Chest Pain: Suspected Cardiac

For any chest pain that is of possible cardiovascular etiology, but NOT STEMI (e.g., non-STEMI, pericarditis, dissection)

**History**
- Age
- Medications (Erectile dysfunction medications)
- Past medical history (e.g., MI, angina, diabetes, or post menopausal)
- Allergies
- Recent physical exertion
- Onset
- Provocation
- Quality (e.g., pressure, constant, sharp, dull, etc.)
- Region/Radiation/Referred
- Severity (0 – 10 scale)
- Time (onset/duration/repetition)

**Signs and Symptoms**
- Heart rate < 60 with associated hypotension, acute altered mental status, chest pain, acute CHF, seizures, syncope, or shock secondary to bradycardia
- Chest pain
- Respiratory distress
- Hypotension or shock
- Altered mental status
- Syncope
- Nausea
- Abdominal Pain
- Diaphoresis

**Differential**
- Acute myocardial infarction
- Hypoxia
- Pacemaker failure
- Hypothermia
- Sinus bradycardia
- Athletes
- Head injury (elevated ICP) or stroke
- Spinal cord lesion
- Sick sinus syndrome
- AV blocks (e.g., 1o, 2o, or 3o)
- Overdose

---

**Flowchart**

Chest pain?

- Signs/symptoms consistent with cardiac etiology?
  - Yes: Acute MI/STEMI
  - No: Continue with history

**Acute MI/STEMI**

(STEMI = 1mm ST segment elevation ≥ 2 contiguous leads; See 12-Lead Procedure) EKG Reads ****ACUTE MI SUSPECTED**** or equivalent

- Establish IV/IO
  - Nitroglycerin (Hold for BP < 110)
  - For pain consider, Fentanyl
  - If systolic BP < 90 Normal Saline bolus 500ml IV/IO Maximum 2L

- Declare a STEMI Alert & Transmit EKG

- Notify receiving facility. Consider Base Hospital for medical direction

**Approved STEMI Receiving Centers**
- Kaiser Redwood City
- Mills - Peninsula Medical Center
- Sequoia Hospital
- Seton Hospital
- Stanford Hospital

---

**Effective November 2018**

**Effective October 2019**
**Chest Pain: Suspected Cardiac**

For any chest pain that is of possible cardiovascular etiology, but NOT STEMI (e.g., non-STEMI, pericarditis, dissection)

**Pearls**
- Avoid Nitroglycerin in any patient who has used Viagra (Sildenafil) or Levitra (Vardenafil) in the past 24 hours or Cialis (Tadalafil) in the past 36 hours due to the potential of severe hypotension.
- Avoid Nitroglycerin in patients who are having an inferior STEMI
- Many STEMI evolve during prehospital care and may not be noted on the initial 12-Lead ECG.
- An ECG should be obtained prior to treatment for bradycardia if patient condition permits.
- If a patient has taken their own Nitroglycerin without relief, consider potency of medication. Provider maximum doses do not include patient administered doses.
- Monitor for hypotension after administration of nitroglycerin and opioids.
- Diabetics, geriatric, and female patients often have atypical pain, or only generalized complaints. Suspect cardiac etiology in these patients, and perform a 12-Lead ECG.

**Effective November 2018**

**ST Elevation in 2 or more leads:**
- Leads II, III, aVF → Inferior wall MI (vessel likely RCA or LCx)
- Leads I, aVL, V5, V6 → Lateral wall MI (vessel likely LCx or LAD branch)
- Leads V1, V2 → Septal wall MI (vessel likely LCx or LAD branch)
- Leads V3, V4 → Anterior wall MI (vessel likely LCx or LAD branch)

**Look for ST DEPRESSION in reciprocal leads (opposite wall) to confirm diagnosis.**

**Isolated ST elevation in aVR with ST depression in all other leads should raise suspicion for a proximal LAD Artery injury or Left Main Coronary Artery abnormality. This is not STEMI criteria, but the 12-Lead ECG should be transmitted to the ED for consultation. Consider transport to a STEMI receiving center.**