Barnsley Hospital NHS
NHS Foundation Trust

CHANGING LIVES

Rapid Access Chest Pain Clinic

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Nicola Wilkinson
Mark Balchin
Daniel Kaye
Cardiac Nurse Specialists
Tel: 01226 432176

Barnsley Hospital Quality in Care

www.barnsleyhospital.nhs.uk

Rapid Access Chest Pain Clinic

National Service Framework 2000

Standard 8: Patients suspected of having stable angina will be reviewed by a specialist in the RACPC within two weeks. Prompt investigations for those in whom it is indicated.

NICE Guidelines

Chest pain of recent onset: assessment and diagnosis, published 24th March 2010.

NICE estimated risk of CVD according to chest pain symptoms, risk factors, age and gender.

Function of the Clinic

- A one-stop service involving clinical assessment and investigation
- To identify patients in need of evidence based treatments and revascularisation
- Early referral for necessary investigations
- Identify and advise on cardiac risk factors, lifestyle advice and referral to appropriate services (smokestop etc)
- Provide reassurance for patients with non-cardiac outcomes
- Initiate medications or advise GP

Criteria for referral

GP referral only (A+E not funded to refer)

Chest pain within past 12 weeks

Symptoms suggestive of angina

Age 30 and above

Refer via Choose and Book service

Patients should be able to attend an out-patient clinic

Referral Exclusions

- Patients suspected of ACS should not be referred (A+E)
- Patients who have been seen in cardiology in the past 12 months should be referred to the main cardiology clinic
- Patients with symptoms suggestive of heart failure should have a BNP and be referred to the one stop diagnostic heart failure clinic
- Patients with symptoms suggestive of cardiac arrhythmias should be referred to general cardiology
- Patients with multiple cardiac problems or complicated chest pain history should be referred to the main cardiology clinic

Clinic Overview

Patient assessment:

- History taking
- Examination
- 12 lead ECG if unable to perform ETT
- CVD risk scoring as per NICE guidelines
- Investigations as deemed appropriate

Consultation with patient:

- Discuss outcomes/diagnosis
- Lifestyle advice and appropriate referrals for support
- Check patients understanding
- Prescribe appropriate medications
- Formulate management plan including letter for GP

CNS reviews every patient case history with Cardiologist/middle grade

Table 1 Percentage of people estimated to have coronary artery disease according to typicality of symptoms, age, sex and risk factors

	Non-anginal chest pain				Atypical angina				Typical angina			
	Men		Women		Men		Women		Men		Women	
Age (years)	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi
35	3	35	1	19	8	59	2	39	30	88	10	78
45	9	47	2	22	21	70	5	43	51	92	20	79
55	23	59	4	25	45	79	10	47	80	95	38	82
65	49	69	9	29	71	86	20	51	93	97	56	84

For men older than 70 with atypical or typical symptoms, assume an estimate > 90%.

For women older than 70, assume an estimate of 61–90% EXCEPT women at high risk AND with typical symptoms where a risk of > 90% should be assumed.

Values are per cent of people at each mid-decade age with significant coronary artery disease (CAD) .

Hi = High risk = diabetes, smoking and hyperlipidaemia (total cholesterol > 6.47 mmol/litre).

Lo = Low risk = none of these three.

The shaded area represents people with symptoms of non-anginal chest pain, who would not be investigated for stable angina routinely.

Note:

These results are likely to overestimate CAD in primary care populations.

If there are resting ECG ST-T changes or Q waves, the likelihood of CAD is higher in each cell of the table.

Case Study

55 year old male with left sided chest pains over recent months on exertion, relieved by GTN. Walking up hills more difficult and has to rest.

RF: Smoking ECG: NSR 68bpm BP: 102/50mmHg

ETT: Bruce protocol 4:44mins, stopped due to chest pain, horizontal ST depression

Existing Medications: Aspirin, Statin, Losartan, Lansoprazole, GTN spray

Medications commenced: ISMN

Referred for echocardiogram and diagnostic angiogram

Outcome: CABG

Case Study

66 year old woman with a 2 month history of tightness under her left breast occurring at rest as well as exertion. Symptoms occurring daily, lasting up to a few minutes at a time and easing with rest.

RF: Smoking ECG: NSR 76bpm BP:140/70mmHg

ETT: Bruce protocol 4:14mins, stopped due to fatigue, no ST changes, minimal chest pain symptoms.

Existing medications: Doxazosin, Bendroflumethiazide, Simvastatin, Lansoprazole, Amitriptyline, Salbutamol, Fluticasone.

Referred for cardiac CT+/- CT angio. Result negative for CAD.