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Skip to main content Renew your Professional Membership before the June 30, 2025 deadline. Renew Today! A new clinical guideline released by the ACC and the American Heart Association includes new evidence and updated recommendations for managing patients with acute coronary syndromes (ACS). The 2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients With Acute Coronary Syndromes was published simultaneously in JACC and Circulation. The guideline primarily focuses on the management of type 1 acute myocardial infarction – both NSTEMI and STEMI – and includes recommendations addressing initial evaluation and management of suspected ACS, standard medical therapies, reperfusion strategies, catheterization lab considerations, cardiogenic shock management, long-term management and secondary prevention, and more. Among the highlights are updated recommendations for pharmacologic care. Dual antiplatelet therapy (DAPT) with aspirin and an oral P2Y12 inhibitor is indicated for at least 12 months as the default strategy in patients with ACS who are not at high bleeding risk, while several strategies are recommended for patients with a higher bleeding risk. Additionally, high-intensity statin therapy is recommended for all patients with ACS. For those already on maximally tolerated statins and who have an LDL-C level ≥70 mg/dL (1.8 mmol/L), a nonstatin lipid-lowering agent such as ezetimibe, evolocumab, alirocumab, inclisiran or bempedoic acid is also recommended. On the procedural front, the guideline stresses the importance of the radial approach over a femoral approach for PCI in patients with ACS to reduce the risk of bleeding, vascular complications and death. Reflecting the latest evidence, intravascular imaging to guide the PCI procedure is now a class 1 recommendation. In addition, the guideline recommends a strategy of complete revascularization in patients with STEMI or NSTEM ACS, with the choice of revascularization method based on the complexity of the coronary artery disease and comorbid conditions. Important recommendations for treating cardiogenic shock, including prompt revascularization, are also included in the guideline. Based on new clinical trial data, use of the microaxial flow pump is recommended for select patients with cardiogenic shock related to acute MI. However, the guideline notes that "careful attention to vascular access and weaning of support is important to appropriately balance the benefits and risks." Secondary prevention following discharge is another important focus of the guideline, with recommendations ranging from referrals to outpatient cardiac rehabilitation (or home-based care if outpatient is not doable) to conducting a fasting lipid panel four to eight weeks after initiating or adjusting the dose of lipid-lowering therapy. "Patients with ACS are at the highest risk for cardiovascular complications both acutely and chronically, which emphasizes the importance of staying up-to-date on the most recent evidence presented in this guideline," said Sunil V. Rao, MD, FACC, chair of the guideline writing committee. "With appropriate management, we can improve outcomes both in the hospital and over the long term." In addition to the ACC and AHA, the guideline was written in collaboration with and endorsed by the American College of Emergency Physicians, the National Association of EMS Physicians, and the Society for Cardiovascular Angiography and Interventions. Clinical Topics: Anticoagulation Management, Cardiac Surgery, Cardiovascular Care Team, Invasive Cardiovascular Angiography and Intervention, Stable Ischemic Heart Disease, Vascular Medicine, Aortic Surgery, Cardiac Surgery and SIHD, Interventions and Vascular Medicine, Chronic Angina Keywords: Anticoagulants, ST Elevation Myocardial Infarction, Non-ST Elevated Myocardial Infarction, Percutaneous Coronary Intervention, Myocardial Revascularization < Back to Listings 25 Aug 2023 The present guideline has been developed to support healthcare professionals in the diagnosis and management of patients presenting with acute coronary syndrome (ACS). The conditions of ST-elevation myocardial infarction (STEMI) and non-ST-elevation ACS (NSTE-ACS) have been covered separately in previous European Guidelines. For the first time, the present guideline presents recommendations for management of patients across the entire spectrum of ACS in one document. The previous guidelines on STEMI were published in 2017 and the previous guidelines on NSTE-ACS were published in 2020. There have been numerous developments in the diagnosis and treatment of patients with ACS in the intervening years, which are reflected in this up-to-date guideline. The current guideline provides a comprehensive overview of the management of patients presenting with ACS, from the point of diagnosis and risk stratification at initial presentation, through to longterm management after the initial hospitalisation period. Particular focus is given to the importance of anti-thrombotic therapy, invasive assessment and revascularisation. This guideline also highlights the importance of providing patient-centred care throughout the patient's ACS journey. Topic(s): Pathophysiology and Mechanisms Epidemiology, Prognosis, Outcome The essentials of the Guidelines in just a few minutes. Watch Insights from the Chairs of the Guidelines Task Force. Read Download ESC Pocket Guidelines App Have the ESC Pocket Guidelines with you all the time. Download for free Back to ESC Guidelines list Create Free Account or Uncategorized webadmin March 7, 2025 0 Summary of the ACC/AHA 2025 ACS Guidelines Update The American College of Cardiology (ACC) and the American Heart Association (AHA), in collaboration with other medical societies, have released a comprehensive guideline for the management of Acute Coronary Syndromes (ACS). This marks the first unified guideline covering STEMI and NSTE-ACS since separate guidelines were issued in 2013 and 2014. The document incorporates the latest evidence, offering updated recommendations on revascularization, imaging, mechanical support devices, transfusion strategies, and secondary prevention. Key Updates and Recommendations Revascularization Strategies • Complete revascularization (including nonculprit arteries) is now a Class 1 recommendation for both STEMI and NSTE-ACS. • Preference is given to completing revascularization in a single procedure, rather than a staged approach. • Intracoronary imaging (IVUS/OCT) has been upgraded to Class 1 for left main and complex lesions, based on new RCT data showing improved stent-related and clinical outcomes. Mechanical Circulatory Support (Impella Device) • Impella CP (Abiomed/Johnson & Johnson MedTech) is reasonable (Class 2a) for patients with severe or refractory cardiogenic shock in STEMI. • This recommendation follows positive findings from the DanGer Shock Trial, though concerns about procedural risks prevented a Class 1 rating. Transfusion Strategies for ACS Patients • Based on the MINT trial, liberal red blood cell transfusion may improve some outcomes in MI patients with anemia. • The guideline provides a Class 2b recommendation for transfusions to maintain hemoglobin ≥10 g/dL in non-bleeding patients with acute or chronic anemia. Antiplatelet Therapy & Bleeding Risk Reduction • Dual Antiplatelet Therapy (DAPT) with aspirin + P2Y12 inhibitor remains a Class 1 recommendation for at least 12 months in low bleeding risk patients. • Bleeding risk reduction strategies: • Use of proton pump inhibitors (PPIs) in patients at risk for GI bleeding. • Ticagrelor monotherapy may be considered one month after PCI in patients who tolerate DAPT. • In patients needing long-term anticoagulation, stopping aspirin 1-4 weeks post-PCI and continuing with a P2Y12 inhibitor (preferably clopidogrel) plus anticoagulant is recommended. Secondary Prevention & Lipid Management • Fasting lipid panel should be conducted 4-8 weeks after starting or adjusting lipid-lowering therapy (Class 1). • LDL cholesterol ≥70 mg/dL despite maximum statin therapy: • Class 1: Add ezetimibe, evolocumab, alirocumab, inclisiran, or bempedoic acid to lower MACE risk. • Class 2a: Consider adding non-statin therapy for LDL 55-69 mg/dL. • Cardiac rehabilitation before discharge is strongly recommended (Class 1), with home-based programs as a reasonable alternative (Class 2a). Class 3 Recommendations (Not Recommended) • Routine manual aspiration thrombectomy during PCI in STEMI due to lack of benefit. • Routine PCI of non-infarct-related arteries in patients with cardiogenic shock, as it increases mortality and renal failure. • Routine use of glycoprotein IIb/IIIa inhibitors due to high bleeding risk without clear ischemic benefits. Conclusion This ACC/AHA 2025 guideline is a rigorous synthesis of the best available evidence, reflecting the latest advances in ACS management. As guideline chair Dr. Sunil Rao emphasized, implementing Class 1 recommendations can significantly improve patient outcomes, while avoiding outdated Class 3 practices ensures safer, more effective care. Source: Todd Neale, “ACC/AHA Release New Comprehensive ACS Guidelines,” TCTMD, February 27, 2025. A new clinical guideline released by the ACC and the American Heart Association (AHA) includes new evidence and updated recommendations for managing patients with an acute coronary syndrome (ACS). The 2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients With Acute Coronary Syndromes was published in JACC. The guideline primarily focuses on the management of type 1 acute myocardial infarction – both NSTEMI and STEMI – and includes recommendations addressing initial evaluation and management of suspected ACS, standard medical therapies, reperfusion strategies, catheterization lab considerations, cardiogenic shock management, long-term management and secondary prevention, and more. Among the highlights are updated recommendations for pharmacologic care. Dual antiplatelet therapy (DAPT) with aspirin and an oral P2Y12 inhibitor is indicated for at least 12 months as the default strategy in patients with ACS who are not at high bleeding risk, while several strategies are recommended for patients with a higher bleeding risk. Additionally, high-intensity statin therapy is recommended for all patients with ACS. 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Charney Division of Cardiology, director of Interventional Cardiology at NYU Langone Health and chair of the guideline writing committee. "With appropriate management, we can improve outcomes both in the hospital and over the long term." In addition to the ACC and AHA, the guideline was written in collaboration with and endorsed by the American College of Emergency Physicians, the National Association of EMS Physicians, and the Society for Cardiovascular Angiography and Interventions. A new joint Scientific Statement from the American Heart Association (AHA) and ACC provides new and updated clinical guidance on how to assess risk when considering competitive sports participation for people with various cardiovascular conditions. Divided into 11 sections, the statement replaces a previous statement from 2014, and addresses sports classifications; the preparticipation cardiac evaluation; ethical aspects of competitive sports eligibility; cardiomyopathies; myocarditis/pericarditis, valvular heart disease and other acquired cardiovascular conditions; congenital heart disease; aortopathy and spontaneous coronary artery dissection; arrhythmias, devices and ECG abnormalities; cardiac channelopathies; masters athletes; and additional cardiac conditions and considerations (i.e., hypertension, performance-enhancing drugs, pregnancy, etc.). Of note, the statement authors, led by Chair Jonathan H. Kim, MD, MSC, FACC, and Vice Chairs Aaron L. Baggish, MD, FACC, and Benjamin D. Levine, MD, FACC, highlight new evidence indicating that athletes of all ages who have certain cardiovascular abnormalities or diseases may often safely participate in competitive sports. It also specifically addresses athlete types, like masters athletes, extreme sports athletes and pregnant athletes, not included in previous documents. Additionally, the statement offers increased guidance for clinicians around risks associated with specific types of sports. For example, certain activities with a higher risk of trauma and bleeding, such as tackle football, competitive cycling, outdoor skiing or baseball, must be considered for athletes taking blood-thinning medications. "We acknowledge that there are times when the risks of competing are much higher than the benefits for athletes with cardiovascular abnormalities," Kim said. Shared decision-making is also front-and-center in the new Statement. "In the past, there was no shared decision-making about sports eligibility for athletes with heart disease. These athletes were automatically prohibited from participating in sports if almost any cardiac issue was present," said Kim. "This new scientific statement reviews best clinical practices for athletes with certain cardiovascular conditions and how health care professionals can guide these athletes – from children to masters athletes – in a shared decision-making discussion about potential risks and rewards." Looking ahead, the statement emphasizes the need for more research to better understand how competitive sports participation impacts overall health among athletes with cardiovascular abnormalities, as well as the impacts of social disparities on these athletes. "We have to look at social disparities because it is a very reasonable hypothesis to believe that disparities play an important role in terms of health outcomes for athletes as they do for people in the general population," said Kim. Read the full statement published in JACC. Clinical Topics: Acute Coronary Syndromes, Arrhythmias and Clinical EP, Congenital Heart Disease and Pediatric Cardiology, Invasive Cardiovascular Angiography and Intervention, Sports and Exercise Cardiology, Valvular Heart Disease, Implantable Devices, SCD/Ventricular Arrhythmias, Atrial Fibrillation/Supraventricular Arrhythmias, Congenital Heart Disease, CHD and Pediatrics and Arrhythmias, CHD and Pediatrics and Interventions, Interventions and ACS, Interventions and Structural Heart Disease, Sports and Exercise and Congenital Heart Disease and Pediatric Cardiology Keywords: Cardiology Magazine, ACC Publications, Percutaneous Coronary Intervention, Acute Coronary Syndrome, Myocardial Infarction, Heart Defects, Congenital, Heart Valve Diseases, Arrhythmias, Cardiac, Athletes