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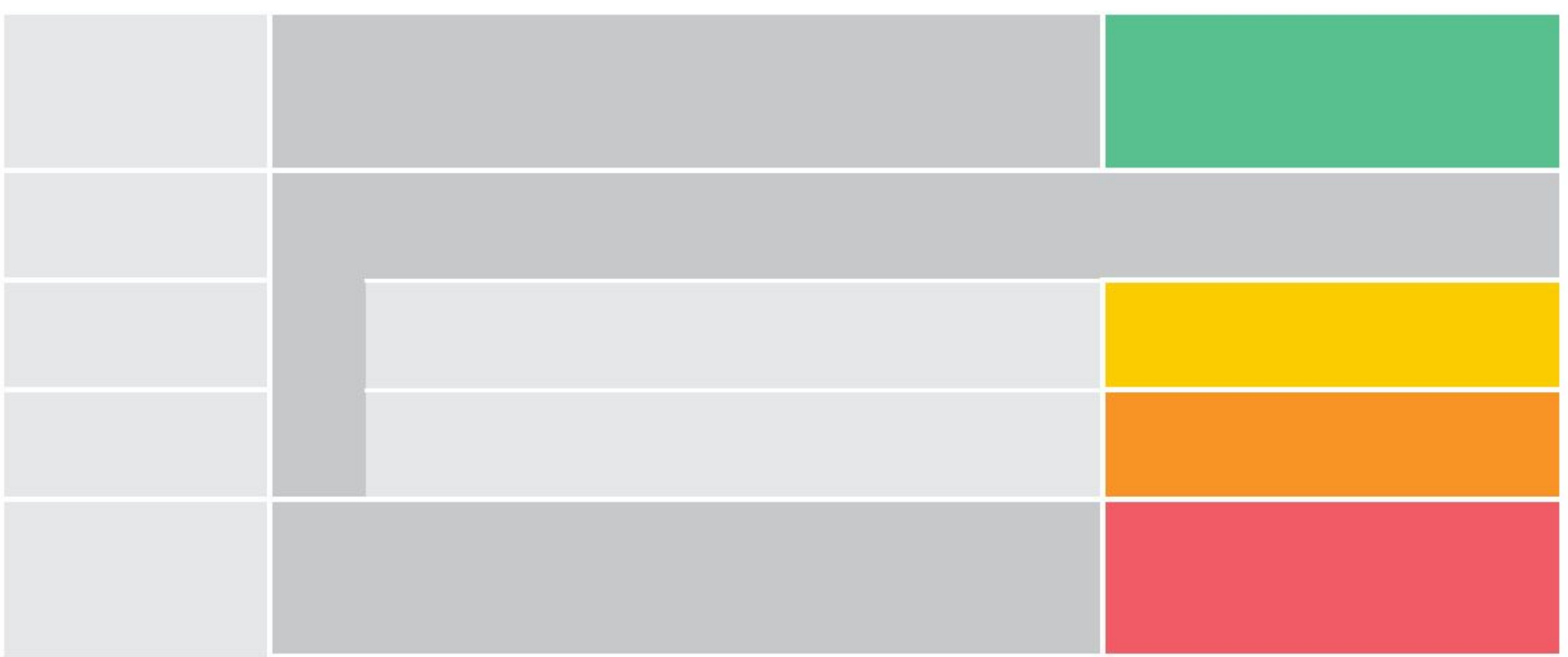

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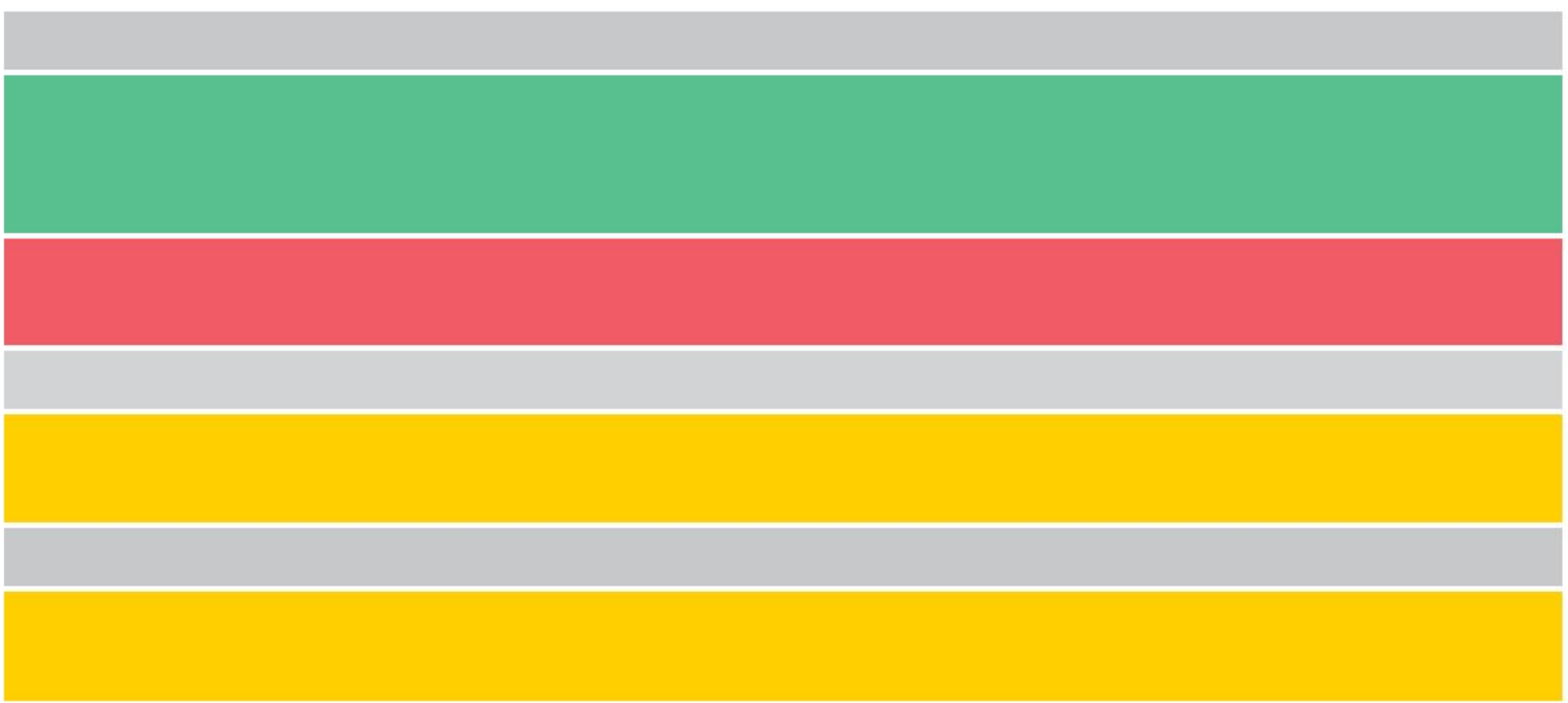

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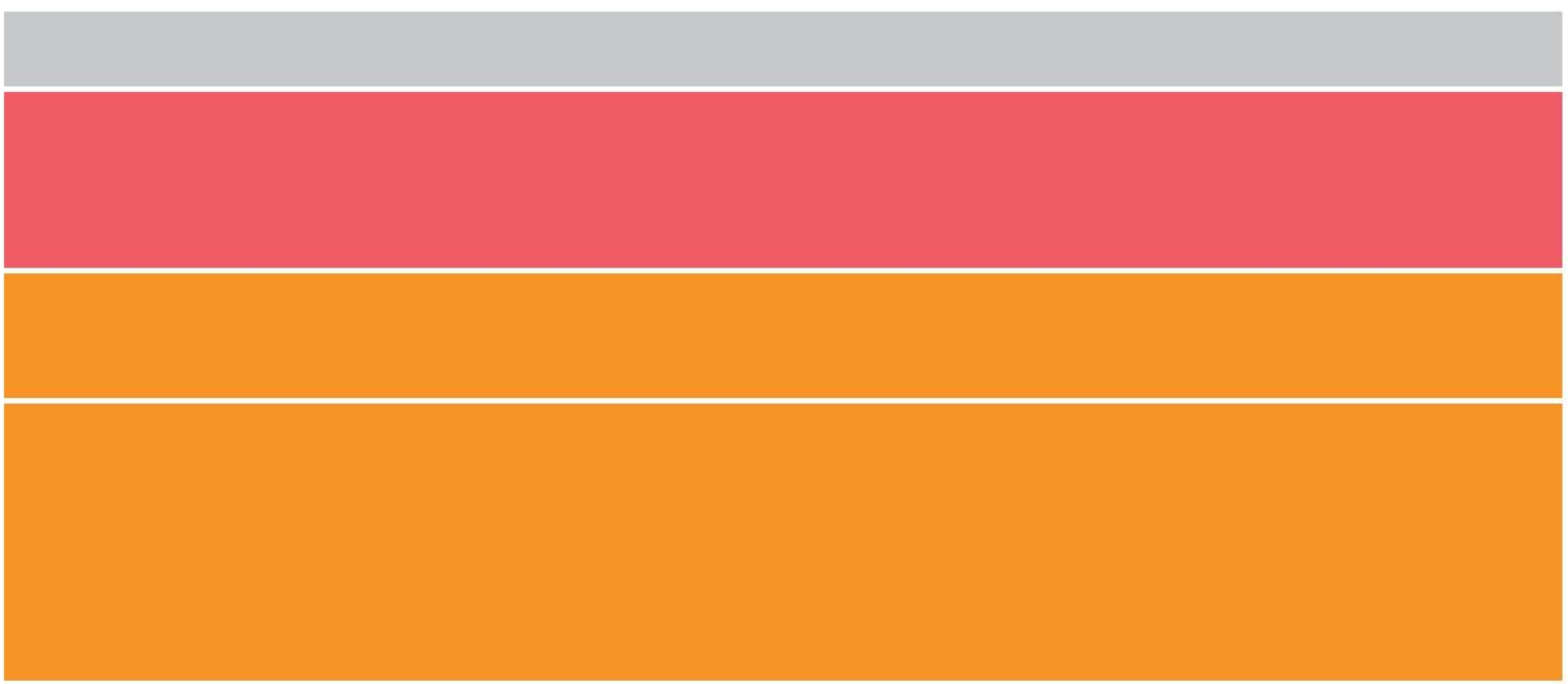

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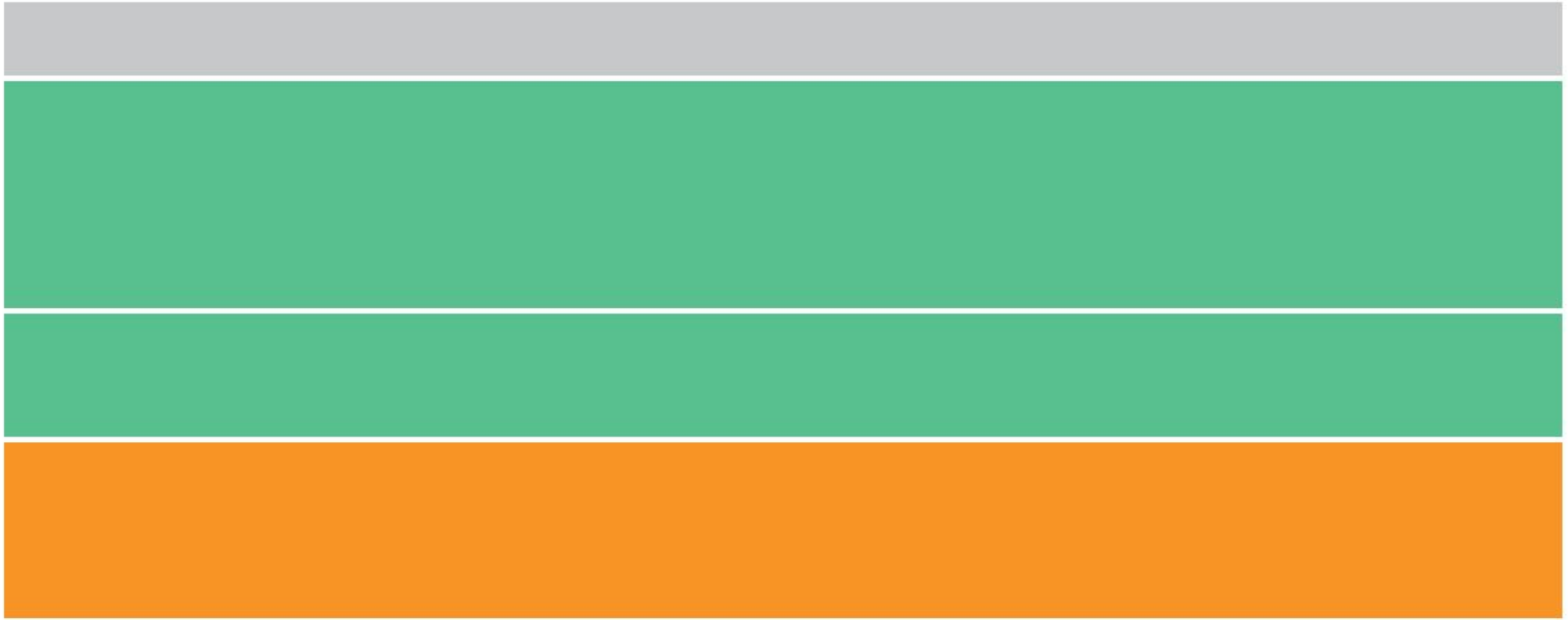

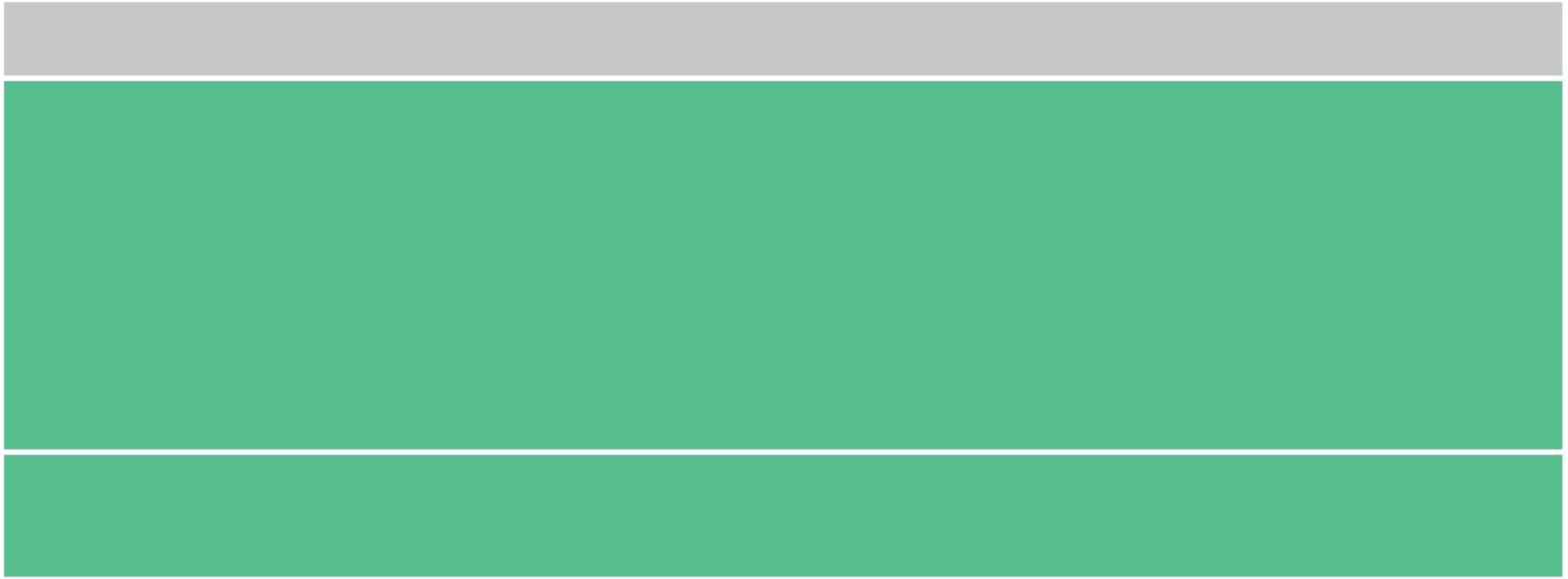

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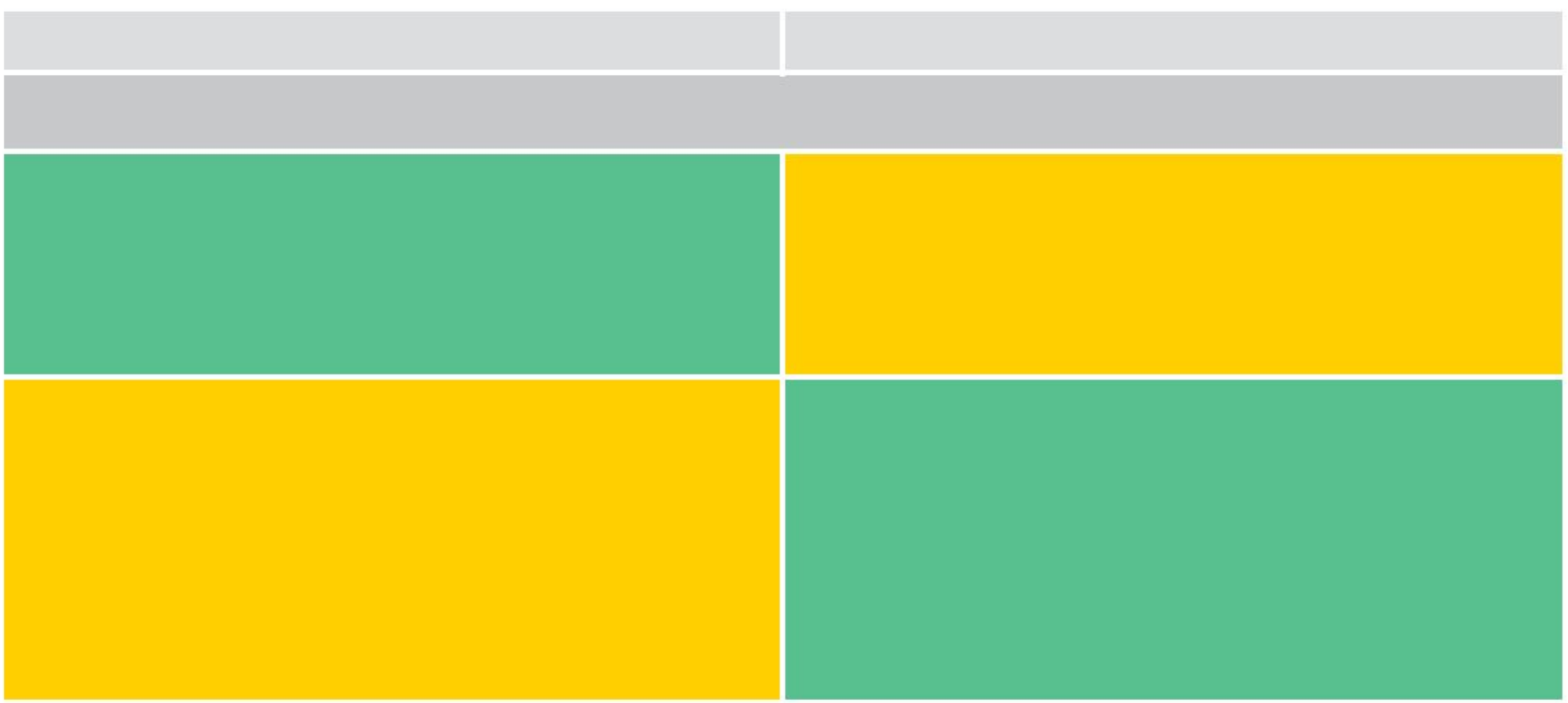

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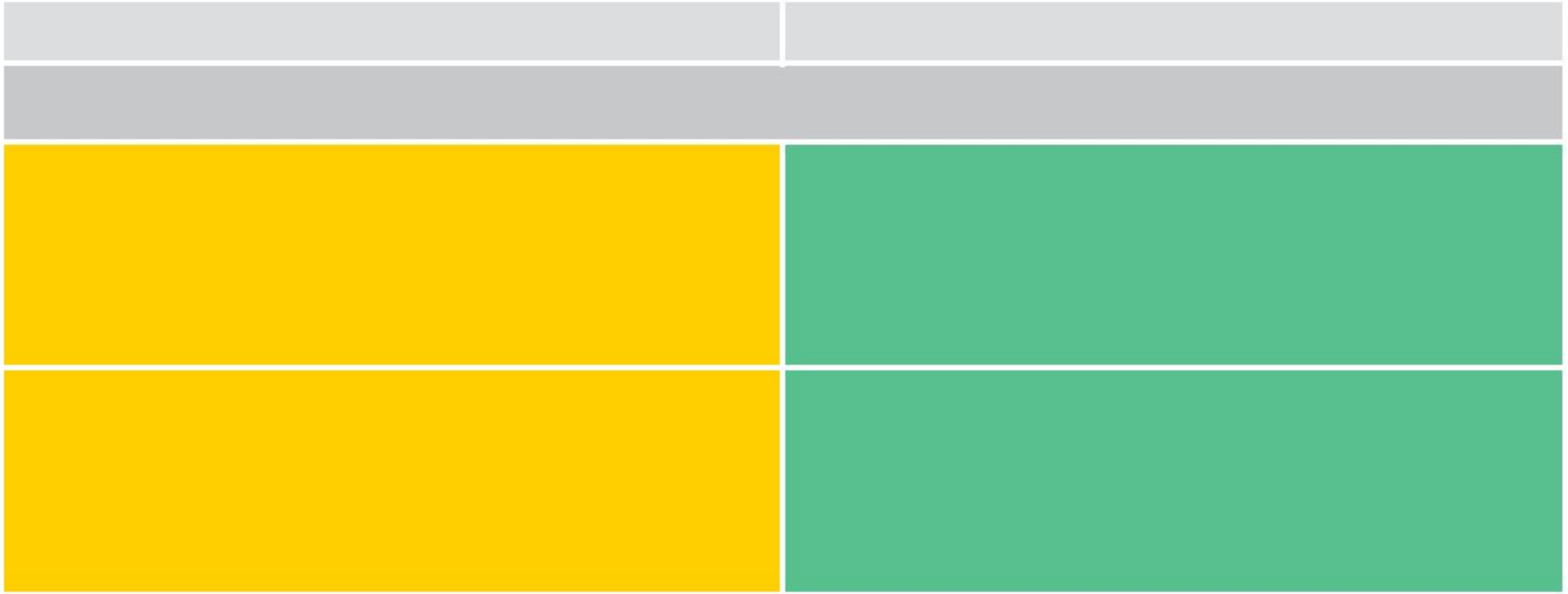

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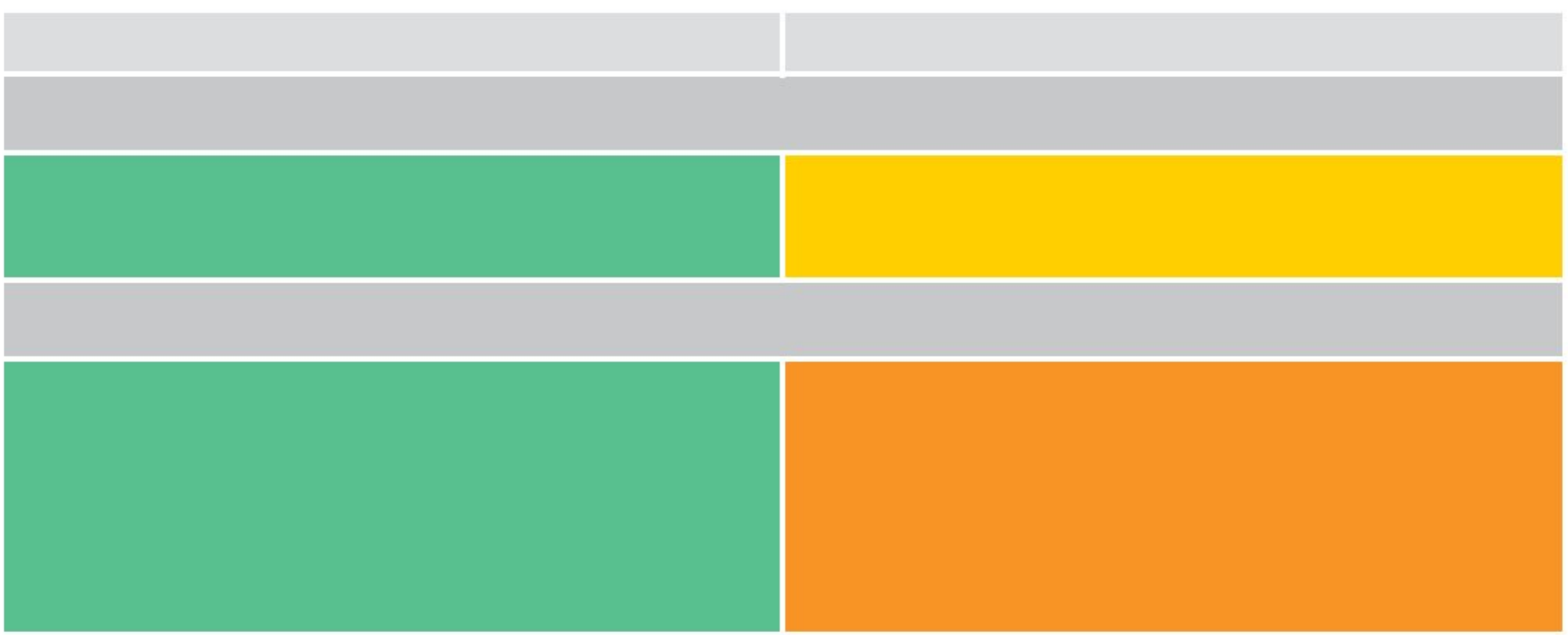

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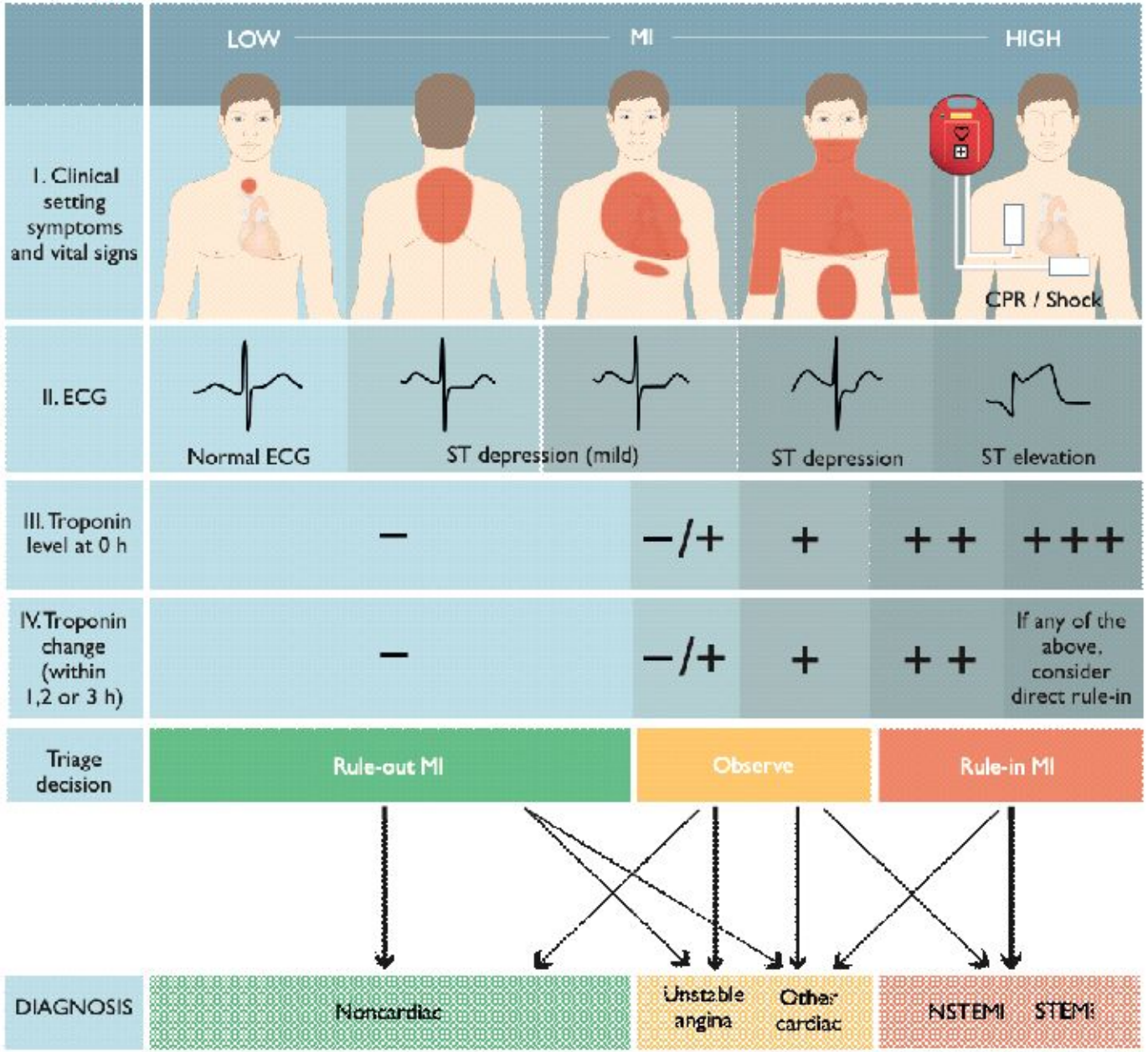

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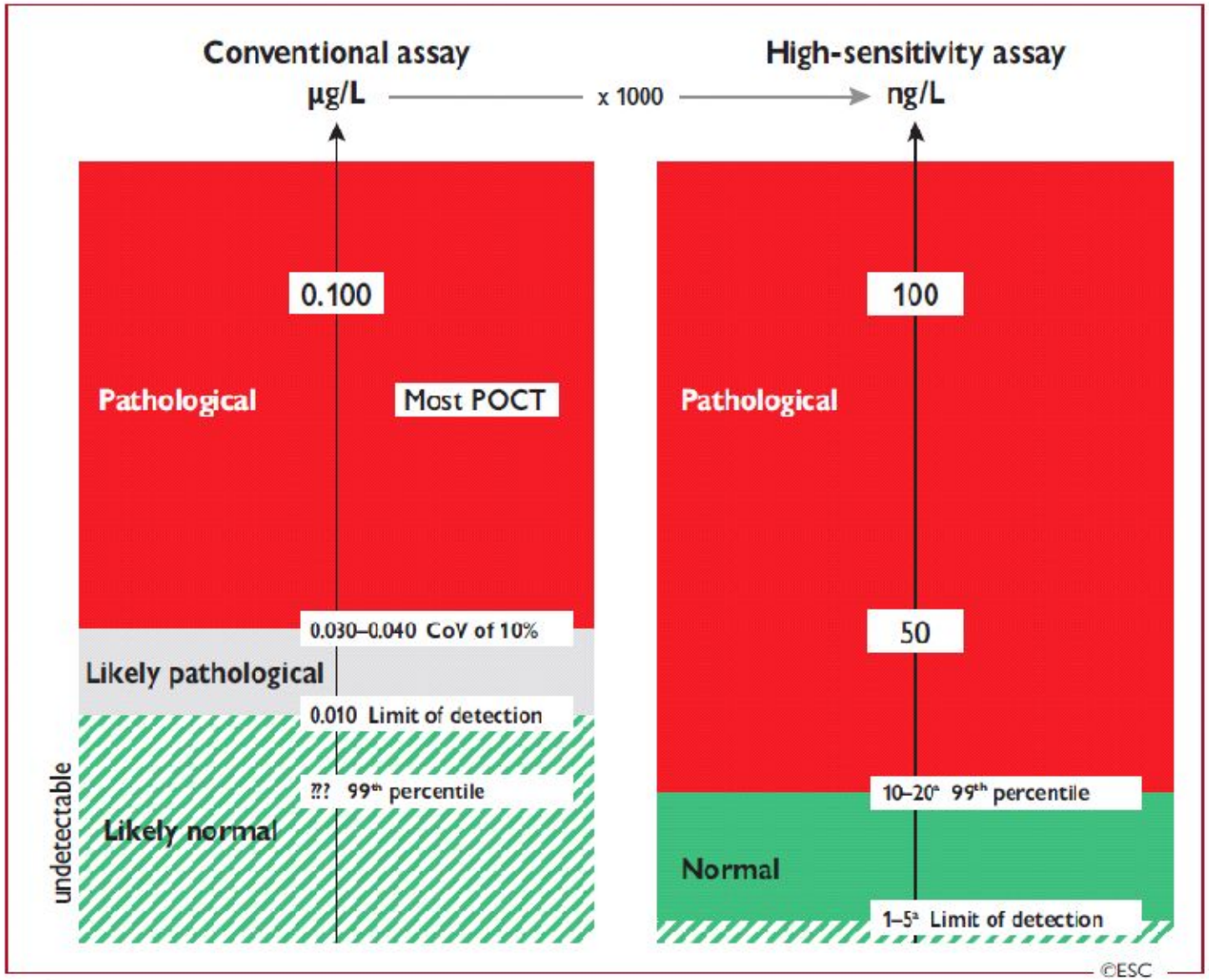
Conventional assay
µg/L
x 1000
High-sensitivity assay
ng/L
0.100
Pathological
Most POCT
0.030–0.040 CoV of 10%
Likely pathological
0.010 Limit of detection
?? 99th percentile
Likely normal
undetectable
100
Pathological
50
10–20a 99th percentile
Normal
1–5a Limit of detection
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Applicable in clinical practice?

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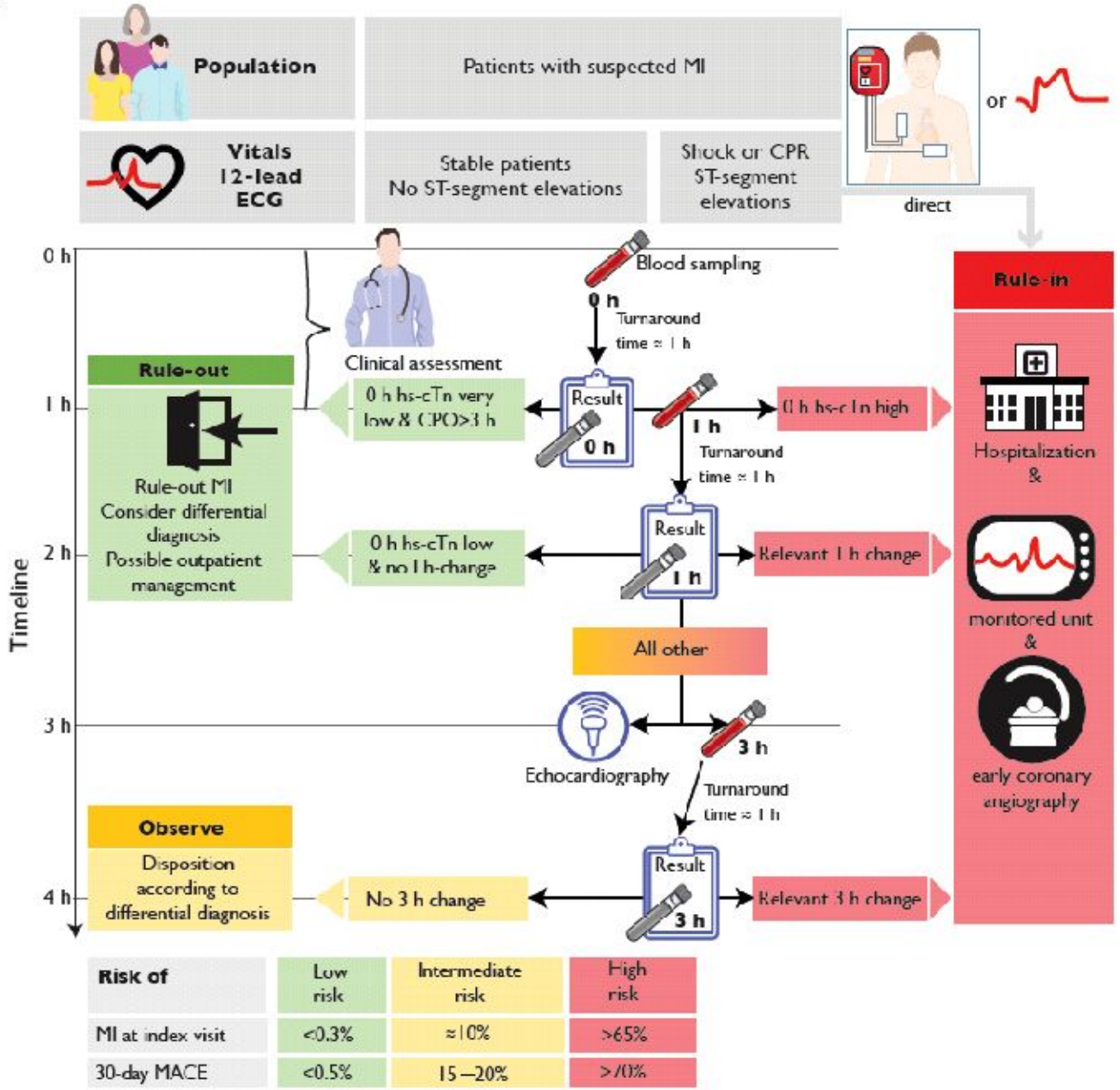

Risk of	Low risk	Intermediate risk	High risk
MI at index visit	<0.3%	≈10%	>65%
30-day MACE	<0.5%	15–20%	>70%

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Cardiac	Pulmonary	Vascular	Gastro-intestinal	Orthopaedic	Other
Myopericarditis	**Pulmonary embolism**	**Aortic dissection**	**Oesophagitis, reflux, or spasm**	**Musculoskeletal disorders**	**Anxiety disorders**
Cardiomyopathies[a]	**(Tension)-pneumothorax**	Symptomatic aortic aneurysm	Peptic ulcer, gastritis	Chest trauma	Herpes zoster
Tachyarrhythmias	Bronchitis, pneumonia	Stroke	Pancreatitis	Muscle injury/inflammation	Anaemia
Acute heart failure	Pleuritis		Cholecystitis	Costochondritis	
Hypertensive emergencies				Cervical spine pathologies	
Aortic valve stenosis					
Takotsubo syndrome					
Coronary spasm					
Cardiac trauma					

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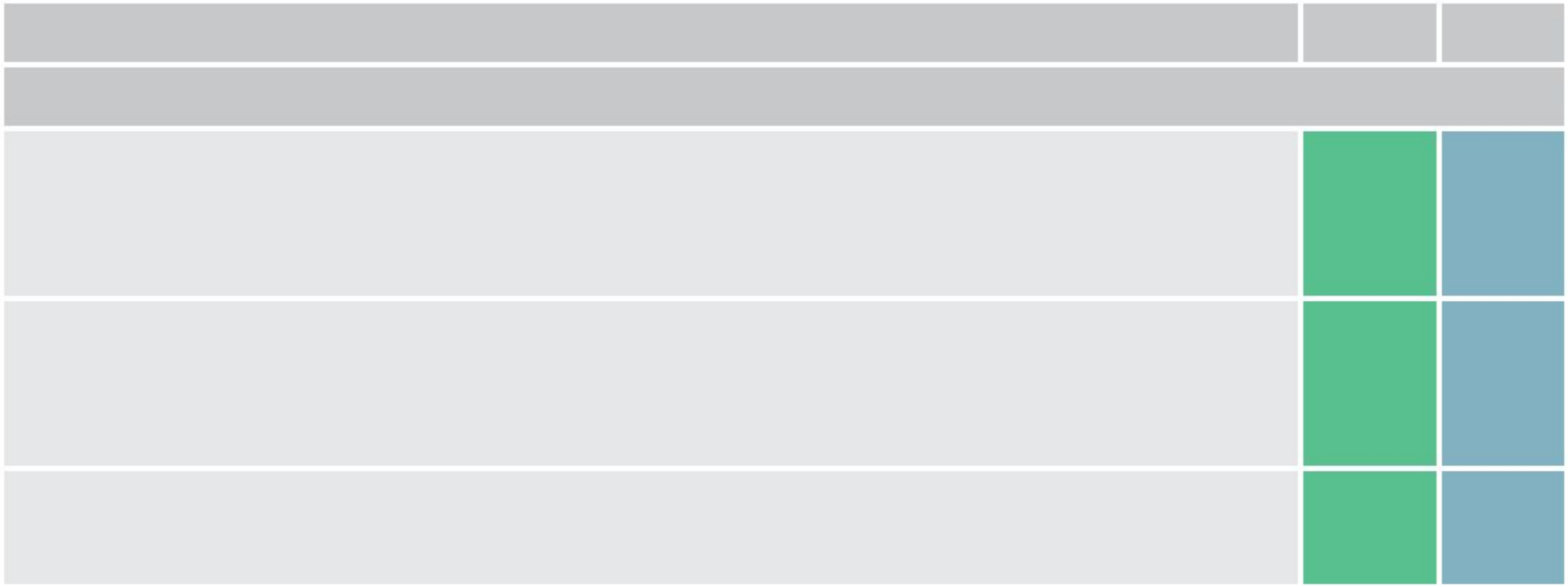

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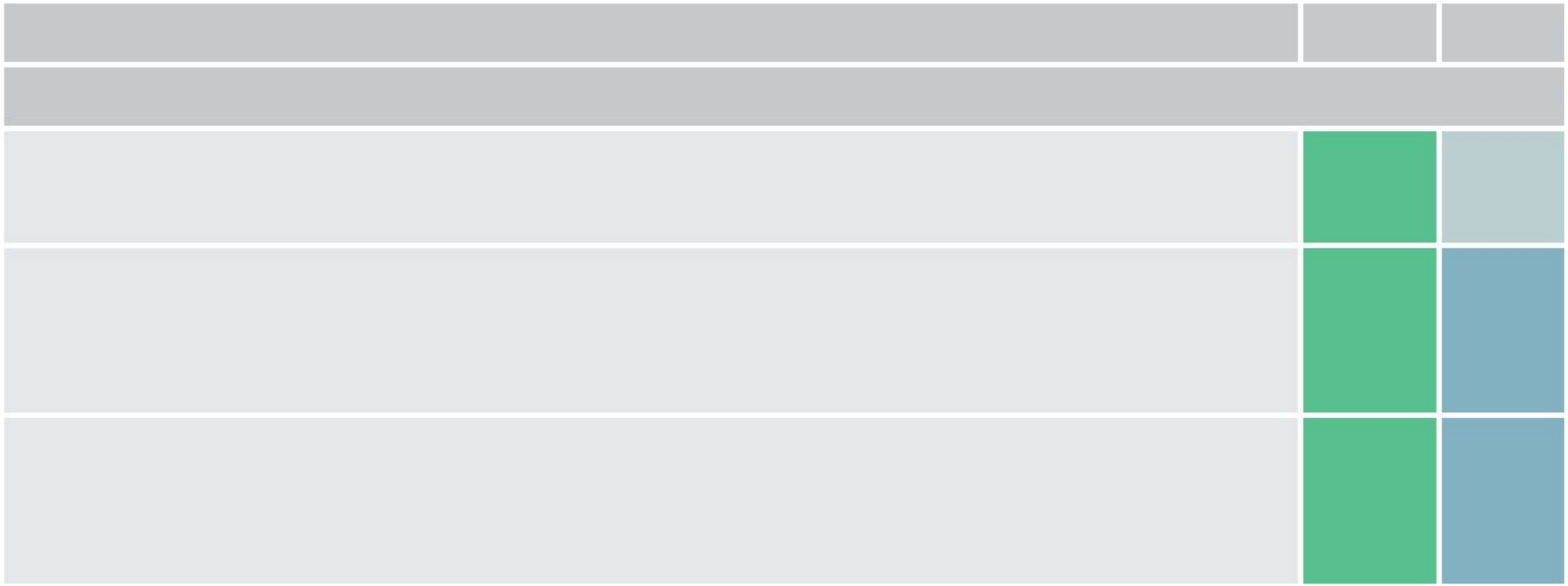

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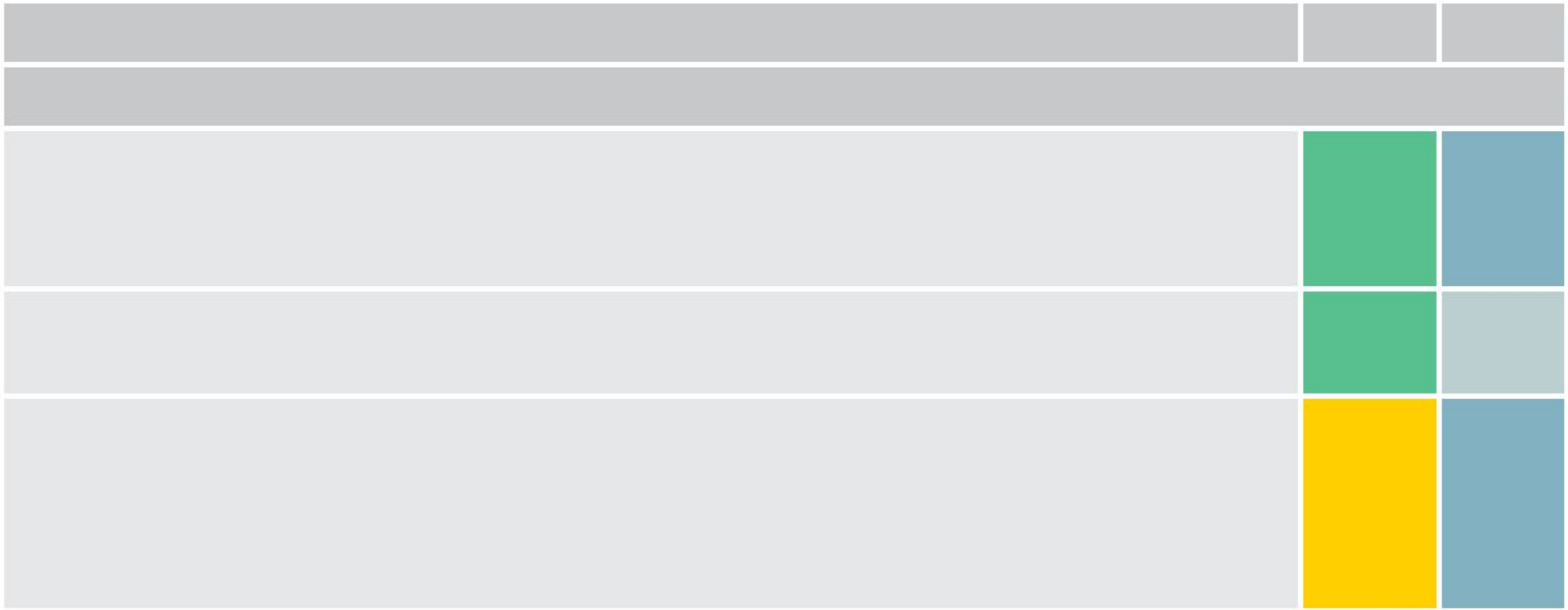

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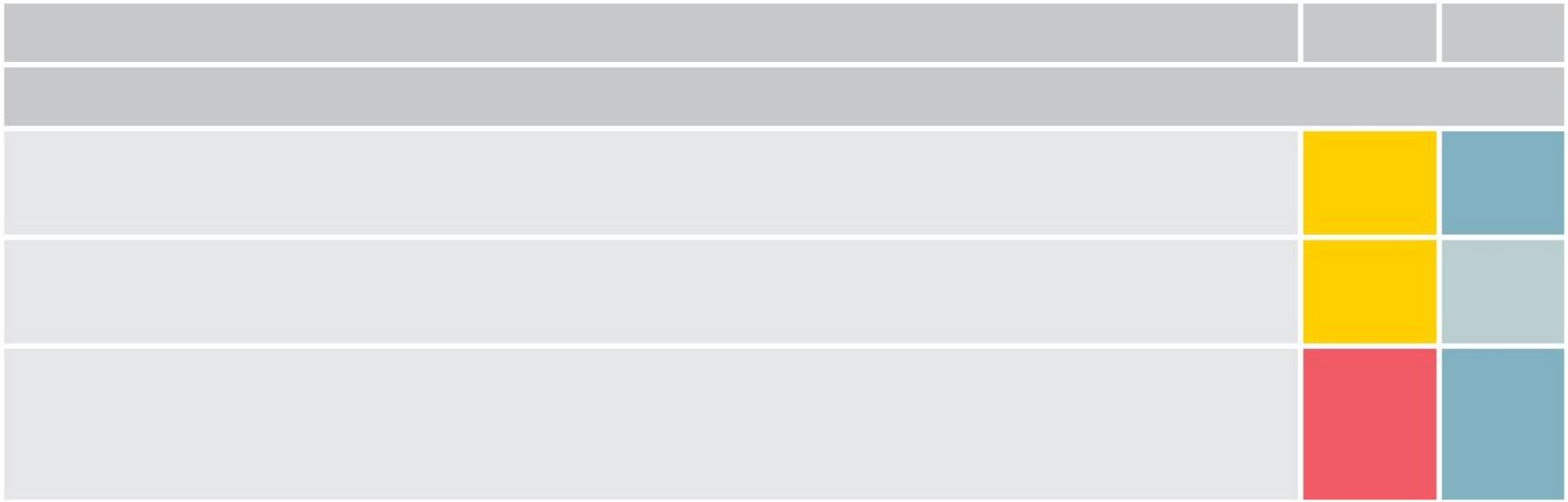

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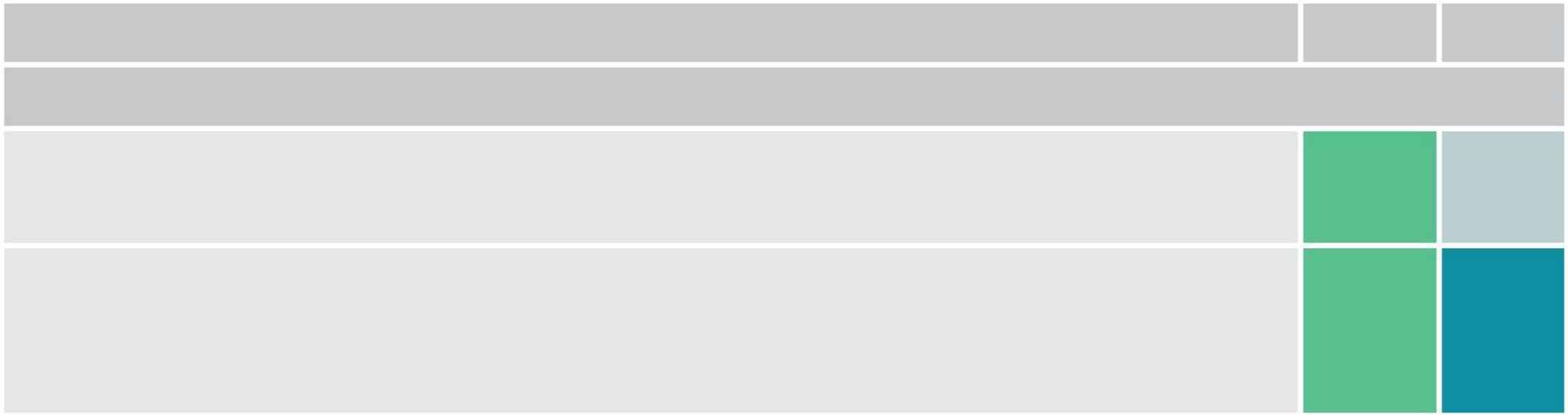

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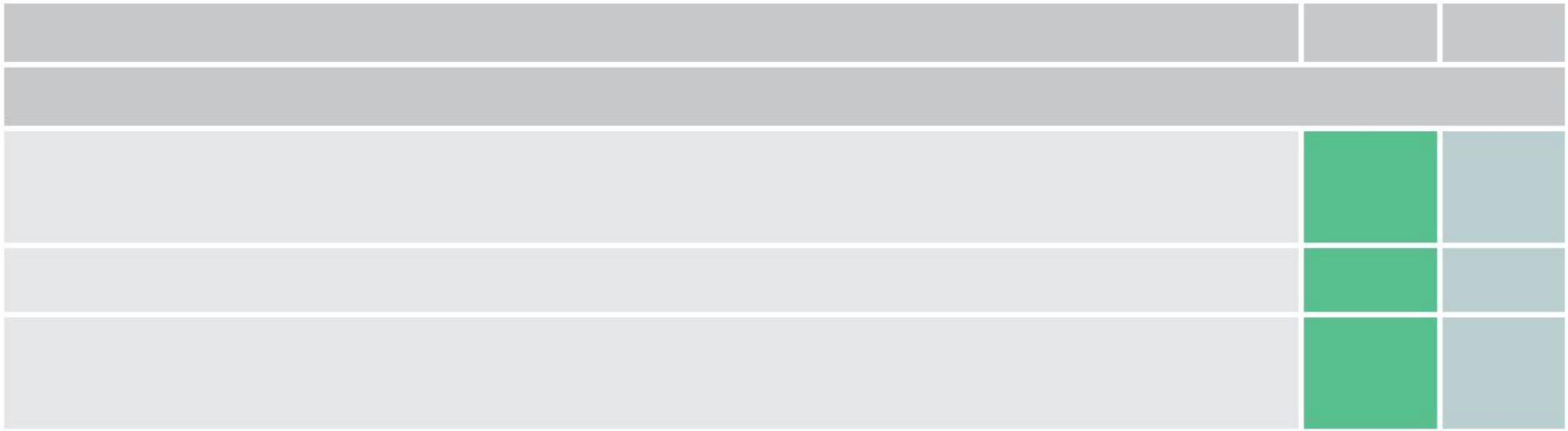

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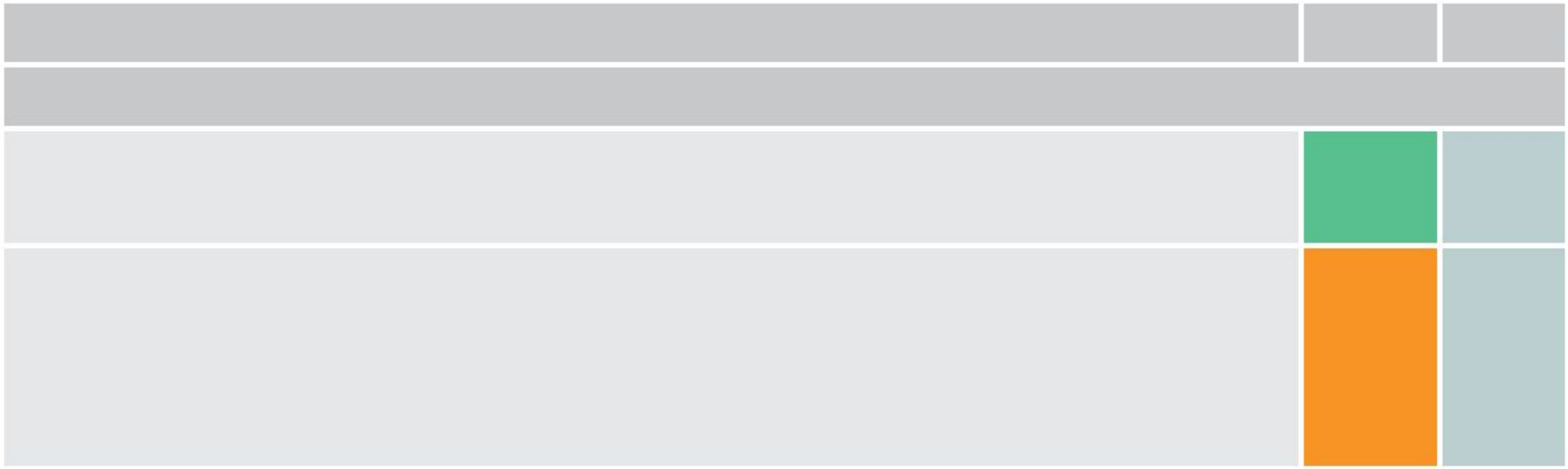

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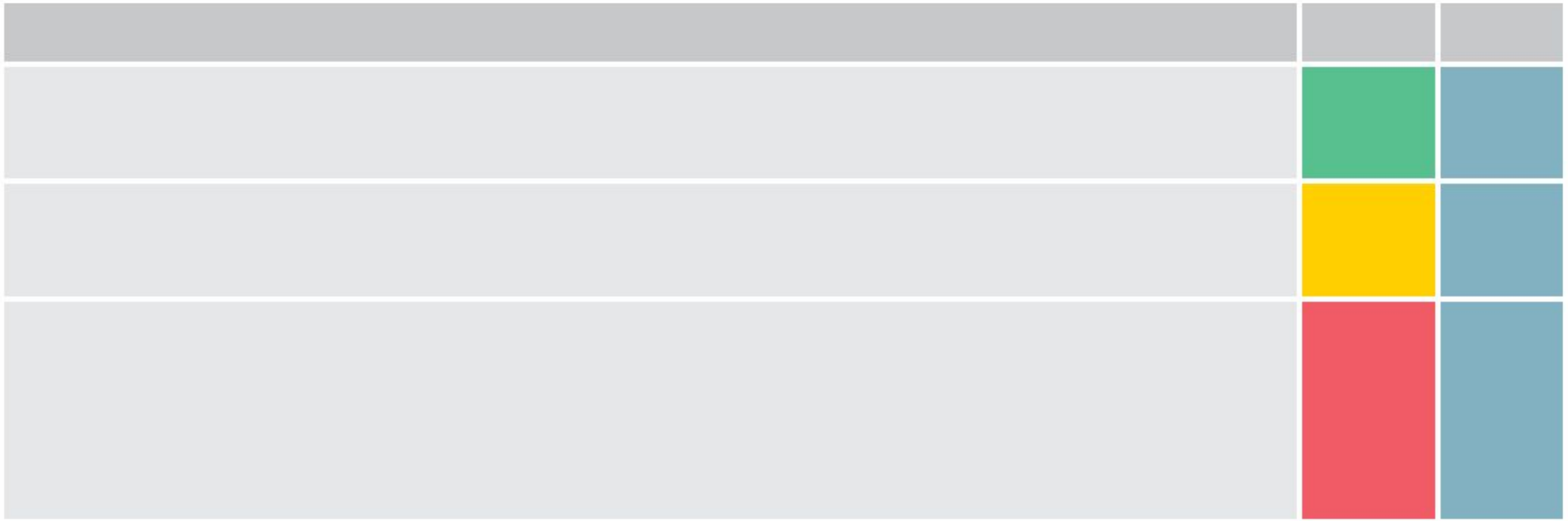

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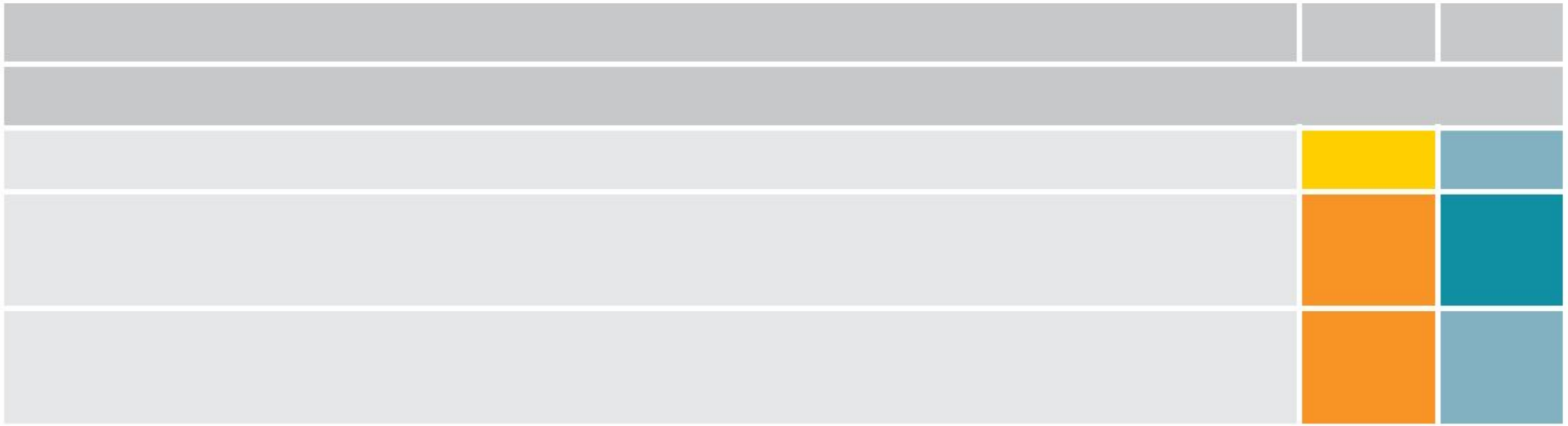

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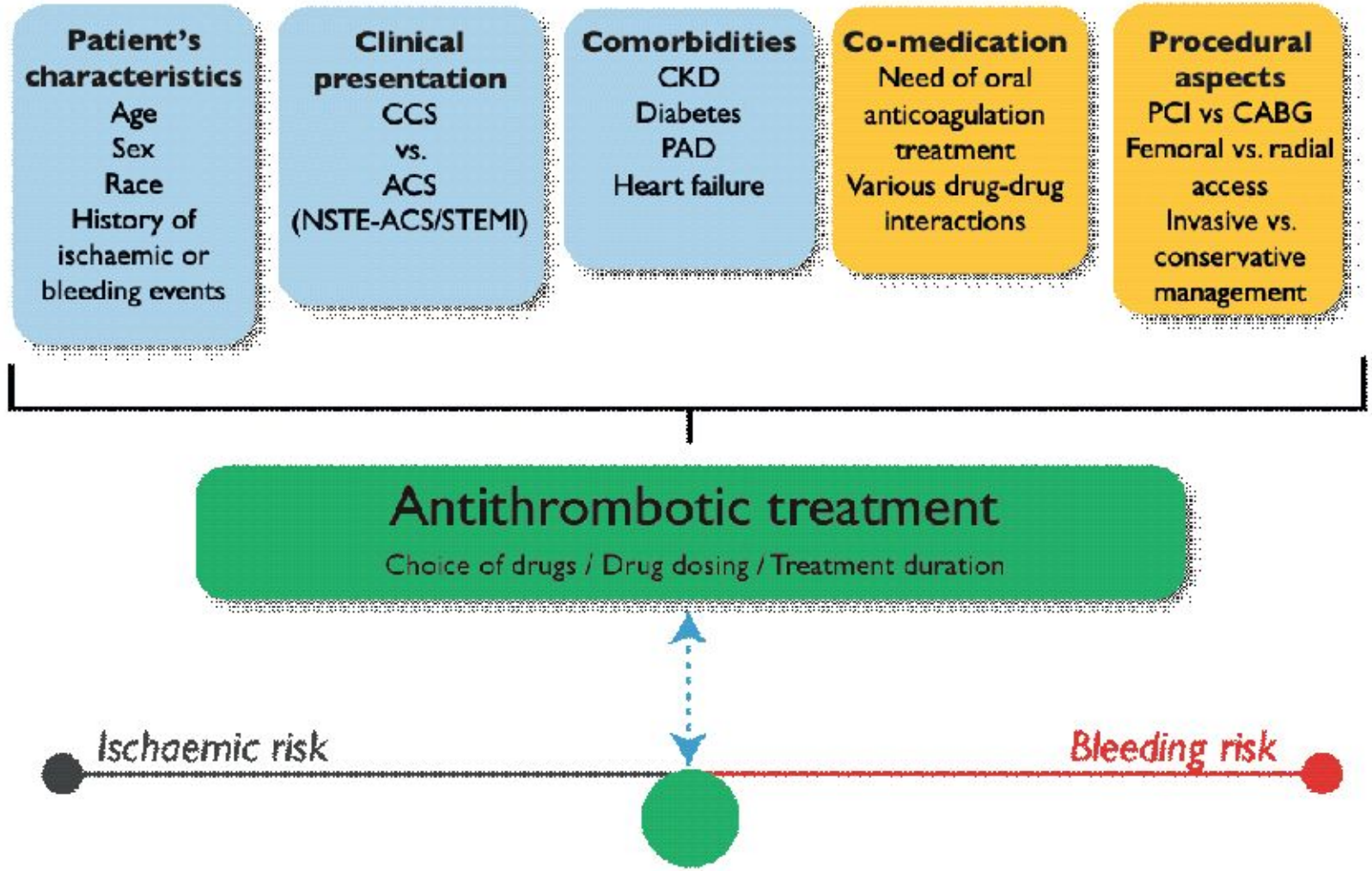
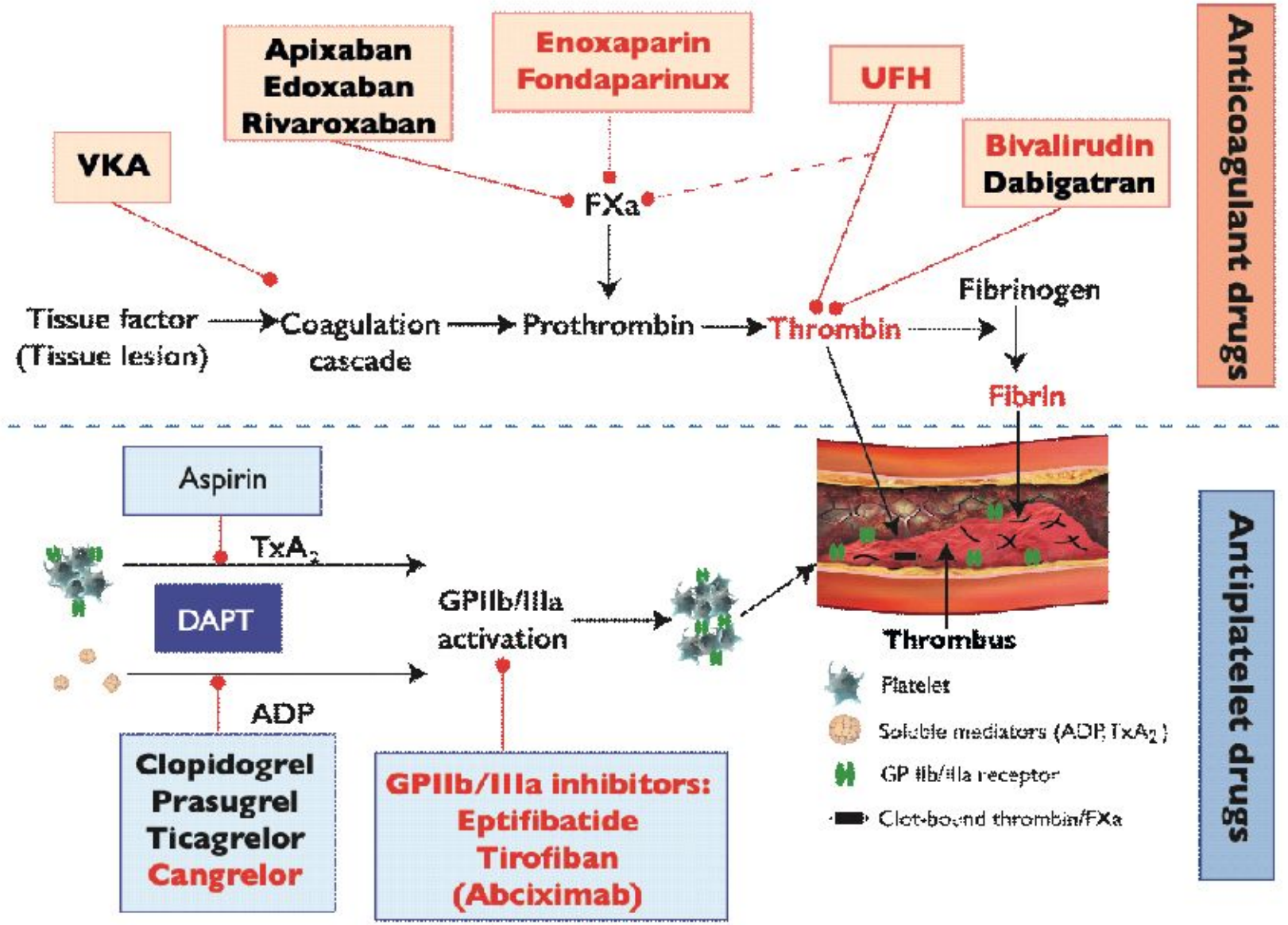

Patient's characteristics
Age
Sex
Race
History of ischaemic or bleeding events
Clinical presentation
CCS
vs.
ACS
(NSTE-ACS/STEMI)
Comorbidities
CKD
Diabetes
PAD
Heart failure
Co-medication
Need of oral anticoagulation treatment
Various drug-drug interactions
Procedural aspects
PCI vs CABG
Femoral vs. radial access
Invasive vs. conservative management
Antithrombotic treatment
Choice of drugs / Drug dosing / Treatment duration
Ischaemic risk
Bleeding risk



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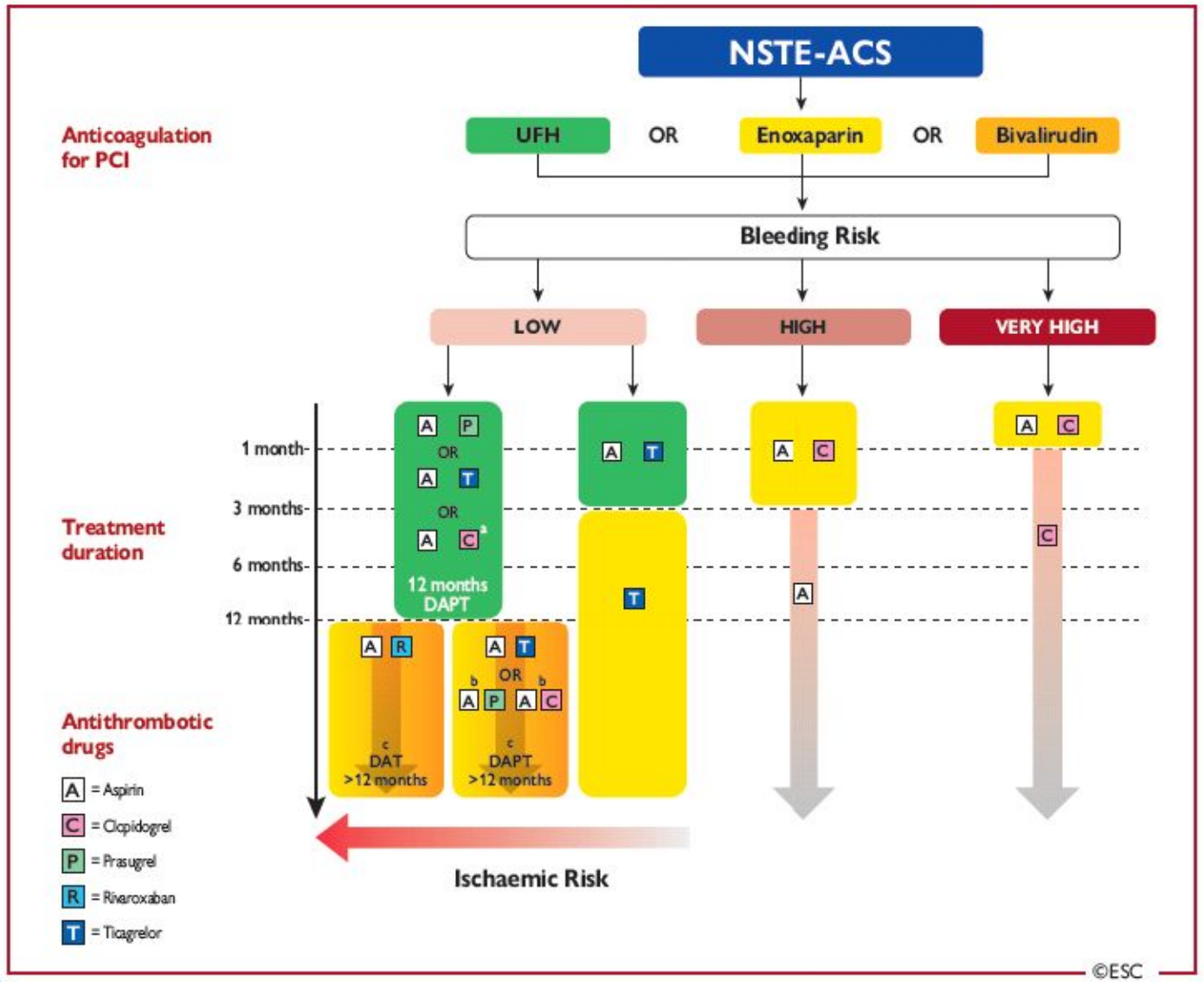

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= Class I = Class IIa = Class IIb

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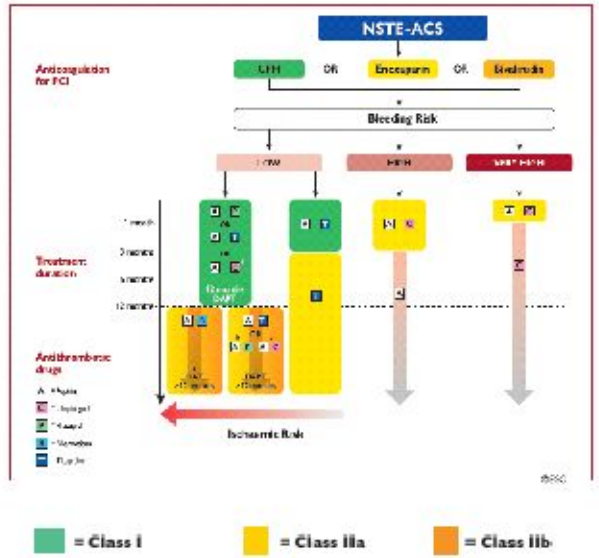

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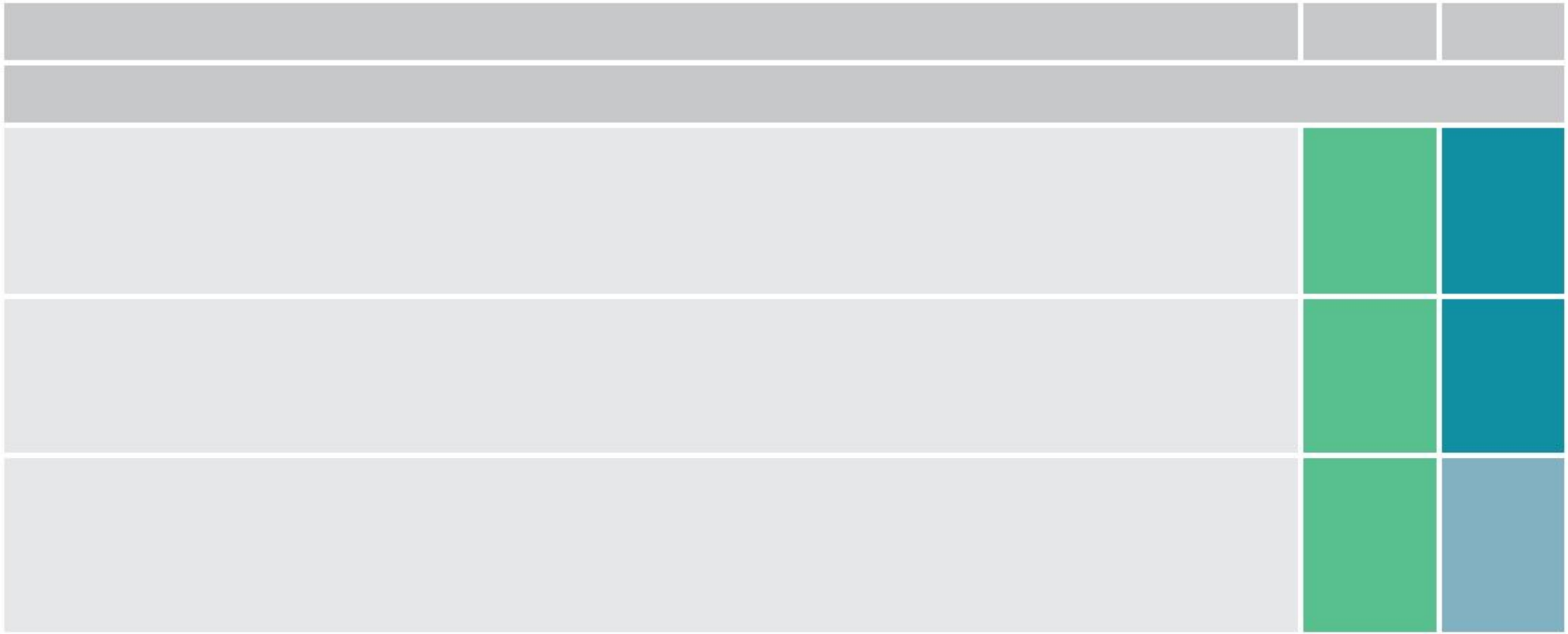

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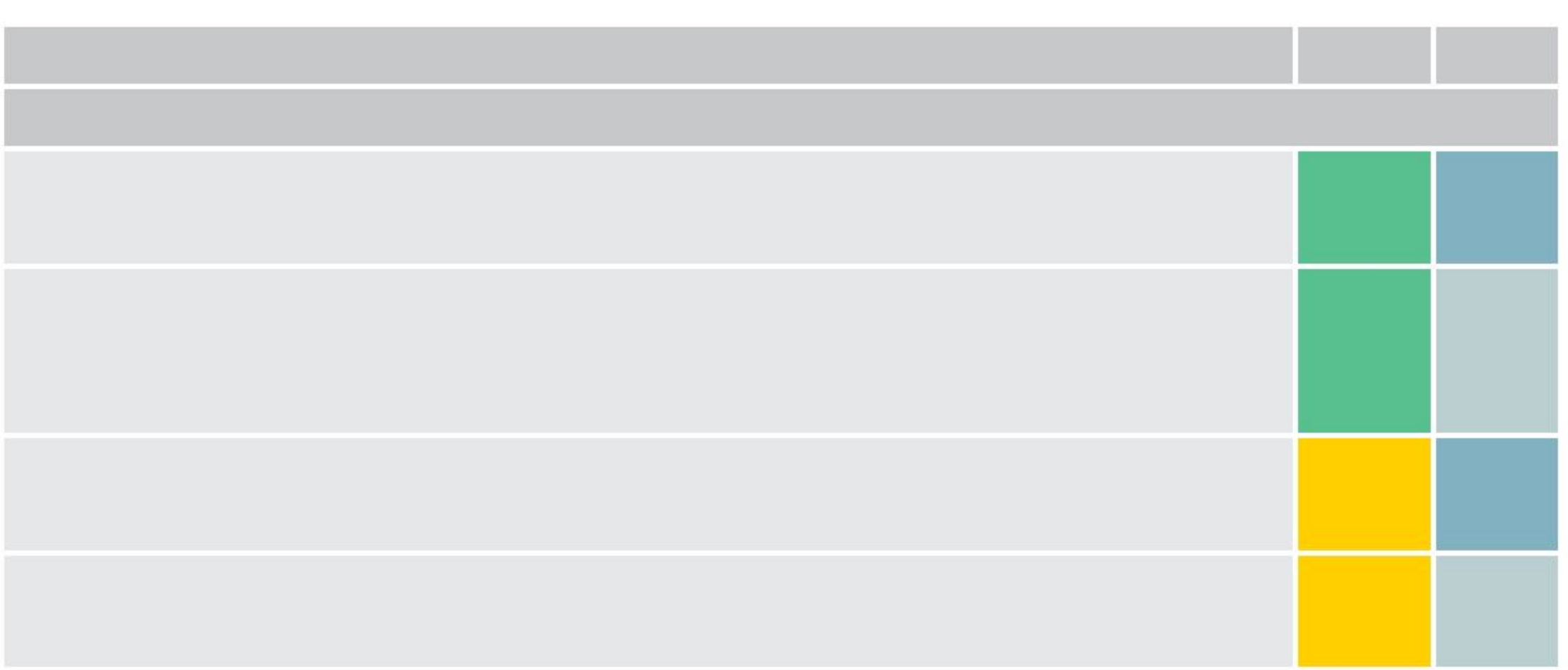

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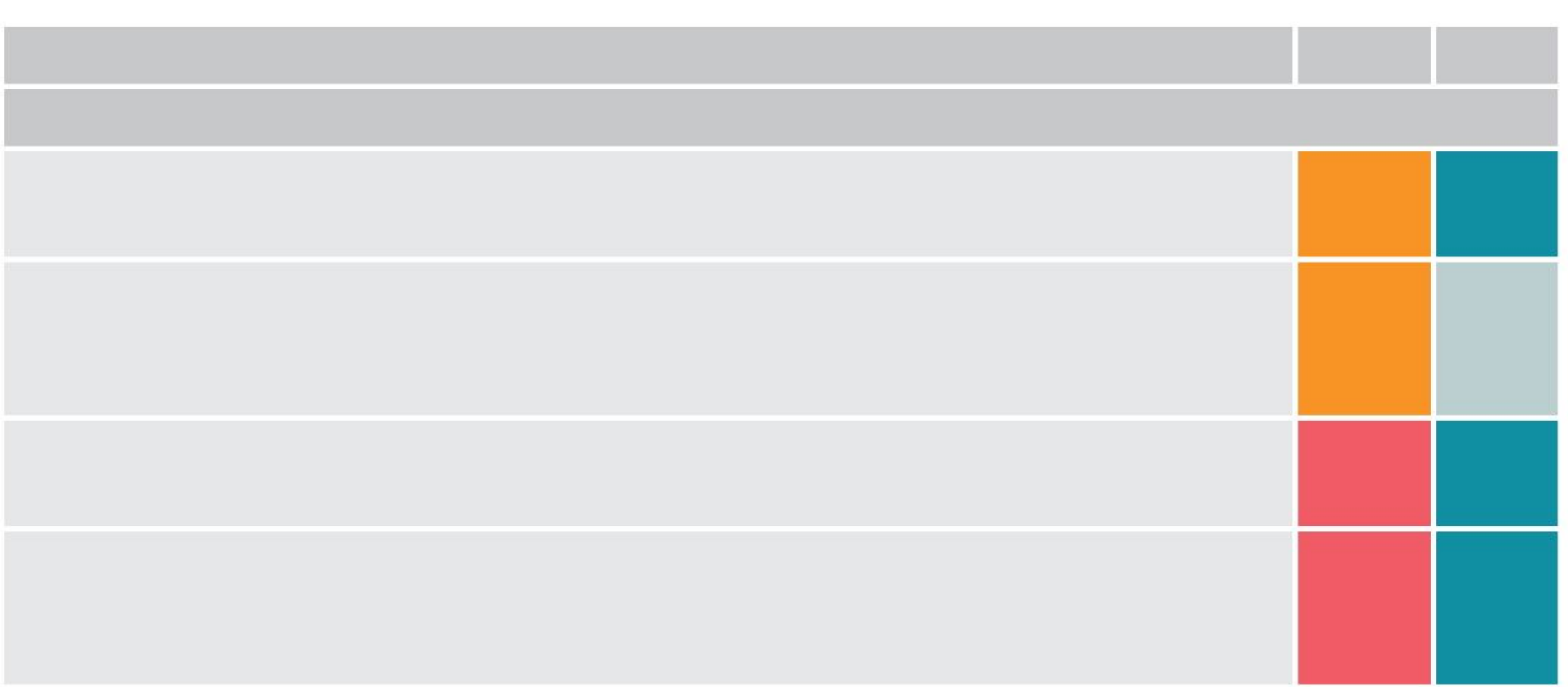

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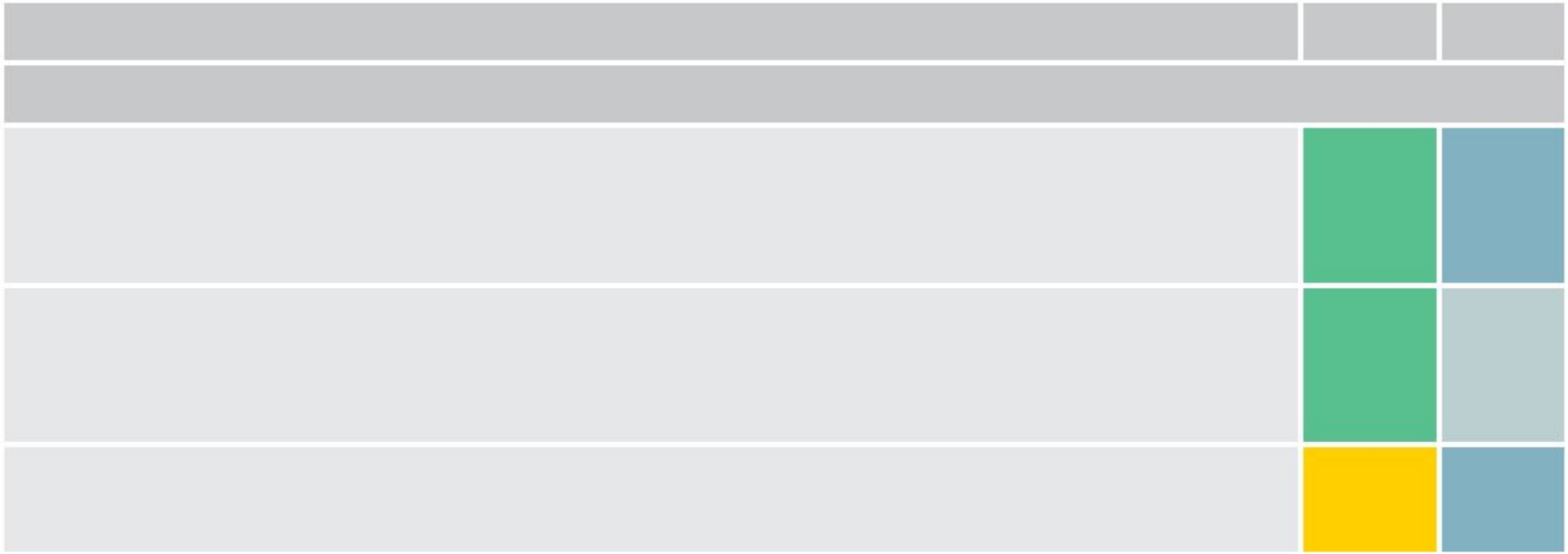

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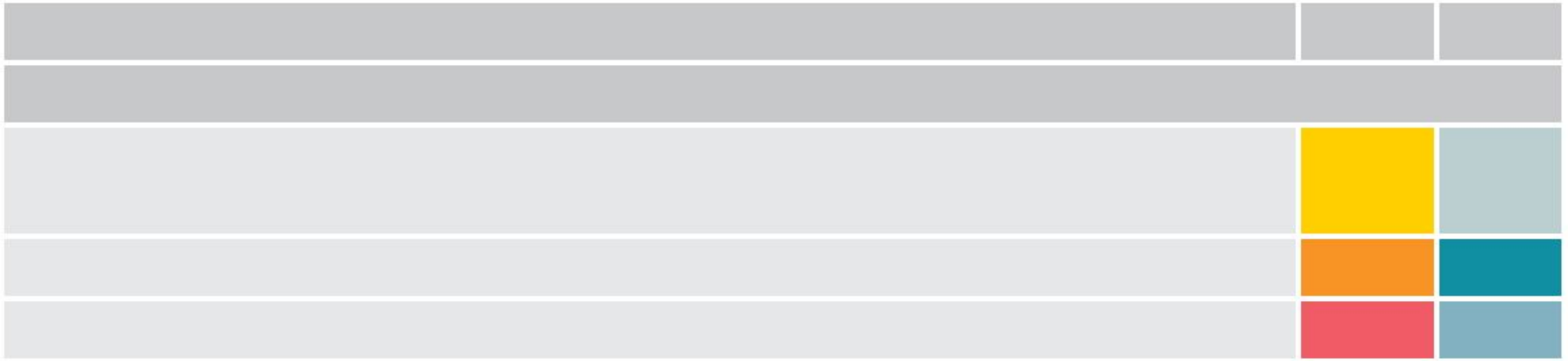

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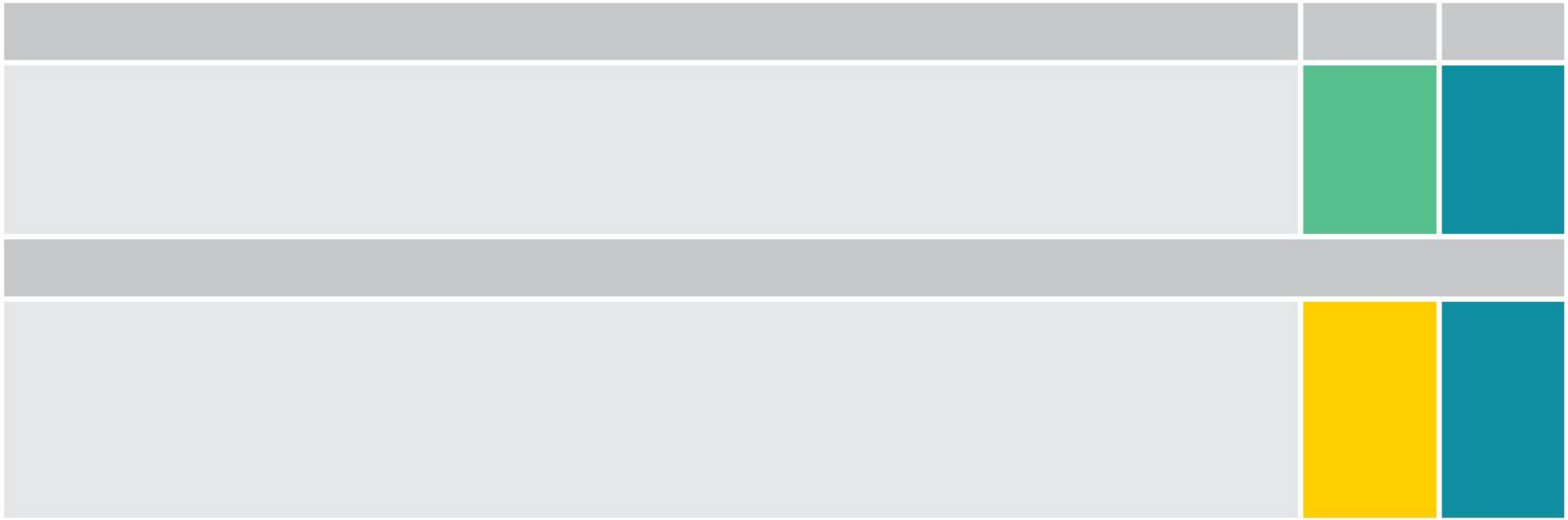

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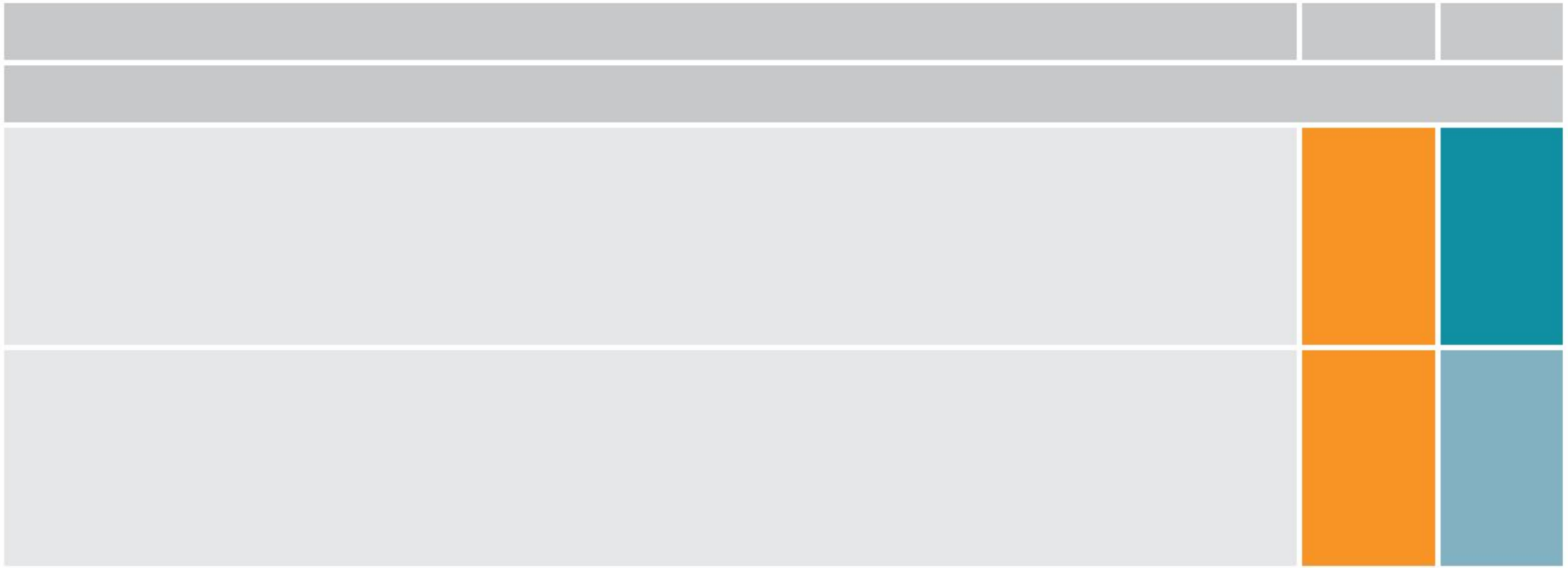

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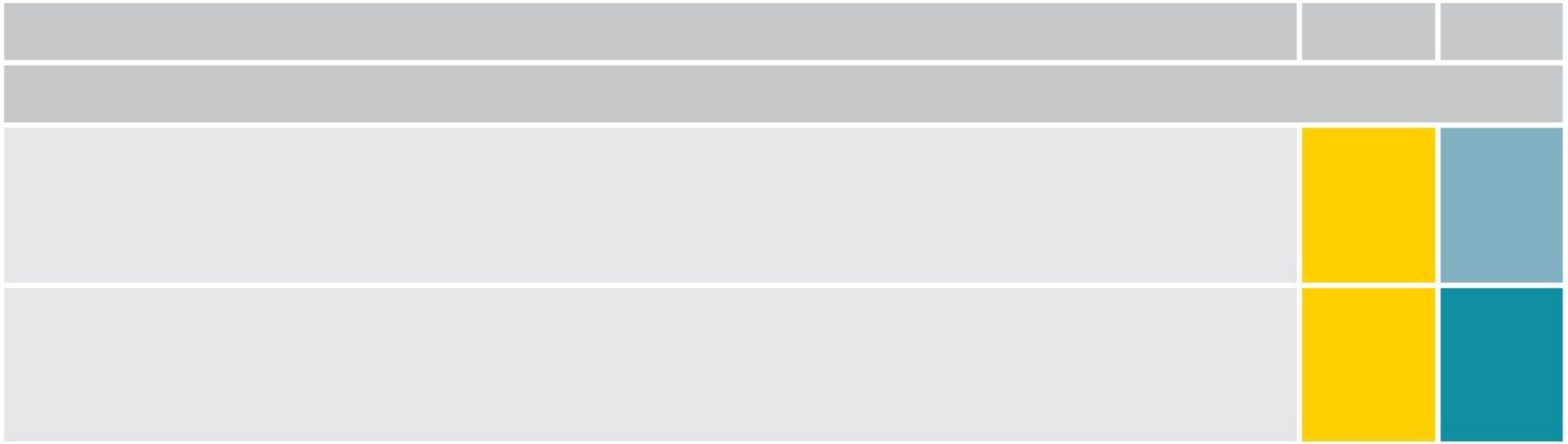

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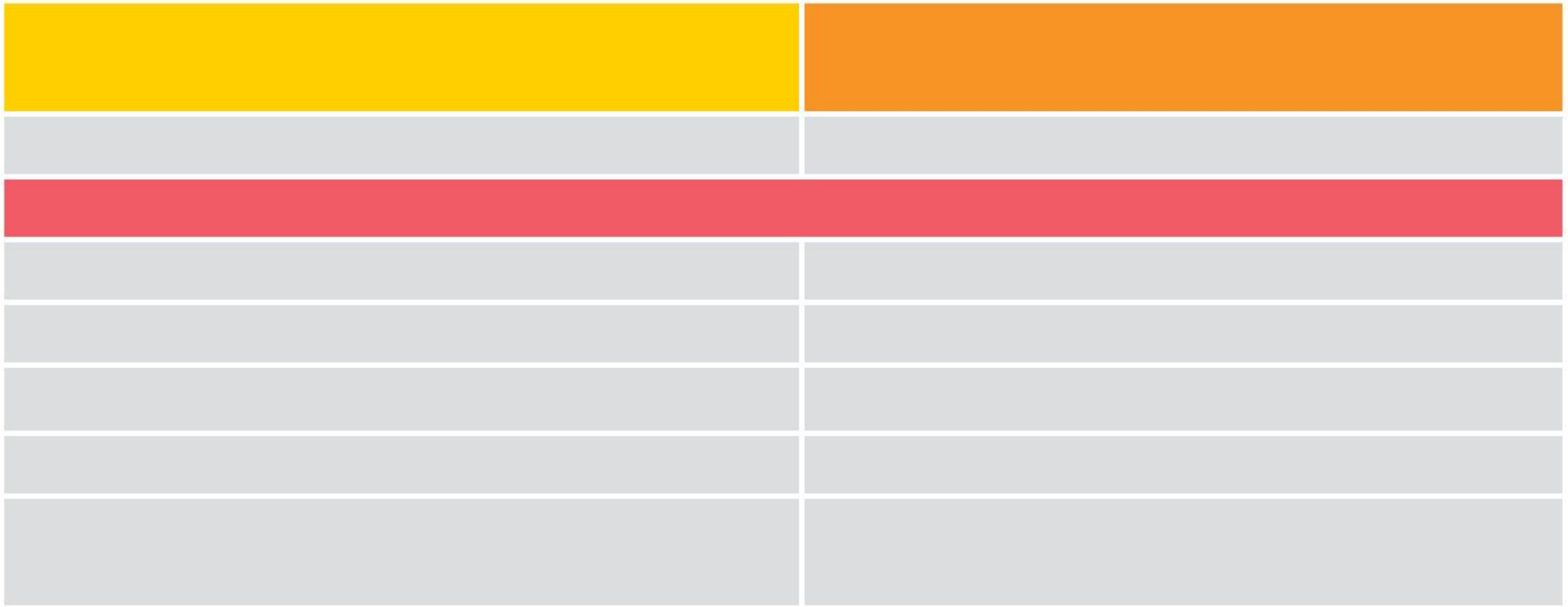

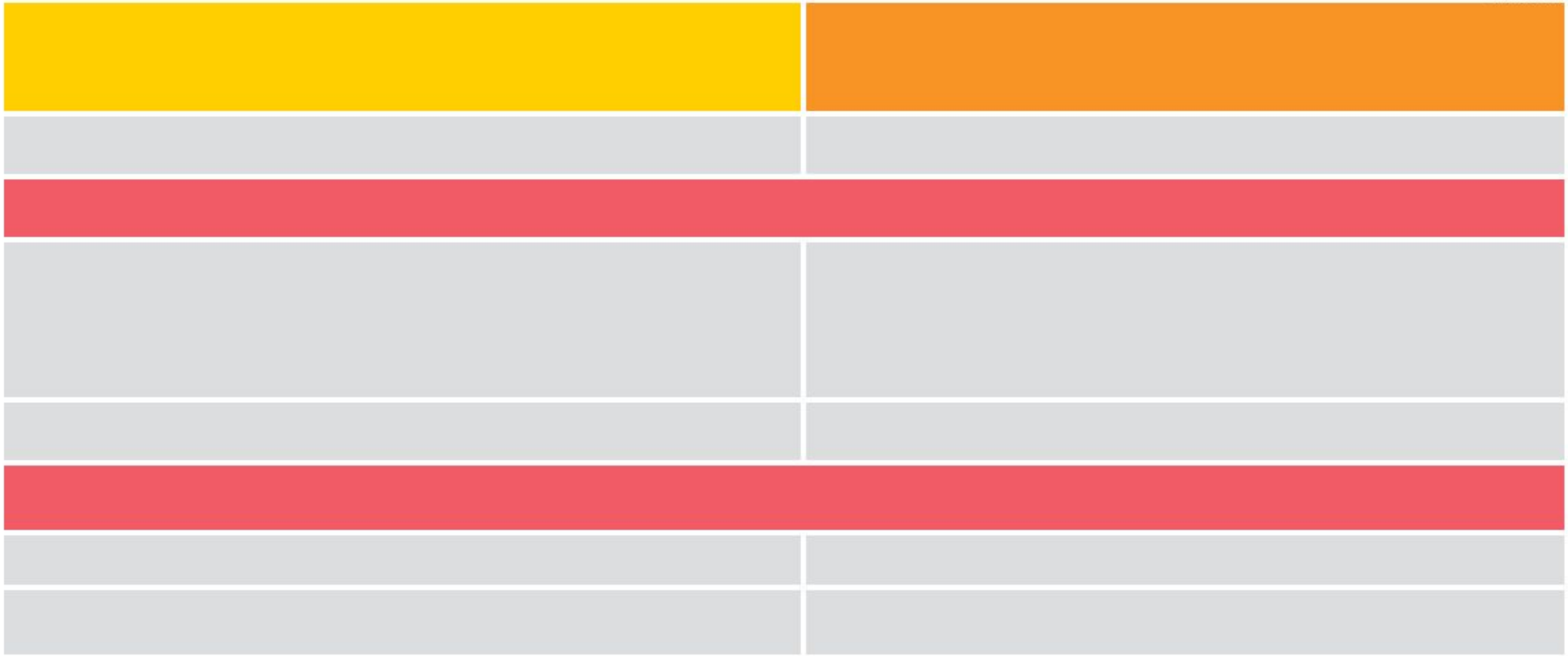

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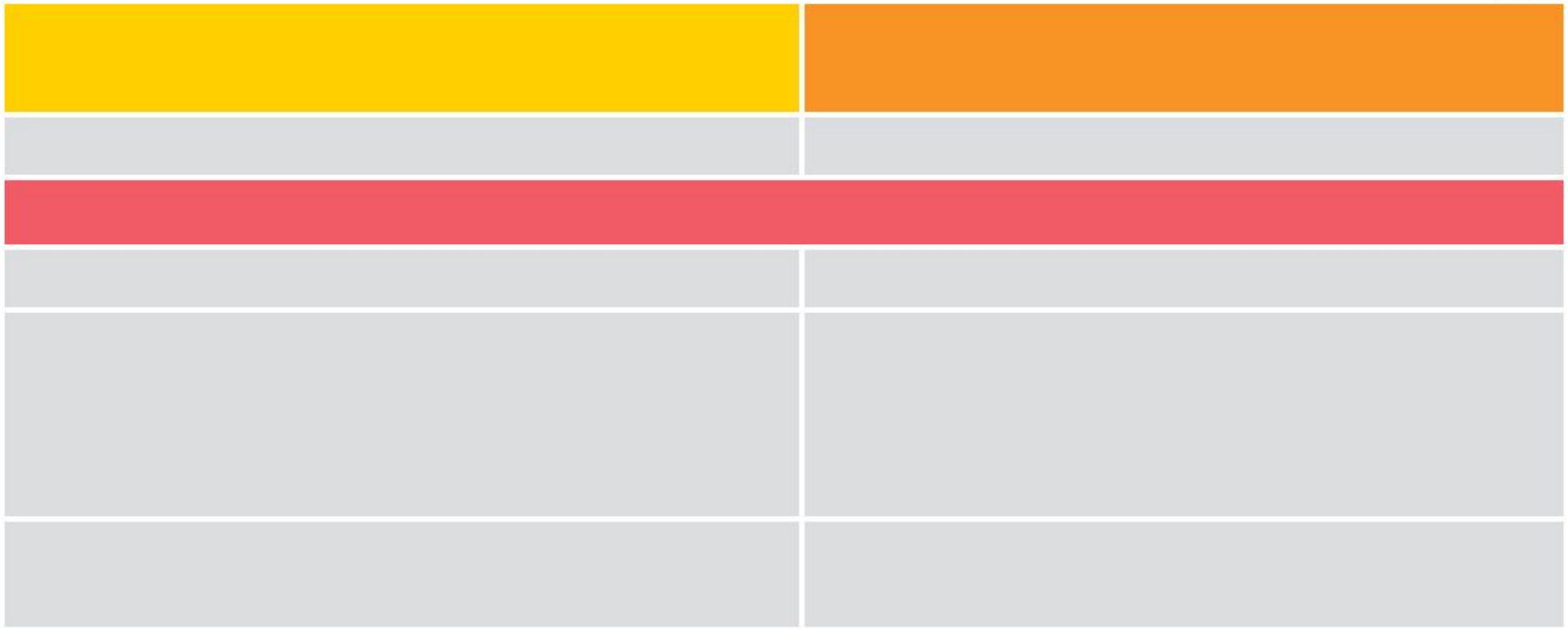

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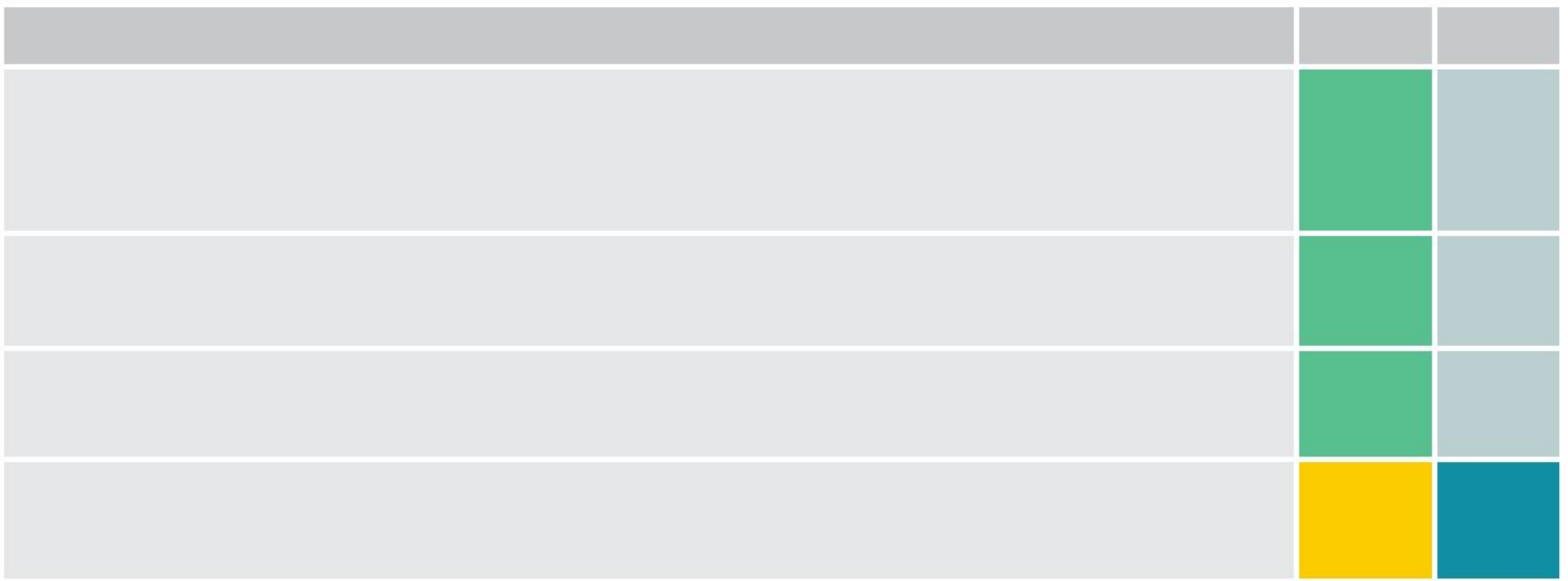

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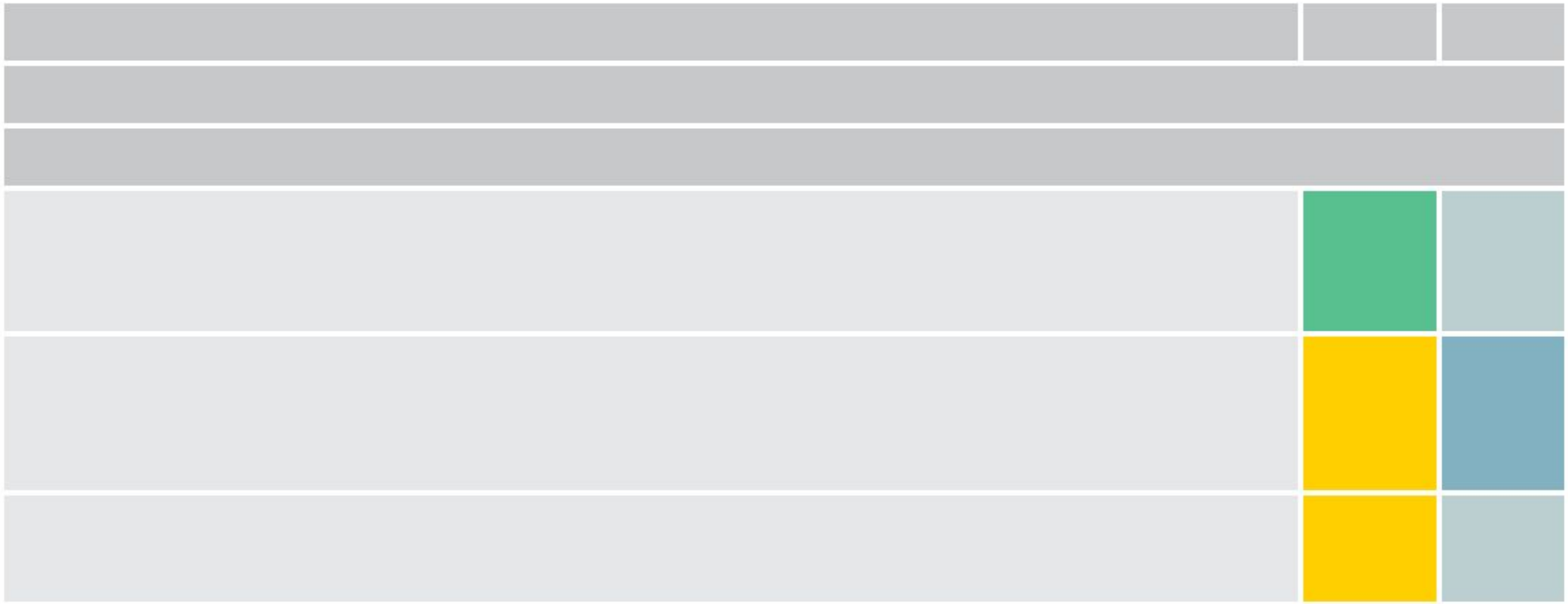

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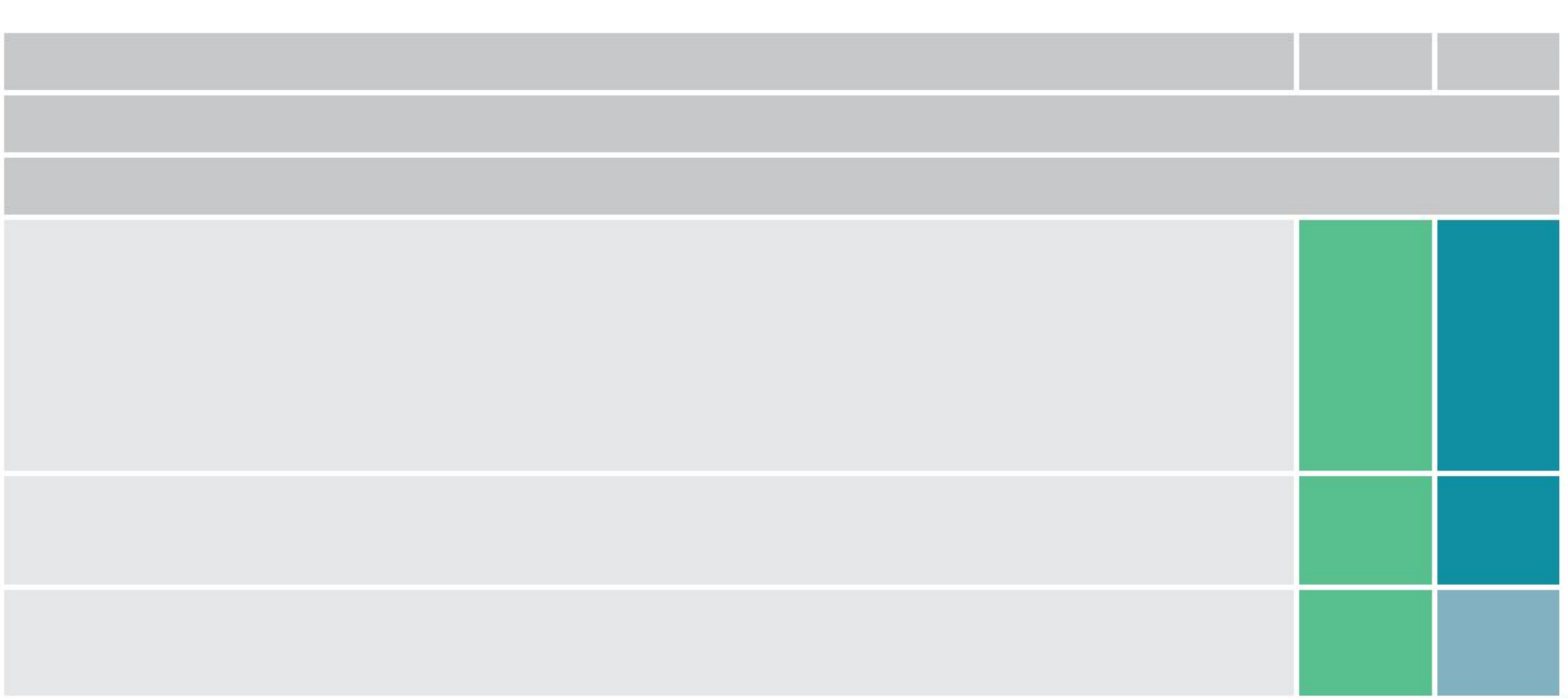

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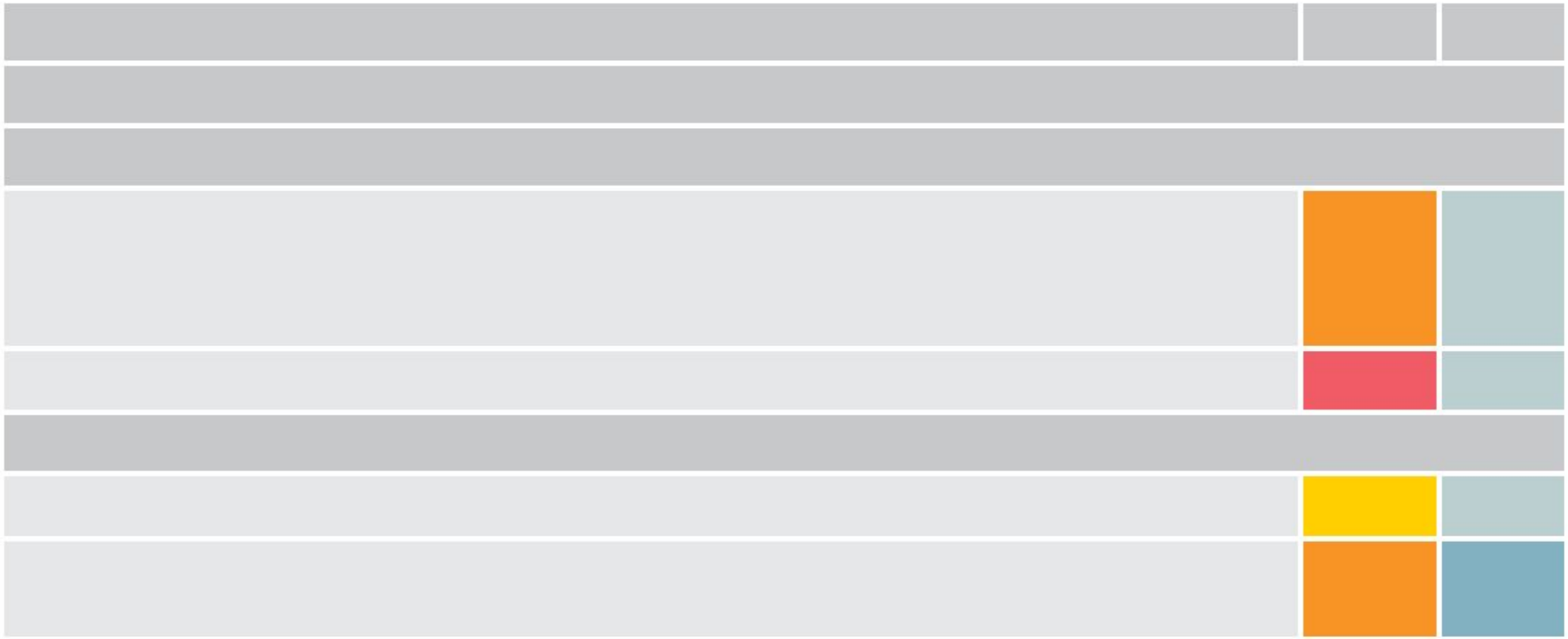

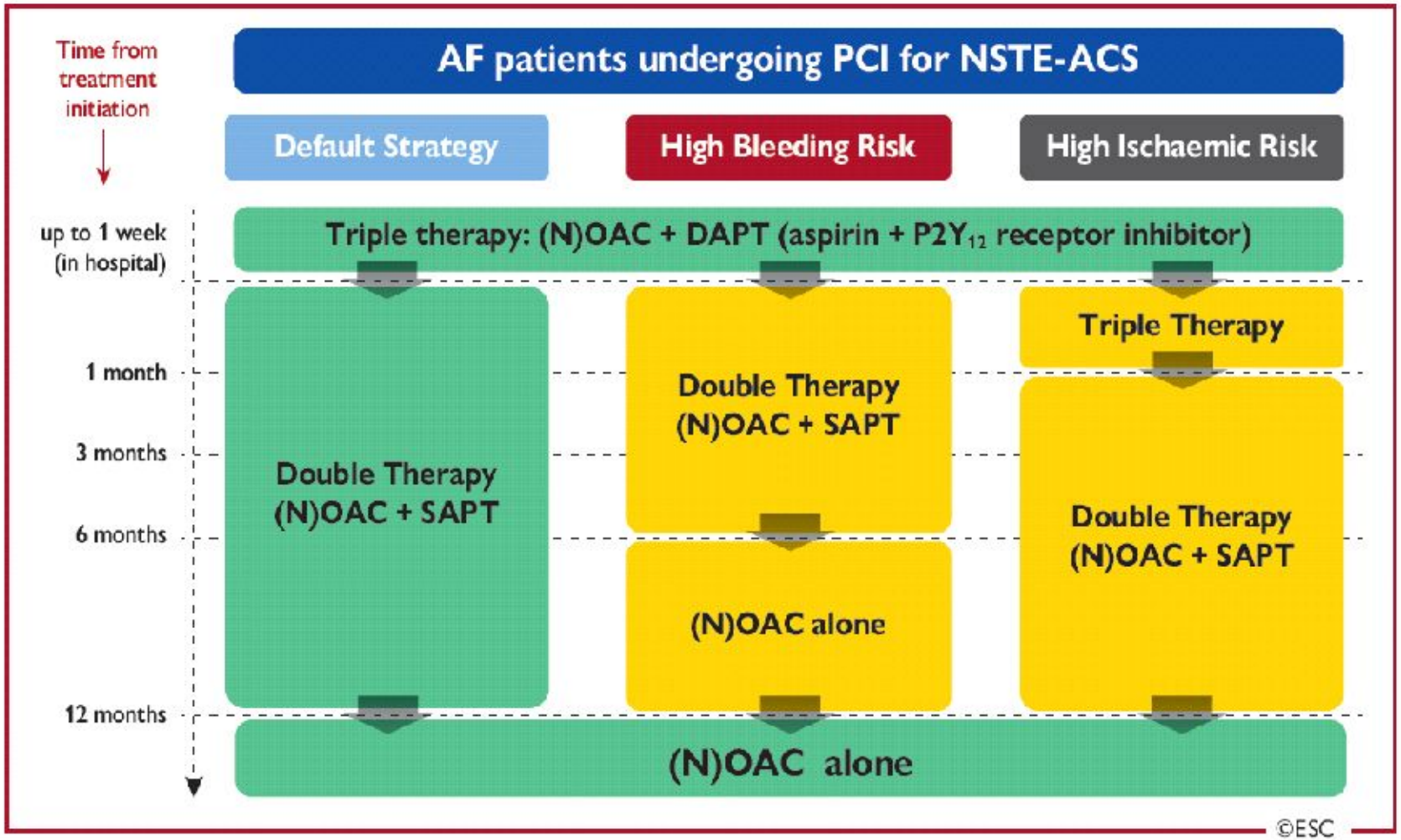
Time from treatment initiation
AF patients undergoing PCI for NSTE-ACS
Default Strategy
High Bleeding Risk
High Ischaemic Risk
up to 1 week (in hospital)
Triple therapy: (N)OAC + DAPT (aspirin + P2Y12 receptor inhibitor)
1 month
3 months
6 months
12 months
Double Therapy (N)OAC + SAPT
Double Therapy (N)OAC + SAPT
(N)OAC alone
Triple Therapy
Double Therapy (N)OAC + SAPT
(N)OAC alone
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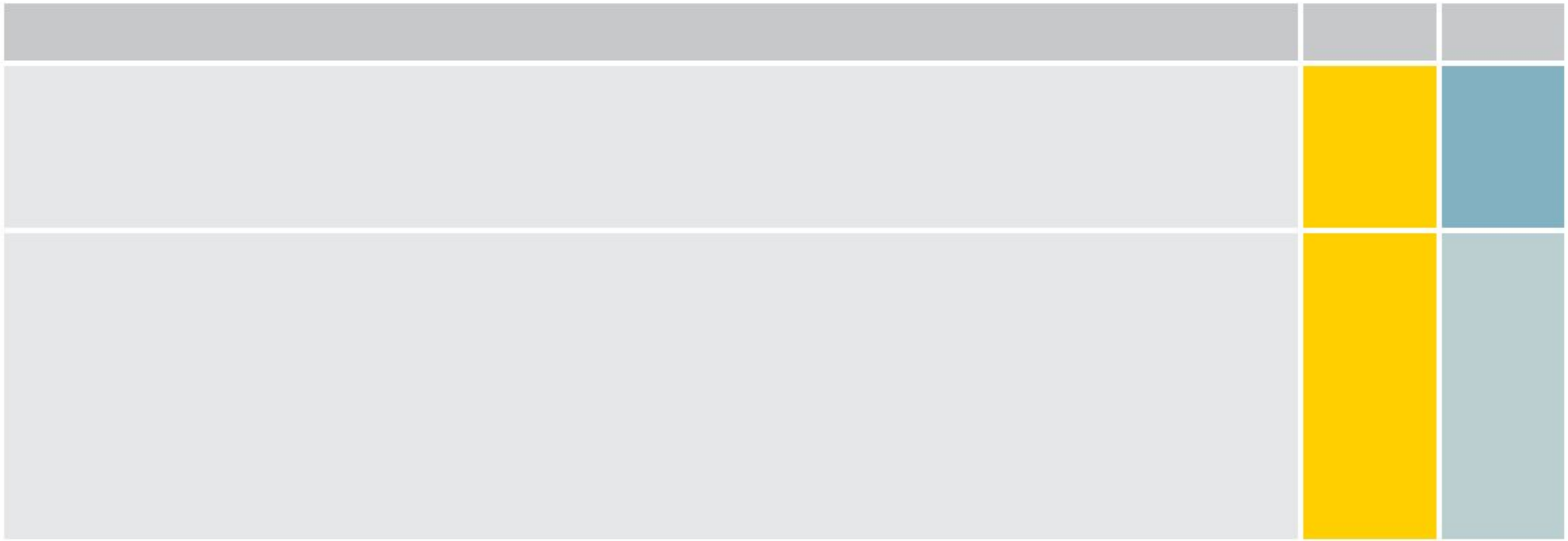

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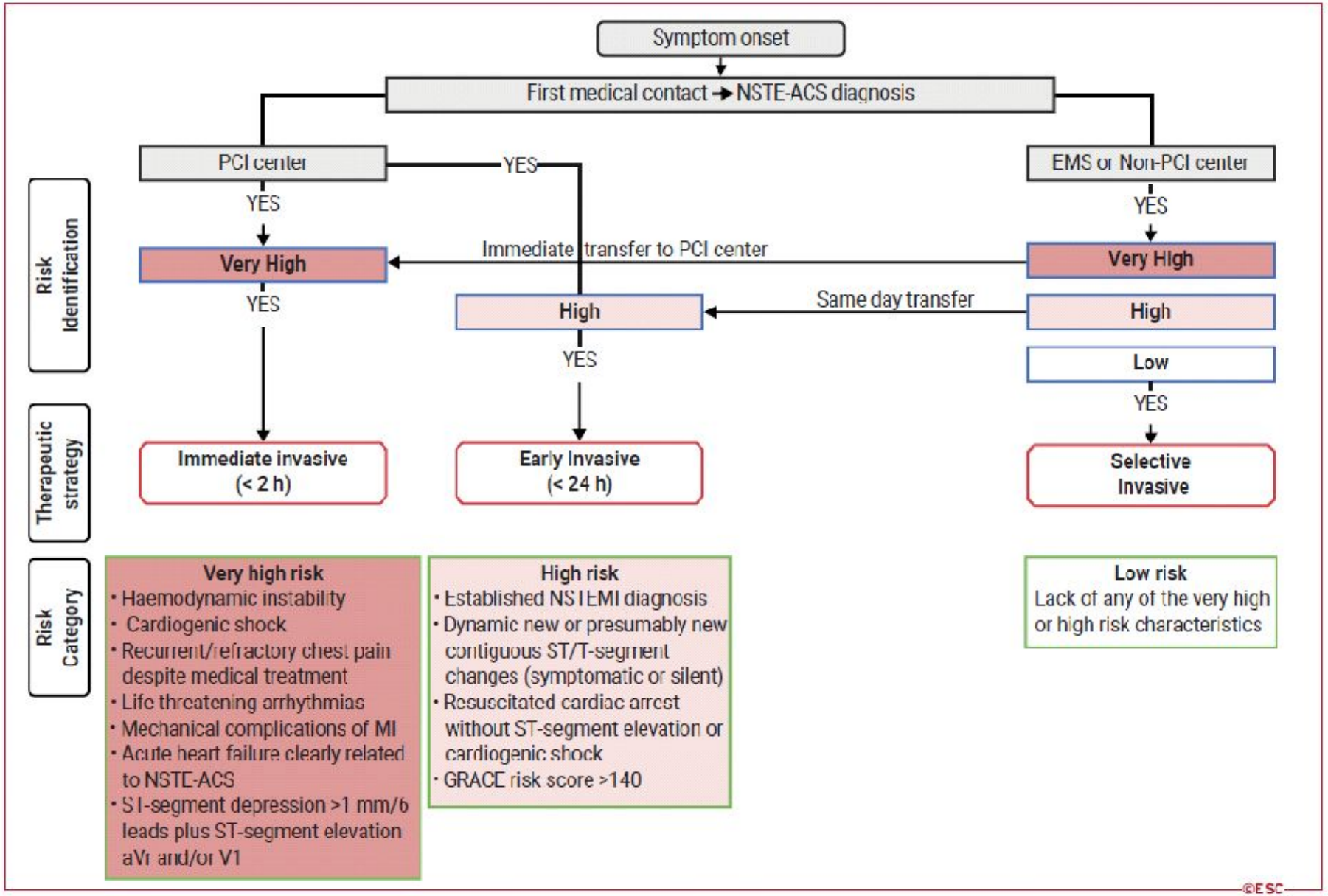

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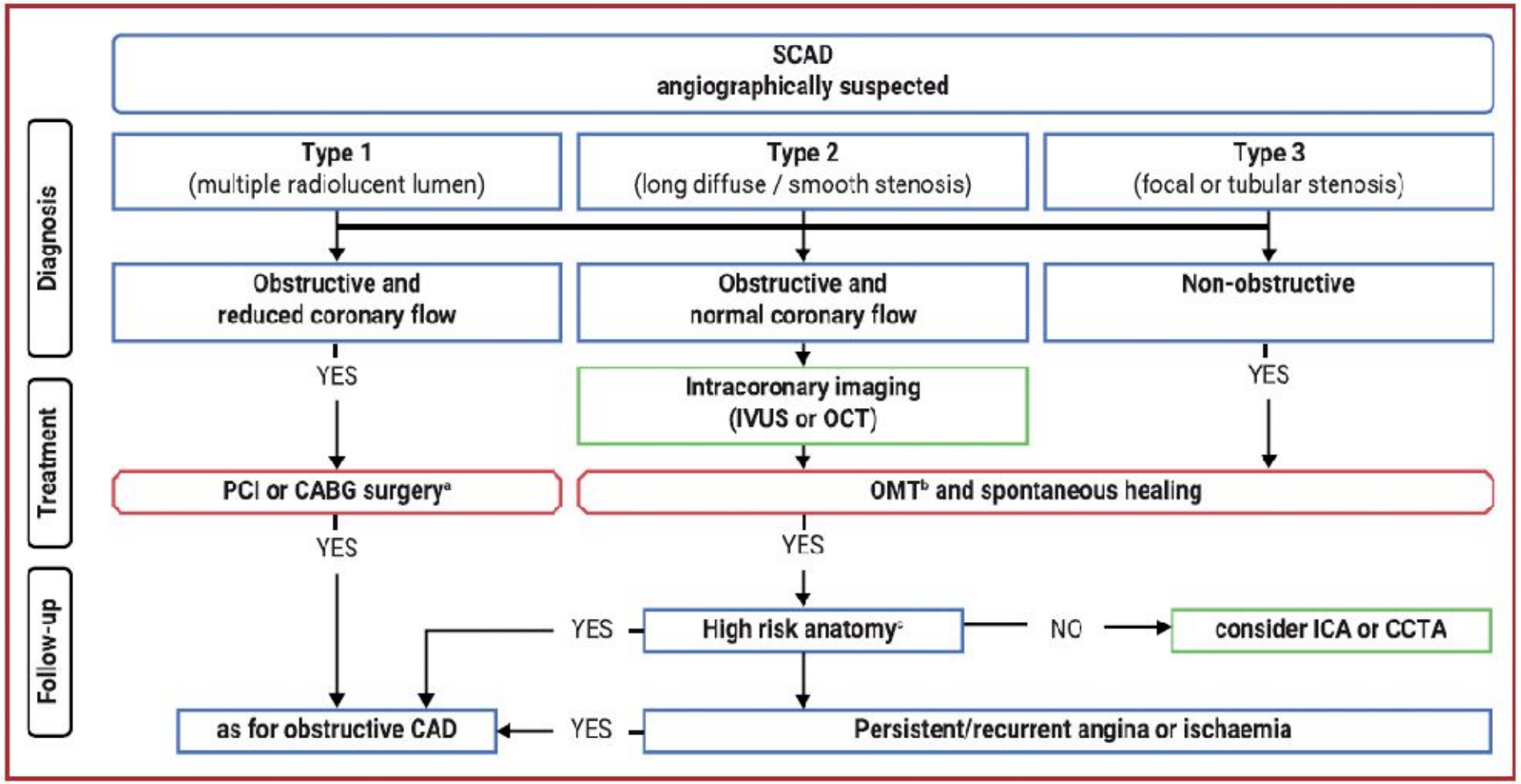
SCAD
angiographically suspected
Diagnosis
Type 1
(multiple radiolucent lumen)
Type 2
(long diffuse / smooth stenosis)
Type 3
(focal or tubular stenosis)
Obstructive and
reduced coronary flow
Obstructive and
normal coronary flow
Non-obstructive
Treatment
YES
Intracoronary imaging
(IVUS or OCT)
YES
PCI or CABG surgery[a]
OMT[b] and spontaneous healing
YES
YES
Follow-up
YES
High risk anatomy[c]
NO
consider ICA or CCTA
as for obstructive CAD
YES
Persistent/recurrent angina or ischaemia
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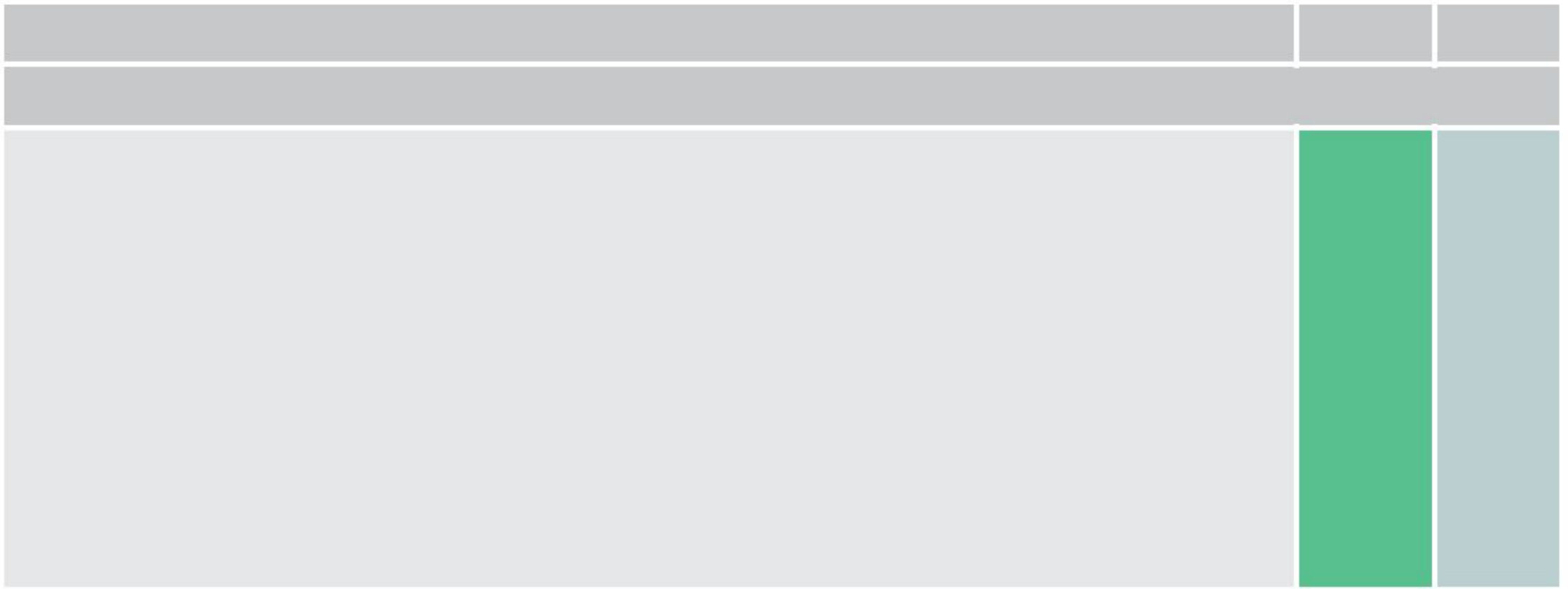

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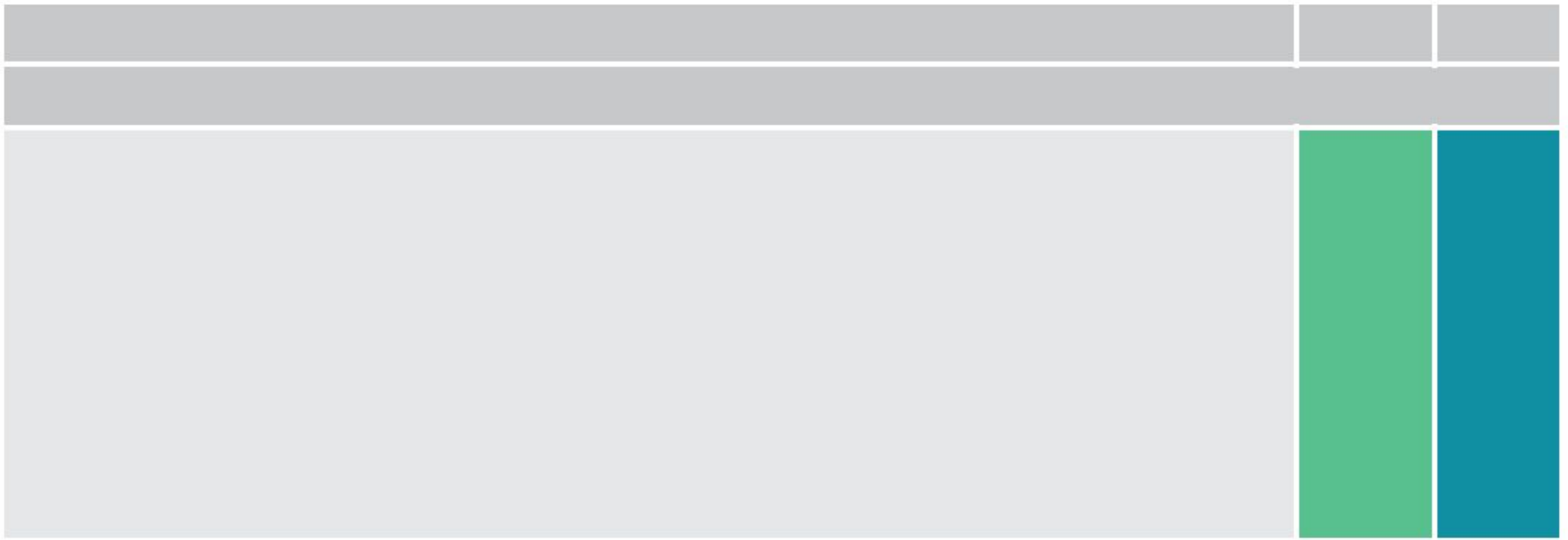

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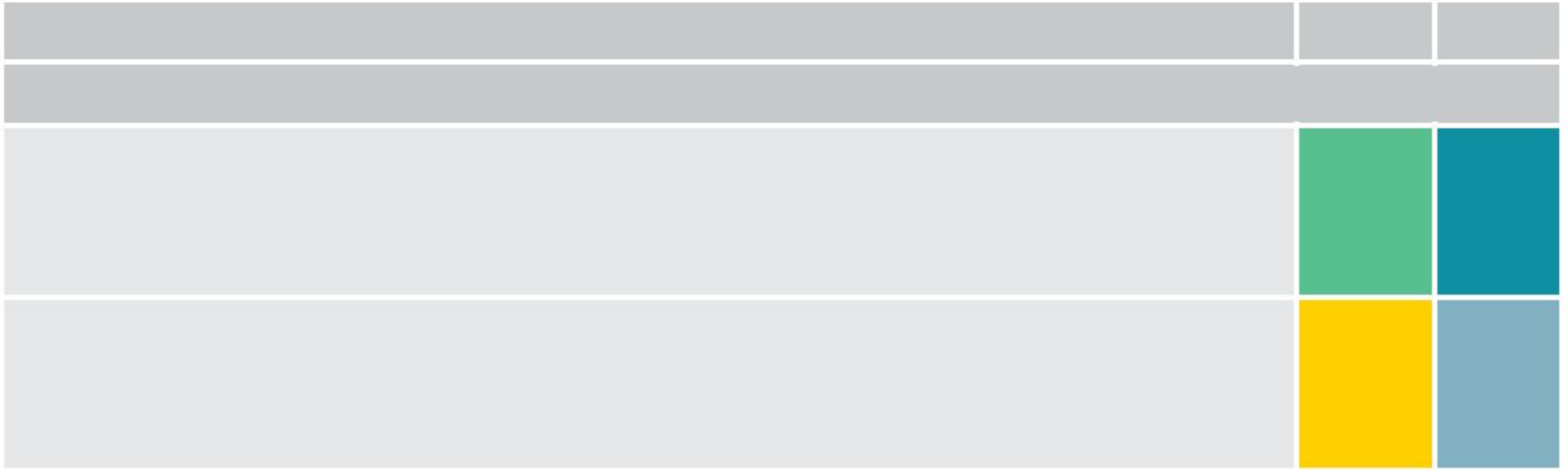

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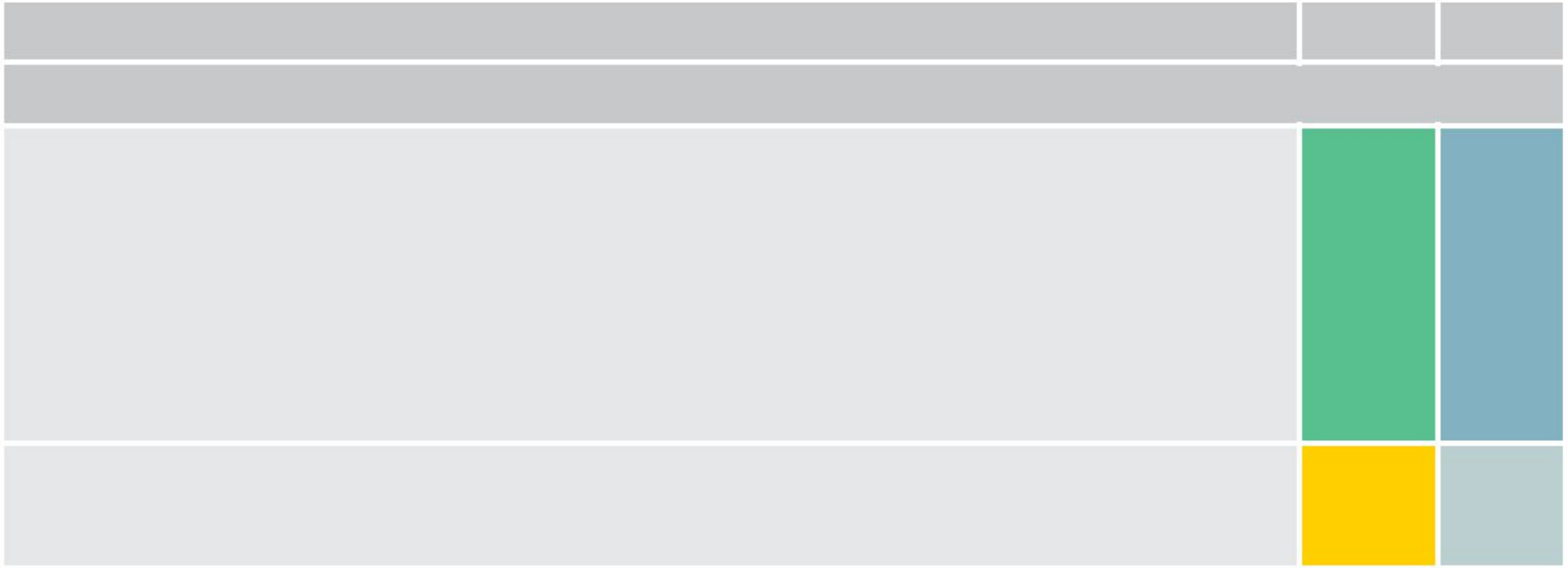

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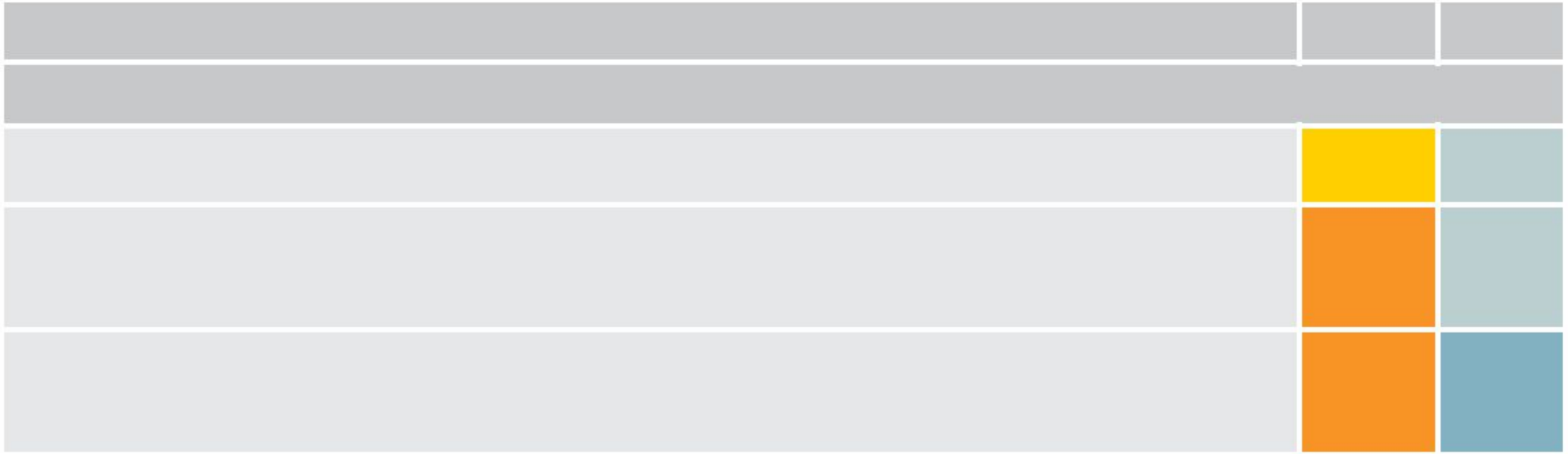

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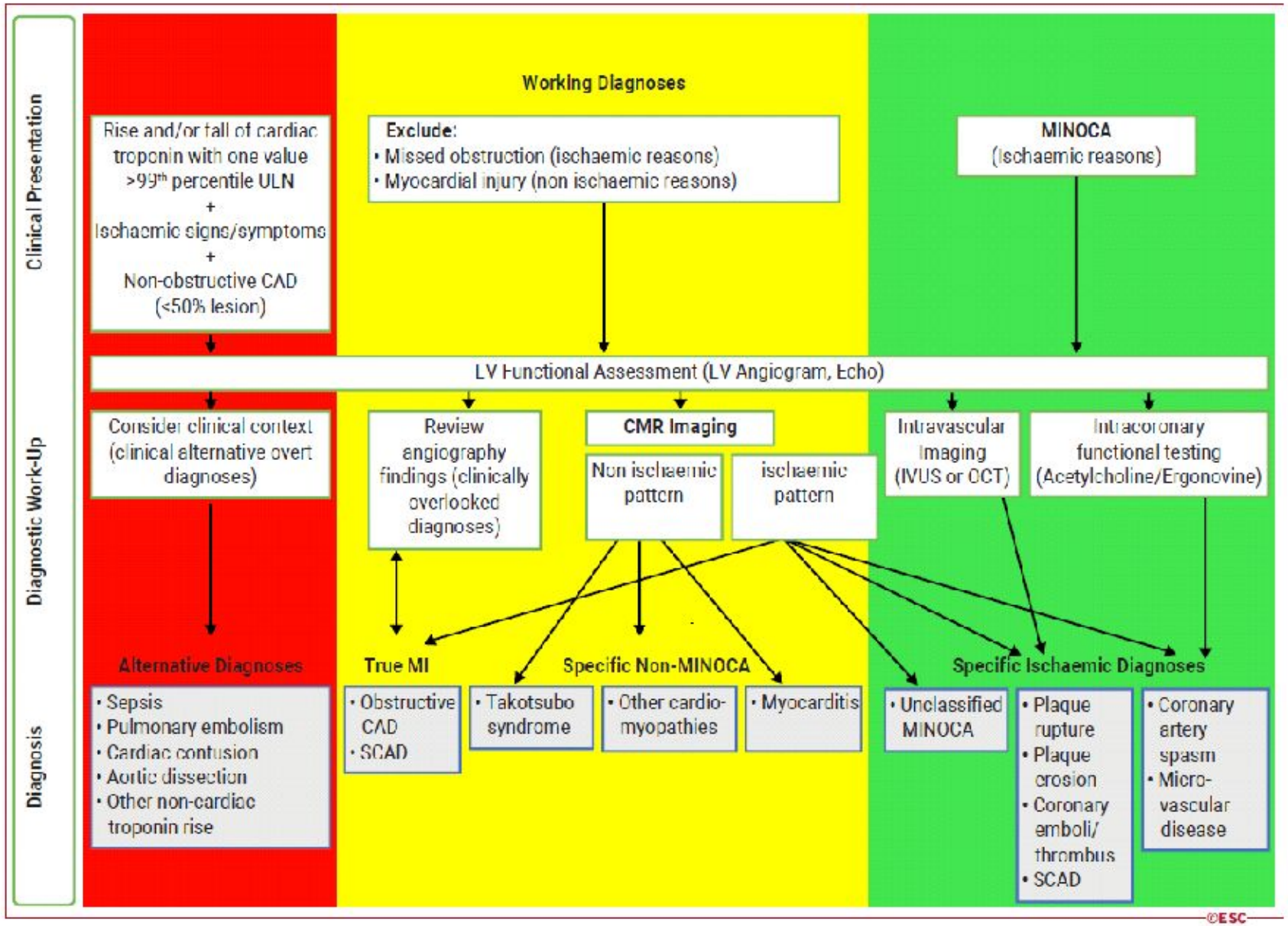

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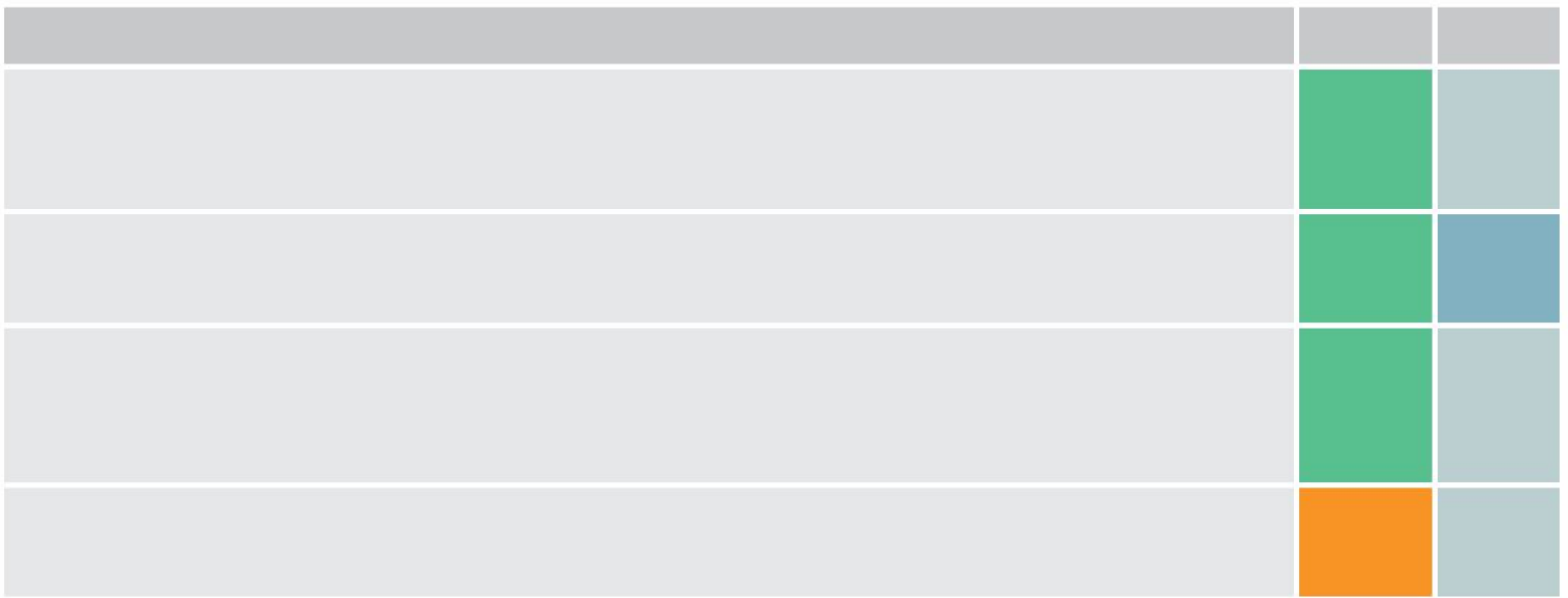

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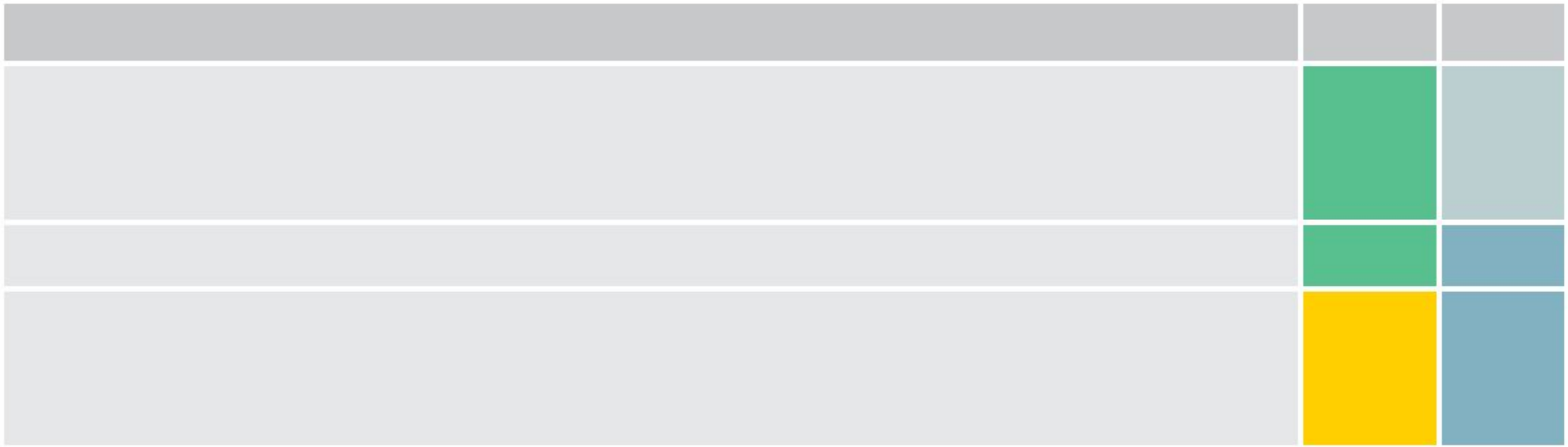

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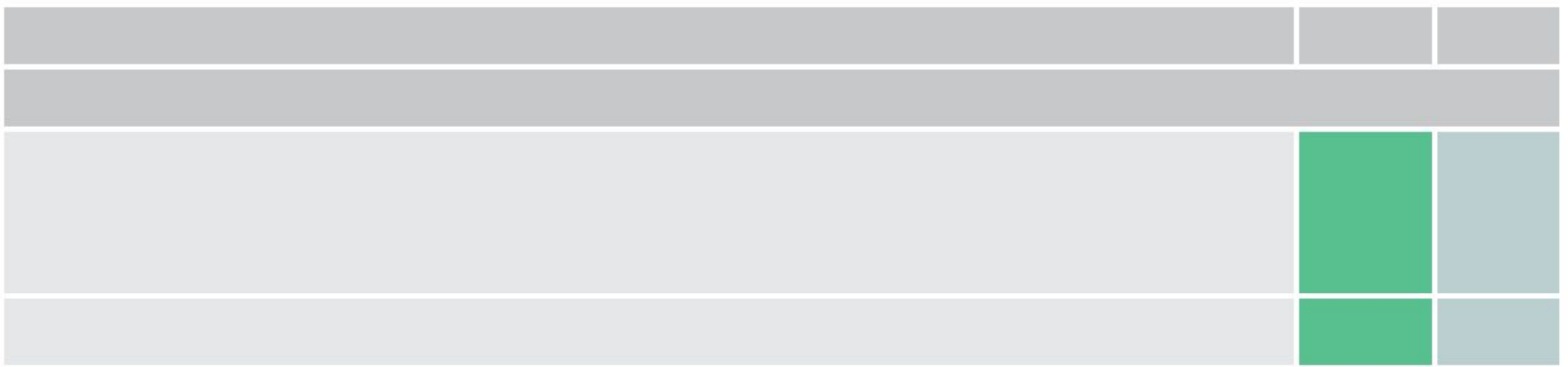

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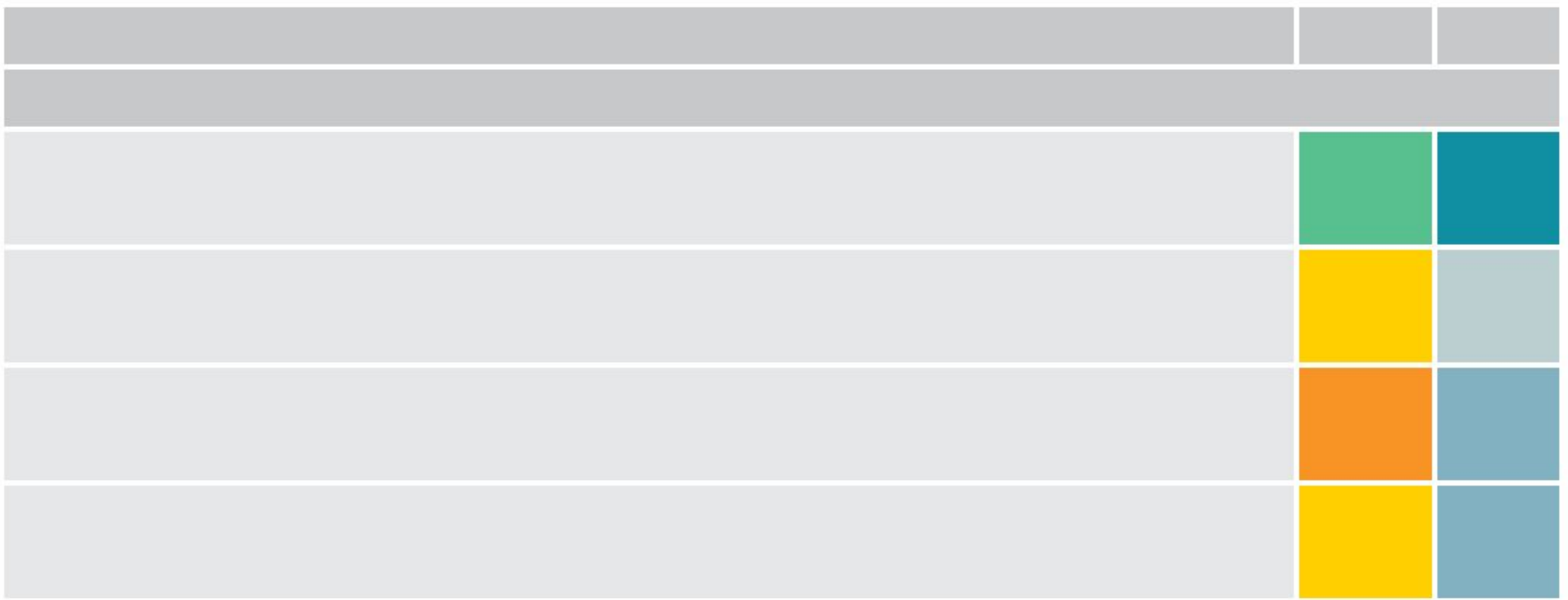

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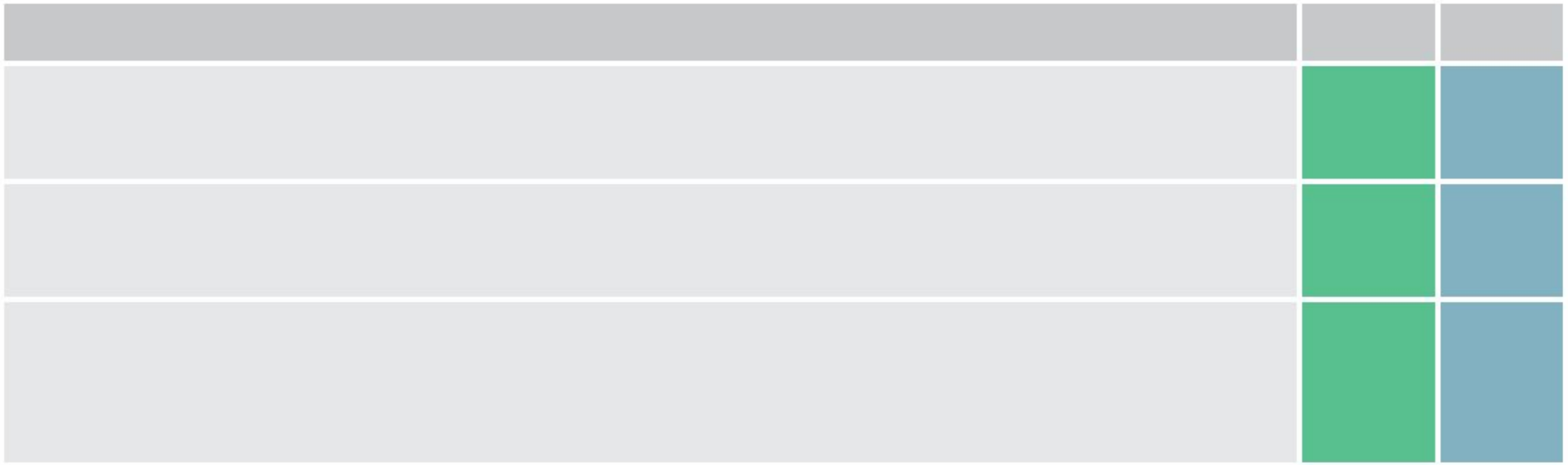

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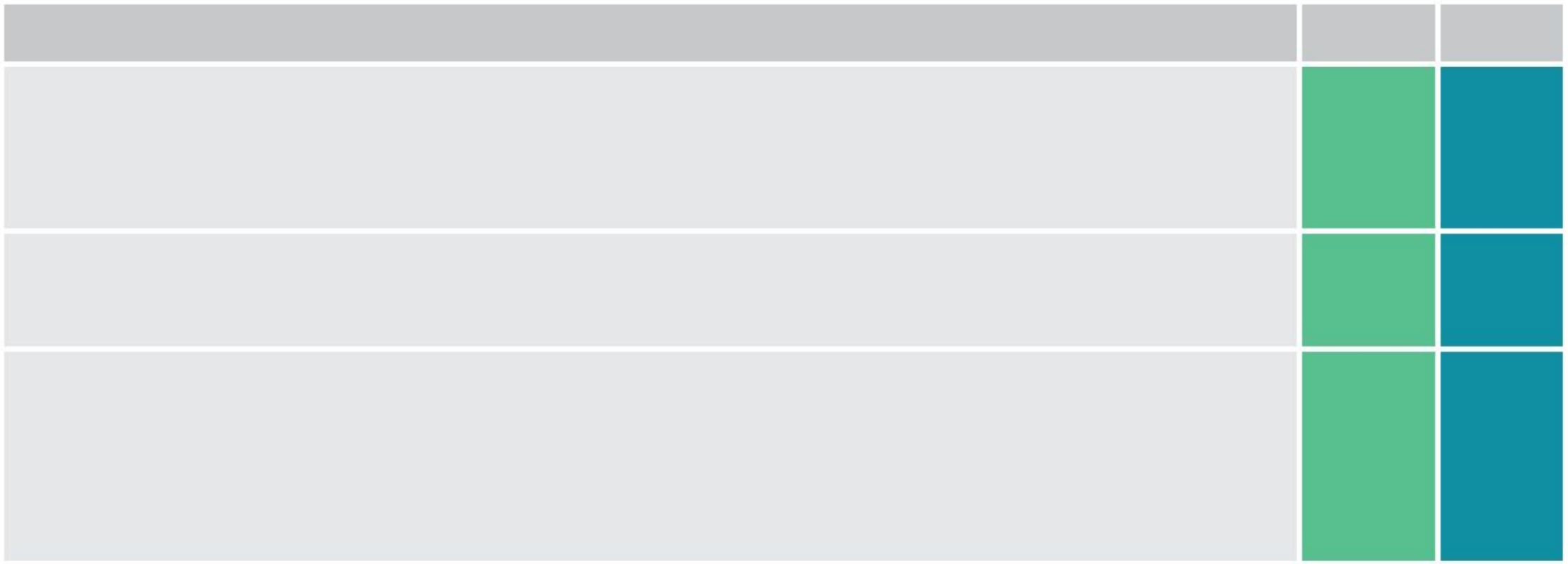

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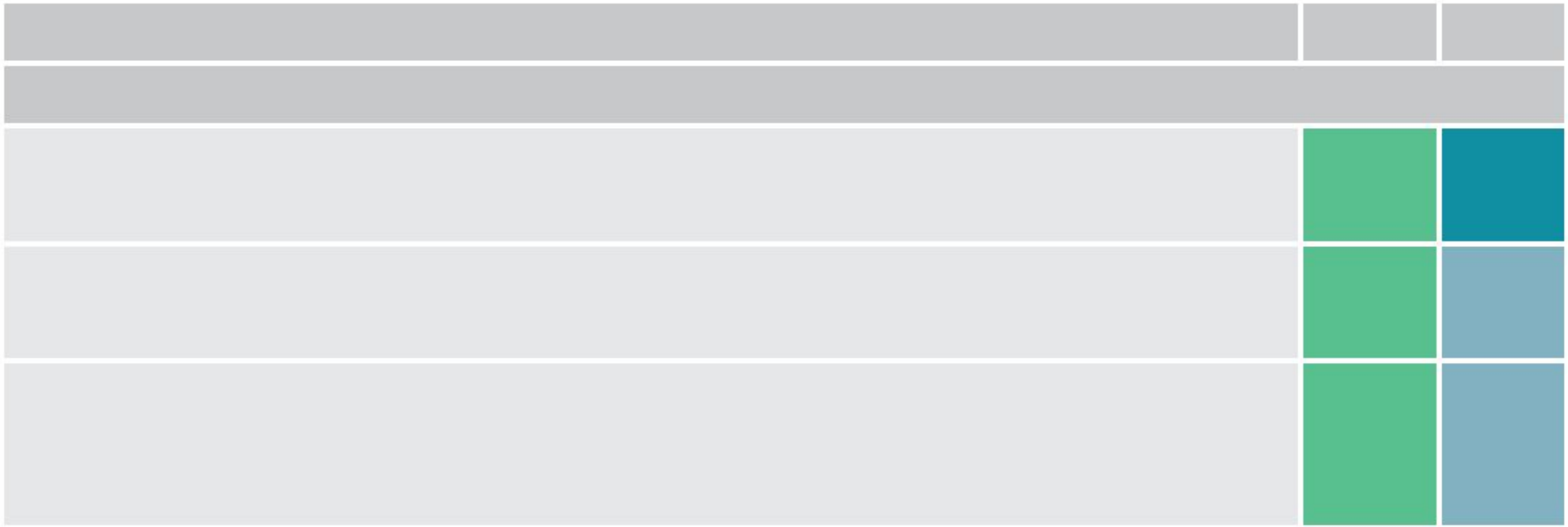

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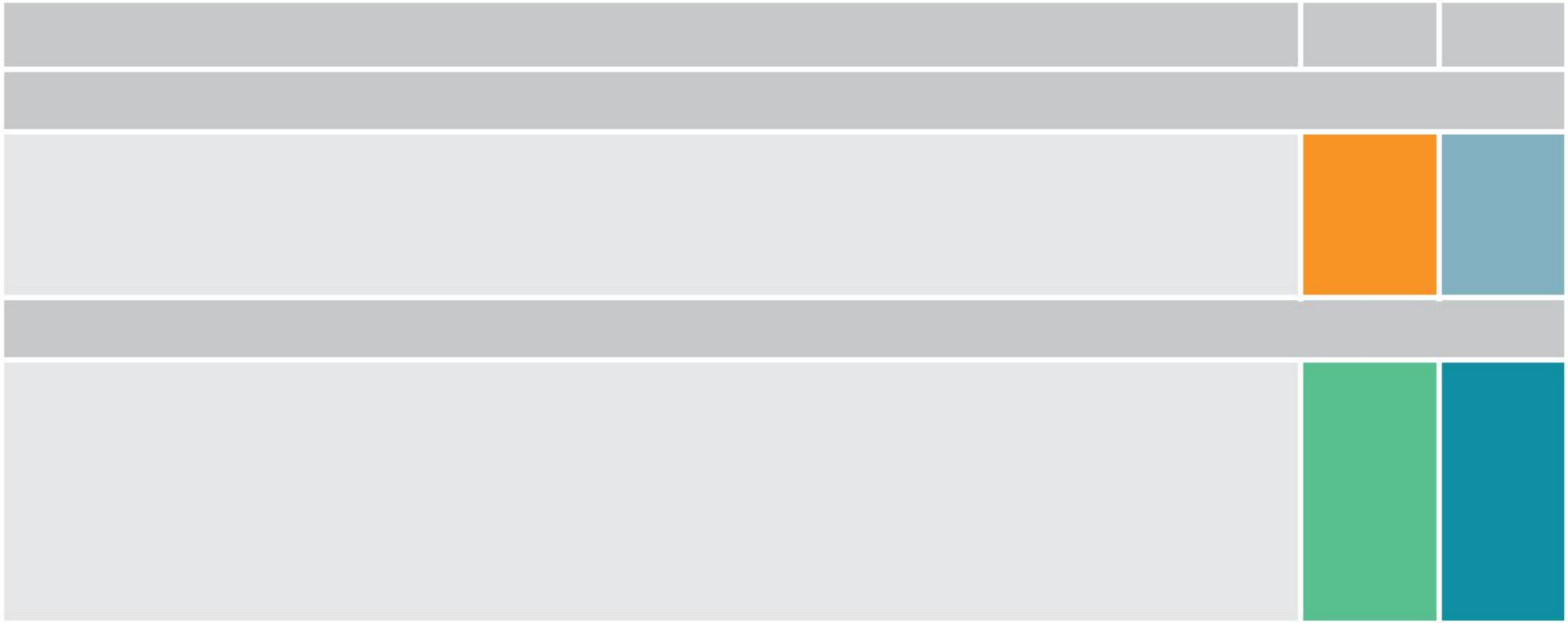

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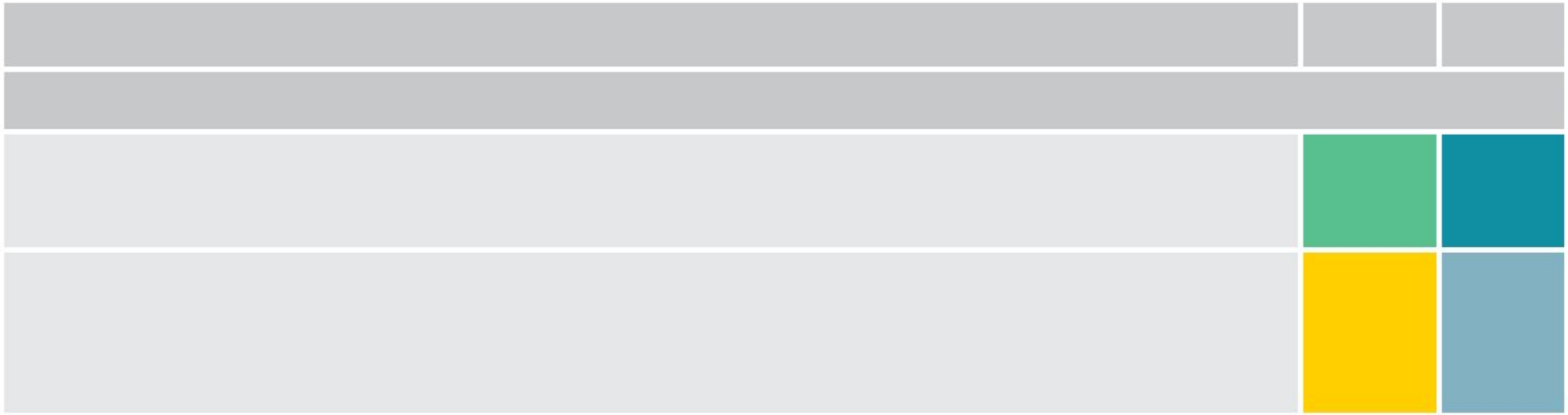

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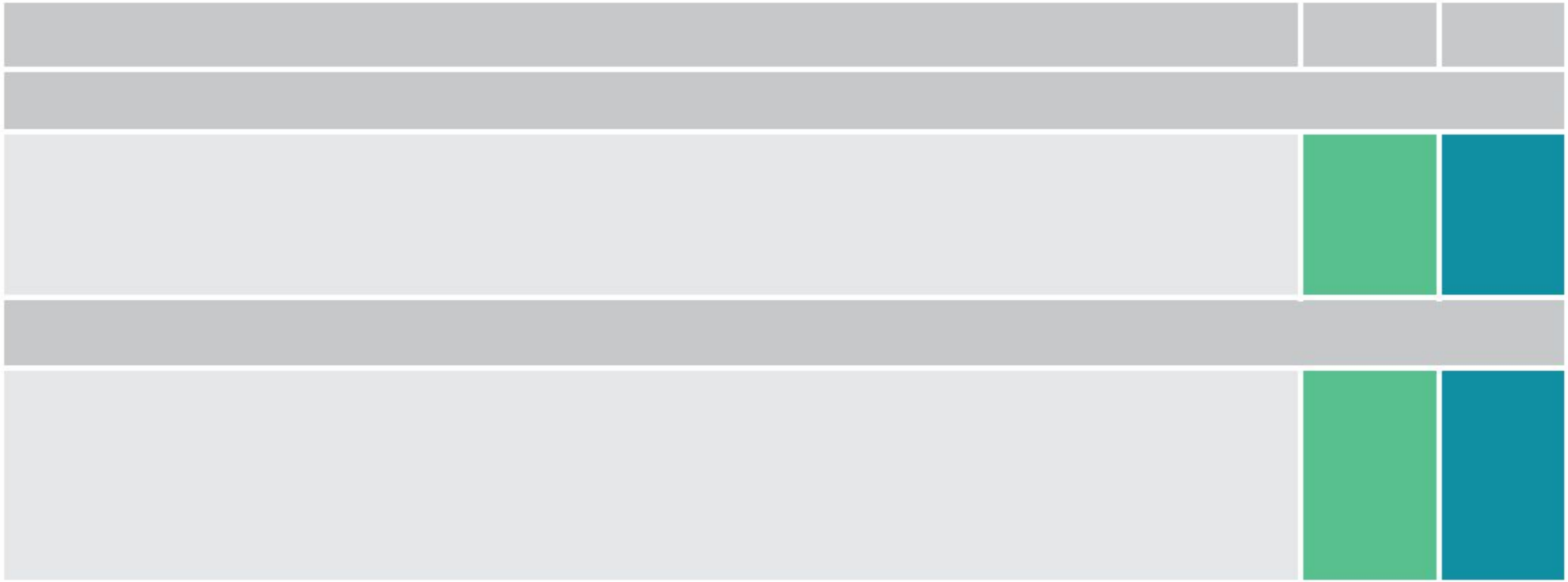

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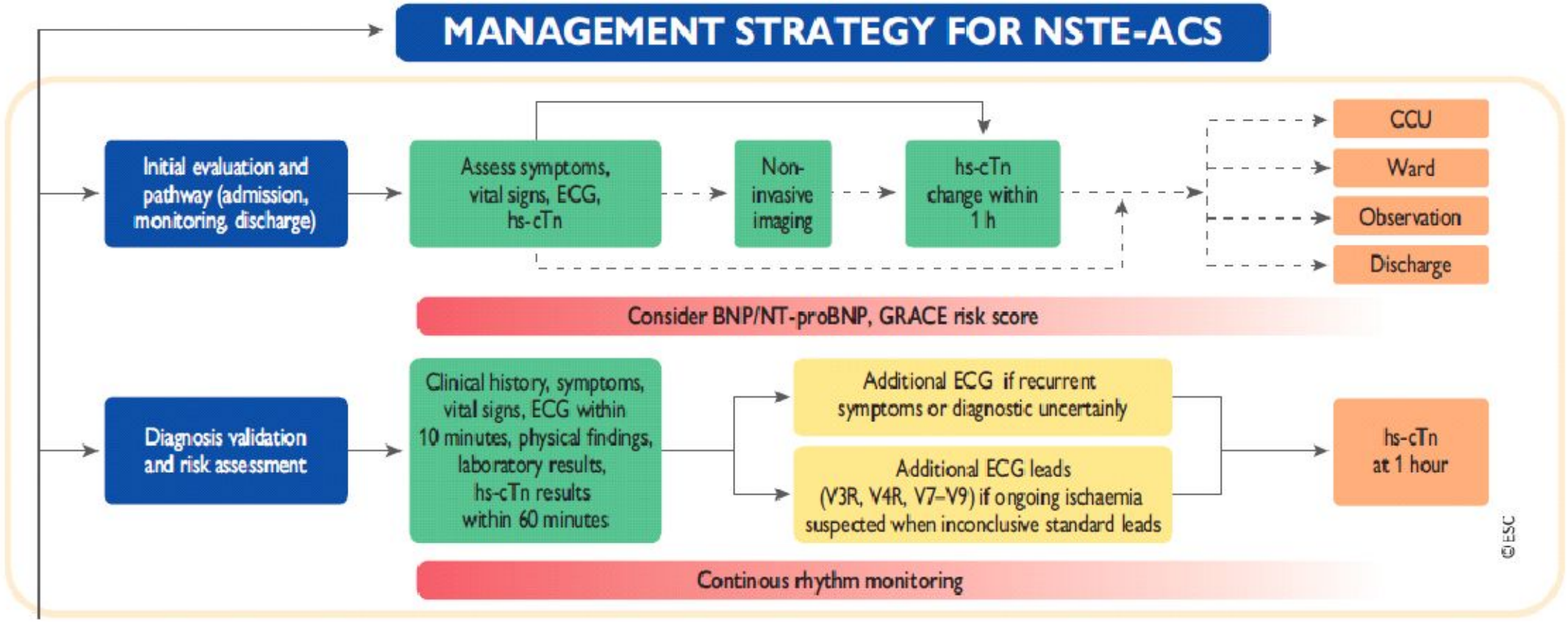

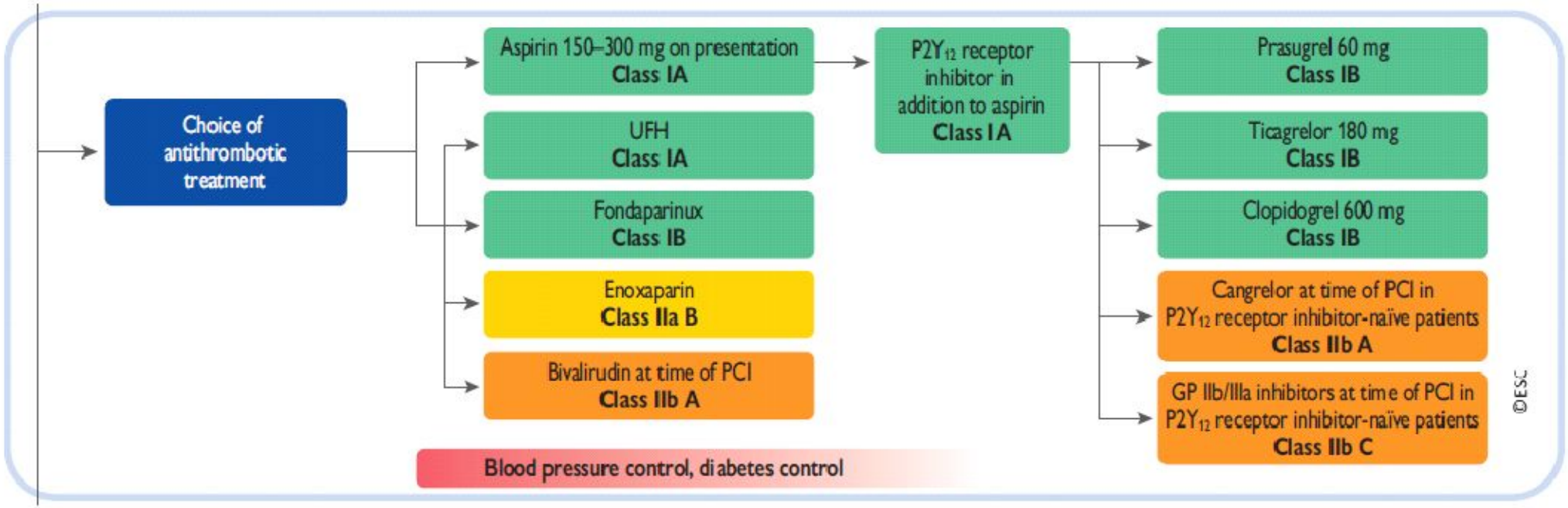
Choice of antithrombotic treatment
Aspirin 150–300 mg on presentation
Class IA
UFH
Class IA
Fondaparinux
Class IB
Enoxaparin
Class IIa B
Bivalirudin at time of PCI
Class IIb A
P2Y12 receptor inhibitor in addition to aspirin
Class I A
Prasugrel 60 mg
Class IB
Ticagrelor 180 mg
Class IB
Clopidogrel 600 mg
Class IB
Cangrelor at time of PCI in P2Y12 receptor inhibitor-naïve patients
Class IIb A
GP IIb/IIIa inhibitors at time of PCI in P2Y12 receptor inhibitor-naïve patients
Class IIb C
Blood pressure control, diabetes control
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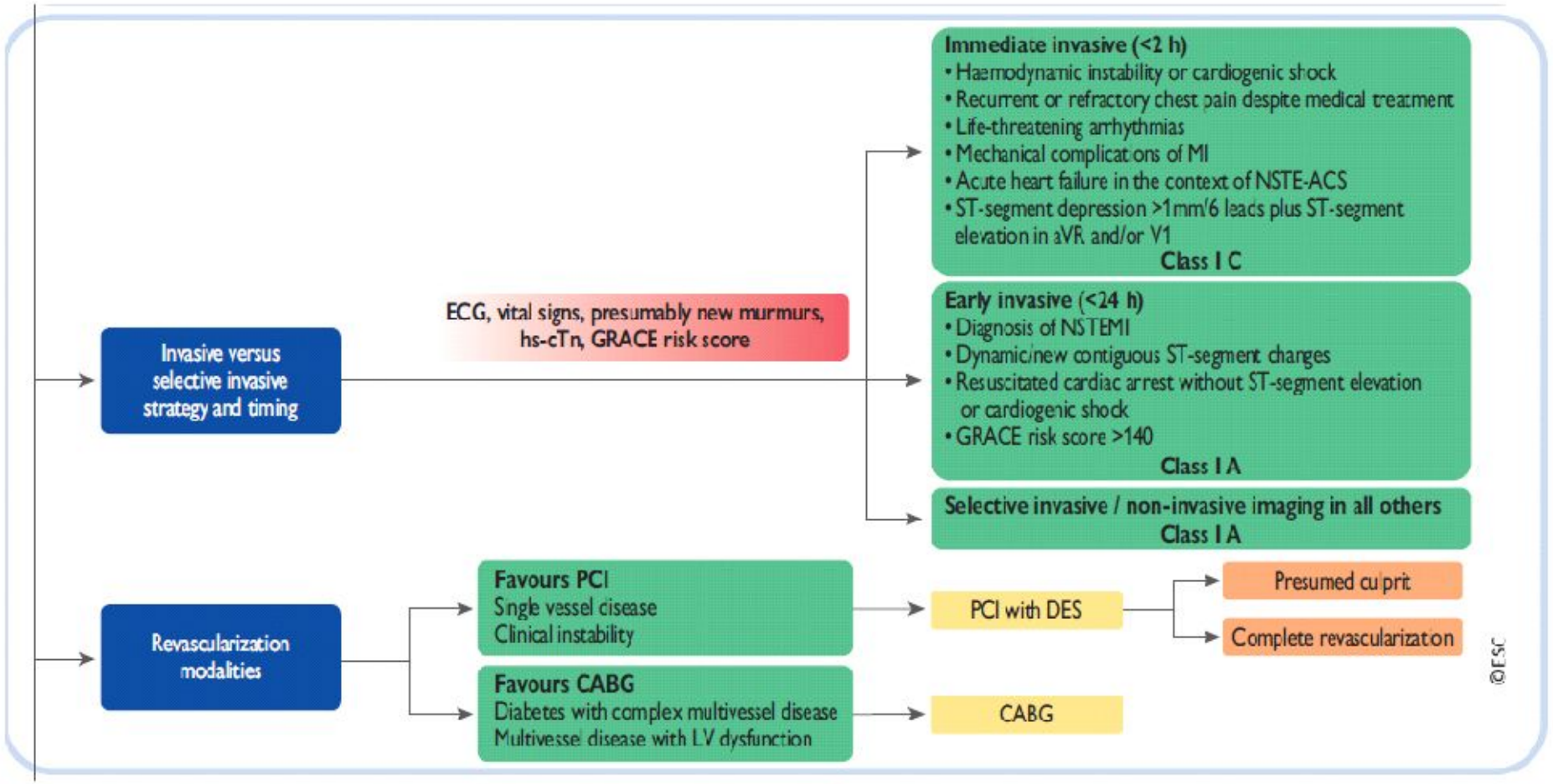
Invasive versus selective invasive strategy and timing
ECG, vital signs, presumably new murmurs, hs-cTn, GRACE risk score
Immediate invasive (<2 h)
• Haemodynamic instability or cardiogenic shock
• Recurrent or refractory chest pain despite medical treatment
• Life-threatening arrhythmias
• Mechanical complications of MI
• Acute heart failure in the context of NSTE-ACS
• ST-segment depression >1mm/6 leads plus ST-segment elevation in aVR and/or V1
Class I C
Early invasive (<24 h)
• Diagnosis of NSTEMI
• Dynamic/new contiguous ST-segment changes
• Resuscitated cardiac arrest without ST-segment elevation or cardiogenic shock
• GRACE risk score >140
Class I A
Selective invasive / non-invasive imaging in all others
Class I A
Revascularization modalities
Favours PCI
Single vessel disease
Clinical instability
Favours CABG
Diabetes with complex multivessel disease
Multivessel disease with LV dysfunction
PCI with DES
CABG
Presumed culprit
Complete revascularization
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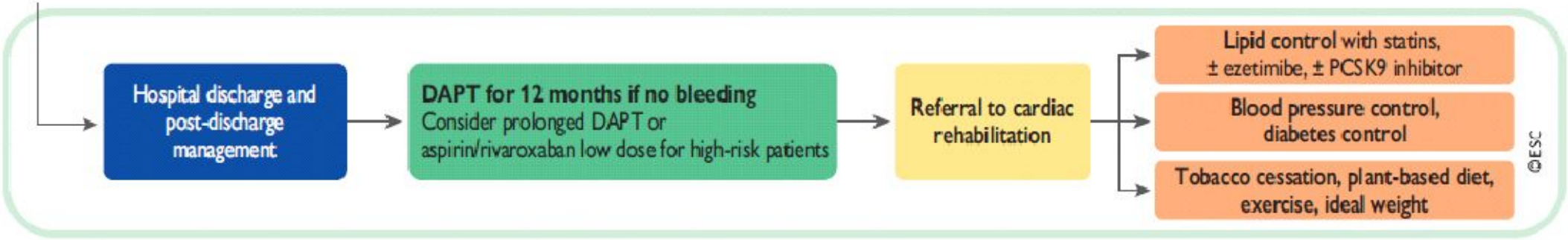
Hospital discharge and post-discharge management
DAPT for 12 months if no bleeding
Consider prolonged DAPT or aspirin/rivaroxaban low dose for high-risk patients
Referral to cardiac rehabilitation
Lipid control with statins, ± ezetimibe, ± PCSK9 inhibitor
Blood pressure control, diabetes control
Tobacco cessation, plant-based diet, exercise, ideal weight
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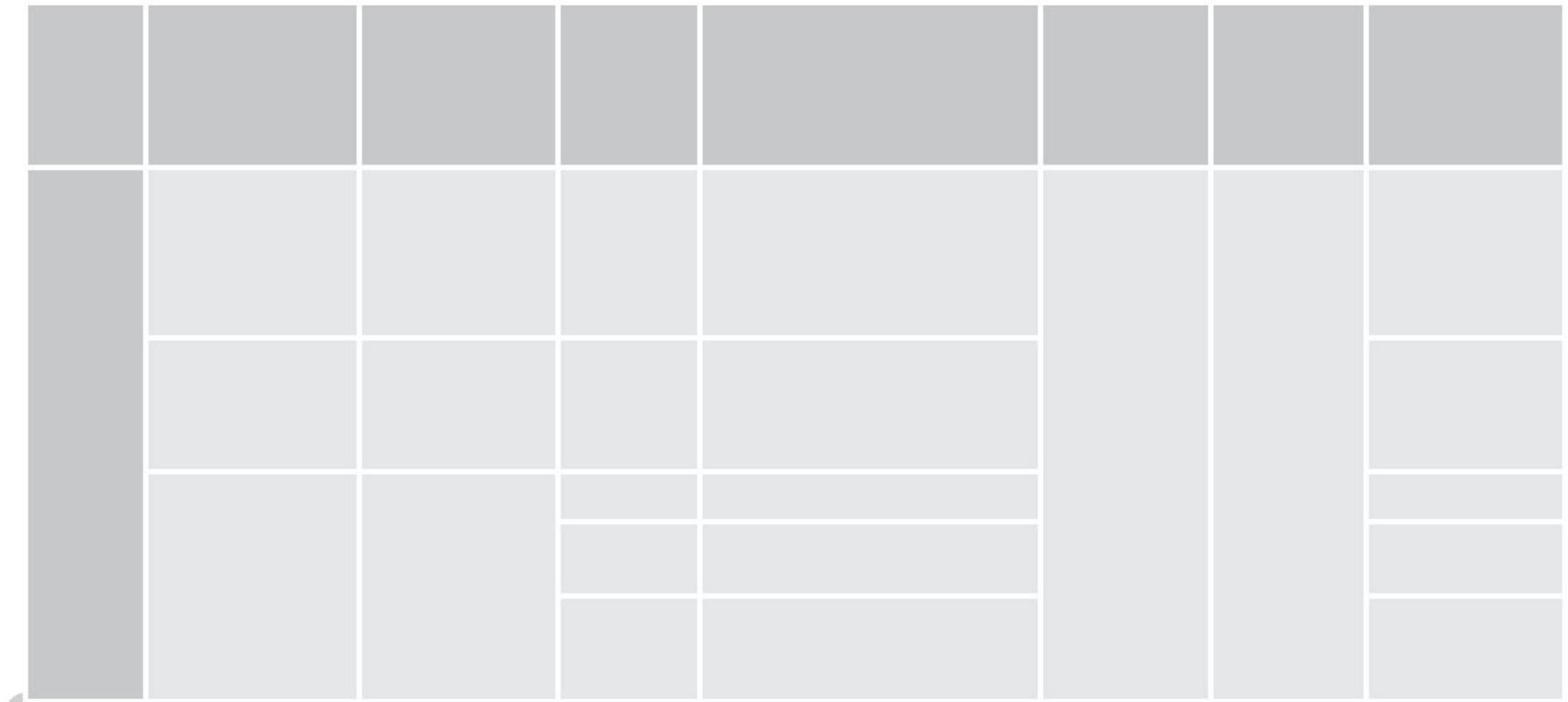

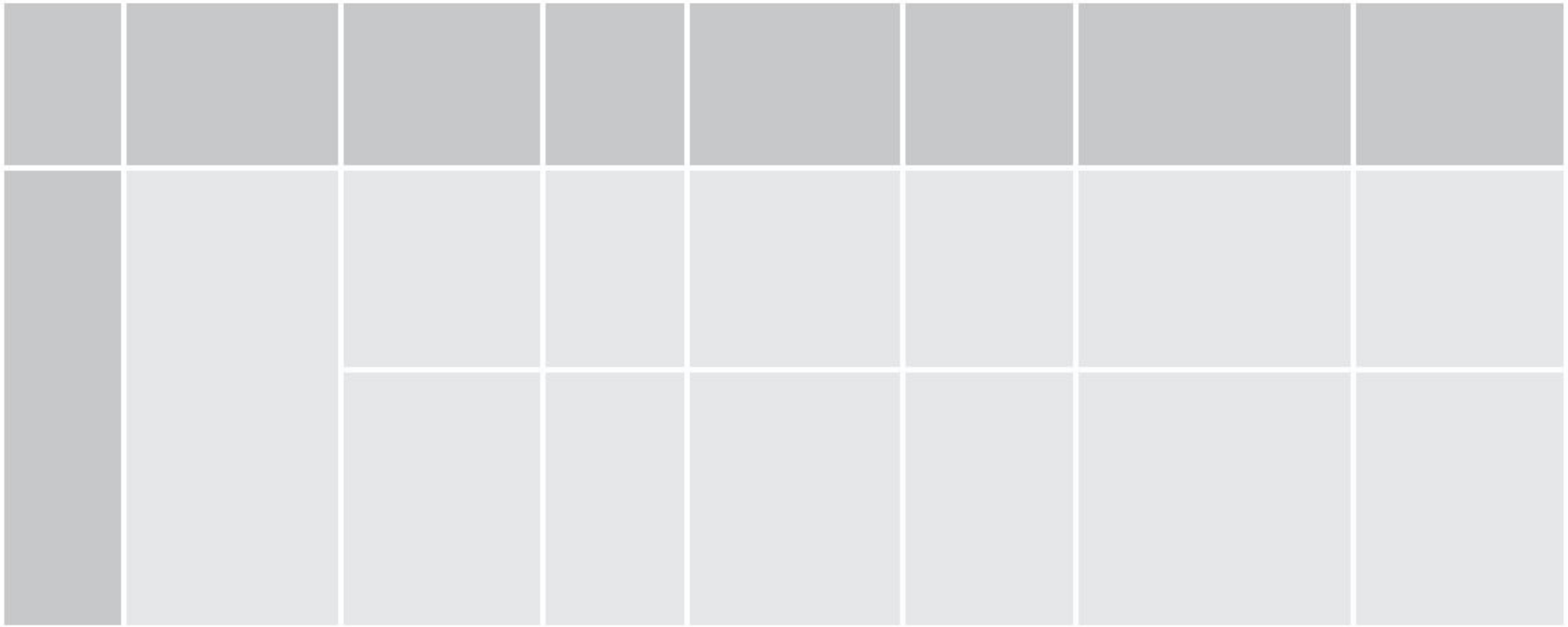

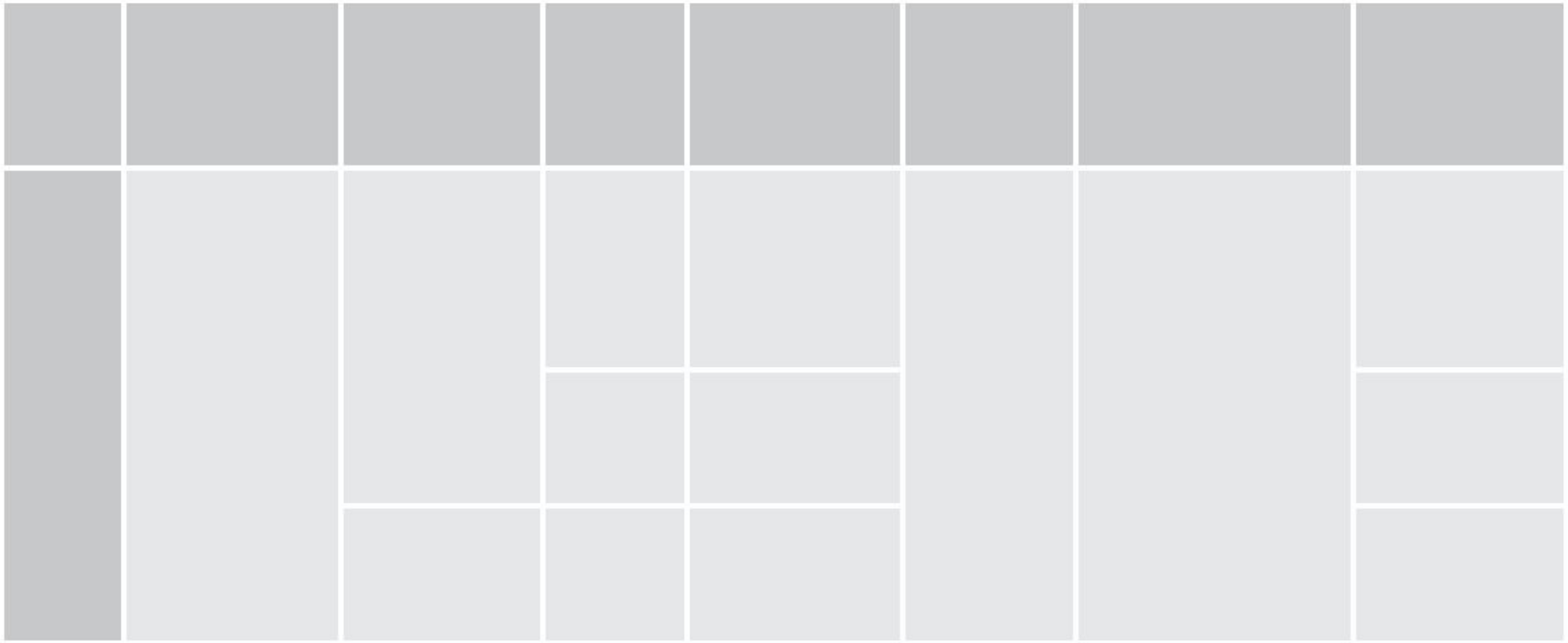

Points	Creatinine Level, mg/dL	Points
0	0–0.39	1
8	0.40–0.79	4
25	0.80–1.19	7
41	1.20–1.59	10
58	1.60–1.99	13
75	2.00–3.99	21
91	≥4.0	28
100		

\+ Elevated Cardiac Enzyme Levels = Total Points

180	190	200	210	220	230	240	≥250
9.8	13	18	23	29	35	44	>52

s of age, has serum creatinine level
ac enzyme levels.

e, has serum creatinine level of 0.4 mg/dL,

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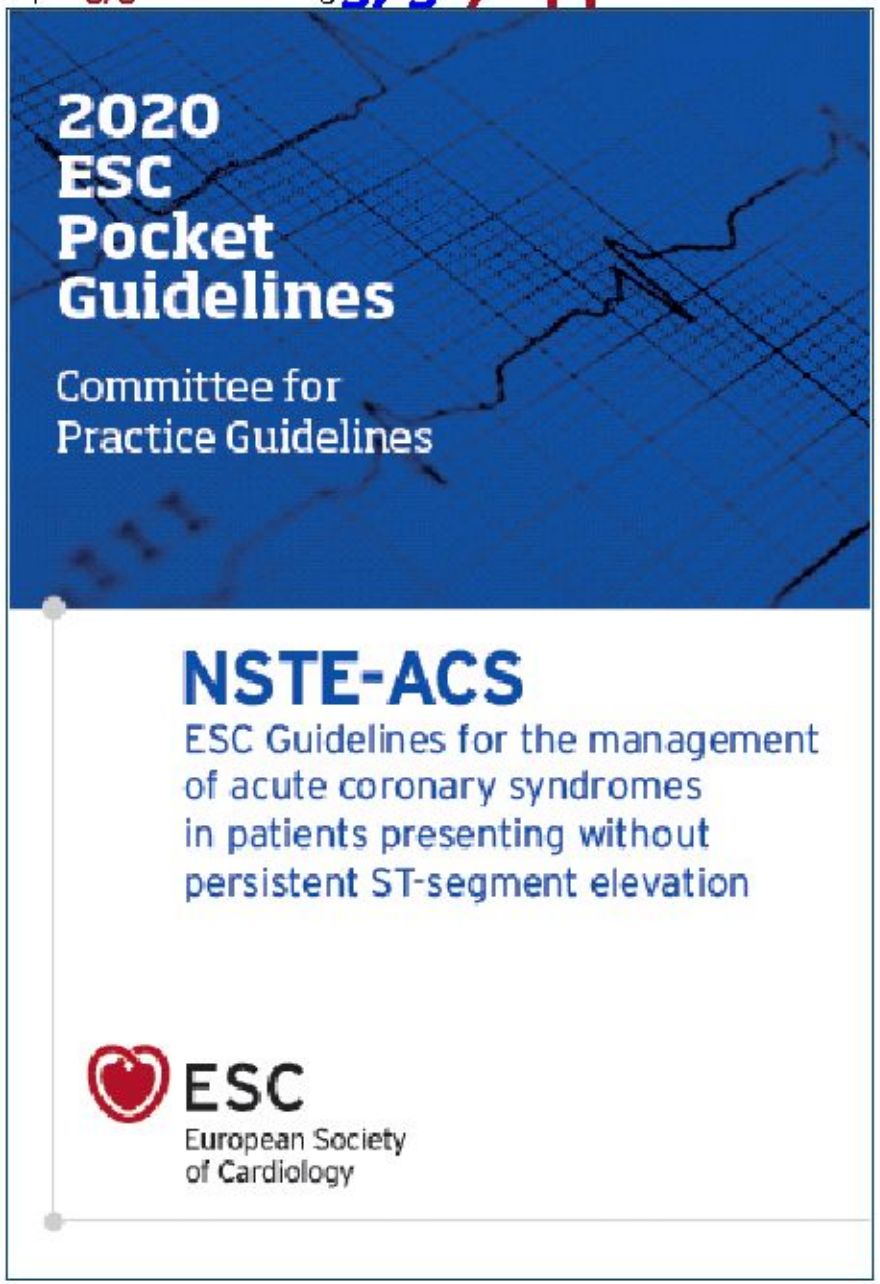

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