

PRIORITISATION OF REFERRALS FOR SUSPECTED ISCHAEMIC HEART DISEASE

Advances in cardiology have created investigation and intervention opportunities for an increasing number of patients.

It can sometimes be difficult to determine who should be referred so that appropriate care is not denied but also that resources are used effectively and remain responsive to those in need of urgent cardiology care.

A careful and thorough history is required from all patients complaining of chest pain together with a full cardiovascular risk assessment.

Typical ischaemic symptoms will usually warrant referral, but if symptoms are atypical consideration needs to be given to the patient's total cardiovascular risk which loosely correlates to the likelihood of the chest pain being cardiological.

The table below provides referrers with a decision support tool to help determine the appropriateness of chest pain referrals.

	Low TCVR <5% at 5 years	Moderate TCVR 5-15% at 5 years	High TCVR >15% at 5 years
TYPICAL ANGINA SYMPTOMS Chest tightness/heaviness on exertion, eased quickly by rest. May radiate to arms, neck or between shoulders. May be associated with SOB and/or sweating.	Non-cardiac chest pain is still possible. Exclude other causes before considering referral.	Refer	Refer
ATYPICAL SYMPTOMS Pain not related to exertion. Sharp or stabbing in nature. Long duration. Absence of associated cardiovascular symptoms.	Public cardiology referral not indicated	Non-cardiac aetiology is more likely. Exclude other causes of chest pain before considering referral.	Refer unless other causes of chest pain found, or unless presenting symptoms are different from known pre-existing angina