Treat right

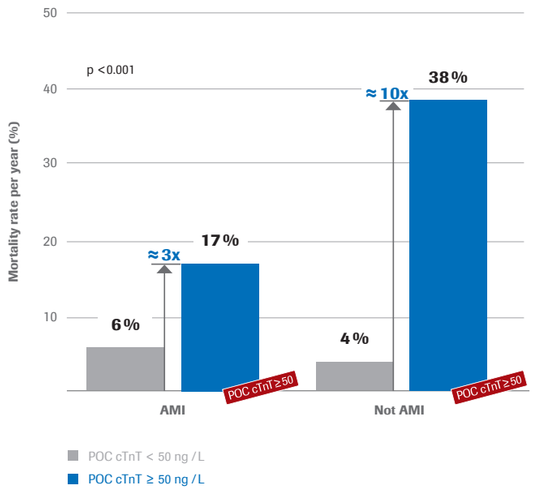
POC cTnT ≥ 50: Identify patients with suspected AMI at high risk of long-term mortality[1]

PreHAP study[1]: Pre-hospital patients with suspected AMI with Roche CARDIAC POC Troponin T ≥ 50 ng/L

POC cTnT ≥ 50

- Represented 12 % of all patients with suspected AMI[1]
- Had a 3 – 10 times higher long-term mortality risk, irrespective of AMI[1]
- Required direct delivery to coronary intensive care or cath lab for medical investigation[1,2]

Long-term mortality risk of patients with suspected AMI[1]



Roche CARDIAC POC Troponin T test on the cobas h 232 POC system

- Results in just 12 minutes – for rapid rule-in of high-risk individuals[1,3]
- Precise results standardized with Elecsys® Troponin T high-sensitive (cTnT-hs) laboratory test in the quantitative range of 40 – 2000 ng / L[3,**]
- Easy to use even in mobile situations

Test early.
Treat right.
Save lives.

Cardiac markers available for **cobas h** POC 232 system: Troponin T, NT-proBNP, D-Dimer, Myoglobin, CK-MB – for rapid on-the-spot decisions.

*AMI, Acute Myocardial Infarction; POC, Point of Care.

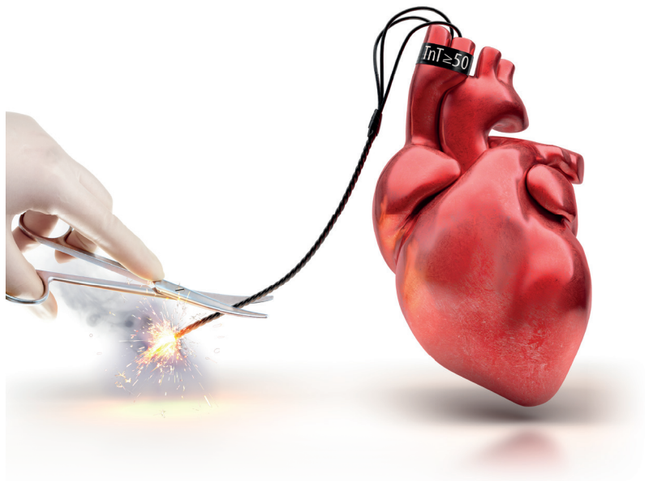
** The Roche CARDIAC POC Troponin T is standardized with Roche's Elecsys® Troponin T high-sensitive laboratory test that showed a 99th percentile upper reference limit of a healthy cohort of 14 ng/L.

1 Stengaard, C. et al. (2013). *Am J Cardiol 112(9)*, 1361 – 6.
2 Windecker, S. et al. (2014). *Eur Heart J 35(37)*, 2541 – 619.
3 Roche CARDIAC POC Troponin T. Package Insert, 2015.

Roche

POC cTnT ≥ 50. Detect the danger. Start action now.

Roche CARDIAC POC Troponin T ≥ 50 ng / L (POC cTnT ≥ 50): Improving patient care by early identification and adequate intervention in patients with suspected AMI* at high risk of long-term mortality.[1]



Test early. Treat right. Save lives.

Test early

New ESC guidelines recommend early intervention

Early invasive strategy within 24 hours recommended for all patients with high-risk non-ST-segment elevation acute coronary syndrome (NSTE-ACS).[2]

Recommendations for invasive evaluation and revascularization in NSTE-ACS[2]		
Recommendations	Class	Level
Urgent coronary angiography (<2 hours) is recommended in patients at very high ischemic risk (refractory angina, with associated heart failure, cardiogenic shock, life-threatening ventricular arrhythmias, or hemodynamic instability).	I	C
An **early** invasive strategy (<24 hours) is recommended in Patients with at least one **primary** high-risk criterion.	I	A

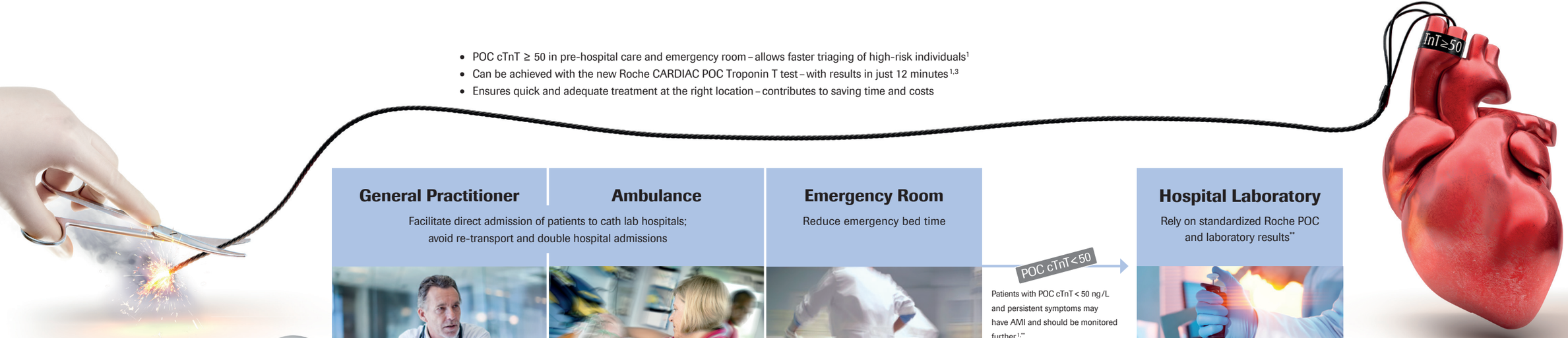
Rise or fall in Troponin T is the #1 criterion for high-risk patients with non-ST-segment elevation acute coronary syndrome.[2]

Criteria for high risk with indication for invasive management[2]
Primary criteria
1. Relevant rise or fall in troponin
2. Dynamic ST- or T-wave changes (symptomatic or silent)
3. GRACE score > 140
Secondary criteria
4. Diabetes mellitus
5. Renal insufficiency (eGFR <60 mL / min / l.73m²)
6. Reduced LV function (ejection fraction < 40 %)

Save lives

POC cTnT ≥ 50 – For faster triaging in pre-hospital care and emergency room

- POC cTnT ≥ 50 in pre-hospital care and emergency room – allows faster triaging of high-risk individuals[1]
- Can be achieved with the new Roche CARDIAC POC Troponin T test – with results in just 12 minutes[1,3]
- Ensures quick and adequate treatment at the right location – contributes to saving time and costs



General Practitioner

Ambulance

Emergency Room

Facilitate direct admission of patients to cath lab hospitals; avoid re-transport and double hospital admissions

Reduce emergency bed time

POC cTnT < 50

Patients with POC cTnT < 50 ng/L and persistent symptoms may have AMI and should be monitored further.[1,**]

Hospital Laboratory

Rely on standardized Roche POC and laboratory results**

cobas h 232 POC cTnT test

cobas h 232 POC cTnT test

Elecsys® cTnT-hs test

Coronary Intensive Care Unit or Cath Lab

Rule-in for medical investigation and life-saving intervention

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