

Mrs. Hess and Her ACS

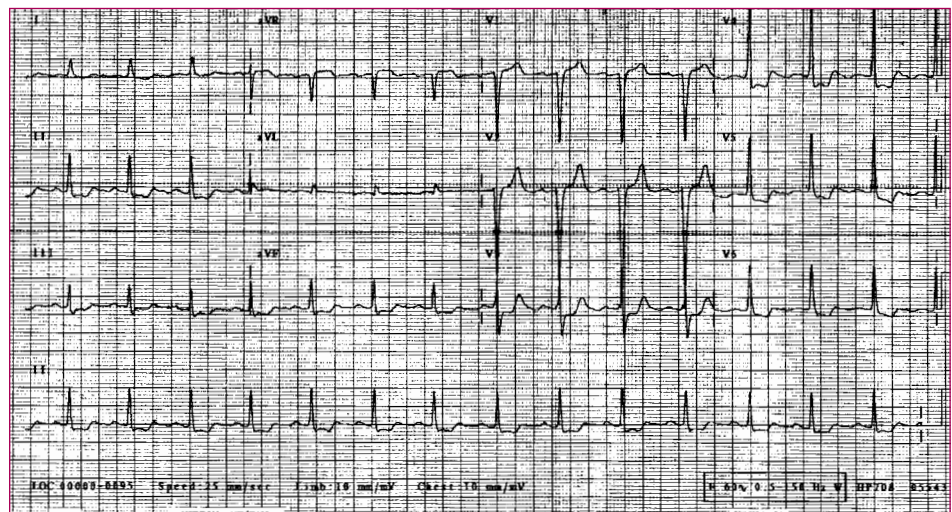
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CardioCase Presentation



Mrs. Hess, 70, is currently a non-smoker, having quit 10 years ago. She is not diabetic, but she does have mild to moderate hypertension controlled by an angiotensin-converting enzyme (ACE) inhibitor. She presents to the office with episodic retrosternal chest discomfort, which she describes as “achy” sensations in the mid-sternal area, with radiation to the jaw. Initially, these pains were associated with activity, especially postprandially, but, more recently, have been occurring with little or no activity. One prolonged episode prompted her to seek medical attention at the emergency department.

Her initial electrocardiogram (ECG) is shown below. The initial troponin measurement is negative.



What's Your CardioCase Diagnosis?

CardioCase Discussion

How should you manage Mrs. Hess?

The findings are very suggestive of accelerating symptoms, and the ECG is compatible with active ischemia on presentation. Acetylsalicylic acid (ASA) should be administered, and intravenous (IV) nitrates should be started for pain control. Beta blockers should be started in the absence of contraindications, initially IV, then followed by oral dosing. Heparin should also be initiated. IV heparin can be used, though low-molecular-weight heparin (LMHW) is preferable. Clopidogrel should also be initiated with 300 mg orally, followed by 75 mg daily.


Mrs. Hess's subsequent troponin came back pos-

itive. Elevated troponin is indicative of myocyte necrosis. A positive troponin aids in further defining the etiology of symptoms, and is a marker for increased risk. Serial troponins at least four to six hours apart should be measured, except if the first value is already positive, or if the chest pain occurred more than four to six hours prior to presentation (as troponins become evident about four hours after an ischemic episode).

Recurrent chest pain, especially on treatment, is indicative of a patient at high risk for death and cardiac ischemic events. Therefore, additional therapies should also be considered for Mrs. Hess. Small molecule IIB/IIIa agents are recommended for high-

risk patients, when there is an intent for imminent coronary angiography. A small molecule IIB/IIIa agent, like eptifibatid or tirofiban, could be initiated along with other therapies, and arrangements should be made for an early angiogram.

Current treatment for ACS includes multiple antiplatelet agents and heparin anticoagulation. This regimen increases the risk of bleeding, particularly at puncture sites for angiography. Small catheters are used to minimize this risk. A vascular closure device may be used if the femoral route is employed; otherwise, the radial artery may be utilized, as it is an easily compressible vessel.

If coronary artery bypass grafting (CABG) is required, clopidogrel should ideally be stopped at least five days prior to the procedure. Small molecule IIB/IIIa agents should be discontinued at least four hours before CABG surgery. 



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