I'm not a bot

خوارزمية إرشادات stemi 2017 pdf

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Women tend to receive reperfusion therapy and other evidence-based treatments less frequently and/or in a delayed way than men. It is important to highlight that women and men receive equal benefit from a reperfusion and other STEMI-related therapies, and so both genders must be managed equally. In some cases, patients may have coronary artery occlusion/global ischemia in the absence of characteristic ST-elevation (e.g., bundle branch block, ventricular pacing, hyperacute T waves, isolated ST-depression in anterior leads, and/or universal ST-depression with ST-elevation in aVR). In patients with the mentioned electrocardiographic (ECG) changes and clinical presentation compatible with ongoing myocardial ischemia, a primary percutaneous coronary intervention (PCI) strategy (i.e., urgent angiography and PCI if indicated) should be followed. STEMI patients should undergo a primary PCI strategy unless the anticipated absolute time from STEMI diagnosis to PCI-mediated reperfusion is >120 minutes, when fibrinolysis should be initiated immediately (i.e., within 10 minutes of STEMI diagnosis). Patients with ST-elevation on post-resuscitation ECG should undergo a primary PCI strategy. In cases without ST-segment elevation on post-resuscitation ECG, but with a high suspicion of ongoing myocardial ischemia, urgent angiography should be done within 2 hours after a quick evaluation to exclude noncoronary causes. In all cases, the decision to perform urgent coronary angiography should take into account factors associated with poor neurological outcome. Routine radial access and routine drug-eluting stent implant is the standard of care during primary PCI. Routine thrombus aspiration or deferred stenting are contraindicated. Treatment of severe stenosis (evaluated either by angiography or fractional flow reserve) should be considered before hospital discharge (either immediately during the index PCI or staged at a later time). In cardiogenic shock, non–infarct-related artery PCI should be considered during the index procedure. Patients taking oral anticoagulants with renal insufficiency and/or the elderly represent a challenge in terms of optimal antithrombotic therapy. Special attention should be paid to dose adjustment of some pharmacological strategies in these subsets. A sizeable proportion of STEMI patients do not present significant coronary artery stenosis on urgent angiography. It is important to perform additional diagnostic tests in these patients to identify the etiology and tailor appropriate therapy, which may be different from typical STEMI. In some cases, there is a gap between optimal guideline-based treatment and actual care of STEMI patients. In order to reduce this gap, it is important to measure established quality indicators to audit practice and improve outcomes in real life. The use of well-defined and validated quality indicators to measure and improve STEMI care is recommended. Clinical Topics: Acute Coronary Syndromes, Anticoagulation Management, Arrhythmias and Clinical EP, Cardiovascular Care Team, Heart Failure and Cardiomyopathies, Invasive Cardiovascular Angiography and Intervention, Noninvasive Imaging, Anticoagulation Management and ACS, EP Basic Science, Acute Heart Failure, Interventions and ACS, Interventions and Imaging, Angiography, Nuclear Imaging Keywords: Acute Coronary Syndrome, Anticoagulants, Bundle-Branch Block, Constriction, Pathologic, Coronary Angiography, Coronary Occlusion, Coronary Stenosis, Diagnostic Tests, Routine, Drug-Eluting Stents, Electrocardiography, Fibrinolysis, Fibrinolytic Agents, Hospital Mortality, Myocardial Infarction, Percutaneous Coronary Intervention, Renal Insufficiency, Reperfusion, Shock, Cardiogenic, Standard of Care, Thrombosis < Back to Listings 0 ratings0% found this document useful (0 votes)139 viewsSaveSave Stemi Guideline 2017 For Later0%0% found this document useful, undefined 100%(1)100% found this document useful (1 vote)199 viewsThe document is the 2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation. 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