Table on Early Invasive Angiography for clinician to use in discussion with patient

This table discusses the benefits and disadvantages of undertaking an **early angiography followed by PCI if indicated within 72 hours of the index *(can use "current"?)* hospital admission for people with UA or NSTEMI who have a medium or high risk of adverse cardiovascular events if they have no contradictions. The alternative is either not to or defer this intervention, and undertaking conservative management without early angiography (**recs B2-4**).** Under the conservative management option the individual is medically managed; the angiography and potential PCI will be deferred unless or until *something in their condition changes leading to a reconsideration of the situation e.g. they subsequently become ischaemic* . Individuals whose condition becomes unstable should be offered immediate angiography (rec 1.5.1). This option is not discussed here as the benefits clearly outweigh the disadvantages.

Individuals should not be offered angiography if there are contraindications which suggest it might be harmful e.g. they are bleeding or have other relevant illnesses. If PCI is indicated this should be done within 72 hours.

Benefits and Disadvantages of each option under discussion

Option	Benefits	Disadvantages	Quality of Evidence
Consider coronary angiography with follow-on PCI within 72 hours of first admission for this condition for people with UA or NSTEMI who have an intermediate or higher risk of adverse cardiovascular events if they have no contraindications	There are medium and long term clinical benefits of the procedure: -patient less likely to die after the initial period following the procedure (evidence of this benefit 6-12 months after procedure and for up to two years - MI rates reduced in the four month follow up period and at the 12-2 year follow up. This benefit did not appear to continue at the 10 year follow up but this needs to be treated with caution. GC noted this length of time may be too long to directly reflect the benefits and harms of an intervention. -There was no appreciable clinical difference between the interventions in the incidence of stroke in the first month but there was a clinical benefit at 1	There are risks with the invasive procedure. There is some evidence that: - patient is at increased risk of dying in hospital and within four months of procedure. This may be more relevant for patients at lower risk who by definition are less likely to experience adverse events regardless of treatment modality. -There is an increased risk of MI whilst the individual is still in hospital -there is an increased risk of bleeding. This is usual in invasive procedures. PCI Clinical practice has evolved since the studies were undertaken. E.g. increased use of radial artery access is associated with reduced risk of bleeding, which in turn is associated with improved survival	A number of studies looked at this issue. The quality of evidence ranged from very low to high with the majority graded low or very low because of risk of bias, imprecision e.g. the effect the treatment did or did not have on MI was not clear because different definitions were used in the trials. This may have led to a lower than expected rate of MI.

(1.5.2)	year. Stoke normally has life changing effects for the patient and possibly for their family which must be considered These benefits are more marked in patients who were in the high risk group and who, without invasive treatment, are more likely to experience adverse events. Doing the procedure within 72 hours ensures a speedy intervention whilst allowing time for the correct diagnosis including the identification of other illnesses, treatment of symptoms and transfer to a centre with PCI facilities if necessary. Conservative management can induce anxiety because of patient concerns about not having an angiography.	Receiving a diagnosis of UA/NSTEMI can be very traumatic for people. If the treatment is carried out very quickly as an emergency there is no scope to explain the risks and for patients to share in the decision making. On the other hand once it is known that an angiography is required then waiting for the procedure is likely to induce further anxiety in the patient. There are broader disadvantages of being in hospital for longer including risk of cross infection and disadvantages to patient and possibly family	Generally people who take part in clinical trials have a lower risk profiles than in the real world so the evidence may have an inbuilt bias and show benefits for low risk populations which will not apply to those at higher risk
Consider conservative management without early coronary angiography for people with UA or NSTEMI who have a low risk of adverse cardiovascular events (1.5.3)	Patient not exposed to immediate risks of invasive procedure namely bleeding, having an MI or death from other causes related to the procedure Patient less at risk of bleeding, having an MI or dying in the four months after the procedure. This is particularly relevant for patients who are in the low risk group i.e. if treated conservatively they were unlikely to experience adverse events. -risk of bleeding	Patient may not get the long term benefits on the invasive procedure which prevents other problems occurring later (e.g. after 6-12 months and up to two years) namely: -reduced risk of MI and mortality Also there appeared to reduced risk of stroke at 1 year. Stroke has life changing impact for the patient and possibly for their family These benefits are more marked in patients who were in the high risk group and without invasive treatment more likely to experience adverse Conservative management can induce	See above

	Patient not exposed to the potential anxiety of having an invasive procedure Patient not exposed to more general risks of hospitalisation e.g. cross-infection or the practical problems.	anxiety in patient because of the concerns about not having an angiography	
Consider coronary angiography with follow on PCI for patients initially assessed to be of low risk of adverse events if ischaemia is subsequently experienced (1.5.4)	Primarily as for option 1	As in option 1	See above

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