

Rapid Angina Assessment Clinic (RAAC) Referral Guidance for Stable Angina

RAACs are designed for the assessment and diagnosis of new onset chest pain (**stable, non-acute**) suggestive of stable angina and for patients who have known ischaemic heart disease and recurrent symptoms not currently under the care of a cardiologist. It is **not** appropriate for screening for CHD or definitively diagnosing non-anginal causes of chest pain.

Patients who clearly have non-anginal chest pain are not likely to benefit from attendance and will not be offered an appointment. Referrals will be returned if there is insufficient information.

Patients who are felt to have unstable symptoms i.e. prolonged (> 15minutes) episodes of chest pain with a high likelihood of being ischaemic should be referred to ED.

Patient presents with chest pain suspected to be stable angina

Assess typicality of chest pain using NICE CG95 criteria (Score 1 for each criterion)

Criterion 1 - Is there constricting discomfort (constricting tightness, pressure, heaviness) in the chest, neck, jaw, shoulders, arms?

Criterion 2 – Is the chest discomfort consistently precipitated by exertion?

Criterion 3 – Is it relieved by rest or GTN within 5 minutes?

Consider features that make diagnosis of stable angina unlikely when the chest pain is

1. continuous or very prolonged **and/or**
2. unrelated to activity **and/or**
3. brought on by breathing in **and/or**
4. associated with symptoms such as dizziness, palpitations, tingling or difficulty swallowing (NICE CG95).
5. Once off episode of chest pain with no further chest pain on exertion.

Score 3
Typical Angina
Refer to RAAC

Score 2
Atypical Angina
Refer to RAAC

Score 0-1
Non-anginal chest pain
Consider other causes
RAAC referral not required unless resting ECG changes

Examination

- Perform routine clinical examination (most importantly to exclude murmurs and A Fib)

Investigation

- Recommended to perform 12 lead ECG where available, and **attach to referral - an ECG will inform triage and in some cases expedite investigation**
- *Consider secondary causes and need for FBP, U&E, lipids, glucose & TFTs

Prescribing

- Start aspirin and GTN if typical/atypical angina and consider starting a beta blocker.

CCG Referral information should include:

- Characteristics of presenting chest pain to include NICE CG95 criteria as above
- Patients CV risk factors e.g. smoking, diabetes, hypertension, lipids, and family history (defined as 1st degree relative < 60 years)
- 12 lead ECG and bloods if available
- Q Risk Score if available.

Advise patient that if pain/discomfort increases in severity or duration to seek urgent medical attention at an ED.

*NICE CG95 <https://pathways.nice.org.uk/pathways/chest-pain#path=view%3A/pathways/chest-pain/assessing-and-diagnosing-suspected-stable-angina.xml&content=view-node%3Anodes-initial-management-and-ecg> suggests outlying anaemia, hyperthyroidism etc.