JACC
VOL. ■, NO. ■, 2025

PUBLISHED BY ELSEVIER

SOCIETAL STATEMENT

2025 Acute Coronary Syndromes Guideline-at-a-Glance

Dharam J. Kumbhani, MD, SM, FACC*
Morgane Cibotti-Sun, MPH
Mykela M. Moore, MPH

INTRODUCTION

The 2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients with Acute Coronary Syndromes[1] (ACC/AHA/Multisociety ACS Guideline) highlights the importance of the most recent clinical evidence in treating patients with heart attacks and other acute coronary syndromes (ACS). It incorporates updated, evidence-based recommendations from 3 key guidelines.[2-4] Together with the 2021 ACC/AHA/SCAI Coronary Artery Revascularization Guideline,[5] this new ACC/AHA/Multisociety ACS Guideline replaces the 2016 Focused Update on the Duration of Dual Antiplatelet Therapy in Patients with Coronary Artery Disease.[6] This Guideline-at-a-Glance highlights practice-changing recommendations from the guideline to accelerate adoption.

American College of Cardiology (ACC) guideline dissemination is an organization-wide effort facilitated by the Solution Set Oversight Committee to ensure the integration of guideline content throughout the ACC's clinical policy, education, registry, membership, and advocacy efforts. For each guideline, an individual ACC Guideline Dissemination Workgroup is created to influence dissemination strategy and to develop tools to facilitate the implementation of key changes in practice. These tools include the **Central Illustration**, as well as tables highlighting updates in the ACC/AHA/Multisociety ACS Guideline and comparisons to the 2023 European Society of Cardiology (ESC) Guidelines for the Management of Acute Coronary Syndromes.[7]

TOP TAKE-HOME MESSAGES

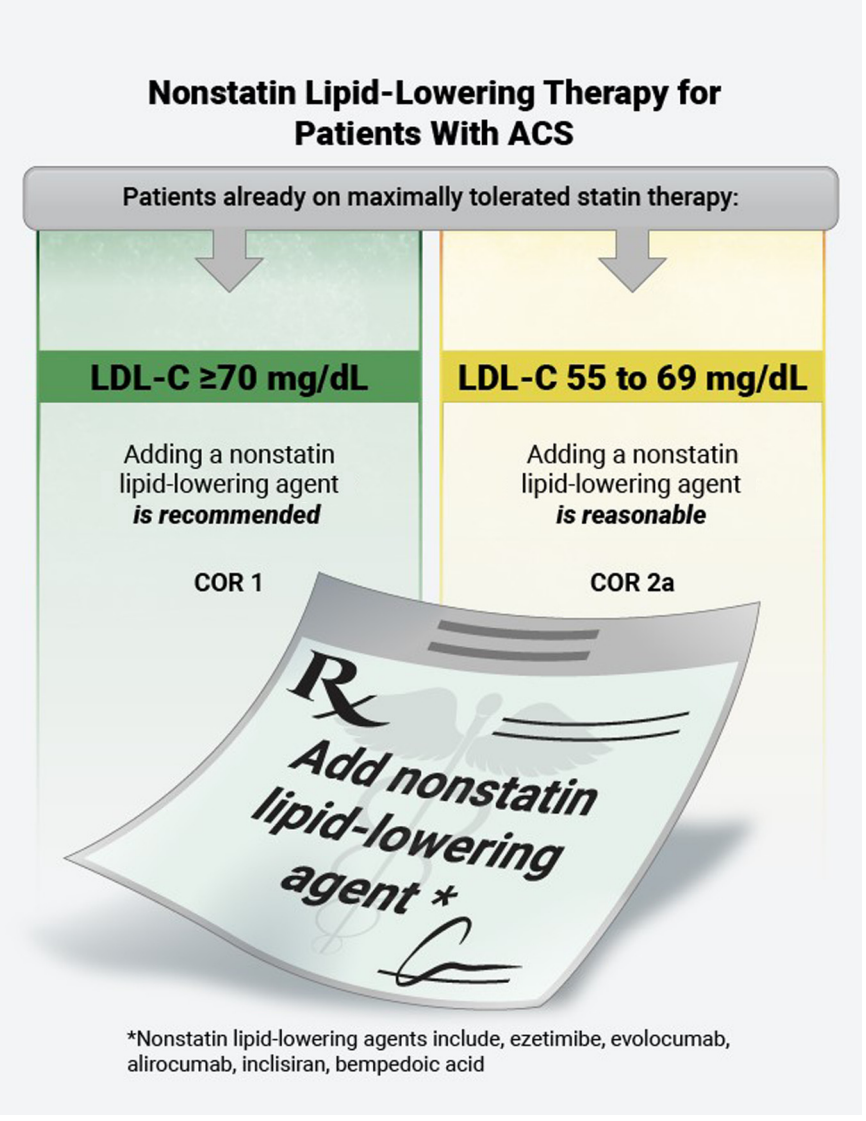
The following Top Take-Home Messages are taken directly from the ACC/AHA/Multisociety ACS Guideline. Messages 2, 3, and 6 (in **bold** below) were selected as key themes for this Guideline-at-a-Glance because they represent the most impactful changes in these recommendations compared with previous guidelines and address known gaps in clinical practice.

1. Dual antiplatelet therapy is recommended for patients with ACS. Ticagrelor or prasugrel is recommended in preference to clopidogrel in patients with ACS who are undergoing percutaneous coronary intervention (PCI). In patients with non-ST-segment elevation ACS who are scheduled for an invasive strategy with timing of angiography to be >24 hours, upstream treatment with clopidogrel or ticagrelor may be considered to reduce major adverse cardiovascular events.
2. **Dual antiplatelet therapy with aspirin and an oral $P2Y_{12}$ inhibitor is indicated for at least 12 months as the default strategy in patients with ACS who are not at high bleeding risk. Several strategies are available to reduce bleeding risk in patients with ACS who have undergone PCI and require antiplatelet therapy: a) in patients at risk for gastrointestinal bleeding, a proton pump inhibitor is recommended; b) in patients who have tolerated dual antiplatelet therapy with ticagrelor, transition to ticagrelor monotherapy is recommended ≥1 month after PCI; or c) in patients who require long-term anticoagulation, aspirin discontinuation is recommended 1 to 4 weeks after PCI with continued use of a $P2Y_{12}$ inhibitor (preferably clopidogrel).**
3. **High-intensity statin therapy is recommended for all patients with ACS, and with the option to initiate concurrent ezetimibe. A nonstatin lipid-lowering agent (eg, ezetimibe, evolocumab, alirocumab,**

*On behalf of the ACC Solution Set Oversight Committee.

ISSN 0735-1097/$36.00
https://doi.org/10.1016/j.jacc.2025.01.018

CENTRAL ILLUSTRATION **2025 Acute Coronary Syndromes Guideline-at-a-Glance**



Kumbhani DJ, et al. JACC. 2025;10.1016/j.jacc.2025.01.018

ACS = acute coronary syndromes; COR = Class of Recommendation; LDL-C = low-density lipoprotein cholesterol.

inclisiran, bempedoic acid) is recommended for patients already on maximally tolerated statin who have a low-density lipoprotein cholesterol level of ≥70 mg/dL (1.8 mmol/L). It is reasonable in this high-risk population to further intensify lipid-lowering therapy if the low-density lipoprotein cholesterol level is 55 to <70 mg/dL (1.4 to <1.8 mmol/L) and the patient is already on a maximally tolerated statin.

4. In patients with non-ST-segment elevation ACS who are at intermediate or high risk of ischemic events, an invasive approach with the intent to proceed with revascularization is recommended during hospitalization to reduce major adverse cardiovascular events. In patients with non-ST-segment elevation ACS who are at low risk of ischemic events, a routine invasive or selective invasive approach with further risk stratification is recommended to help identify those who may require revascularization and to reduce major adverse cardiovascular events.
5. Two procedural strategies are recommended in patients with ACS who are undergoing PCI: a) radial approach is preferred over femoral approach in

TABLE 1 Select Differences Between the 2013 STEMI, 2014 NSTEMI, 2015 PCI, 2016 DAPT, 2021 Revascularization Guidelines, and the 2025 ACC/AHA/Multisociety ACS Guideline

	2013/2014/2015/2016/2021 Guidelines[2-6]		2025 Guideline[1]	
	COR*	Old Recommendations	COR*	New Recommendations
Nonstatin lipid-lowering agents (Top Take-Home Message 3)	1	High-intensity statin therapy should be initiated or continued in all patients with STEMI and no contraindications to its use.[2]	1	In patients with ACS, high-intensity statin therapy is recommended to reduce the risk of MACE.
	1	High-intensity statin therapy should be initiated or continued in all patients with NSTE-ACS and no contraindications to its use.[3]		
	No corresponding guideline recommendation.		1	In patients with ACS who are already on maximally tolerated statin therapy with LDL-C ≥70 mg/dL (≥1.8 mmol/L), adding a nonstatin lipid-lowering agent is recommended to further reduce the risk of MACE.
			1	In patients with ACS who are statin intolerant, nonstatin lipid-lowering therapy is recommended to lower LDL-C and reduce the risk of MACE.
			2a	In patients with ACS who are already on maximally tolerated statin therapy with LDL-C 55 to 69 mg/dL (≥1.4 to <1.8 mmol/L), adding a nonstatin lipid-lowering agent is reasonable to reduce the risk of MACE.
			2b	In patients with ACS, the concurrent initiation of ezetimibe in combination with maximally tolerated statin may be considered to reduce the risk of MACE.
Revascularization strategy (Top Take-Home Message 6)	1	In selected hemodynamically stable patients with STEMI and MVD, after successful primary PCI, staged PCI of a significant noninfarct artery stenosis is recommended to reduce the risk of death or MI.[5]	1	In selected, hemodynamically stable patients with STEMI and MVD, after successful PCI of the infarct-related artery, PCI of significantly stenosed† noninfarct-related arteries is recommended to reduce the risk of death or MI and improve angina-related quality of life.
	2b	PCI of a noninfarct artery may be considered in selected patients with STEMI and multivessel disease who are hemodynamically stable, either at the time of primary PCI or as a planned staged procedure.[4]	2b	In selected hemodynamically stable patients with STEMI and low-complexity MVD (those not intended for CABG surgery), multivessel PCI of significantly stenosed noninfarct-related arteries at the time of PPCI may be preferred over a staged approach to reduce the risk of cardiovascular events.
	3: Harm	In patients with STEMI complicated by cardiogenic shock, routine PCI of a noninfarct artery at the time of primary PCI should not be performed because of the higher risk of death or renal failure.[5]	3: Harm	In patients with STEMI complicated by cardiogenic shock, routine PCI of a noninfarct-related artery at the time of PPCI should not be performed because of the higher risk of death or renal failure.†
	2b	A strategy of multivessel PCI, in contrast to culprit lesion only PCI, may be reasonable in patients undergoing coronary revascularization as part of treatment for NSTE-ACS.[3]	1	In stable patients with NSTE-ACS with MVD but without left main stenosis who are not intended for CABG surgery and undergoing culprit-lesion PCI, PCI of significant nonculprit lesions (at the time of the index procedure or as a staged procedure) is recommended to reduce the risk of MACE.
	3: Harm	In patients with NSTE-ACS who present in cardiogenic shock, routine multivessel PCI of nonculprit lesions in the same setting should not be performed.[5]	3: Harm	In patients with NSTE-ACS complicated by cardiogenic shock, routine PCI of a nonculprit artery at the time of index procedure should not be performed because of the higher risk of death or kidney failure.

Continued on the next page

patients with ACS undergoing PCI to reduce bleeding, vascular complications, and death; and b) intracoronary imaging is recommended to guide PCI in patients with ACS with complex coronary lesions.

6. **A strategy of complete revascularization is recommended in patients with ST-segment elevation myocardial infarction or non–ST-segment elevation ACS. The choice of revascularization method (ie, coronary artery bypass graft surgery vs multivessel PCI) in non–ST-segment elevation ACS and multivessel disease should be based on the complexity of the coronary artery disease and comorbid conditions. PCI of significant nonculprit stenoses for patients with ST-segment elevation myocardial infarction can be performed in a single procedure or staged with some preference toward performing multivessel PCI in a single procedure. In patients with ACS and cardiogenic shock, emergency revascularization of the culprit vessel is indicated; however, routine PCI of noninfarct-related arteries at the time of PCI is not recommended.**
7. Based on one trial, use of the microaxial flow pump in selected patients with cardiogenic shock related to

TABLE 1 Continued

	2013/2014/2015/2016/2021 Guidelines[2-6]		2025 Guideline[1]	
	COR*	Old Recommendations	COR*	New Recommendations
DAPT duration vs. bleeding risk (Top Take-Home Message 2)	1	In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after BMS or DES implantation, $P2Y_{12}$ inhibitor therapy (clopidogrel, prasugrel, or ticagrelor) should be given for at least 12 mo.[6]	1	In patients with ACS who are not at high bleeding risk, DAPT with aspirin and an oral $P2Y_{12}$ inhibitor should be administered for at least 1 y to reduce MACE.
	2a	In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after coronary stent implantation, it is reasonable to use ticagrelor in preference to clopidogrel for maintenance $P2Y_{12}$ inhibitor therapy.[6]	1	In patients with NSTE-ACS undergoing PCI, prasugrel or ticagrelor is recommended to reduce MACE and stent thrombosis.
			1	In patients with STEMI managed with PPCI, prasugrel or ticagrelor should be administered to reduce MACE and stent thrombosis.
	2a	In selected patients undergoing PCI, shorter-duration DAPT (1-3 mo) is reasonable, with subsequent transition to $P2Y_{12}$ inhibitor monotherapy to reduce the risk of bleeding events.[5]	1	In patients with ACS who have tolerated DAPT with ticagrelor, transition to ticagrelor monotherapy ≥1 mo post-PCI is useful to reduce bleeding risk.
	2b	In patients with ACS treated with DAPT after DES implantation who develop a high risk of bleeding (eg, treatment with oral anticoagulant therapy), are at high risk of severe bleeding complication (eg, major intracranial surgery), or develop significant overt bleeding, discontinuation of $P2Y_{12}$ inhibitor therapy after 6 mo may be reasonable.[6]	2b	In patients with ACS undergoing PCI who are at high bleeding risk, transition to single antiplatelet therapy (aspirin or $P2Y_{12}$ inhibitor) after 1 mo may be reasonable to reduce bleeding risk.
			2b	In patients with ACS undergoing PCI, de-escalation of DAPT (switching from ticagrelor or prasugrel to clopidogrel) after 1 mo may be reasonable to reduce bleeding risk.
	1	The duration of triple antithrombotic therapy with a vitamin K antagonist, aspirin, and a $P2Y_{12}$ receptor inhibitor in patients with NSTE-ACS should be minimized to the extent possible to limit the risk of bleeding.[3]	1	In patients with ACS who require oral anticoagulant therapy, aspirin should be discontinued after 1 to 4 wks of triple antithrombotic therapy, with continued use of $P2Y_{12}$ inhibitor (preferably clopidogrel) and oral anticoagulant to reduce bleeding risk.

*Colors in this table align with the classification system found in Table 2, "Applying American College of Cardiology/American Heart Association Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care," in the ACC/AHA/Multisociety ACS Guideline.[1]
†Significantly stenosed refers to lesions that are severely diseased as defined by the "2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization" as a visually estimated diameter stenosis severity of ≥70% for non-left main disease and ≥50% for left main disease.[5]

ACC = American College of Cardiology; ACS = acute coronary syndromes; AHA = American Heart Association; BMS = bare-metal stent; CABG = coronary artery bypass grafting; COR = class of recommendation; DAPT = dual antiplatelet therapy; DES = drug-eluting stents; LDL-C = low-density lipoprotein cholesterol; MACE = major adverse cardiovascular event; MI = myocardial infarction; MVD = multivessel disease; NSTE-ACS = non-ST-segment elevation acute coronary syndrome; NSTEMI = non-ST-segment elevation myocardial infarction; PCI = percutaneous coronary intervention; PPCI = primary percutaneous coronary intervention; STEMI = ST-segment elevation myocardial infarction.

acute myocardial infarction is reasonable to reduce death. However, complications such as bleeding, limb ischemia, and renal failure are higher with the micro-axial flow pump compared with usual care. Therefore, careful attention to vascular access and weaning of support is important to appropriately balance the benefits and risks.

8. Red blood cell transfusion to maintain a hemoglobin of 10 g/dL may be reasonable in patients with ACS and acute or chronic anemia who are not actively bleeding.
9. After discharge, focus on secondary prevention is fundamental. A fasting lipid panel is recommended 4 to 8 weeks after initiating or adjusting the dose of lipid-lowering therapy. Referral to cardiac rehabilitation is also recommended, with the option for home-based programs for patients unable or unwilling to attend in person.

CENTRAL ILLUSTRATION: NONSTATIN LIPID-LOWERING THERAPY FOR PATIENTS WITH ACS

Atherosclerotic cardiovascular disease event rates are higher in patients with recent ACS, with 1-year rates of cardiovascular death, myocardial infarction, and ischemic stroke elevated after an ACS hospitalization. Due to the higher risk, the ACC/AHA/Multisociety ACS Guideline recommends more aggressive LDL cholesterol targets in patients with recent ACS. The 2025 ACS Guideline-at-a-Glance **Central Illustration** highlights a shift in focus from maximally tolerated statins in previous guidelines[2,3] to maximally tolerated statins with the addition of a nonstatin lipid-lowering agent to manage cholesterol levels. The illustration focuses on Top Take-Home Message 3.

COMPARISON WITH PREVIOUS ACC/AHA GUIDELINES

The ACC/AHA/Multisociety ACS Guideline updates content from 5 previous guidelines:

- The 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction (2013 STEMI)[2];
- The 2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (2014 NSTEMI)[3];

TABLE 2 Select Comparison of 2025 ACC/AHA/Multisociety ACS Guideline and 2023 ESC ACS Guidelines

	ESC ACS Guideline[7]		ACC/AHA/Multisociety ACS Guideline[1]	
	COR*	ESC Recommendation	COR*	ACC/AHA/Multisociety Recommendation
Nonstatin lipid-lowering agents (Top Take-Home Message 3)	1	It is recommended that high-dose statin therapy is initiated or continued as early as possible, regardless of initial LDL-C values.	1	In patients with ACS, high-intensity statin therapy is recommended to reduce the risk of MACE.
	1	It is recommended to aim to achieve an **LDL-C level of <1.4 mmol/L (<55 mg/dL)** and to reduce LDL-C by ≥50% from baseline.	1	In patients with ACS who are already on maximally tolerated statin therapy with **LDL-C ≥70 mg/dL (≥1.8 mmol/L)**, adding a nonstatin lipid-lowering agent is recommended to further reduce the risk of MACE.
	1	If the LDL-C goal is not achieved despite maximally tolerated statin therapy after 4-6 wks, the addition of ezetimibe is recommended.	2a	In patients with ACS who are already on maximally tolerated statin therapy with **LDL-C 55 to 69 mg/dL (≥1.4 to <1.8 mmol/L)**, adding a nonstatin lipid-lowering agent is reasonable to reduce the risk of MACE.
	1	If the LDL-C goal is not achieved despite maximally tolerated statin therapy and ezetimibe after 4-6 wks, the addition of a PCSK9 inhibitor is recommended.		
	2b	Combination therapy with high-dose statin plus ezetimibe may be considered during index hospitalization.	2b	In patients with ACS, the concurrent initiation of ezetimibe in combination with maximally tolerated statin may be considered to reduce the risk of MACE.
	2b	For patients with a recurrent atherothrombotic event (recurrence within 2 y of first ACS episode) while taking maximally tolerated statin-based therapy, an LDL-C goal of <1.0 mmol/L (<40 mg/dL) may be considered.		No corresponding guideline recommendation.
Revascularization strategy (Top Take-Home Message 6)	1	In hemodynamically stable STEMI patients with MVD who have undergone primary PCI of the culprit vessel, complete revascularization is recommended either during the index PCI procedure or within 45 d.	1	In selected, hemodynamically stable patients with STEMI and MVD, after successful PCI of the infarct-related artery, PCI of significantly stenosed† noninfarct-related arteries is recommended to reduce the risk of death or MI and improve angina-related QOL.
			2b	In selected hemodynamically stable patients with STEMI and low-complexity MVD (those not intended for CABG surgery), multivessel PCI of significantly stenosed noninfarct-related arteries at the time of PPCI may be preferred over a staged approach to reduce the risk of cardiovascular events.
	1	In ACS patients presenting with cardiogenic shock who have MVD, IRA-only PCI during the index procedure is recommended.‡	3: Harm	In patients with STEMI complicated by cardiogenic shock, routine PCI of a noninfarct-related artery at the time of PPCI should not be performed because of the higher risk of death or renal failure.†‡
	2a	In ACS patients presenting with cardiogenic shock who have MVD, staged PCI of non-IRA should be considered.‡	3: Harm	In patients with NSTE-ACS complicated by cardiogenic shock, routine PCI of a nonculprit artery at the time of index procedure should not be performed because of the higher risk of death or kidney failure.‡
	2a	In hemodynamically stable patients presenting with NSTE-ACS and MVD undergoing PCI, complete revascularization should be considered, preferably during the index procedure.	1	In stable patients with NSTE-ACS with MVD but without left main stenosis who are not intended for CABG surgery and undergoing culprit-lesion PCI, PCI of significant nonculprit lesions (at the time of the index procedure or as a staged procedure) is recommended to reduce the risk of MACE.

Continued on the next page

- The 2015 ACC/AHA/SCAI Focused Update on Primary Percutaneous Coronary Intervention for Patients With ST-Elevation Myocardial Infarction (2015 PCI)[4];
- The 2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients With Coronary Artery Disease (2016 DAPT)[6];
- The 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization (2021 Revasc).[5]

Table 1 outlines changes in nonstatin lipid-lowering agents, revascularization strategies, and dual antiplatelet therapy (DAPT) duration in relation to bleeding risk. The comparison focuses on Top Take-Home Messages 2, 3, and 6.

For further details, refer to the corresponding sections of the ACC/AHA/Multisociety ACS Guideline[1]:

- Section 4.3.2. "Oral $P2Y_{12}$ Inhibitors During Hospitalization"
- Section 4.5. "Lipid Management"
- Section 7.4.1. "Management of Multivessel CAD in STEMI"
- Section 7.4.2. "Management of Multivessel CAD in NSTE-ACS"
- Section 11.1. "DAPT Strategies in the First 12 Months Postdischarge"
- Section 11.1.1. "Antiplatelet Therapy in Patients on Anticoagulation Postdischarge"

TABLE 2 Continued

	ESC ACS Guideline[7]		ACC/AHA/Multisociety ACS Guideline[1]	
	COR*	ESC Recommendation	COR*	ACC/AHA/Multisociety Recommendation
DAPT duration vs bleeding risk (Top Take-Home Message 2)	1	In all ACS patients, a $P2Y_{12}$ receptor inhibitor is recommended in addition to aspirin, given as an initial oral LD followed by an MD for 12 mo unless there is HBR.	1	In patients with ACS who are not at high bleeding risk, DAPT with aspirin and an oral $P2Y_{12}$ inhibitor should be administered for at least 1 y to reduce MACE.
	1	In ACS patients, prasugrel is recommended in $P2Y_{12}$ receptor inhibitor-naïve patients proceeding to PCI.	1	In patients with STEMI managed with PPCI, prasugrel or ticagrelor should be administered to reduce MACE and stent thrombosis.
			1	In patients with NSTE-ACS undergoing PCI, prasugrel or ticagrelor is recommended to reduce MACE and stent thrombosis.
	2a	In ACS patients, prasugrel should be considered in preference to ticagrelor for ACS patients who proceed to PCI.		No corresponding guideline recommendation.
	2a	In patients who are event-free after 3-6 mo of DAPT and who are not high ischemic risk, single antiplatelet therapy (preferably with a $P2Y_{12}$ receptor inhibitor) should be considered.	1	In patients with ACS who have tolerated DAPT with ticagrelor, transition to ticagrelor monotherapy ≥1 mo post PCI is useful to reduce bleeding risk.
	2b	De-escalation of $P2Y_{12}$ receptor inhibitor treatment (eg, with a switch from prasugrel/ticagrelor to clopidogrel) may be considered as an alternative DAPT strategy to reduce bleeding risk.	2b	In patients with ACS undergoing PCI, de-escalation of DAPT (switching from ticagrelor or prasugrel to clopidogrel) after 1 mo may be reasonable to reduce bleeding risk.
	3	De-escalation of antiplatelet therapy in the first 30 d after an ACS event is not recommended.		
	2b	In HBR patients, aspirin or $P2Y_{12}$ receptor inhibitor monotherapy after 1 mo of DAPT may be considered.	2b	In patients with ACS undergoing PCI who are at high bleeding risk, transition to single antiplatelet therapy (aspirin or $P2Y_{12}$ inhibitor) after 1 mo may be reasonable to reduce bleeding risk.
	1	As the default strategy for patients with atrial fibrillation and CHA_2DS_2-VASc score ≥1 in men and ≥2 in women, after up to 1 wk of triple antithrombotic therapy following the ACS event, dual antithrombotic therapy using a NOAC at the recommended dose for stroke prevention and a single oral antiplatelet agent (preferably clopidogrel) for up to 12 mo is recommended.	1	In patients with ACS who require oral anticoagulant therapy, aspirin should be discontinued after 1 to 4 wks of triple antithrombotic therapy, with continued use of $P2Y_{12}$ inhibitor (preferably clopidogrel) and oral anticoagulant to reduce bleeding risk.
	2a	In patients treated with an OAC, aspirin plus clopidogrel for longer than 1 wk and up to 1 mo should be considered in those with high ischemic risk or with other anatomical/procedural characteristics that are judged to outweigh the bleeding risk.		

*Colors in this table align with the classification system found in Table 2, "Applying American College of Cardiology/American Heart Association Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care," in the ACC/AHA/Multisociety ACS Guideline.[1]
†Significantly stenosed refers to lesions that are severely diseased as defined by the "2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization" as a visually estimated diameter stenosis severity of ≥70% for non-left main disease and ≥50% for left main disease.[5]
‡These recommendations are qualitatively similar, but the phrasing in the respective guidelines makes them appear to be opposites (class 1 vs class 3).

ACC = American College of Cardiology; ACS = acute coronary syndrome; AHA = American Heart Association; CABG = coronary artery bypass grafting; CHA2DS2-VASc = Congestive heart failure, Hypertension, Age, Diabetes, Stroke or TIA-Vascular disease; COR = class of recommendation; DAPT = dual antiplatelet therapy; ESC = European Society of Cardiology; HBR = high bleeding risk; IRA = infarct-related artery; LD = loading dose; LDL-C = low-density lipoprotein cholesterol; MACE = major adverse cardiovascular event; MD = maintenance dose; MI = myocardial infarction; MVD = multivessel disease; NOAC = non-vitamin K antagonist oral anticoagulant; NSTE-ACS = non-ST-segment elevation acute coronary syndrome; OAC = oral anticoagulant/anticoagulation; PCI = percutaneous coronary intervention; PCSK9 = proprotein convertase subtilisin/kexin type 9; PPCI = primary percutaneous coronary intervention; QOL = quality of life; STEMI = ST-segment elevation myocardial infarction.

COMPARISON OF ACC/AHA/MULTISOCIETY ACS GUIDELINE TO ESC ACS GUIDELINE

In 2023, the ESC published a guideline on the management of ACS. Table 2 compares the recommendations for nonstatin lipid-lowering agents, revascularization strategies, and DAPT duration in relation to bleeding risk between the 2025 ACC/AHA/Multisociety ACS Guideline[1] and the 2023 ESC ACS Guideline.[7] The comparison focuses on Top Take-Home Messages 2, 3, and 6.

For further details, refer to the corresponding sections of the 2023 ESC ACS Guidelines[7]:

- Section 6.3. "Maintenance Antithrombotic Therapy After Revascularization"
- Section 6.4. "Long-term Treatment"
- Section 10.1. "Management of Multivessel Disease in Acute Coronary Syndrome Complicated by Cardiogenic Shock"
- Section 10.5. "Hybrid Revascularization"
- Section 13.3. "Pharmacological Treatment"

ACKNOWLEDGMENTS The authors would like to thank the ACC Solution Set Oversight Committee: Nicole M. Bhave, MD, FACC, *Chair*; Niti R. Aggarwal, MD, FACC; Katie Bates, ARNP, DNP; John P. Erwin, III, MD, FACC; Martha Gulati, MD, MS, FACC; Gurusher S. Panjrath, MBBS, FACC; Barbara Wiggins, PharmD, FACC; and Megan Coylewright, MD, MPH, FACC, *Ex Officio*.

The authors would also like to thank the ACC Acute Coronary Syndromes Guideline Dissemination Workgroup: Michelle L. O'Donoghue, MD, FACC; Joaquin E. Cigarroa, MD, FACC; Laura Davidson, MD, MS, FACC; and Mirvat A. Alasnag, MBBS, FACC.

REFERENCES

1. Rao SV, O'Donoghue ML, Ruel M, et al. 2025 ACC/AHA/ACEP/NAEMSP/SCAI guideline for the management of patients with acute coronary syndromes: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol*. Published online February 27, 2025. https://doi.org/10.1016/j.jacc.2024.11.009

2. O'Gara PT, Kushner FG, Ascheim DD, et al. 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2013;61:e78–e140.

3. Amsterdam EA, Wenger NK, Brindis RG, et al. 2014 AHA/ACC guideline for the management of patients with non-ST-elevation acute coronary syndromes: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2014;64:e139–e228.

4. Levine GN, Bates ER, Blankenship JC, et al. 2015 ACC/AHA/SCAI focused update on primary percutaneous coronary intervention for patients with ST-elevation myocardial infarction: an update of the 2011 ACCF/AHA/SCAI guideline for percutaneous coronary intervention and the 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction. *J Am Coll Cardiol*. 2016;67:1235–1250.

5. Lawton JS, Tamis-Holland JE, Bangalore S, et al. 2021 ACC/AHA/SCAI guideline for coronary artery revascularization: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol*. 2022;79:e21–e129.

6. Levine GN, Bates ER, Bittl JA, et al. 2016 ACC/AHA guideline focused update on duration of dual antiplatelet therapy in patients with coronary artery disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *J Am Coll Cardiol*. 2016;68:1082–1115.

7. Byrne RA, Rossello X, Coughlan JJ, et al. 2023 ESC guidelines for the management of acute coronary syndromes. *Eur Heart J*. 2023;44:3720–3826.