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Quick Takes Intervention Early routine invasive strategy is recommended for non-ST-segment elevation myocardial infarction (NSTEMI) determined by high-sensitivity cardiac troponin (hs-cTn) measurements, a GRACE risk score >140, and dynamic new ST-segment changes. Radial access is preferred. Coronary computed tomography angiography (CCTA) is equivalent to coronary angiography for low- to modest-risk patients with suspected acute coronary syndrome to confirm the diagnosis and assess prognosis. Management Pretreatment with a P2Y12 receptor inhibiter for patients with non-ST-segment elevation acute coronary syndrome (NSTE-ACS) undergoing an early invasive management strategy is no longer recommended. Dual antiplatelet therapy (DAPT) should be individualized based on bleeding versus ischemic risk. In patients requiring long-term anticoagulation, novel oral anticoagulants (NOACs) are preferred with triple agents for 1 week and then dual treatment with clopidogrel plus a NOAC for up to 1 year. Discussion The recently updated European Society of Cardiology (ESC) NSTE-ACS guidelines were presented at ESC Congress 2020.1 This was an update of the 2017 guidelines and, previously, the 2015 guidelines. In contrast, the last American College of Cardiology (ACC) and American Heart Association (AHA) guidelines for ST-segment elevation myocardial infarction were published in 2013,2 and the guidelines for NSTE-ACS were published in 2014.3 There have, however, been partial updates addressing specific subgroups of patients such as use of DAPT patients undergoing percutaneous coronary intervention (PCI) in the 2015 PCI guidelines4 and use of dual and triple antithrombotic treatment after PCI in patients with atrial fibrillation in the updated 2019 atrial fibrillation guidelines.5 Discussion of the notable differences between recommendations in the European and American guidelines follows. Invasive Strategies Early Invasive Strategy An early routine invasive strategy within 24 hours is recommended for NSTEMI determined by hs-cTn measurements, a GRACE risk score >140, and dynamic new ST-segment changes. This strategy is shown to reduce complications and potentially improve outcomes. Urgent invasive treatment is indicated only for significant ischemic and/or hemodynamic instability. A radial access strategy is recommended to minimize vascular complications and bleeding and is associated with better outcomes. Low- to moderate-risk patients still require definitive diagnosis of coronary artery disease as well as identifying not infrequent, unique ischemic syndromes such as myocardial infarction with nonobstructive coronary arteries, spontaneous coronary artery dissection, myocarditis, and takotsubo syndrome. Coronary Computed Tomography Angiography CCTA is now recognized as an equally effective diagnostic modality to coronary angiography in low- to moderate-risk patients. CCTA can exclude coronary artery disease and provide equivalent prognostic information in the setting of coronary artery disease compared to coronary angiography. This upgrade for CCTA is a major change in the ESC guidelines that was not included in the older US guidelines. Management Strategies Troponin Assessment European guidelines recommend using hs-cTn for assessment of acute myocardial infarction with accelerated protocols using a 0- and 1-hour protocol or a 0- and 2-hour protocol. Because hs-cTn were just being developed when the US guidelines were written, those guidelines are based on the use of contemporary troponin assays and recommend troponin sampling at presentation and 3-6 hours after symptom onset. Those guidelines briefly addressed hs-cTn with the recognition that use of hs-cTn would increase the proportion of patients identified with NSTEMI. Use of hs-cTn assays in the United States is increasing, with 1 hsTnT assay approved in 2017 and 3 hsTnI assays approved in 2019. Choice of P2Y12 Inhibitor For patients with NSTE-ACS undergoing PCI, prasugrel was recommended (60 mg loading dose, 10 mg daily or 5 mg daily for patients ≥75 years or