

- ***ACUTE MI SUSPECTED***
- Abnormal ECG **Unconfirmed**
- Sinus bradycardia
- ST elevation consider anterolateral

ACUTE MI SUSPECTEDACUTE M

Acute Coronary Syndrome Case Study

or...what do you do with the
"not so simple" MI?



John Davanzo, MBA, BSN, RN, CEN, EMT-P, CHSE, NEA-BC, FACHE

Consulting Manager

Philips Healthcare Transformation Services

Acute & Critical Care Consulting

“Classic” ACS Presentation



Image Source: Google Images

- Chest Pain
 - Substernal
 - Crushing
 - Squeezing
 - “Truck or elephant laying on my chest”
- Short-of-breath
- Diaphoretic

- ***ACUTE MI SUSPECTED***
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*ACUTE MI SUSPECTED***ACUTE M

So...What's The Problem?

“Classic” is **Bunk**
54% of ACS cases do
not present “classically”



A.C.S. Case: S.D.

- Alpha 2 and Engine 1 respond to a call for a person who “passed out” at the hair salon. On arrival they are presented with a 73 y/o female who states she “does not want an ambulance” she just got light headed.
- Further discussion reveals the patient “felt faint” and collapsed. According to the hair dresser, she was “not speaking” for about 15 seconds and then looked around and asked “what happened”.

A.C.S. Case: S.D.



Image Source: Patient

- Initial assessment
 - A – Open and patent
 - B – RR 22, “mild SOB”
 - C – Pulse 88
- Additional assessment
 - B/P: 100/60, SaO₂: 97%
 - Denies chest pain or pressure

A.C.S. Case: S.D.

- History
 - Smoker (1 pack/day x 30 years)
 - Angina
 - “Small” MI in 2001
- Medications
 - NitroStat SL
 - Plavix
 - M-Vitamin

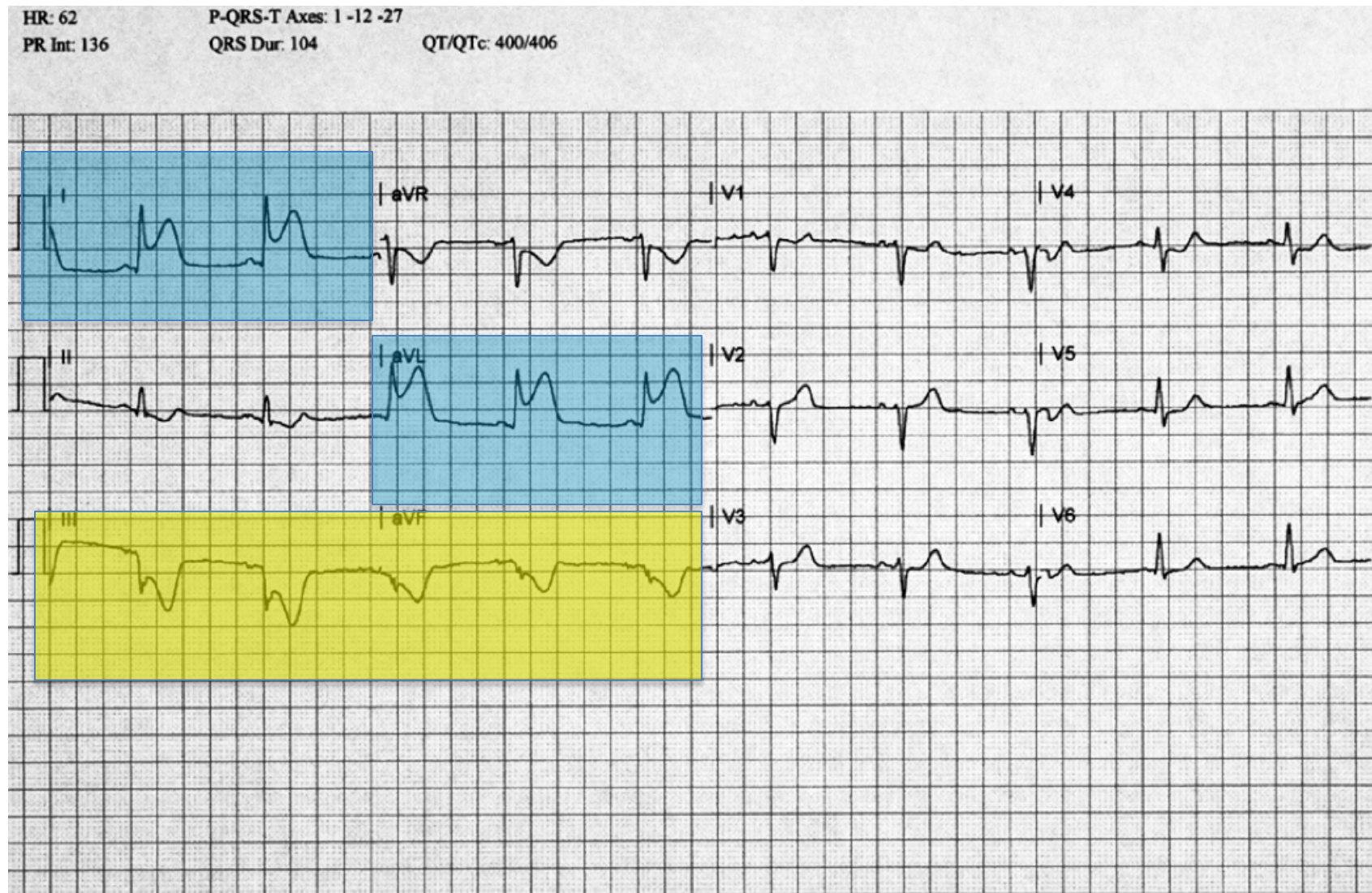


Image Source: Google Images

A.C.S. Case: S.D.

- Initial treatment
 - Convince patient to allow medics to continue assessment!
 - 3 Lead / 12 Lead ECG

A.C.S. Case: S.D.



Quick Review: ST Segment / J-Point

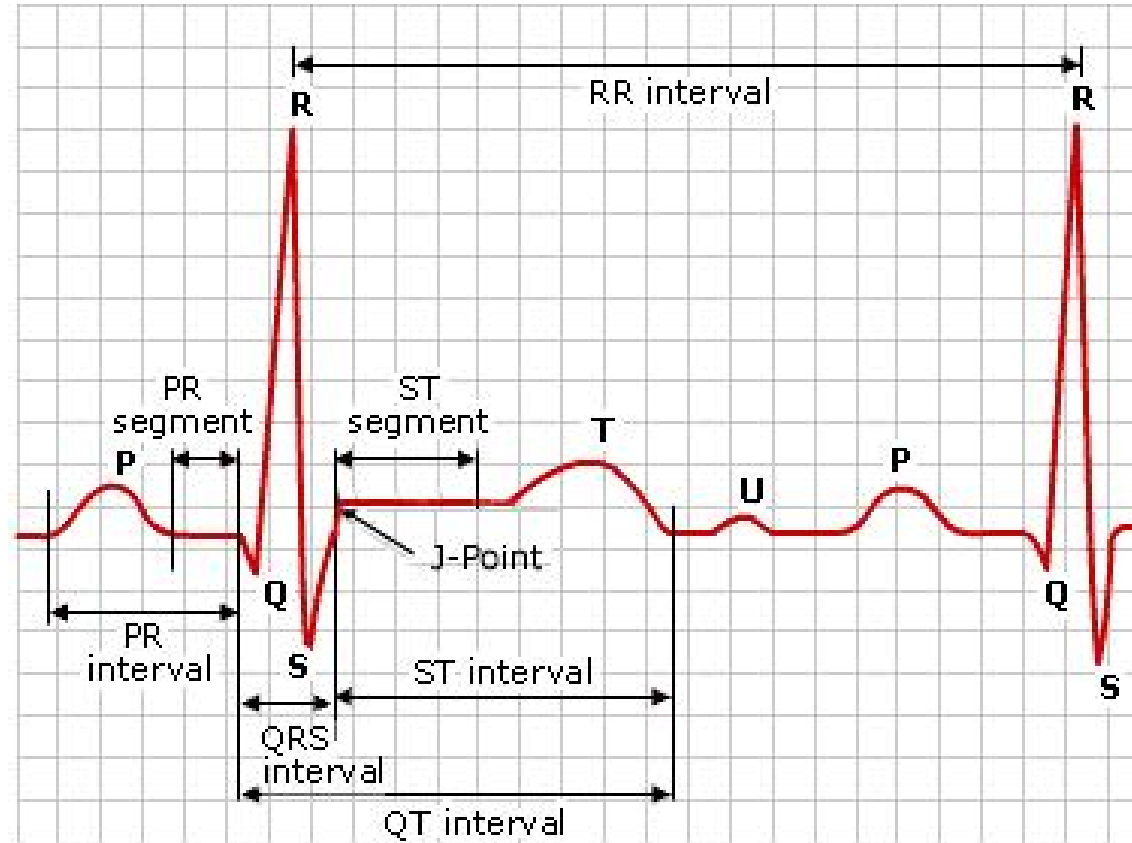


Image Source: Philips

Quick Review: AMI Recognition

- AMI Recognition
 - What to look for
 - ST segment elevation
 - One millimeter or more (one small box)
 - Present in two anatomically contiguous leads
 - Where are you looking

I Lateral	aVR	<i>V1 Septal</i>	<i>V4 Anterior</i>
II Inferior	aVL Lateral	<i>V2 Septal</i>	<i>V5 Lateral</i>
III Inferior	aVF Inferior	<i>V3 Anterior</i>	<i>V6 Lateral</i>

Image Source: Tim Phalen

A.C.S. Case: S.D.

- Initial treatment
 - Convince patient to allow medics to continue assessment!
 - 3 Lead / 12 Lead ECG
 - Oxygen 4L via NC
 - ASA 325mg PO
 - IV 0.9% NS, 18g, LFA
 - Morphine 2mg IVP

A.C.S. Case: S.D.

- Outcome
 - Transported to Regional Cardiac Center
 - Scene time: 20 minutes including treatment discussion
 - Radio report activates cath lab team
 - Time in ED: 10 minutes
 - Door-to-balloon: 65 minutes
 - Two stents placed
 - Patient discharged to home!

“Atypical” Presentation

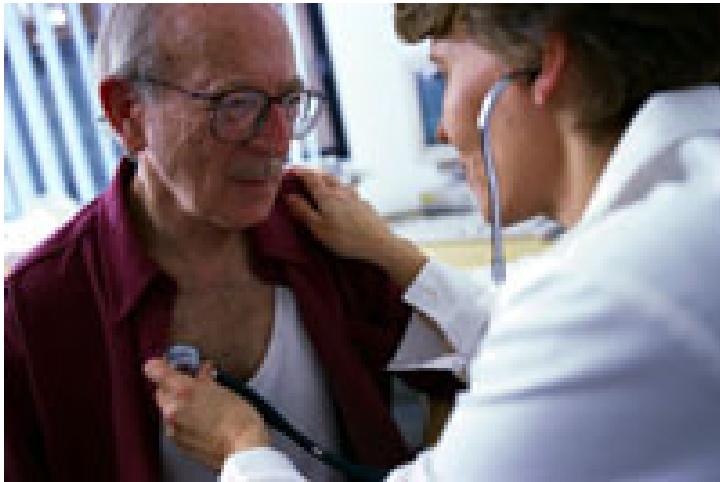


Image Source: Google Images

- “Atypical” is a misnomer
- Often present without pain or
 - Different quality
 - Different location
 - Different duration
 - Different intensity
- Anginal equivalents

Who Presents “Atypically”



Image Source: John Davanzo

- Anyone!
 - Especially suspect those with anginal equivalents
- Most likely
 - Diabetics
 - Postmenopausal women
 - Seniors

Anginal Equivalents

- Shortness of breath
- Dyspnea on exertion
- Diaphoresis
- Weakness
- Fatigue
- Palpitations
- Syncope / Pre-syncope
- Nausea / Vomiting



Image Source: Google Images



Why is STEMI identification so important?

Weeding out false positives...

Why is a “false positive” rate important?



There is one thing worse than a 0300 false positive...



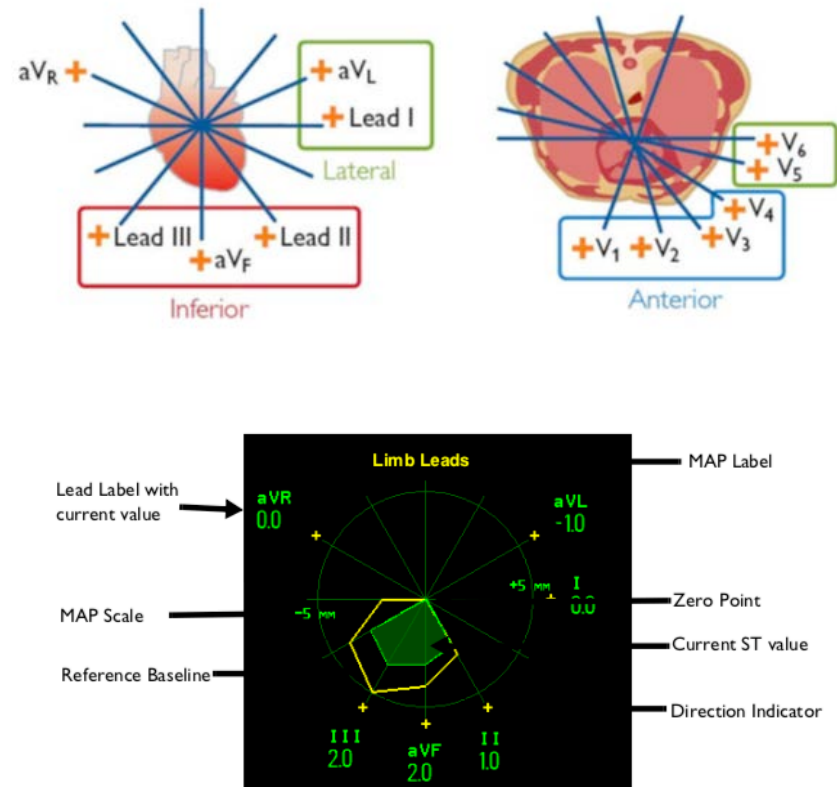
A healthcare professional, likely a nurse or doctor, is shown in a clinical setting. She is wearing blue scrubs and glasses, looking off to the side with a thoughtful expression. A stethoscope is visible around her neck. In the background, other healthcare professionals are partially visible, also in scrubs, working in a busy environment.

How can Philips help?

Clinical Decision Tools Like *ST Map*

ST Map

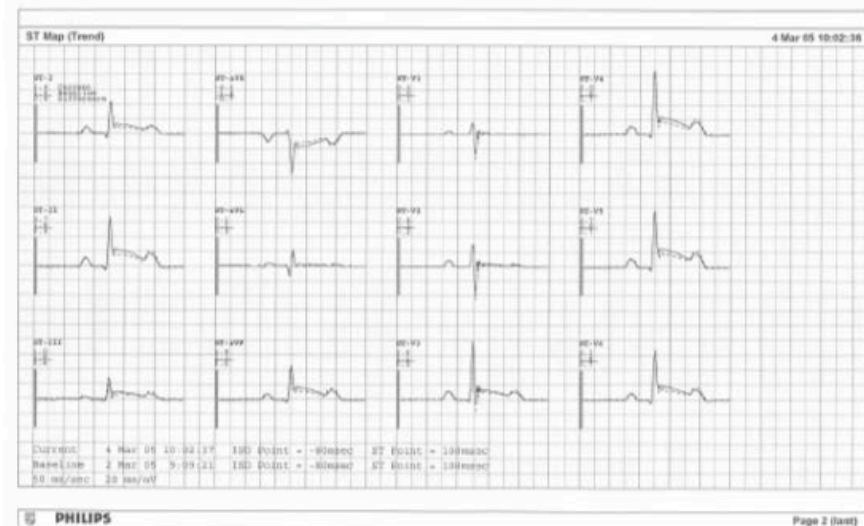
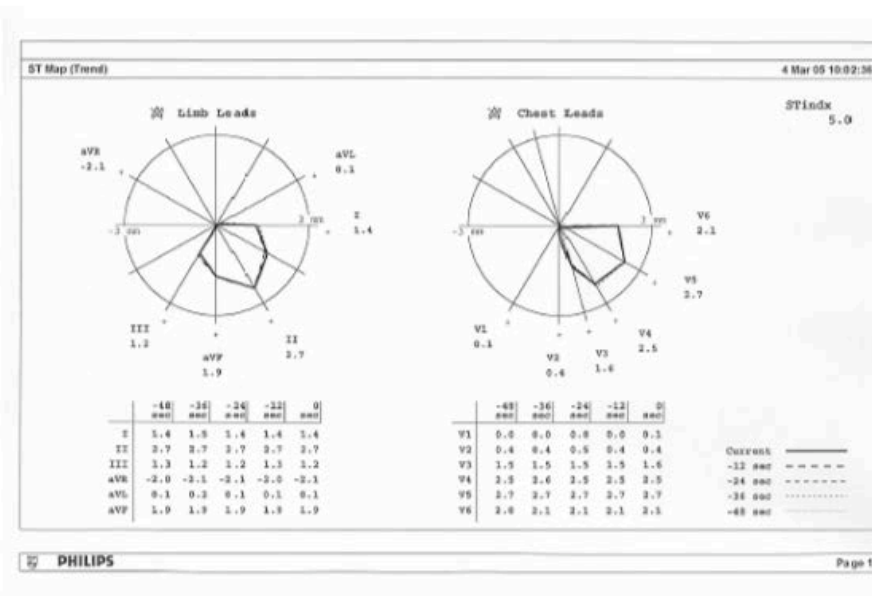
- ST Map provides an integrated overview derived from a multi-axis portrait (map) of the ST analysis to help you detect changes in ST values



Viewing an ST Map

Image Source: Philips

ST MAP Printouts



Hopefully

***"GREAT
PRESENTATION."***
I HAVEN'T SLEPT THAT WELL IN WEEKS."

felt like!

