OPTIMUM
PHYSICIAN
ALLIANCE

Chest Pain Work Up for the Emergency Department/Urgent Care Settings

Developed by Participating OPA Cardiologists in OPA's Chest Pain Management Variation Analysis Group

CRITERIA: Any patient admitted to the Emergency Department or Urgent Care Center with a complaint of chest pain that the physician deems appropriate for an ACS workup.

ASSESSMENT: NOTE: Obtain EKG and Troponin level on all patients at the time of the assessment

THE HEART SCORE

developed by the European Society of Cardiology

HISTORY	* **Highly suspicious** - substernal or exertional chest pain - *Constricting chest discomfort, pain, pressure, or tightness originating in and/or radiating to the sternum, neck, shoulders, jaw or arms which may be precipitated by physical exertion*	2 points
	* **Moderately suspicious** – *intermittent chest, jaw or arm discomfort which may or may not be related to activity in a patient with known CAD or with multiple risk factors for which no other etiology may be found*	1 point
	* **Slightly or Non-Suspicious** – *chest pain worse with palpation or movement of the torso or arms, worse when lying supine or relieved with antacids*	0 points
EKG	* Significant ST Depression * Nonspecific Repolarization * Normal	2 points 1 point 0 points
AGE	* ≥ 65 years * 46-64 years * ≤45 years	2 points 1 point 0 points
****RISK FACTORS**	* ≥ 3 Risk Factors or History of CAD * 1 or 2 Risk Factors * No Risk Factors	2 points 1 point 0 points
TROPONIN	* ≥ 3x Normal Limit * >1 - <3x Normal Limit * Normal Limit	2 points 1 point 0 points

****RISK FACTORS: DM , smoker current or recent (<1 month) , HTN, Hypercholesterolemia, family history of CAD, obesity, history of significant atherosclerosis (MI, stroke, PVD)**

INTERPRETATION - Risk of Major Adverse Cardiac Event (MACE)

RISK LEVEL	HEART SCORE	MACE RATE
LOW RISK	0-3	1.7%
INTERMEDIATE	4-6	16.6%
RISK HIGH RISK	7-10	50.1%

APPLICATION: Relied upon the OPA Cardiologists to create this application table using current dated research and most relevant relied upon sources

LOW RISK	* Discharge to Home * Follow up with PCP or cardiologist in 24-48 hrs. * Consider cardiology referral
If score ≤ 4 <u>AND</u> Provider is concerned of possible cardiac etiology – CALL PCP or cardiologist on-call for formulation of care plan.	
INTERMEDIATE RISK	* Admit to Observation * Repeat Troponin levels * Stress Testing – be mindful of radiation exposure * Exercise Stress Test is first-line for most men and women if normal baseline EKG * Stress Imaging (Nuclear or ECHO) test if abnormal baseline EKG (ST segment abnormality, LBBB, paced rhythm, or atrial fib), prior revascularization, taking Digoxin, or h/o Diabetes Mellitus. If readily available consider CT angiography * Pharmacologic Stress Test if unable to exercise. If readily available consider CT angiography * Consider phone consult with a Cardiologist to help determine which of the above would be the most appropriate stress test for your patient
HIGH RISK	* In-Patient Admission * Call Cardiology to arrange consult ASAP; consider coronary angiogram

Reference: *A prospective validation of the HEART score for chest pain patients at the emergency department, International Journal of Cardiology •Volume 168, Issue 3, October 2013*
S.A. Mahler et al. / International Journal of Cardiology 168 (2013) Identifying patients for early discharge: Performance of decision rules among patients with acute chest pain.

NOTICE: This document is for general informational purposes only and is not intended and shall not be used as a substitute for professional medical advice, diagnosis, treatment and/or independent medical judgment. Optimum Physician Alliance, LLC is not responsible for any reliance on any information in this document and/or any errors or omissions, results and/or consequences arising from or related to any adoption and/or use of such information.

v1: 1-25-2016