**VA Cardiology Policies for Medicine Residents** (updated 6/7/12)

**ACS Patients**
- Please do not write “r/o ACS” in your assessment/plan. Instead, if you think the patient may be having acute coronary syndrome, write “chest pain” or “probable CAD” or “symptomatic CAD” for example.
- All troponin results >0.04 have to be commented on by the cardiology fellow or attending.
  - HIGH SUSPICION FOR ACS: (e.g. typical, CP, dynamic /or new, EKG changes etc) should be admitted to cardiology.
    - ASA must be given immediately
    - Beta block must be given within 24 hours, (indicated in Ant, anterolateral MI, in the absence of hypotension
    - If there is any contraindication to either of the above medications it should be stated in your progress note or in a separate noted titled “Medicine Contraindication.”
    - Consider heparin (either UFH or LMWH) in appropriate doses
    - Follow the protocol of ACS in the CPRS.
  - Intermediate Suspicion for ACS: typical chest pain with risk factors, or hx of heart disease, no EKG changes, or cardiac marker, place a consult in CPRS for Cardiology AND call the fellow personally to tell them about the patient.
  - LOW SUSPICION FOR ACS: (e.g. no symptoms or EKG changes BUT minimal troponin elevation (0.041-0.5 for example, “Trop Note”
    - DURING THE DAY: call the cardiology fellow to notify them of the elevated troponin
    - AT NIGHT: signout to the primary team that they must call the cardiology fellow early in the morning to notify him/her

**CHF Patients**
- Patients with the diagnosis of CHF:
  - State the EF and NYHA Class (I-IV), in your progress notes and discharge summary. A repeat EF determination on each admission is not required.
  - In the discharge instructions, check the “CHF is one of the patient’s discharge diagnoses” box & fill out the additional information required. If any of the CHF medications e.g. BB, ACEi, ASA etc. could not be used, please state the reason in the Discharge Instructions.

**Cardiology vs. Internal Medicine admissions**

The following patients should be admitted to the Cardiology service:
- Acute coronary syndrome (must be housed in CCCU-M)
  - NSTEMI
  - STEMI
- Heart Failure
  - New-onset CHF
    - If patient is stable and does not need a CCCU-M bed, this patient should be admitted to Cardiology on a telemetry bed.
    - If the Cardiology service is already following 3 such patients on the floor then the next patient should be admitted to medicine and a cardiology consult must be requested.
    - Advanced, decompensated CHF, new or recurrent, with either hypotension and/or renal disease, patient to be admitted to cardiology CCU, and can be transferred to medicine after improvement.
• In the case of unavailability of CCU beds, the patient may be admitted to medicine, and a cardiology consult must be consulted and co managed

Atrial Fibrillation
Acute-onset atrial fibrillation with rapid ventricular response should be admitted to Cardiology and housed in CCCU-M

• Chronic, recurrent atrial fibrillation that is easily rate-controlled in ED can be admitted to medicine on telemetry.