

Management of acute ST segment elevation MI (STEMI) (update April 2007).

Your attention is drawn to the recent recommendations regarding management of acute ST segment elevation MI and related matters which have been accepted on behalf of the JRCALC Guidelines Group. The manner in which these recommendations are implemented will of course be subject to local schedules and priorities.

- The Cardiac Care Group agrees with the international guidance that where appropriate facilities and expertise are readily available primary PCI should be the first choice of treatment of STEMI, but in the absence of such facilities then thrombolysis should continue to be the intervention of choice.
- Regarding the model JRCALC checklist for pre-hospital thrombolysis the following changes are now recommended:
 1. an upper age limit of **80 years** (unless on advice from a senior clinician on an individual patient basis) (Q2)
 2. extension of the time window to **12 hours** (Q4).
 3. deletion of Q10. **LBBB** no longer to be a contraindication where the clinical picture strongly supports acute MI and preferably after consultation with a senior clinician (eg telemetry/telephone discussion).
 4. removal of **tooth extraction** as a contraindication (Q16)
- The importance of recording the estimated patient weight when administering unfractionated heparin is again emphasised, especially for patients receiving tenecteplase .
- The evidence of benefit for low molecular weight heparin versus risk of bleeding has been reconsidered. Unfractionated heparin should remain the recommended adjunctive therapy for the time being although discussions with the MHRA are ongoing. The use of Clopidogrel has also been discussed and will also be taken up with the MHRA in the future.
- You are reminded that unfractionated heparin as an adjunct in thrombolysis does NOT currently have a POMs exemption and therefore should only be used under a PGD.
- The Group reiterates previous advice on the provision of ICD magnets on emergency vehicles.

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