A. Anti-Ischemic Therapy
Recommendations for Anti-Ischemic Therapy

Class I
1. Bed rest with continuous ECG monitoring for ischemia and arrhythmia detection in patients with ongoing rest pain. (Level of Evidence: C)
2. NTG, sublingual tablet or spray, followed by intravenous administration, for the immediate relief of ischemia and associated symptoms. (Level of Evidence: C)
3. Supplemental oxygen for patients with cyanosis or respiratory distress; finger pulse oximetry or arterial blood gas determination to confirm adequate arterial oxygen saturation (SaO2 greater than 90%) and continued need for supplemental oxygen in the presence of hypoxemia. (Level of Evidence: C)
4. Morphine sulfate intravenously when symptoms are not immediately relieved with NTG or when acute pulmonary congestion and/or severe agitation is present. (Level of Evidence: C)
5. A beta-blocker, with the first dose administered intravenously if there is ongoing chest pain, followed by oral administration, in the absence of contraindications. (Level of Evidence: B)
6. In patients with continuing or frequently recurring ischemia when beta-blockers are contraindicated, a nondihydropyridine calcium antagonist (e.g., amlodipine, verapamil, or diltiazem) as initial therapy in the absence of severe LV dysfunction or other contraindications. (Level of Evidence: B)
7. An ACEI when hypertension persists despite treatment with NTG and a beta-blocker in patients with LV systolic dysfunction or CHF and in ACS patients with diabetes. (Level of Evidence: B)

Class IIa
1. Oral long-acting calcium antagonists for recurrent ischemia in the absence of contraindications and when beta-blockers and nitrates are fully used. (Level of Evidence: C)
2. An ACEI for all post-ACS patients. (Level of Evidence: B)
3. Intra-aortic balloon pump (IABP) counterpulsation for severe ischemia that is continuing or recurs frequently despite intensive medical therapy or for hemodynamic instability in patients before or after coronary angiography. (Level of Evidence: C)

Class IIb
1. Extended-release form of nondihydropyridine calcium antagonists instead of a beta-blocker. (Level of Evidence: B)
2. Immediate-release dihydropyridine calcium antagonists in the presence of a beta-blocker. (Level of Evidence: B)

Class III
1. NTG or other nitrate within 24 h of sildenafil (Viagra) use. (Level of Evidence: C)
2. Immediate-release dihydropyridine calcium antagonists in the absence of a beta-blocker. (Level of Evidence: A)

B. Antiplatelet and Anticoagulation Therapy
Recommendations for Antiplatelet and Anticoagulation Therapy

Class I
1. Antiplatelet therapy should be initiated promptly. ASA should be administered as soon as possible after presentation and continued indefinitely. (Level of Evidence: A)
2. Clopidogrel should be administered to hospitalized patients who are unable to take ASA because of hypersensitivity or major gastrointestinal intolerance. (Level of Evidence: A)
3. In hospitalized patients in whom an early noninterventional approach is planned, clopidogrel should be added to ASA as soon as possible on admission and administered for at least 1 month (Level of Evidence: A) and for up to 9 months (Level of Evidence: B).
4. In patients for whom a PCI is planned, clopidogrel should be started and continued for at least 1 month (Level of Evidence: A) and up to 9 months in patients who are not at high risk for bleeding (Level of Evidence: B).
5. In patients taking clopidogrel in whom CABG is planned, if possible the drug should be withheld for at least 5 days, and preferably for 7 days. (Level of Evidence: B).
6. Anticoagulation with subcutaneous LMWH or intravenous unfractionated heparin (UFH) should be added to antiplatelet therapy with ASA and/or clopidogrel. (Level of Evidence: A)
7. A platelet GP IIb/IIIa antagonist should be administered, in addition to ASA and heparin, to patients in whom catheterization and PCI are planned. The GP IIb/IIIa antagonist may also be administered just prior to PCI. (Level of Evidence: A)

Class IIa
1. Eptifibatide or tirofiban should be administered, in addition to ASA and LMWH or UFH, to patients with continuing ischemia, an elevated troponin or with other high-risk features in whom an invasive management strategy is not planned. (Level of Evidence: A)
2. Enoxaparin is preferable to UFH as an anticoagulant in patients with UA/NSTEMI, unless CABG is planned within 24 h. (Level of Evidence: A)
3. A platelet GP IIb/IIIa antagonist should be administered to patients already receiving heparin, ASA, and clopidogrel in whom catheterization and PCI are planned. The GP IIb/IIIa antagonist may also be administered just prior to PCI. (Level of Evidence: B)

Class IIb
Eptifibatide or tirofiban, in addition to ASA and LMWH or UFH, to patients without continuing ischemia who have no other high-risk features and in whom PCI is not planned. (Level of Evidence: A)

Class III
1. Intravenous fibrinolytic therapy in patients without acute ST-segment elevation, a true posterior MI, or a presumed new left bundle-branch block (LBBB). (Level of Evidence: A)
2. Abciximab administration in patients in whom PCI is not planned. (Level of Evidence: A)