



Queensland Government

# Thrombolysis for STEMI Clinical Pathway

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

Use this pathway for thrombolysing patients identified with Acute (<12hours) ST-elevation Myocardial Infarction (STEMI) **If Primary Percutaneous Coronary Intervention (pPCI) is possible within 90 mins of First Medical Contact (FMC) URGENTLY contact the on-call Interventional Cardiologist.**

Clinical pathways never replace clinical judgement. Variances must be clearly documented in patient notes  
 Every person documenting in this clinical pathway must supply a sample of their signature page 2

**Presentation time / date:** ..... : ..... / ..... / ..... **Symptom onset time / date:** ..... : ..... / ..... / .....

## 1. Confirm Indications for Thrombolytic Reperfusion

- Cannot be treated with pPCI within 90 mins of FMC
  - Chest pain >30min and <12 hours
  - \*ECG:
    - Persistent ST-elevation ≥1mm in 2 contiguous limb leads, or
    - Persistent ST-elevation ≥2mm in 2 contiguous chest leads, or
    - New or presumed new Left Bundle Branch Block (LBBB)
  - Myocardial infarct likely from history
- \*Contact cardiology referral service if ECG interpretation advice is required*

NO TO ANY OR UNSURE

## Urgent Consult with

Emergency Consultant and / or Interventional Cardiologist for advice / plan  
 (e.g. ECG interpretation, PCI availability, contraindications, advanced age, post thrombolysis referral, failed thrombolysis, shock, bleeding)

YES TO ALL

## 2. Contra-indications to Thrombolysis (answer EVERY question)

### Absolute

- Active Bleeding or bleeding diathesis (excluding menses)  Y  N
- Suspected aortic dissection  Y  N
- Significant closed head or facial trauma within 3 months  Y  N
- Any prior intracranial haemorrhage  Y  N
- Ischaemic stroke within 3 months  Y  N
- Known cerebral vascular lesion  Y  N
- Known malignant intracranial neoplasm  Y  N

### Relative

- Current anticoagulants (including novel anticoagulant agents)  Y  N
- Non-compressible vascular puncture  Y  N
- Recent major surgery (<3 weeks)  Y  N
- Traumatic or prolonged (>10 minutes) CPR  Y  N
- Recent internal bleeding (within 4 weeks) / Active Peptic Ulcer  Y  N
- Suspected Pericarditis  Y  N
- Advanced Liver Disease / Advanced Metastatic Cancer  Y  N
- History of chronic, severe, poorly controlled hypertension  Y  N
- Severe uncontrolled hypertension on this presentation (systolic >180mmHg or diastolic >110mmHg)  Y  N
- Ischaemic Stroke >3months ago / known intracranial abnormality (not discussed in Absolute Contraindications) / Dementia  Y  N
- Pregnancy or within 1 week postpartum  Y  N

YES TO ANY OR UNSURE

Discussed with:

Facility:

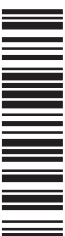
Referral time / date:

*Document advice / plan in clinical notes*

NO CONTRA-INDICATIONS

**Immediately proceed to thrombolysis (target <30 mins of FMC). Follow directions page 2.**

DO NOT WRITE IN THIS BINDING MARGIN





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### 3. General

- Informed verbal consent
- Record baseline observations: vitals, circulation, neurological
- 2 x IV access



### 4. Thrombolysis Medication

Confirm administration of or give:

(Record all medications prescribed in patient medication chart)

	Dose	Time
<input type="checkbox"/> Aspirin 300mg		
<input type="checkbox"/> Clopidogrel 300mg		
<input type="checkbox"/> Tenecteplase (see weight adjusted dose guide)		
• Patient weight: ..... kg		
<input type="checkbox"/> Enoxaparin (see dose guide)		
<b>OR</b>		
<input type="checkbox"/> Unfractionated Heparin		
• Consider with severe renal failure (eGFR <30mL / min)		
• IV bolus 60 units / kg (max 4000 units)		
• Then infusion 12 units / kg / hr (maximum 1000 units / hr)		



### 5. Management Post Thrombolysis

- Refer ALL thrombolysed STEMI patients for immediate transfer to Interventional Cardiac Facility (complete urgent consult details on page 1)
- 12 lead ECGs reviewed at 30 mins, 60 mins and 90 mins
- If failed reperfusion (i.e. unresolved pain and ST elevation has not reduced >50% at 60 mins) for urgent consult with on-call Interventional Cardiologist (complete referral details on page 1)
- Continuous cardiac monitoring
- Nurse Special (1:1) for first hour post thrombolysis
- Frequent observations: vital signs, circulation and neurological

### MEDEVAC checklist

- QAS / Retrieval Services QLD notified - phone: 1300 799 127  
Contact time / date: ..... : ..... / ..... / ..... ETA: ..... : .....
- Patient and NOK informed
- Photocopy all ECGs and documentation

### Treating Emergency Department Medical Officer

Name: .....

Time: ..... : ..... Date: ..... / ..... / ..... Signature: .....

### Signature Log Every person documenting in this clinical pathway must supply a sample of their initials and signature below

Initials	Signature	Print name	Role	Initials	Signature	Print name	Role

Body weight (kg)	IU	mg	mL
<60	6,000	30	6
≥60 to <70	7,000	35	7
≥70 to <80	8,000	40	8
≥80 to <90	9,000	45	9
≥90	10,000	50	10

**Age ≥75yr**  
Administration of half the standard dose of tenecteplase might be considered in reducing the risk of intracranial bleeding.  
Consult with Interventional Cardiologist for advice / plan.

	Age <75yr	Age ≥75yr	Renal failure (eGFR<30mL / min)
Loading Dose (omit if given pre-hospital)	30mg IV bolus	None / Omit	Use Unfractionated Heparin
Maintenance Dose	1mg / kg SC BD begin 15 mins after bolus (maximum 100mg for first 2 doses)	0.75mg / kg SC BD (maximum 75mg for first 2 doses)	

DO NOT WRITE IN THIS BINDING MARGIN