

Strike and Delete

AC-8 Myocardial Infarction

Designation of Condition: A chief complaint, which has signs and symptoms suggestive of AMI. Patient may present with one or more of the following: chest pain/discomfort (radiating or non-radiating), discomfort or altered sensations to neck, jaw, and either shoulder/arm or into the back. There may be complaints of SOB, weakness, diaphoresis, syncope, nausea, &/or vomiting.

Field Treatment:

- Oxygen Therapy:
 - If appropriate, obtain RA O₂ sat.
 - O₂ administration of sufficient liter flow to treat associated complaint of shortness of breath.
- Allow patient to assume position of comfort.
- Baseline vital signs
- Administer two 81 mg chewable ASA (Unless contra-indicated) if the patient has not taken ASA since the onset of current symptoms.
- Heart Monitor/ECG* - Monitor cardiac rhythm and acquire a 12 lead ECG. If there is evidence of inferior wall AMI, or if you have other reasons to suspect right ventricular AMI, obtain a right sided 12 lead ECG (either V4R or V1R-V6R).
- Initiate 1 IV of 0.9 NS. Titrate fluids to patient vital signs
- If systolic BP > 100 mmHg and no signs/symptoms or ECG findings consistent with acute right ventricular infarct or injury, administer 0.4 mg Nitroglycerin SL q 3-5 minutes to a maximum of 1.2 mg, provided vital signs remain stable
- **Administration of NTG is contraindicated for the following:**
 - **Patients who have taken Sexual Performance Enhancing Drugs within 48 hours**
 - **In the setting of suspected acute right ventricular MI.**
 - **Hypotension SBP< 100mmHG**
- Acquisition of a 12 lead ECG should be integrated into the initial flow of patient assessment and management whenever possible, and should not delay transport. Place limb lead monitoring electrodes in such a manner as to facilitate 12 lead acquisition (Use standard limb electrode placement: Distal medial forearm/wrist and on the medial aspect of each calf. Placement on proximal limbs may be used if significant motion artifact is obtained). Serial 12 lead ECG's may be acquired en route when the patient's clinical condition warrants. If 12 lead ECG interprets as "Acute MI suspected" or if history, physical exam, and/or ECG findings are suspicious of an ischemic cardiac event, limit scene times to a minimum and initiate rapid transport to a core facility with a cath lab (VAMC, UNMH, Pres DT, Lovelace Downtown, HHNM).
- Early Cath Lab Activation Protocol: Whenever the 12 ECG interpretation reads "Acute MI" or "Acute MI Suspected", it is imperative that early cath lab activation occur. In these situations the EMS provider (including Fire & Rescue personnel if applicable) should contact the receiving hospital or Albuquerque Base as soon as possible and transmit the following information: 'age', 'gender', "acute MI by EKG", 'destination hospital', 'ETA'. If Albuquerque Base is contacted they will forward this information to the receiving hospital. A more complete patient report can be transmitted to the receiving hospital en route over the radio.
 - If acute MI is suspected and no transport unit is available, the rescue unit should transport the patient without delay.

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Deleted: <#>If 12 lead ECG is unavailable and patient presents with chest pain and hypertension (SBP > 150 mmHg and/or DBP > 100 mmHg) or signs of acute pulmonary edema with normal or elevated blood pressure then 0.4 mg Nitroglycerin may be administered prior to acquisition of 12 lead ECG.¶

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- Titrate Morphine Sulfate, up to 10 mg SIVP PRN for pain. Monitor hemodynamic and respiratory status closely.
- Administer Morphine Sulfate cautiously (in 1-2 mg increments). Do not administer in the setting of acute right ventricular MI without MCEP approval.
- If additional Morphine Sulfate is required, contact receiving hospital/MCEP.

MCB Action	Passed	Implemented	Revised	Revision #	Implemented
	4/20/94	06/01/94	07/15/09	15	10/01/09

Deleted: <#>If short intermittent runs of ventricular tachycardia occur, refer to AC-14 Unstable Ventricular Tachycardia protocol¶

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Changes Accepted; Final

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Action	4/20/94	06/01/94	07/15/09	15	10/01/09

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AC-9 Pulmonary Edema, Congestive Heart Failure

Designation of Condition: The patient will present with shortness of breath and rales (wet noisy respirations/crackles). Pink frothy sputum is a classic sign, but usually absent. The patient will often appear anxious, pale, clammy and acutely dyspneic/tachypneic. Individuals will avoid recumbency, and attempt to sit upright. Signs of right heart failure are also often present (jugular venous distention and dependent edema). Most patients will have a history of CHF, but if not, consider an acute concomitant precipitating cause, eg, cardiac ischemia or valvular failure.

Field Treatment:

- Oxygen at a flow rate sufficient to treat any component of associated shortness of breath. Allow the patient to seek a position of comfort, if possible (fowlers). Airway management as necessary.
- Obtain a baseline set of vital signs.
- Establish an IV of NS TKO.
- Monitor cardiac rhythm.
 - Acquisition of a 12 lead ECG should be integrated into the initial flow of patient assessment and management whenever possible, and should not significantly delay transport. Place limb lead monitoring electrodes in such a manner as to facilitate 12 lead acquisition (Use standard limb electrode placement: Distal medial forearm/wrist and on the medial aspect of each calf. Placement on proximal limbs may be used if significant motion artifact is obtained). If 12 lead ECG interprets as "Acute MI suspected" or if history, physical exam, and/or ECG findings are suspicious of an ischemic cardiac event, See AC-8.
 - Administer Nitroglycerine: 0.4 mg S/L q 5 minutes until the shortness of breath is relieved, or up to a maximum of 3 doses. Monitor BP closely after each dose. NTG is contraindicated in the following:
 - Patients who have taken Sexual Performance Enhancing Drugs within 48 hours
 - In the setting of suspected acute right ventricular MI.
 - Hypotension SBP < 100mmHG
 - In patients with clinically significant pulmonary edema, with a history of CHF, who are on diuretics, and the systolic BP is > 110mmHg. Administer:
 - Lasix, 0.25 – 0.50 mg/kg up to 40 mg total, SIVP.
 - If available, consider CPAP in patients with severe respiratory distress (See P-40 CPAP)

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	4/20/94	06/01/94	07/15/09	4	10/01/09

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P-27 Public Inebriate

Designation of Condition: Upon evaluation, adult patient (Age 18 or greater) is determined to be intoxicated with ethanol.

Transport criteria: All intoxicated or withdrawing persons who require or request evaluation or transport to a hospital should be transported to the appropriate emergency department (hospital of request, or if no preference, closest ED). Inebriates may also be transported to MATS if they meet admission criteria.

1. Transport to social detoxification facility at MATS:

- a. Person must be easy to arouse.
- b. Person must be able to make focused eye contact and state name.
- c. Person must be ambulatory without assistance and have no focal motor or sensory deficits.
- d. Person should have no evidence of acute injury or illness.
- e. Person must accept offer to be transported to MATS.
- f. Vital Signs

HR	60-110	Systolic BP	90-160
RR	12-25	Oxygen Saturation	>90%
CBG	70-200 (if obtained)		

If these criteria are met then transport to MATS is also permitted by non-EMS personnel, including: police, PSO or MATS van driver.

2. Transport to MATS medical monitoring facility. Prior to transport, EMS must confirm medical facility is open and accepting patients. Patients eligible for transport MUST:

- a. Be arousable: All patients MUST demonstrate the following:
 - 1) Opens eyes spontaneously, or opens eyes to verbal or gentle physical stimulation (e.g. shoulder shake).
 - 2) Be Verbal: Able to state name and answer basic questions or make simple statements (e.g. "leave me alone").
 - 3) Demonstrate purposeful movement to physical stimulation and/or commands, such as rolling away from examiner or pushing examiners' hand away.
- b. Have no evidence of acute head trauma. Pupils must be equal, round and reactive to light.
- c. Not voice active, suicidal intentions
- d. Not be actively seizing or apparently post-ictal
- e. Not be combative or belligerent
- f. Not manifest physical evidence to suggest that he is suffering from anything other than acute ETOH intoxication, and will not require studies such as X-ray, blood tests or specialist consultation.

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g. Have Vital Signs that fall within following parameters:

HR	55-115	Systolic BP	90-175
RR	12-25	Oxygen Saturation	>90%
CBG	60-350	Temp: >34.9C <38.1C	

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h. Deemed safe for transport to MATS by EMT-P

Inebriates who are arousable and non-ambulatory due to ETOH intoxication, as well as persons who are suffering from alcohol withdrawal, are potential candidates for transport to the MATS medical monitoring unit if all above criteria are met.

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Upon arrival to MATS, if the inebriate is not a candidate for the social detox facility and requires medical monitoring, the EMT-P shall await medical personnel at the MATS medical monitoring facility, who will take report and assume care of the patient. Patients who are not accepted into the facility must be transported to the requested ED. If patient has no hospital preference, he/she will be transported to area core hospitals on a rotational basis.

3. Transfer protocol enabling transport from EDs or other medical facilities

Patients deemed stable in emergency departments after an appropriate medical screening exam are eligible for transfer to MATS, if medically cleared and transfer approved by physician.

The following criteria must be met for transfer:

- a. Patient must require no further testing.
- b. Patient must require no further therapies that are available only in a hospital setting.
- c. Patient has required no Narcan for 2 hours.
- d. Vital signs stable
- e. Meets criteria for van transport to MATS

MCB Action	Passed 11/15/00	Implemented 01/01/01	Revised 09/16/09	Revision # 4	Implemented 10-01-09
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