SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Effective Date: 9/1/11
Supersedes: 1/1/11 **Protocol: #P-010**

CHEST PAIN/ACUTE CORONARY SYNDROME

INFORMATION NEEDED

- Discomfort or pain: OPQRST, Previous episodes
- Associated symptoms: Weakness, nausea, vomiting, diaphoresis, dyspnea, dizziness, palpitations, "indigestion", syncope
- Medical history (cardiac history, other medical problems, including hypertension, diabetes or stroke)
- Use of erectile dysfunction drug (see PRECAUTION AND COMMENTS)

OBJECTIVE FINDINGS

- General appearance: level of distress, skin color, diaphoresis
- Signs of CHF (peripheral edema, respiratory distress, distended neck veins)
- Lung sounds
- Interpretation of EKG rhythm, 12 lead if available
- Assessment of pain on a 1-10 scale

BLS Treatment	ALS Treatment
• Reassure patient and place in position of comfort, or supine if patient is hypotensive • Oxygen 2-6 L/min by nasal cannula or non-rebreather mask at 10-15 L/min • Assess patient: primary, secondary survey and history • Assist patient with taking their own NTG repeating q 5 min. to a max of 3 if SBP > 100 mm Hg. Use with caution when administering NTG to patients who have taken any erectile dysfunction drug [see PRECAUTIONS AND COMMENTS] • Prehospital screening for thrombolytic therapy • RMC	• IV access [see PRECAUTIONS AND COMMENTS] and cardiac monitoring • **NTG** 0.4 mg sublingual spray or tablet, repeat q 5 min. if SBP > 100 mmHg (IV not required prior to **NTG** administration, but should be started as soon as possible) [see PRECAUTIONS AND COMMENTS] • **ASA** 81 mg x 4 PO (chew) - total 324 mg • Obtain 12 lead EKG • If discomfort persists; consider **Morphine Sulfate** 2-4 mg slow IVP, repeat as indicated if SBP > 100 mm Hg, to maximum dose of 20 mg. • Consider **Ondansetron** 4 mg IV/IM for nausea/vomiting, may be repeated q 20" to a maximum dose of 12 mg. • If dysrhythmia is present, and persists after treatment above, see DYSRHYTHMIA Protocol(s) • If hypotension develops, consider 500 ml fluid challenge; if hypotension persists consider **Dopamine** 5 to 20 mcg/kg/min IV infusion titrated to SBP > 90 mm Hg.
	Base Contact Criteria • Additional treatment for ongoing pain when BP < 100

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Effective Date: 9/1/11
Supersedes: 1/1/11 **Protocol: #P-010**

Documentation for Adherence to Protocol:
Presence of OPQRST history
Vital signs before/after **NTG** administration
Cardiac rhythm and 12 lead EKG documentation
Oxygen administration
IV access
NTG use unless hypotension or use of erectile dysfunction drug (See PRECAUTIONS AND COMMENTS)
ASA unless allergy documented

PRECAUTIONS AND COMMENTS

- Minimize scene time. If the computer interpretation of the EKG indicates ST Segment Elevation Myocardial Infarction, take the patient to an appropriate Receiving Facility per EMS Agency Policies on Destination and Communication. **Notify Appropriate receiving hospital with the following information:**
    - This is a STEMI Alert Call
    - Read the message from the 12 Lead EKG computer
    - Proceed as usual with report indicating any pertinent information from the patient's assessment and any pertinent observations from the paramedic interpretation of the 12 Lead EKG
- 12 lead EKG should be completed within 5 minutes of decision to obtain.
- Suspicion of Acute Coronary Syndrome (ACS) is based upon patient history. Be alert to patients likely to present with atypical symptoms or "silent AMI's": women, elderly, and diabetics.
- Do not administer **NTG** to patients who have taken any erectile dysfunction drug within the following time frames.
    - Sildenafil - > 24 hours
    - Tadalafil - > 72 hours
    - Vardenafil - > 72 hours
- Administer **Morphine Sulfate** slow IVP to avoid respiratory depression and/or hypotension; be ready to support ventilations and have **Naloxone** available.
- Consider other potential causes of chest pain: pulmonary embolus, pneumonia, aortic aneurysm and pneumothorax.
- If fluid challenge/replacement or drug administration is required, place IV of NS.