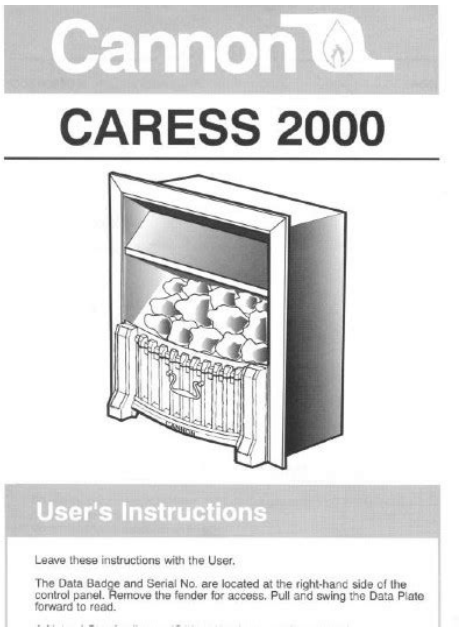

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Members of this Task Force were selected by the ESC, including representation from its relevant ESC subspecialty groups, in order to represent professionals involved with the medical care of patients with this pathology. Selected experts in the field undertook a comprehensive review of the published evidence for management of a given condition according to ESC Committee for Practice Guidelines CPG policy. The level of evidence and the strength of the recommendation of particular management options were weighed and graded according to predefined scales, as outlined in Tables 1 and 2. Table 1 Classes of recommendations Table 1 Classes of recommendations Table 2 Levels of evidence Table 2 Levels of evidence The experts of the writing and reviewing panels provided declaration of interest forms for all relationships that might be perceived as real or potential sources of conflicts of interest. These forms were compiled into one file and can be found on the ESC website

. Any changes in declarations of interest that arise during the writing period were notified to the ESC and updated. The Task Force received its entire financial support from the ESC without any involvement from the healthcare industry. The ESC CPG supervises and coordinates the preparation of new ESC Guidelines. The Committee is also responsible for the endorsement process of these Guidelines. The ESC Guidelines undergo extensive review by the CPG and external experts. After appropriate revisions the Guidelines are approved by all the experts involved in the Task Force. The finalized document is approved by the CPG for publication in the European Heart Journal. The Guidelines were developed after careful consideration of the scientific and medical knowledge and the evidence available at the time of their dating.

The task of developing ESC Guidelines also includes the creation of educational tools and implementation programmes for the recommendations including condensed pocket guideline versions, summary slides, booklets with essential messages, summary cards for nonspecialists and an electronic version for digital applications smartphones, etc.. These versions are abridged and thus, if needed, one should always refer to the full text version, which is freely available via the ESC website and hosted on the EHJ website. The National Societies of the ESC are encouraged to endorse, translate and implement all ESC Guidelines. Implementation programmes are needed because it has been shown that the outcome of disease may be favourably influenced by the thorough application of clinical recommendations. Surveys and registries are needed to verify that reallife daily practice is in keeping with what is recommended in the guidelines, thus completing the loop between clinical research, writing of guidelines, disseminating them and implementing them into clinical practice. Health professionals are encouraged to take the ESC Guidelines fully into account when exercising their clinical judgment, as well as in the determination and the implementation of preventive, diagnostic or therapeutic medical strategies. It is also the health professionals responsibility to verify the rules and regulations applicable to drugs and devices at the time of prescription. 2. Introduction It must be recognized that, even when excellent clinical trials have been undertaken, the results are open to interpretation and treatments may need to be adapted to take account of clinical circumstances and resources. The levels of evidence and the strengths of recommendation of particular treatment options were weighed and graded according to predefined scales, as outlined in Tables 1 and 2.

Despite recommendations with a level of evidence being based on expert opinion, this Task Force decided to add references to guide the reader regarding data that were taken into consideration for these decisions in some cases. 2.1 Definition of acute myocardial infarction In contrast, patients without STsegment elevation at presentation are usually designated as having a nonSTsegment elevation myocardial infarction MI NSTEMI and separate guidelines have recently been developed for these. 2 Some patients with MI develop Qwaves Qwave MI, but many do not nonQwave MI. In addition to these categories, MI is classified into various types, based on pathological, clinical, and prognostic differences, along with different treatment strategies see the Third Universal Definition of MI document, 8 which will be updated in 2018.Acute coronary syndrome ACS occurs three to four times more often in men than in women below the age of 60years, but after the age of 75, women represent the majority of patients. 26 Women tend to present more often with atypical symptoms, up to 30% in some registries, 27 and tend to present later than men. 28, 29 It is therefore important to maintain a high degree of awareness for MI in women with potential symptoms of ischaemia. Women also have a higher risk of bleeding complications with PCI. There is an ongoing debate regarding whether outcomes are poorer in women, with several studies indicating that a poorer outcome is related to older age and more comorbidities among women suffering MI. 26, 30, 31 Some studies have indicated that women tend to undergo fewer interventions than men and receive reperfusion therapy less frequently. 26, 32, 33 These guidelines aim to highlight the fact that women and men receive equal benefit from a reperfusion strategy and STEMIrelated therapy, and that both genders must be managed in a similar fashion. 3. What is new in the 2017 version For explanation of trial

names, see list of.

In left and mid panels, below each recommendation, the most representative trial acronym and reference driving the indication is mentioned. Figure 1 Open in new tab Download slide What is new in 2017 STEMI Guidelines. For explanation of trial names, see list of.In left and mid panels, below each recommendation, the most representative trial acronym and reference driving the indication is mentioned. 4. Emergency care It is recommended that a regional reperfusion strategy should be established to maximize efficiency. Important clues are a history of CAD and radiation of pain to the neck, lower jaw, or left arm. A complete normalization of the STsegment elevation after nitroglycerin administration, along with complete relief of symptoms, is suggestive of coronary spasm, with or without associated MI. In these cases, an early coronary angiography within 24h is recommended. In cases of recurrent episodes of STsegment elevation or chest pain, immediate angiography is required. It is recommended to initiate ECG monitoring as soon as possible in all patients with suspected STEMI in order to detect lifethreatening arrhythmias and allow prompt defibrillation if indicated. If interpretation of prehospital ECG is not possible onsite, field transmission of the ECG is recommended. 42 ECG criteria are based on changes of electrical currents of the heart measured in millivolts. Therefore 0.1mV equals to 1mm square on the vertical axis. For simplicity, in this document ECG deviations are expressed in mm following the standard calibration.The ECG diagnosis may be more difficult in some cases, which nevertheless deserve prompt management and triage. Among these Bundle branch block. In the presence of LBBB, the ECG diagnosis of AMI is difficult but often possible if marked STsegment abnormalities are present. Somewhat complex algorithms have been offered to assist the diagnosis, 50, 51 but they do not provide diagnostic certainty. 52 The presence of concordant STsegment elevation i.e.

in leads with positive QRS deflections appears to be one of the best indicators of ongoing MI with an occluded infarct artery. 53 Patients with a clinical suspicion of ongoing myocardial ischaemia and LBBB should be managed in a way similar to STEMI patients, regardless of whether the LBBB is previously known. It is important to remark that the presence of a presumed new LBBB does not predict an MI per se. 54 Patients with MI and right bundle branch block RBBB have a poor prognosis. 55 It may be difficult to detect transmural ischaemia in patients with chest pain and RBBB. 55 Therefore, a primary PCI strategy emergent coronary angiography and PCI if indicated should be considered when persistent ischaemic symptoms occur in the presence of RBBB. Ventricular pacing. Pacemaker rhythm may also prevent interpretation of STsegment changes and may require urgent angiography to confirm diagnosis and initiate therapy. Reprogramming the pacemaker—allowing an evaluation of ECG changes during intrinsic heart rhythm—may be considered in patients who are not dependent on ventricular pacing, without delaying invasive investigation. 56, 57 Nondiagnostic ECG. Some patients with an acute coronary occlusion may have an initial ECG without STsegment elevation, sometimes because they are seen very early after symptom onset in which case, one should look for hyperacute Twaves, which may precede STsegment elevation. It is important to repeat the ECG or monitor for dynamic STsegment changes. In addition, there is a concern that some patients with acute occlusion of a coronary artery and ongoing MI, such as those with an occluded circumflex coronary artery, 58, 59 acute occlusion of a vein graft, or left main disease, may present without STsegment elevation and be denied reperfusion therapy, resulting in a larger infarction and worse outcomes. Isolated posterior MI. These should be managed as a STEMI. Left main coronary obstruction.

If in doubt regarding the possibility of acute evolving MI, emergency imaging aids the provision of timely reperfusion therapy to these patients. Recommendations for the use of echocardiography for initial diagnosis are described in section 6.6.2. If echocardiography is not available or if doubts persist after echo, a primary PCI strategy is indicated including immediate transfer to a PCI centre if the patient is being treated in a nonPCI centre. In the STEMI emergency setting, there is no role for

routine computed tomography CT. Use of CT should be confined to selected cases where acute aortic dissection or pulmonary embolism is suspected, but CT is not recommended if STEMI diagnosis is likely. Some nonAMI conditions can present with symptoms and ECG findings similar to STEMI. An emergency coronary angiography is therefore indicated in these cases Chapter 9 expands on this topic. 4.2 Relief of pain, breathlessness, and anxiety Titrated intravenous i.v. opioids e.g. morphine are the analgesics most commonly used in this context.Reassurance of patients and those closely associated with them is of great importance. A mild tranquillizer usually a benzodiazepine should be considered in anxious patients. 4.3 Cardiac arrest It is indicated that all medical and paramedical personnel caring for patients with suspected MI have access to defibrillation equipment and are trained in cardiac life support, and that, at the point of FMC, ECG monitoring must be implemented immediately for all patients with suspected MI. The decision to perform urgent coronary angiography and PCI if indicated should also take into account factors associated with poor neurological outcome. Moreover, metabolic conversion of clopidogrel in the liver may be reduced in hypothermia conditions. 83 Cooling should not delay primary PCI and can be started in parallel in the catheterization laboratory. Close attention to anticoagulation needs to be paid in patients reaching low temperatures.

84 Prevention and improved treatment of outofhospital cardiac arrest is crucial to reduce the mortality related to CAD.If projected target times are not met, then interventions are needed to improve performance of the system. Components of the ischaemic time, delays of initial management, and selection of reperfusion strategy are shown in Figure 2. The recommended mode of patient presentation is by alerting the EMS call national emergency number 112 or similar number according to region. When STEMI diagnosis is made in the outofhospital setting via EMS or in a nonPCI centre, the decision for choosing reperfusion strategy is based on the estimated time from STEMI diagnosis to PCImediated reperfusion wire crossing. System delay for patients alerting the EMS starts at the time of phone alert, although FMC occurs when EMS arrives to the scene see Table 4 . denotes minutes. a Patients with fibrinolysis should be transferred to a PCI centre immediately after administration of the lytic bolus. Figure 2 Open in new tab Download slide Modes of patient presentation, components of ischaemia time and flowchart for reperfusion strategy selection. The recommended mode of patient presentation is by alerting the EMS call national emergency number 112 or similar number according to region. To minimize patient delay, it is recommended to increase public awareness of how to recognize common symptoms of AMI and to call the emergency services. All components of the system delay represent the quality of care and it is recommended to measure them as quality indicators see Chapter 10. In hospitals and EMS participating in the care of STEMI patients, the goal is to reduce the delay between FMC and STEMI diagnosis to10min. STEMI diagnosis refers to the time when the ECG is interpreted as STsegment elevation or equivalent and it is the time zero to guide appropriate therapy. Bypassing the emergency department is associated with a 20min saving in the time from FMC to wire crossing.

92 For patients presenting in a nonPCI centre, doorin to doorout time, defined as the duration between arrival of the patient at the hospital to discharge of the patient in an ambulance en route to the PCI centre, is a new clinical performance measure, and 30min is recommended to expedite reperfusion care. 93 4.4.2 Emergency medical system Parallel circuits for referral and transport of patients with a STEMI that bypass the EMS should be avoided. The ambulance system has a critical role in the early management of STEMI patients and it is not only a mode of transport but also a system to enhance early initial diagnosis, triage, and treatment. 87, 94 It is indicated that all ambulances in the EMS are equipped with ECG recorders, defibrillators, and at least one person trained in advanced life support. The quality of the care provided depends on the training of the staff involved. The goal of these networks is to provide optimal care while minimizing delays, thereby improving clinical outcomes. Cardiologists should actively collaborate with all stakeholders, particularly emergency physicians, in establishing such networks. The main features of such a

network are. Other models, although not ideal, may include weekly or daily rotation of primary PCI centres or multiple primary PCI centres in the same region.STEMI diagnosis is the time 0 for the strategy clock. The decision for choosing reperfusion strategy in patients presenting via EMS outofhospital setting or in a nonPCI centre is based on the estimated time from STEMI diagnosis to PCImediated reperfusion. Target times from STEMI diagnosis represent the maximum time to do specific interventions.Figure 3 Open in new tab Download slide Maximum target times according to reperfusion strategy selection in patients presenting via EMS or in a nonPCI centre. STEMI diagnosis is the time 0 for the strategy clock. Target times from STEMI diagnosis represent the maximum time to do specific interventions.

Geographic areas where the expected transfer time to the primary PCI centre makes it impossible to achieve the maximal allowable delays indicated in the recommendations Figure 2 should develop systems for rapid fibrinolysis, at the place of STEMI diagnosis, with subsequent immediate transfer to primary PCI centres.If general practitioners respond quickly they can be very effective, as they usually know the patient and can perform and interpret the ECG. Their first task after the STEMI diagnosis should be to alert the EMS. In addition, they can administer opioids and antithrombotic drugs including fibrinolytics, if that management strategy is indicated, and can undertake defibrillation if needed. However, in most settings, consultation with a general practitioner—instead of a direct call to the EMS—will increase prehospital delay. Therefore, in general, the public should be educated to call the EMS rather than the primary care physician for symptoms suggestive of MI.Primary PCI is the preferred reperfusion strategy in patients with STEMI within 12h of symptom onset, provided it can be performed expeditiously i.e. 120min from STEMI diagnosis, Figures 2 and 3 by an experienced team. An experienced team includes not only interventional cardiologists but also skilled support staff. The extent to which the PCIrelated time delay diminishes the advantages of PCI over fibrinolysis has been widely debated. Because no specifically designed study has addressed this issue, caution is needed when interpreting available data from post hoc analyses. A PCIrelated time delay potentially mitigating the benefits of PCI has been calculated as 60min 117, 110min, 118 and 120min 119 in different studies. Registry data estimated this time limit as 114min for inhospital patients 107 and 120min in patients presenting in a nonPCI centre.