CHEST PAIN/ACUTE CORONARY SYNDROME (ACS)

**BLS TREATMENT**

**ROUTINE MEDICAL CARE** - administer oxygen at appropriate flow rate. Keep patient in position of comfort and don’t allow patient to walk.

**ASPIRIN** – Give 324 MG PO.

BLS personnel may assist patient with own medications (NTG), see Field Policy: BLS Medication Administration.

**PROTOCOL PROCEDURE:** Possible thrombolytic/STEMI candidates should be identified and transported immediately with treatment performed en route. Not all AMI/ACS patients present with chest pain; other signs or symptoms (such as: feelings of impending doom, diaphoresis, palpitations, nausea, dyspnea, pain in back, arm, or jaw) may be present that could also indicate an ACS/AMI. Contact the base station for all STEMI patients and for orders in all suspected AMI/ACS cases not presenting with chest discomfort, pain, or pressure. Consider air transport for STEMI patients in remote areas or for long ground transport times. **12 lead EKGs cannot solely diagnose an AMI, treat all potential cardiac symptoms as such, regardless of 12 lead findings.**

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**ALS TREATMENT**

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<th>SBP over 100/</th>
<th>SBP under 100/</th>
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| **NTG** 0.4 mg SL q 5 min x 3 (withhold if SBP <100 or CP is relieved completely) | **Establish IV***
| **Establish IV***
| **Apply 1” NTG** paste after reaching max of three SL NTG | **Consider 250cc bolus(es) x 2**
| Consider pain management with Fentanyl/MS for CP not relieved with NTG | If BP increases begin treatment with NTG**
| **Refer to Shock Protocol if SBP <100** |

**NOTES:**

*ASA should be given even if the patient’s symptoms have subsided or the patient has self-administered prior to your arrival.

**If patient has taken any erectile dysfunction medication in the last 48 hours do not give NTG or apply NTG paste. Go directly to Fentanyl or MS if SBP >100 in this situation.

**NTG paste should be applied after reaching maximum dose of SL NTG and should only be removed if SBP <100.

**Consider second IV and/or Twin Cath with saline lock for suspected STEMI/thrombolytic candidates.