Subject: Treatment Guidelines – ALS
Cardiac Emergencies – Suspected Acute MI / Acute Coronary Syndrome

Associated Policies:

I. Priorities
- A. ABC's
- B. Identify dysrhythmia and degree of distress.
- C. Initiate treatment before transport.
- D. Re-assess rhythm and vital signs frequently.

II. Indications:
- A. Chest Pain Suspicious of Cardiac Origin (Typical or Atypical)
- B. Syncopal episode.
- C. History of previous AMI
- D. History of heart disease.
- E. Angina

III. Treatment:
1. Reduce anxiety, allow patient to assume position of comfort.
2. Oxygen to maintain oxygen saturations no greater than 94%.
3. Obtain rhythm strip for documentation.
4. IV access. (Blood draw for labs, if possible.)
5. Aspirin chewed and swallowed.
6. Nitroglycerine SL use caution prior to obtaining 12 Lead. May repeat every 3-5min, if BP>100 systolic.
7. Morphine Sulfate or Fentanyl IVP titrated to relieve chest pain, if BP > 90-systolic.
8. Obtain 12 Lead ECG as early as possible.
9. If signs of inadequate tissue perfusion or if inferior wall infarct is suspected, consider obtaining a right-chest 12 Lead. (V4R)
10. If right ventricular infarct is suspected with signs of inadequate tissue perfusion, consider 300ml NS bolus, may repeat. Early consultation with Base Station. (Nitrates should be avoided in the presence of suspected Right Ventricular Infarct or hypotension.)
11. Leave 12 Lead monitoring in place. Repeat 12 Lead at regular intervals if monitor is not equipped with trending.
12. If computerized interpretation of accurately performed 12 Lead indicates either ***ACUTE MI*** or ***STEMI MI***, the patient should be evaluated for transport directly to the PCI center.
13. Or if paramedic identifies signs of Acute MI

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a. Active chest pain or equivalent symptoms (nausea, SOB)
b. ST-elevation
i. > or = 2mm in 2 contiguous leads (V1-V4), and/or
ii. > or = 1 mm in 2 contiguous leads (limb, lateral)
c. QRS duration < or = 0.12 seconds

14. With consent, a patient with an identified STEMI or ACUTE MI should be transported to the designated STEMI Receiving Center.
15. Patients without these findings should be transported to the nearest receiving facility if possible.
16. Patients developing cardiac arrest or unmanageable airway enroute should be transported to the nearest appropriate Receiving hospital.
17. For patients with nausea and vomiting, consider Zofran.as tolerated.
18. Reevaluate frequently for any changes.
19. Consider shock protocols below for clinical signs of hypoperfusion.

IV. Clinical Signs of Hypoperfusion:

1. Oxygen as indicated by clinically presentation.
2. Obtain early IV access. (Blood draw for labs, if possible.)
3. Consider the cause:
   a. Volume problem:
      1) Fluid challenge 300-500ml normal saline, repeat as needed to obtain adequate volume replacement.
   b. Rate problem:
      1) Use tachycardia or bradycardia treatment protocols.
   c. Pump problem:
      1. Fluid challenge – 300ml-500ml NS, repeat as needed to obtain adequate volume replacement.
      2. If systolic BP < 70, consider Dopamine infusion or Push Dose Epinephrine after adequate fluid replacement.

V. Special Considerations:

1. Approximate time to acquire a 12 lead should not be longer than three (3) minutes.
2. Emergency Medical Technicians (Basics) can assist with application and acquisition of the 12 lead EKG under the direct supervision of the paramedic.

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Associated Policies:

Approved: _____ Date: 1-22-2020

Approved as to Form: _____ Date: 1-22-2020