phn TASMANIA
An Australian Government Initiative

primary health TASMANIA

Chest pain in general practice- assessment, investigation and referral pathways

This webinar will begin soon.

Chest pain in general practice- assessment, investigation and referral pathways

Zoom webinar – Tuesday 24 February 6.30-8pm

Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.

Learning outcomes

After this session, I will be able to:

- Use a structured, risk-based approach to assess chest pain in general practice, distinguishing patients who require urgent emergency referral from those suitable for outpatient assessment or reassurance.
- Select appropriate initial investigations for patients presenting with chest pain, including ECGs, troponin testing and non-invasive cardiac investigations, based on clinical presentation and pre-test probability.
- Explain the role, strengths and limitations of contemporary cardiac investigations, including CT coronary angiography, functional stress testing and echocardiography, and interpret results in the primary care context.
- Utilise local chest pain and rapid access referral pathways, as well as alternative direct referral options for functional testing or cardiac imaging, to streamline care and ensure timely specialist input.
- Recognise the high prevalence of cardiovascular risk factors in patients presenting with chest pain and identify opportunities during assessment to address modifiable risk and reduce future cardiovascular events.

Some housekeeping

- Tonight's webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
- Please visit our events page to see upcoming education

Scan here

Cardiology at the Interface of Primary and Secondary Care – webinar series

To access the first four webinars, please visit Primary Health Tasmania's Learning Hub:

- A vision for contemporary cardiac rehabilitation with Dr Paul MacIntyre
- Managing atrial fibrillation in primary care: A practical approach for GP's
- How to improve heart failure outcomes
- Lipids 201: Beyond atorvastatin 40

Scan here

Presenters

Dr Andrew Black
Cardiologist
Tasmanian Health Service

Dr Graeme Bleach
Lead Clinical Editor Tasmanian HealthPathways
Primary Health Tasmania

Dr Paul MacIntyre
Statewide clinical lead for cardiac services in Tasmania and consultant cardiologist at the Royal Hobart Hospital

Chest Pain in General Practice

A practical, risk-based approach for primary care

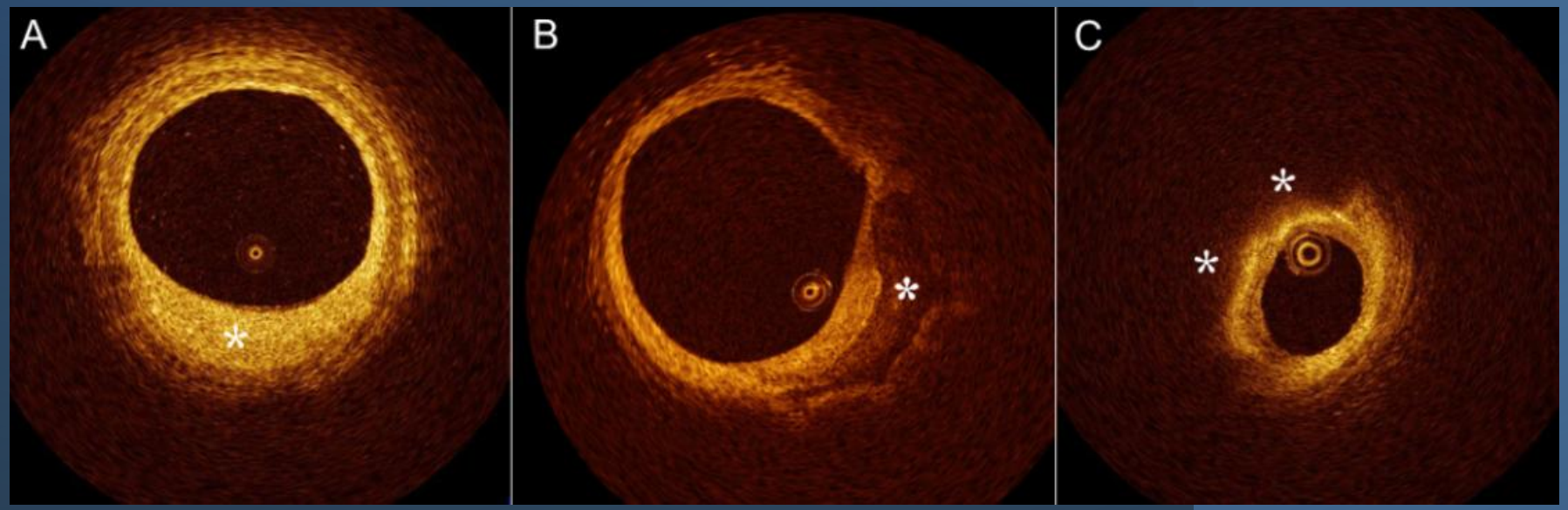
Learning Objectives

- Apply a risk-based approach to chest pain assessment
- Identify red flags requiring urgent referral
- Use pre-test probability to guide investigations
- Understand the role and limitations of ECGs and troponins
- Choose appropriate non-invasive cardiac tests
- Navigate referral pathways efficiently
- Use chest pain as a prevention opportunity

Coronary disease presentations

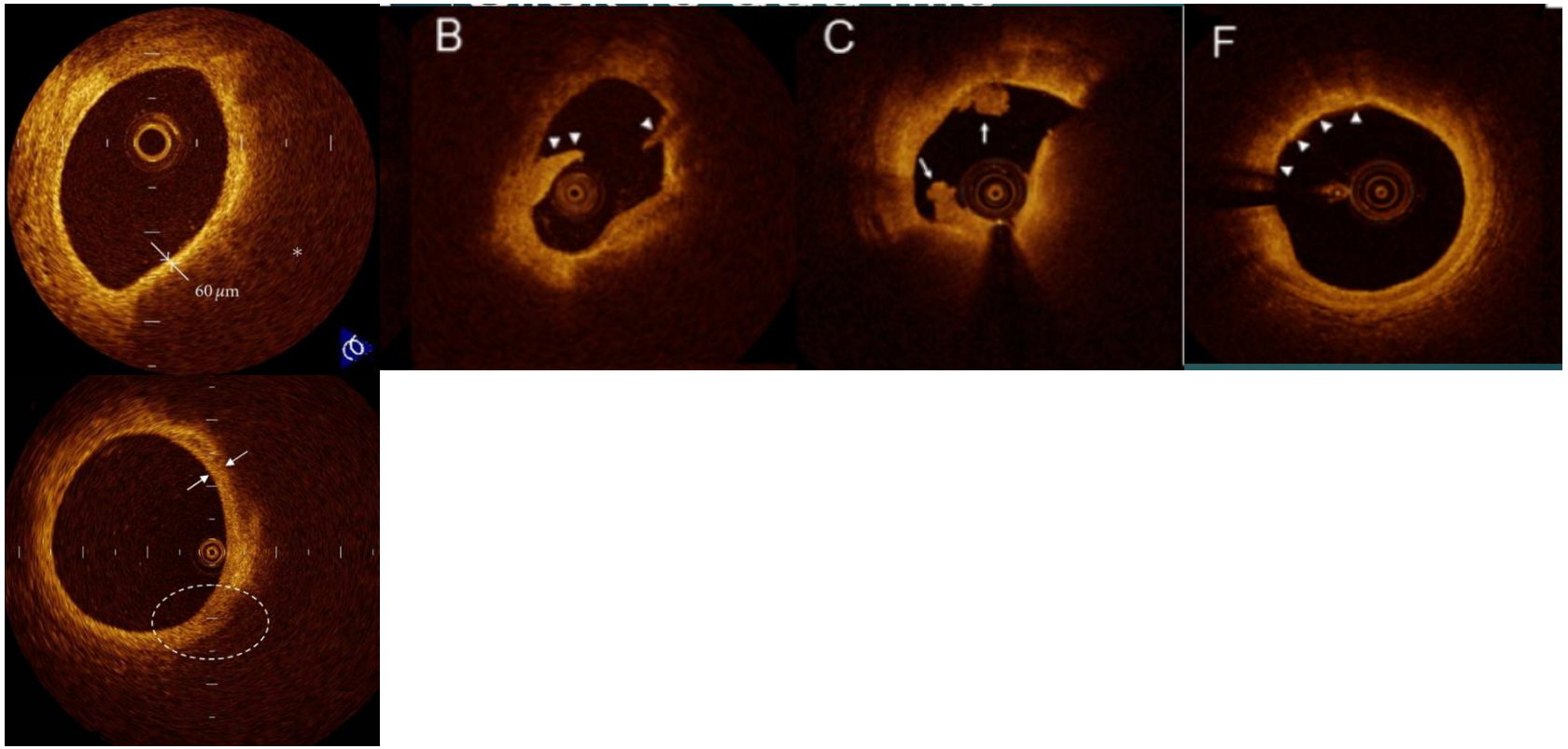
- Asymptomatic coronary disease
- Stable angina
- Acute Coronary Syndrome (ACS)
  - STEMI
  - NSTEMI / NSTEACS
  - Unstable Angina

Arbab-Zadeh A, et al, Circulation 2012;125(9):1147-1156



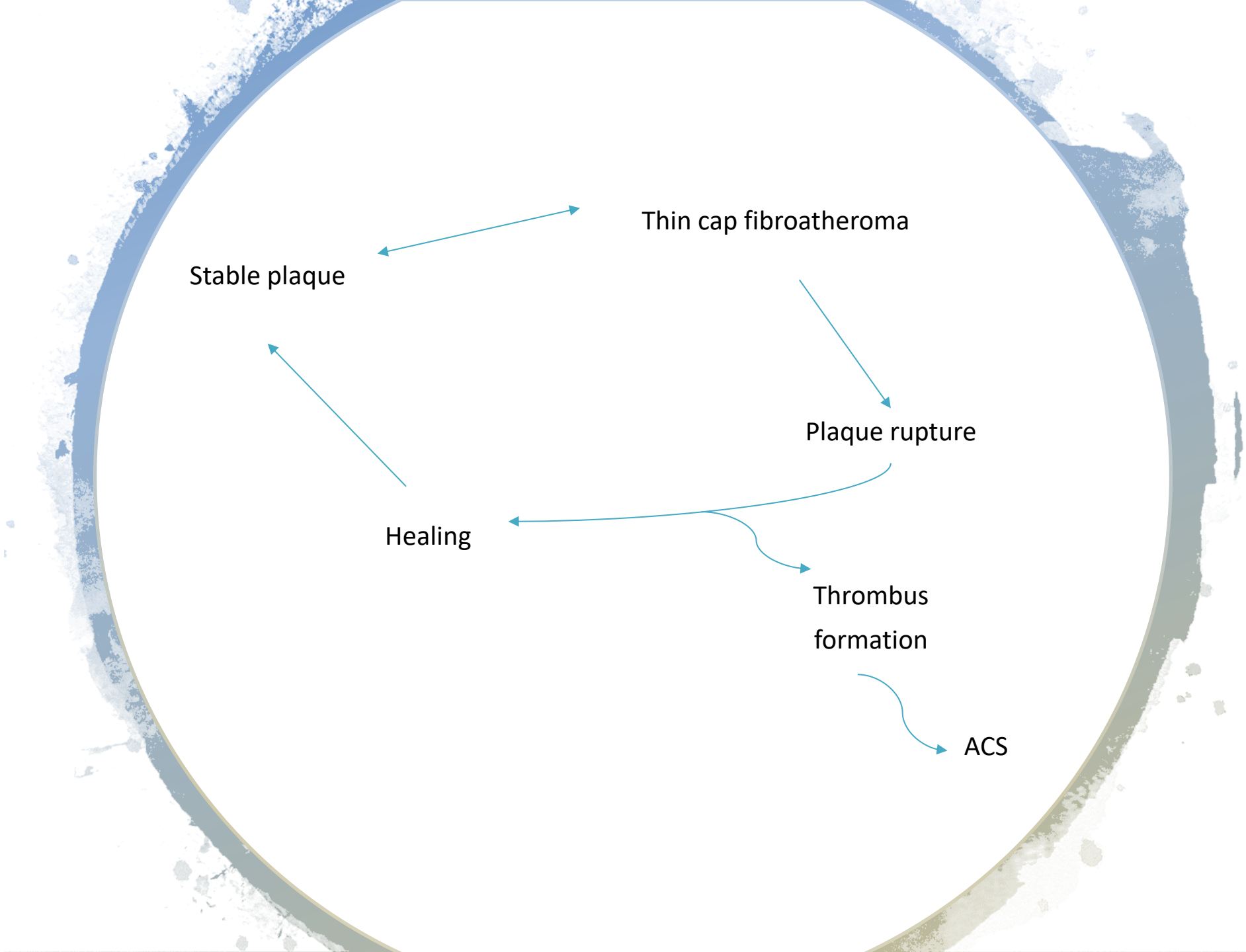
Hasegawa T & K Shimada, “Coronary Artery Disease - Assessment, Surgery, Prevention”, 2015

- OCT: Vulnerable plaque features



Yoshinori M et al, *J Am Coll Cardiol Img* 2011;4:638-46

Takarada S et al. *Atherosclerosis* 2009;202(2):491-7


Thin cap fibroatheroma
Stable plaque
Plaque rupture
Healing
Thrombus formation
ACS

Therapeutic implications

- Revascularization (PCI)
  - Stable stenotic lesions
    - ± Symptom improvement
    - No consistent ↓ death / MI
  - Acute coronary syndrome
    - ↓ Reinfarction + death
- Medical therapy (LDL lowering)
  - Minimal (?) effect on degree of stenosis
  - ↓ MACE (1º and 2º)

Why Chest Pain Matters

Common presentation in general practice

High diagnostic uncertainty

Risk of both over- and under-investigation

Opportunity for prevention

First Principles

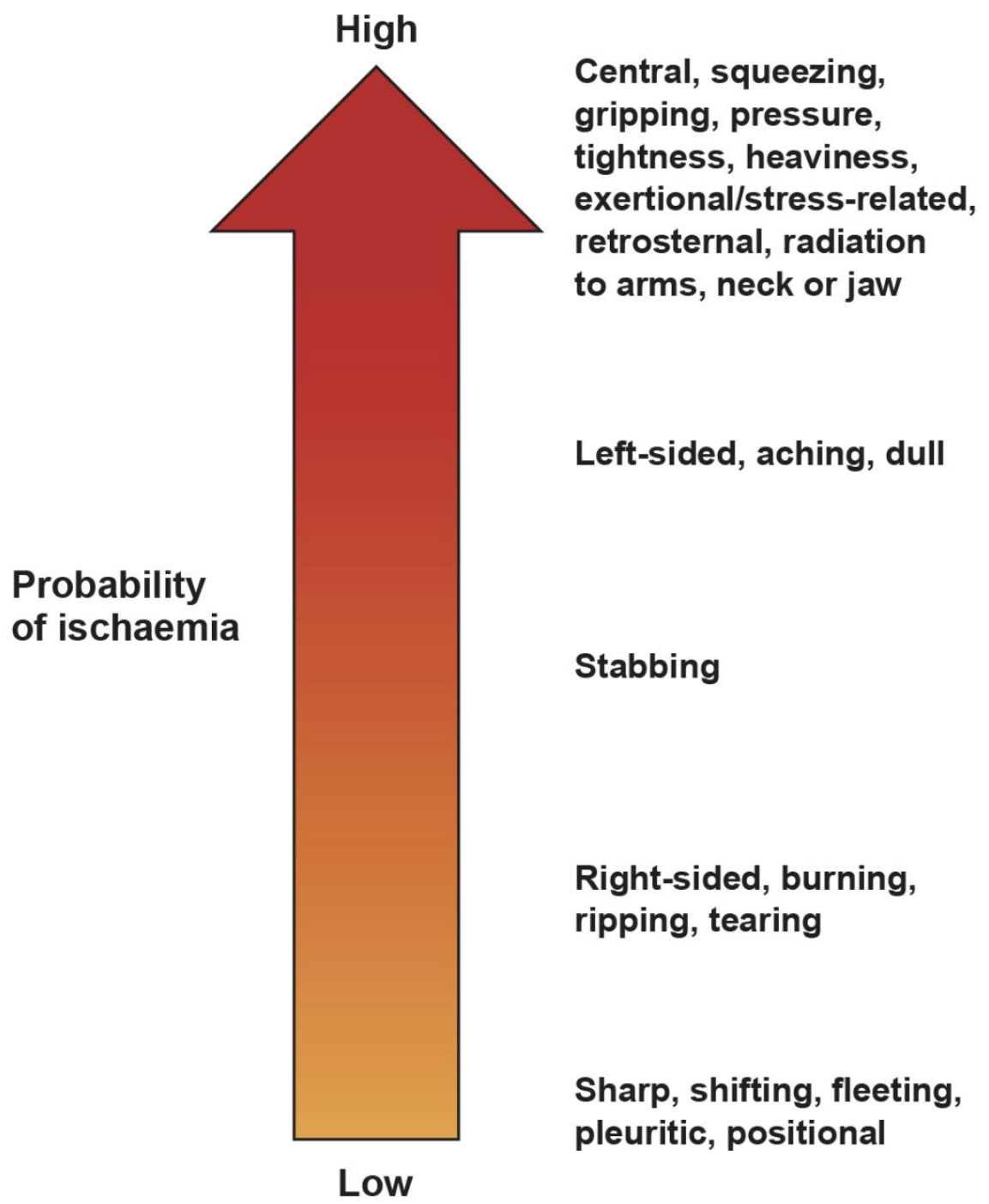
Most diagnoses come from history

Risk = symptoms + comorbidities + context

Early stratification is key

Key History Features

- Character, location, radiation
- Triggers and relieving factors
- Duration and pattern
- Associated symptoms
- Atypical presentations



GTN response

ACS in women

Chest pain remains most common symptom

Associated: jaw, neck, shoulder, back, fatigue, N&V, indigestion

Present later, investigated less, missed diagnosis more common

Consider SCAD

Older patients

- Coronary disease common
- Chest pain less frequent

First nations peoples

- Higher rates of risk factors
- Present at younger ages
- Lower intervention rates
- Poorer outcomes

Red Flags

Haemodynamic instability	Ongoing or crescendo pain	Syncope or presyncope
Neurological deficits / back pain	Dyspnoea	CAD, diabetes, CKD, RA

D-dimer

Early Stratification

Ongoing pain → Ambulance (ECG)

Pain < 24hrs → ED

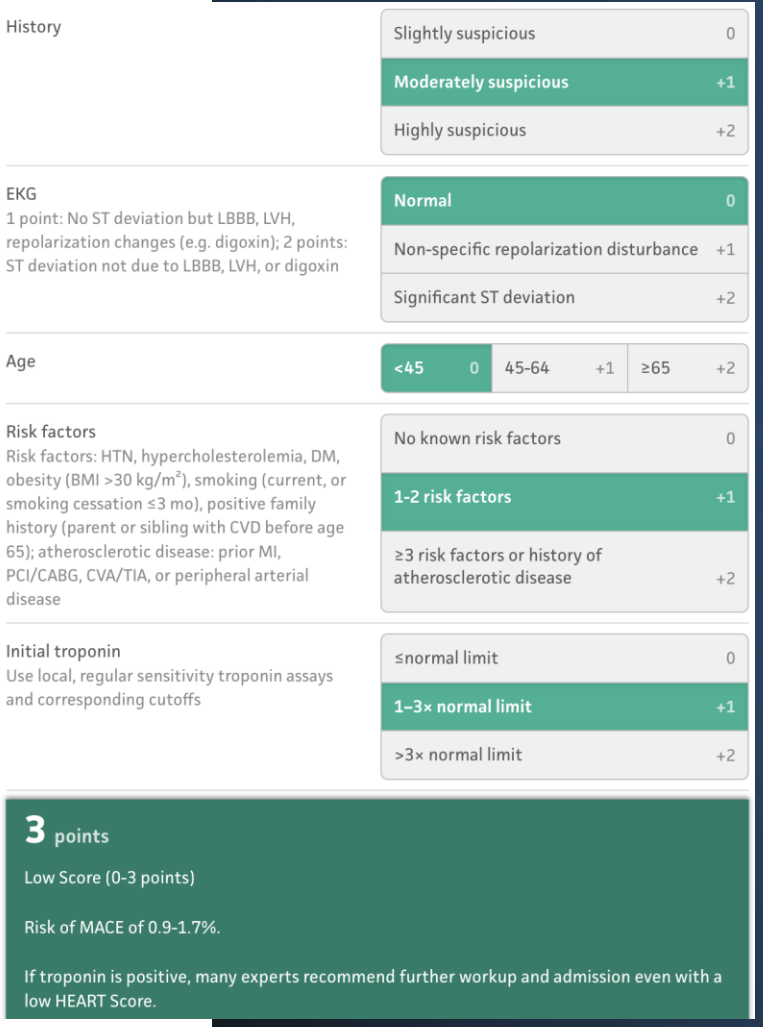
Low risk → Outpatient review / further testing / reassurance

Following ED exclusion of ACS

(Troponin negative, nil recurrence, minimal risk factors)

HEART Score

- 0-3 low risk → outpatient assessment
- 4 – 6 → inpatient assessment
- 7 + → cardiology admission



History	Slightly suspicious	0
	Moderately suspicious	**+1**
	Highly suspicious	+2
EKG 1 point: No ST deviation but LBBB, LVH, repolarization changes (e.g. digoxin); 2 points: ST deviation not due to LBBB, LVH, or digoxin	**Normal**	**0**
	Non-specific repolarization disturbance	+1
	Significant ST deviation	+2
Age	**<45**	**0**
	45-64	+1
	≥65	+2
Risk factors Risk factors: HTN, hypercholesterolemia, DM, obesity (BMI >30 kg/m^2), smoking (current, or smoking cessation ≤3 mo), positive family history (parent or sibling with CVD before age 65); atherosclerotic disease: prior MI, PCI/CABG, CVA/TIA, or peripheral arterial disease	No known risk factors	0
	1-2 risk factors	**+1**
	≥3 risk factors or history of atherosclerotic disease	+2
Initial troponin Use local, regular sensitivity troponin assays and corresponding cutoffs	≤normal limit	0
	1–3× normal limit	**+1**
	>3× normal limit	+2

3 points

Low Score (0-3 points)

Risk of MACE of 0.9-1.7%.

If troponin is positive, many experts recommend further workup and admission even with a low HEART Score.

Absolute Cardiovascular Risk

Use risk calculators

Chest pain often reveals unmanaged risk

Negative test ≠ low risk

Troponin in Primary Care

- Single troponin rarely useful
- Timing matters
- PoC vs hsTrop
- False reassurance
- ED serial testing is standard

Non-Invasive Testing Overview

- Anatomical vs functional testing
- Choosing the right test

Anatomical: CT Coronary Angiography (CTCA)

- Strengths:
  - First-line for stable chest pain
  - Excellent negative predictive value
  - Shows plaque burden
- Limitations:
  - Calcification
  - Heart rate control
  - Incidental findings

44yo, Tn negative CP, with family history, LDL 3.6

76yo, Tn negative CP, T2DM, AF, CKD, LDL 1.2

44yo, Tn negative CP, with family history, LDL 3.6

Conclusion:
Proximal LAD shows moderate burden of low-attenuation (lipid rich) plaque with high-risk features including positive remodeling and spotty calcification causing minimal to mild stenosis.
Other vessels free of disease.
Calcium score zero.

Functional testing

- Known coronary disease or extensive calcification
- Correlate symptoms with ischemic burden and prognosis
- Options:
  - Exercise stress ECG (ETT)
  - Exercise stress echo or dobutamine echo
  - Myocardial perfusion scan
  - Stress cardiac MRI

- “Consider… availability of health services”

Exercise stress ECG

- Strengths:
  - Low cost
  - Available
  - Assess exercise symptoms
  - No radiation
- Limitations:
  - Accuracy
  - Exercise
  - False positives

Stress echo

- Strengths:
  - Relatively available
  - High specificity
  - Assess ventricle, valves, pressures
  - No radiation
- Limitations:
  - Sensitivity
  - Image quality dependent
  - Exercise

62yo, previous PCI, drop in exercise capacity, possible cardiac CP, SOBOE

62yo, previous PCI, drop in exercise capacity, possible cardiac CP, SOBOE

Conclusion:
Patient exercised to a high workload with mild shortness of breath at peak exertion.
Hypertensive response to exercise with peak BP 220/110.
Normal baseline systolic function (mildly increased wall thickness).
No significant valvular pathology.
Post-exercise images were challenging. A small area of PDA territory ischemia is not excluded.

Myocardial perfusion scan (MIBI)

- Strengths:
  - Relatively available
  - High sensitivity
- Limitations:
  - Radiation
  - Often 2-part test

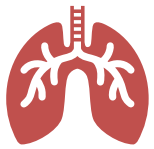
82yo, previous CABG, drop in exercise capacity, exertional angina

38yo, family history, LDL 3.6, possible cardiac chest pain

82yo, previous CABG, drop in exercise capacity, exertional angina

Conclusion:
Phramacological stress with dipyridamole reproduced typical anginal symptoms without associated diagnostic ECG changes.
Myocardial perfusion imaging demonstrates a fixed perfusion defect in the inferior wall consistent with prior infarction. There is no evidence of inducible ischemia.
Left ventricular systolic function is mildly impaired. EF 45%.

Referral pathways



Rapid Access Chest Pain Clinics (RACPCs)

Public, private

Note exclusions

General cardiology referral

Public, private

Direct referral for testing

Testing referral

- Exercise test: RHH
- Stress echo: RHH, Calvary, Heart Centre, Cardio Tas (cost varies)
- Cardiac CT: Qscan, iMed ($800 vs $200)
- Myocardial perfusion scan: iMed (bulk-billed)
  - “unable to exercise adequately for an exercise test”

RHH RACPC

- Est 2014
- ~ 1,000 new patients / year
- Referral base 80% ED, 20% community
- Single attendance clinic
- Investigate +/- recall
- Re-engage with GP
- Emphasis on preventive measures

4 Cardiac diagnoses for rapid access chest pain clinic (RACPC) and usual care (control) patients

	RACPC group	Control group	*P*
Number of patients	1479	435	
Any cardiac diagnosis	153 (10.3%)	29 (6.7%)	0.022
Ischaemia requiring revascularisation	59 (4.0%)	15 (3.4%)	0.61
Ischaemia managed medically	46 (3.1%)	7 (1.6%)	0.09
Arrhythmia	8 (0.5%)	3 (0.7%)	0.72
Cardiomyopathy	8 (0.5%)	1 (0.2%)	0.40
Heart failure with preserved ejection fraction	18 (1.2%)	1 (0.2%)	0.07
Valvular heart disease	7 (0.5%)	0	0.15
Pericarditis	2 (0.1%)	1 (0.2%)	0.66
Aortic aneurysm	1 (0.1%)	0	0.59
Hypertensive heart disease	4 (0.3%)	1 (0.2%)	0.88

Black JA, et al. *Med J Aust* 2019;210(7):321-325

- 5-year ACR (n=1400, 94.7%)
  - 68.1% low risk (< 10%)
  - 9.9% intermediate risk (10 – 15%)
  - 21.9% high risk (> 15%)

1 Baseline characteristics of rapid access chest pain clinic (RACPC) and usual care (control) patients

	RACPC group	Control group	*P*
Number of patients	1479	435	
Demographic characteristics			
Age (years), mean (SD)	55.9 (13.1)	54.6 (13.5)	0.07
Sex (men)	709 (47.9%)	204 (46.9%)	0.77
Risk factors			
Hypertension	656 (44.4%)	200 (46.0%)	0.55
Diabetes mellitus	198 (13.4%)	58 (13%)	0.98
Current smoking	389 (26.3%)	91 (21%)	0.023
Dyslipidemia	546 (36.9%)	164 (37.7%)	0.77
Referral source			< 0.001
Emergency department	1042 (70.5%)	80 (18%)	
General practitioner	437 (29.5%)	355 (81.6%)	
Pre-referral electrocardiogram			< 0.001
Not documented in referral	0	112 (25.7%)	
Available for review	1479 (100%)	323 (74.3%)	
Normal	1303 (88.1%)	277 (85.8%)	0.24
Non-specific ST changes	160 (10.8%)	41 (13%)	0.33
Ischaemic changes	16 (1.1%)	5 (1.5%)	0.48
Pre-referral troponin level			< 0.001
Not documented in referral	168 (11.3%)	334 (76.8%)	
Available for review	1311 (88.6%)	101 (23.2%)	
Normal	1225 (93.4%)	97 (96%)	0.30
1–3 × upper limit of normal*	81 (6.2%)	3 (3.0%)	0.20
≥ 3 × upper limit of normal*	5 (0.4%)	1 (1.0%)	0.36

SD = standard deviation. * Defined as 99th percentile reference limit. ◆

Black JA, et al. *Med J Aust* 2019;210(7):321-325

5 Adverse events for rapid access chest pain clinic (RACPC) and usual care (control) patients

	RACPC group	Control group	Adjusted odds ratio (95% CI)*
Number of patients	1479	435	
Emergency re-presentation (30 days)	24 (1.6%)	19 (4.4%)	0.36 (0.19–0.67)
Emergency re-presentation (12 months)	85 (5.7%)	56 (13%)	0.41 (0.28–0.58)
Major adverse cardiovascular event (12 months)	3 (0.2%)	6 (1.4%)	0.09 (0.02–0.46)
Unplanned revascularisation	3 (0.2%)	2 (0.5%)	0.35 (0.05–2.65)
Acute coronary syndrome	2 (0.1%)	3 (0.7%)	0.09 (0.01–0.97)
Stroke	0	3 (0.7%)	—
Cardiac death	0	0	—

CI = confidence interval. * Adjusted for age, sex, hypertension, diabetes, smoking, and dyslipidemia. ◆

- No investigation n=285 (19.3%) – zero MACE
- Referral to review – zero MACE

Black JA, et al. *Med J Aust* 2019;210(7):321-325

COVID-RACPC

- Telehealth n=140, face-to-face control n=1,479
- Baseline characteristics similar
  - Troponin normal (matched cohort) 90.2% vs 96.9% (p=0.05)
- Additional testing 35.0% vs 80.7% (p<0.001)
- Cardiac diagnosis 11.4% vs 10.3%, p=0.80)

Black JA, et al. *Telemed J E Health* 2023;29(10):1476-1483

Table 2. Clinical Outcomes for Coronavirus Disease 2019 Telehealth Clinics and Rapid Access Chest Pain Clinic Controls

	UNMATCHED COHORT			MATCHED COHORT[a]		
	RACPC CONTROL (n=1,479)	COVID-19 TELEHEALTH (n=140)	p	RACPC CONTROL (n=140)	COVID-19 TELEHEALTH (n=140)	p
Thirty-day representation	24 (1.6)	2 (1.4)	1.00	3 (2.1)	2 (1.4)	1.00
Twelve-month representation	85 (5.7)	9 (6.4)	0.89	7 (5.0)	9 (6.4)	0.80
MACE (12 months)	3 (0.2)	2 (1.4)	0.09	0 (0.0)	2 (1.4)	0.48
Acute coronary syndrome	2 (0.1)	0 (0.0)	1.00	0 (0.0)	0 (0.0)	–
Unplanned revascularization	3 (0.2)	0 (0.0)	1.00	0 (0.0)	0 (0.0)	–
Stroke	0 (0.0)	2 (1.4)	<0.01	0 (0.0)	2 (1.4)	0.48
Cardiac death	0 (0.0)	0 (0.0)	–	0 (0.0)	0 (0.0)	–

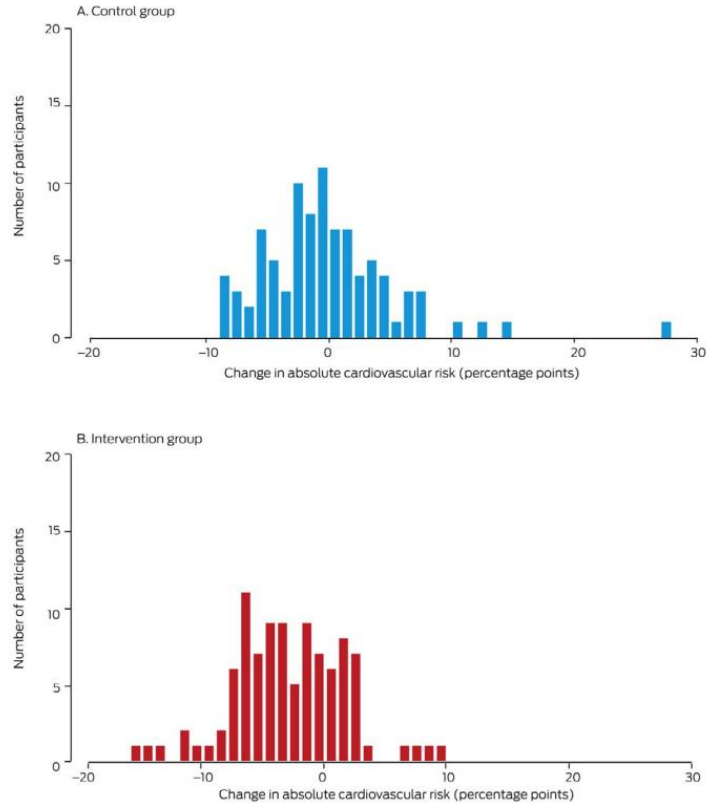
Values are presented as n (%).

[a]Matched for age, sex, history of hypertension, dyslipidemia, diabetes, smoking status, and baseline ECG.

Black JA, et al. *Telemed J E Health* 2023;29(10):1476-1483

Opportunistic risk management

3 Changes in individual absolute cardiovascular risk scores between baseline and follow-up assessments, by study arm



5 Adjusted between-group difference in changes in absolute cardiovascular risk and modifiable risk factors between baseline assessment and follow-up (minimum, 12 months), intervention *v* control

	Between-group difference (percentage points) (95% CI) *
Primary endpoint	
5-year absolute risk	2.70 (1.32 to 4.09)
Secondary endpoints	
Total cholesterol (mmol/L)	0.27 (−0.02 to 0.56)
LDL-C (mmol/L)	0.28 (0.02 to 0.54)
HDL-C (mmol/L)	−0.03 (−0.09 to 0.02)
Systolic blood pressure (mmHg)	2.28 (−1.92 to 6.49)
Body mass index (kg/m^2)	0.39 (−0.65 to 1.43)
	Rate ratio (95% CI)†
Smoker status	1.96 (0.93–4.15)

CI = confidence interval; HDL-C = high-density lipoprotein cholesterol; LDL-C = low-density lipoprotein cholesterol. * Baseline-adjusted analysis of variance. † Log binomial regression, adjusted for baseline smoking. ◆

Black JA, et al. *MJA* 2021;214(6):266-271

Tasmanian HealthPathways

Tasmanian HealthPathways is a web-based information portal developed by Primary Health Tasmania. It is designed to help primary care clinicians plan local patient care through primary, community and secondary healthcare systems.

tasmania.communityhealthpathways.org

Community HealthPathways

Tasmania

Cardiology

In This Section

See Also

Search results for **chest pain**

600 results found

Try Smart Search

Acute Chest Pain

This pathway is about the initial approach to acute (< 72 hour) chest pain in adults. See also: Non-acute Chest Pain and Angina | Acute Coronary Syndrome

Chest Pain

Non-acute Chest Pain and Angina

Breast Pain (Mastalgia)

See also: Acute Chest Pain | Breast Symptoms and Suspected Breast Cancer | Chest Pain (Non-acute)

Shoulder Pain

Acute Coronary Syndrome

This pathway is for patients with suspected acute coronary syndrome in the last 72 hours and for follow-up of patients with a confirmed diagnosis. See also Acute Chest Pain....

Pain Management

Painful Scrotum in Adults

See also Scrotal Pain and Swelling in Children.

Neck Pain

Community HealthPathways

Tasmania

Home
COVID-19
About HealthPathways
Aboriginal and Torres Strait Islander Health
Acute Services
Allied Health and Nursing
Child Health
End-of-Life Care
Investigations
Legal and Ethical
Lifestyle and Preventive Care
Medical
Advance Care Planning (ACP)
Assault or Abuse
Cardiology
Acute Coronary Syndrome
Anticoagulation
Atrial Fibrillation (AF)
Cardiac Catheterisation Complications
Cardiovascular Drugs and Monitoring
Cardiovascular Risk Assessment (CVRA)
Chest Pain

/ Medical / Cardiology / Acute Coronary Syndrome

Acute Coronary Syndrome

This pathway is for patients with suspected acute coronary syndrome in the last 72 hours and for follow-up of patients with a confirmed diagnosis. See also Acute Chest Pain.

Red flags

- New chest pain which:
  - is severe, ongoing, or associated with haemodynamic instability
  - lasts 10 minutes or more
  - occurs at rest or with minimal activity.
- New ischaemic changes on ECG

Background

About acute coronary syndrome

Assessment

Practice point

Immediately call 000 if high likelihood

If high likelihood of acute coronary syndrome (ACS), immediately phone **000** for an ambulance before continuing with comprehensive assessment.

1. For a broader overview of important potentially life-threatening differential diagnoses and to assist in the initial diagnosis, see Acute Chest Pain.
2. If suspected acute coronary syndrome (ACS), immediately perform an ECG – A normal ECG does not exclude ACS.

   Look for:

Expand all Print Share Copy

ABOUT THIS PAGE

Sources
Page information
Topic ID: 1132671

CPD REPORTING

Add learning notes
Create a CPD report

SEND FEEDBACK

in the community.

Management

1. Immediately arrange emergency assessment with ambulance transport if:
   - red flags or high suspicion of ACS.
   - Unstable angina.
   - EDACS score ≥ 16.

   Do not delay transfer, as appropriate patients are fast-tracked for rapid reperfusion therapy.
2. Provide interim management for those referred for emergency assessment, while waiting for the ambulance:
   - give aspirin 300 mg to chew and swallow, even if on regular low-dose aspirin.
   - provide pain relief.
   - only give oxygen if the patient is in cardiogenic shock or if oxygen saturation is less than 90%. If oxygen is used, maintain SpO_2 ≤ 96%.
   - monitor closely.
   - document ECGs and all medications given with doses and times.
3. If EDACS score is ≤ 15 and there:
   - is ongoing concern of possible ACS, and < 24 hours since onset, seek cardiology advice.
   - remains some suspicion of ACS, consider arranging troponin testing in the community if the patient presents 24 to 72 hours after a suspicious episode has resolved, with a normal ECG.
4. Discuss management of any further episodes of acute chest pain.
5. If unsure how to best manage the patient, seek cardiology advice.
6. Arrange long-term follow-up and life-long secondary prevention for all post-ACS patients. Post-ACS patients are at high risk (about half of ACS events occur in patients with a previous ACS) and ongoing care is essential for optimal outcomes.
   - Review patients 3 months post-ACS.
   - Review annually thereafter.

Request

- Immediately arrange emergency assessment with ambulance transport, and include ECGs and details of all treatments given in

Community HealthPathways

Tasmania

- Child Health
- End-of-Life Care
- Investigations
- Legal and Ethical
- Lifestyle and Preventive Care
- Medical
  - Advance Care Planning (ACP)
  - Assault or Abuse
  - Cardiology
    - Acute Coronary Syndrome
    - Anticoagulation
    - Atrial Fibrillation (AF)
    - Cardiac Catheterisation Complications
    - Cardiovascular Drugs and Monitoring
    - Cardiovascular Risk Assessment (CVRA)
    - Chest Pain
      - Acute Chest Pain
      - Non-acute Chest Pain and Angina
    - Presyncope and Syncope
    - Heart Failure
    - Heart Murmurs in Adults
    - Heart Valve Disease
    - Hyperlipidaemia and Familial

- Non-acute Chest Pain and Angina
- Acute Coronary Syndrome

Red flags

- Abnormal vital signs
- Acute coronary syndrome
- Associated syncope, marked dyspnoea, or heart block
- Suspected life-threatening disease e.g., pulmonary embolism, aortic dissection, pneumothorax, or oesophageal rupture

Assessment

1. If acute coronary syndrome is likely:
   - phone an ambulance on **000** before any further assessment, then perform an ECG.
   - follow the Acute Coronary Syndrome Pathway.
2. Take a history:
   - Use SOCRATES – Ask about pain Site, Onset, Character, Radiation, Associated symptoms, Time course (when did the pain start and how long did it last), Exacerbating and relieving factors, and Severity.
   - If pain persists for 72 hours, follow the Non-acute Chest Pain and Angina pathway.
   - Check for cardiovascular risk factors:
     - If aged ≤ 50 years, cardiovascular risk factors increase the likelihood of chest pain being acute coronary syndrome or angina. Consider rare spontaneous coronary artery dissection (SCAD) in young low risk women, especially if pregnant or postpartum (< 3 months).
     - If aged ≥ 50 years, age and symptoms are more important.
     - In Aboriginal and Torres Strait Islander or Pacific patients, cardiovascular disease is more common and presents at a younger age.
3. Perform patient examination.
4. Investigate with an ECG for all but the most trivial chest pain.
5. Consider life-threatening diagnoses:

Expand all | Print | Share | Copy

ABOUT THIS PAGE

Sources

Page information

Topic ID: 97468

CPD REPORTING

Add learning notes

Create a CPD report

SEND FEEDBACK

- In Aboriginal and Torres Strait Islander or Pacific patients, cardiovascular disease is more common and presents at a younger age.

3. Perform patient examination.
4. Investigate with an ECG for all but the most trivial chest pain.
5. Consider life-threatening diagnoses:
   - Acute coronary syndrome (ACS)
   - Oesophageal rupture
   - Pneumothorax
   - Pulmonary embolism – common and easily missed
   - Thoracic aortic dissection
6. Consider other differential diagnoses:
   - Respiratory e.g., pneumonia and/or pleuritic pain
   - Pericarditis, endocarditis, myocarditis
   - Musculoskeletal
   - Gastrointestinal
   - Anxiety or panic attack
   - Viral causes e.g., herpes zoster (shingles), Bornholm disease (viral myalgia in chest and abdomen)
   - Breast pain
7. Arrange any further investigations according to the most likely cause.

Management

1. If red flags, call an ambulance – phone **000**, resuscitate, and provide analgesia. Arrange emergency assessment.
2. If ECG interpretation is required, seek cardiology advice and transmit the image.
3. Manage the most likely cause:
   - Acute coronary syndrome (ACS)
   - Angina
   - Respiratory cause e.g., pneumonia, pulmonary embolism, pneumothorax.
   - Pericarditis, endocarditis, myocarditis – arrange emergency assessment.

Non-acute Chest Pain and Angina

This pathway is about angina and other chest pain presenting after ≥ 72 hours. See also:

- Acute Coronary Syndrome
- Acute Chest Pain – for approach to differential diagnosis and management of causes

Red flags

- Acute coronary syndrome
- Unstable angina
- Life-threatening diagnosis e.g., pulmonary embolism, severe aortic stenosis

Background

About non-acute chest pain and angina

Assessment

1. Take a detailed history of symptoms, which is key to making the diagnosis.
2. Based on the symptoms:
   - assess the probability of typical angina pain.
   - consider if atypical symptoms could be myocardial ischaemia if reliably triggered by exertion, stress, or cold, but not considered typical of angina.
   - note symptoms or features which suggest a non-cardiac cause.
3. Check for cardiovascular risk factors for ischaemic heart disease.
4. Consider other causes of chest pain.
5. Examine the patient:
   - Check blood pressure, pulse rate and rhythm, and oxygen saturation.

Q&A

Pathways to safety – clinical workshop southern Tasmania

EDUCATION

Strengthen your practice's response to family and sexual violence

Tuesday **24 March 2026 – 5.30pm start**

Hotel Grand Chancellor Hobart

Safer Families Centre, University of Melbourne, tailored workshops focused on the whole of practice approach to FSV.

Workshop, dinner and opportunity to connect with peers and discuss this important topic – free event funded by Primary Health Tasmania

Stay tuned for future workshops soon to be announced in north and north-west Tasmania

Some final words

- After this webinar ends, your browser will open a link to an evaluation survey.
- Statements of attendance will be emailed to participants.
- For event queries, please contact events@primaryhealthtas.com.au

Thank you

Disclaimer

- Information presented in webinars organised by Primary Health Tasmania can come from a number of sources, and does not necessarily reflect the views of Primary Health Tasmania. Every reasonable effort is taken to ensure the information is accurate and current.
- The content is general in nature – please refer to any referenced guidelines or standards for further information. Health professionals should rely on their own independent inquiries and professional judgement when making any decisions.
- Primary Health Tasmania and the Australian Government are not responsible for any injury, loss or damage however arising from the use of or reliance on the information provided in this webinar.

Stay informed

primaryhealthtas.com.au

facebook.com/primaryhealthtas

linkedin.com/primary-health-tasmania