

NZ Cardiac Network recommendations for referral and access to secondary care for common cardiac conditions *for patients in whom intervention by secondary care will influence management*



- Cardiology referral not necessarily appropriate, consider declining referral.
- Cardiology referral appropriate
- Auditable standard. All patients should have an assessment, initial investigation and management plan within 4 months of referral. Priority for more urgent assessment is expected.
- Indication for an echocardiogram with a verified report from an accredited cardiologist or CSANZ level 1 trained physician)

Non Acute Chest Pain
Patients with low cardiovascular risk and atypical symptoms
<ul style="list-style-type: none"> • Patients with symptoms consistent with angina regardless of CV risk • Patients with uncertain symptoms and increased cardiovascular risk
<ol style="list-style-type: none"> 1. Ensure that referred patients where appropriate have been adequately assessed with either non-invasive testing to a level that can satisfactorily rule out prognostic coronary artery disease or referred for invasive angiography 2. Perform above within an audited clinical governance structure that includes an accredited cardiologist.
Acute Chest Pain
All patients presenting with possible acute coronary syndrome
<ol style="list-style-type: none"> 1. Assess with an accelerated chest pain pathway 2. 70% of appropriate patients admitted with acute coronary syndrome receive angiography within 3 days
Confirmed ST elevation myocardial infarction
<ol style="list-style-type: none"> 1. Primary percutaneous intervention if it can be reliably delivered within 120 minutes from first medical contact 2. In patients who cannot receive timely primary percutaneous intervention thrombolysis as soon as possible unless contraindicated 3. When rescue percutaneous intervention would be considered in the event of failed thrombolysis the patient should be transferred immediately to a PCI centre
If LV function not known to assess left ventricular function in all patients with ACS. To occur before discharge in all patients at higher risk
Secondary Prevention for IHD
Primary and Secondary Care are expected to work together to provide a community and evidence based prevention programme tailored to individual needs and geographic location for patients with ACS

Suspected Heart Failure
Patients with non-limiting symptoms and normal cardiac biomarkers (when not on treatment), normal ECG and normal chest X-ray
<ul style="list-style-type: none"> • Symptomatic patients with elevated cardiac biomarkers, abnormal Chest X-ray or ECG
<ul style="list-style-type: none"> • Timely assessment including early echocardiography • A clinical governance structure that includes a multi-disciplinary heart failure service
<p>Optimisation of Heart Failure medication phase:</p> <ul style="list-style-type: none"> • at the end of (approx. 3 months) the titration phase, post revascularisation and or post MI when initial EF suspected to be <35% in order to determine future management including device implantation. <p>Follow up:</p> <ul style="list-style-type: none"> • if change in clinical status or cardiac exam • Baseline and serial re-evaluation in a patient undergoing therapy with cardiotoxic agents
Atrial Fibrillation
Patients with uncomplicated AF and clearly defined embolic risk
<ul style="list-style-type: none"> • Rhythm control or cardioversion is considered • Heart rate not adequately controlled, ongoing symptoms, or treatment intolerance • Abnormal resting ECG (other than AF) or significant finding on echocardiogram
<p>Echocardiography appropriate for</p> <ol style="list-style-type: none"> 1. New diagnosis of atrial fibrillation 2. Change in clinical status 3. Suspected underlying structural heart disease or LV dysfunction
Access to cardiology assessment, appropriate investigation and evidence based treatment within an appropriate time frame

Palpitations /syncope/arrhythmia			
Patients with infrequent symptoms non-limiting symptoms and low probability of cardiac disease			
<ul style="list-style-type: none"> • Symptoms consistent with sustained tachycardia • Syncope consistent with cardiac cause • Exercise induced pre syncope/palpitations 			
Access to cardiology assessment , appropriate investigation and treatment within an appropriate time frame			
Echocardiography for suspected valve/ structural /inherited/ heart disease			
<ul style="list-style-type: none"> • A persistent heart murmur which <ul style="list-style-type: none"> • Cannot be explained by fever, anaemia, high output, pregnancy. • Is associated with new or changing symptoms • Is associated with a raised BNP, abnormal ECG or Chest X-ray • Screening of first-degree relatives for inherited cardiomyopathy • Monitoring for potential treatment related cardiotoxicity 			
Follow-up Echocardiography for known heart valve disease			
Valve pathology	Mild	Moderate	Severe
Aortic/Mitral regurgitation	Not necessary	1-2 years	6/12-1 y
Aortic Stenosis	Vmax 2.0-2.9 m/s 3-5 years	Vmax 3.0-3.9 m/s 1-2 years	Vmax > 4.0 m/s 6/12-1 y
Mitral Stenosis	MVA > 1.5 cm2 3-5 years	1.0 – 1.5 cm2 1-2 years	< 1.0 cm2 1y
Follow up echocardiography for prosthetic valves			
Bioprosthetic	< 2y not necessary	2-3y for first 10y then annually	
Mechanical	<3y not necessary	3-5y	
Repaired	<5y not necessary	5y	