We previously used RATPAC criteria to assess patients with suspected cardiac chest pain. Low risk patients had a 90-minute rule-out using a triple cardiac biomarker panel. High risk patients were admitted for serial Troponin testing. Pathway revised in 2014 to use the HEART score for risk stratification and high sensitivity Troponin T (hsTnT) for rule out of myocardial infarction in all patients (figure 1). Aimed to increase safety without causing a large increase in acute admissions.


During the initial audit month when the previous pathway was in use 173 patients presented to the ED and were investigated for cardiac chest pain. 62% were admitted and 12% of all investigated patients had a final diagnosis of acute coronary syndrome. In the second audit period after introduction of the new pathway, 159 patients were investigated for cardiac chest pain. 56% were admitted and 10% had a final diagnosis of acute coronary syndrome. Acute Coronary Syndrome was the discharge diagnosis in 17% of those admitted to hospital in both groups.

We have been able to redesign our cardiac chest pain pathway to improve safety by using a validated risk assessment score (HEART) and high-sensitivity Troponin testing in all patients. Despite removing the 90-minute triple cardiac marker pathway, we achieved a slight reduction in admissions to acute medical beds. Given the need to be risk-verse with chest pain presentations, a relatively high rate of negative investigations is to be expected.