients With STEMI

Urgent CABG is indicated in patients with STEMI and coronary anatomy not amenable to PCI who have ongoing or recurrent ischemia, cardiogenic shock, severe HF, or other high-risk features.

CABG is recommended in patients with STEMI at time of operative repair of mechanical defects.

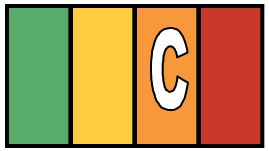
CABG in Patients With STEMI

I IIa IIb III



The use of mechanical circulatory support is reasonable in patients with STEMI who are hemodynamically unstable and require urgent CABG.

I IIa IIb III



Emergency CABG within 6 hours of symptom onset may be considered in patients with STEMI who do not have cardiogenic shock and are not candidates for PCI or fibrinolytic therapy.

Timing of Urgent CABG in Patients With STEMI in Relation to Use of Antiplatelet Agents

Timing of Urgent CABG in Patients With STEMI in Relation to Use of Antiplatelet Agents

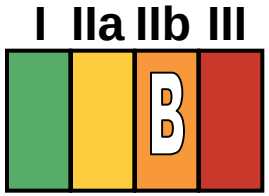
Aspirin should not be withheld before urgent CABG.

Clopidogrel or ticagrelor should be discontinued at least 24 hours before urgent on-pump CABG, if possible.

Short-acting intravenous GP IIb/IIIa receptor antagonists (eptifibatide, tirofiban) should be discontinued at least 2 to 4 hours before urgent CABG.

Timing of Urgent CABG in Patients With STEMI in Relation to Use of Antiplatelet Agents

Abciximab should be discontinued at least 12 hours before urgent CABG.



Urgent off-pump CABG within 24 hours of clopidogrel or ticagrelor administration might be considered, especially if the benefits of prompt revascularization outweigh the risks of bleeding.

Urgent CABG within 5 days of clopidogrel or ticagrelor administration or within 7 days of prasugrel administration might be considered, especially if the benefits of prompt revascularization outweigh the risks of bleeding.

Routine Medical Therapies

Routine Medical Therapies

Beta Blockers

Beta Blockers

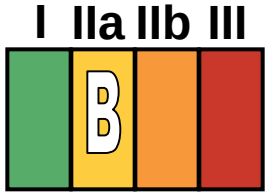
Oral beta blockers should be initiated in the first 24 hours in patients with STEMI who do not have any of the following: signs of HF, evidence of a low output state, increased risk for cardiogenic shock,* or other contraindications to use of oral beta blockers (PR interval >0.24 seconds, second- or third-degree heart block, active asthma, or reactive airways disease).

Beta blockers should be continued during and after hospitalization for all patients with STEMI and with no contraindications to their use.

*Risk factors for cardiogenic shock (the greater the number of risk factors present, the higher the risk of developing cardiogenic shock) are age >70 years, systolic BP <120 mm Hg, sinus tachycardia >110 bpm or heart rate <60 bpm, and increased time since onset of symptoms of STEMI.

Beta Blockers

Patients with initial contraindications to the use of beta blockers in the first 24 hours after STEMI should be reevaluated to determine their subsequent eligibility.

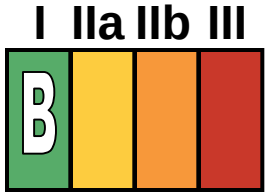


It is reasonable to administer intravenous beta blockers at the time of presentation to patients with STEMI and no contraindications to their use who are hypertensive or have ongoing ischemia.

Renin-Angiotensin-Aldosterone System Inhibitors

Renin-Angiotensin-Aldosterone System Inhibitors

An ACE inhibitor should be administered within the first 24 hours to all patients with STEMI with anterior location, HF, or EF less than or equal to 0.40, unless contraindicated.



An ARB should be given to patients with STEMI who have indications for but are intolerant of ACE inhibitors.

Renin-Angiotensin-Aldosterone System Inhibitors

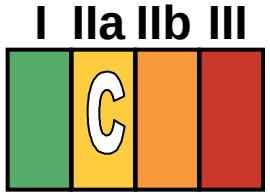
An aldosterone antagonist should be given to patients with STEMI and no contraindications who are already receiving an ACE inhibitor and beta blocker and who have an EF less than or equal to 0.40 and either symptomatic HF or diabetes mellitus.

ACE inhibitors are reasonable for all patients with STEMI and no contraindications to their use.

Lipid Management

Lipid Management

High-intensity statin therapy should be initiated or continued in all patients with STEMI and no contraindications to its use.



It is reasonable to obtain a fasting lipid profile in patients with STEMI, preferably within 24 hours of presentation.

Complications After STEMI

Complications After STEMI

Cardiogenic Shock

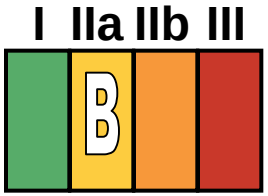
Treatment of Cardiogenic Shock

Treatment of Cardiogenic Shock

Emergency revascularization with either PCI or CABG is recommended in suitable patients with cardiogenic shock due to pump failure after STEMI irrespective of the time delay from MI onset.

In the absence of contraindications, fibrinolytic therapy should be administered to patients with STEMI and cardiogenic shock who are unsuitable candidates for either PCI or CABG.

Treatment of Cardiogenic Shock



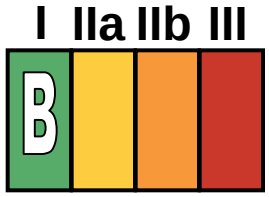
The use of intra-aortic balloon pump counterpulsation can be useful for patients with cardiogenic shock after STEMI who do not quickly stabilize with pharmacological.

Alternative LV assist devices for circulatory support may be considered in patients with refractory cardiogenic shock.

Electrical Complications During the Hospital Phase of STEMI

Implantable Cardioverter-Defibrillator Therapy Before Discharge

Implantable Cardioverter-Defibrillator Therapy Before Discharge



ICD therapy is indicated before discharge in patients who develop sustained VT/VF more than 48 hours after STEMI, provided the arrhythmia is not due to transient or reversible ischemia, reinfarction, or metabolic abnormalities.

Bradycardia, AV Block, and Intraventricular Conduction Defects

Complications After STEMI

Pacing in STEMI

Pacing in STEMI

Temporary pacing is indicated for symptomatic bradyarrhythmias unresponsive to medical treatment.

Complications After STEMI

Pericarditis

Management of Pericarditis After STEMI

Management of Pericarditis After STEMI

Aspirin is recommended for treatment of pericarditis after STEMI.

Administration of acetaminophen, colchicine, or narcotic analgesics may be reasonable if aspirin, even in higher doses, is not effective.

Harm

Glucocorticoids and nonsteroidal antiinflammatory drugs are potentially harmful for treatment of pericarditis after STEMI.

Thromboembolic and Bleeding Complications

Complications After STEMI

Anticoagulation

Anticoagulation

The following recommendations apply to patients who receive intracoronary stents during PCI for STEMI. Among individuals with STEMI who do not receive an intracoronary stent, the duration of DAPT beyond 14 days has not been studied adequately for patients who undergo balloon angioplasty alone, are treated with fibrinolysis alone, or do not receive reperfusion therapy. In this subset of patients with STEMI who do not receive an intracoronary stent, the threshold for initiation of oral anticoagulation for secondary prevention, either alone or in combination with aspirin, may be lower, especially if a shorter duration (i.e.,14 days) of DAPT is planned.

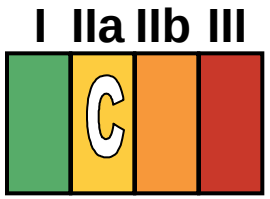
Anticoagulation

Anticoagulant therapy with a vitamin K antagonist should be provided to patients with STEMI and atrial fibrillation with CHADS2* score greater than or equal to 2, mechanical heart valves, venous thromboembolism, or hypercoagulable disorder.

The duration of triple-antithrombotic therapy with a vitamin K antagonist, aspirin, and a $P2Y_{12}$ receptor inhibitor should be minimized to the extent possible to limit the risk of bleeding.†

*CHADS2 (Congestive heart failure, Hypertension, Age ≥75 years, Diabetes mellitus, previous Stroke/transient ischemic attack (doubled risk weight)) score.
†Individual circumstances will vary and depend on the indications for triple therapy and the type of stent placed during PCI. After this initial treatment period, consider therapy with a vitamin K antagonist plus a single antiplatelet agent. For patients treated with fibrinolysis, consider triple therapy for 14 days, followed by a vitamin K antagonist plus a single antiplatelet agent.

Anticoagulation



Anticoagulant therapy with a vitamin K antagonist is reasonable for patients with STEMI and asymptomatic LV mural thrombi.

Anticoagulant therapy may be considered for patients with STEMI and anterior-apical akinesis or dyskinesis.

Targeting vitamin K antagonist therapy to a lower international normalized ratio (e.g., 2.0 to 2.5) might be considered in patients with STEMI who are receiving DAPT.

Risk Assessment After STEMI

Use of Noninvasive Testing for Ischemia Before Discharge

Use of Noninvasive Testing for Ischemia Before Discharge

Noninvasive testing for ischemia should be performed before discharge to assess the presence and extent of inducible ischemia in patients with STEMI who have not had coronary angiography and do not have high-risk clinical features for which coronary angiography would be warranted.

Noninvasive testing for ischemia might be considered before discharge to evaluate the functional significance of a noninfarct artery stenosis previously identified at angiography.

Noninvasive testing for ischemia might be considered before discharge to guide the postdischarge exercise prescription.

Assessment of LV Function

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LVEF should be measured in all patients with STEMI.

Assessment of Risk for SCD

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Patients with an initially reduced LVEF who are possible candidates for ICD therapy should undergo reevaluation of LVEF 40 or more days after discharge.

Posthospitalization Plan of Care

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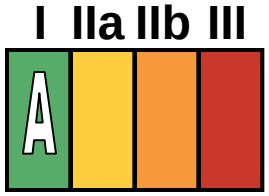
Posthospital systems of care designed to prevent hospital readmissions should be used to facilitate the transition to effective, coordinated outpatient care for all patients with STEMI.

Exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI.

Posthospitalization Plan of Care

A clear, detailed, and evidence-based plan of care that promotes medication adherence, timely follow-up with the healthcare team, appropriate dietary and physical activities, and compliance with interventions for secondary prevention should be provided to patients with STEMI.



Encouragement and advice to stop smoking and to avoid secondhand smoke should be provided to patients with STEMI.