ALS STANDING ORDERS:

1. Monitor cardiac rhythm.
2. Obtain 12-lead ECG as soon as possible prior to leaving scene; if acute MI indicated or suspected, make Base Hospital contact for CVRC destination with cardiac catheterization lab open and available.
3. Administer aspirin if none of the following contraindications exists:
   - If pain directly in the mid-back, mid-line region, hold aspirin as this may be a symptom of a dissecting aorta, particularly in a patient with a history of hypertension.
   - Patient is on anticoagulant ("blood thinners") medication such as Coumadin, Pradaxa®, Effient®, and Lovenox® or antiplatelet medications such as Plavix®.
   - Patient reports history of aspirin allergy

   ► *Aspirin 4 (four) 81 mg chewable tablets (chew) or one 325 mg regular tablet to chew.*
4. Pulse oximetry; if room air O_2 Saturation less than 95%:

   ► *Administer oxygen by mask or nasal cannula at 6 L/min flow rate, as tolerated.*
5. For initial management of suspected cardiac pain give:

   ► *Nitroglycerine 0.4 mg SL if systolic BP above 100 mm/Hg; repeat approximately every 3 minutes for continued discomfort; maximum total of 3 doses if systolic BP above 100 mm/Hg*
   (Do not include possible doses patient took prior to ALS arrival as part of 3 EMS doses).
6. If pain unrelieved with 3 doses of nitroglycerine or nitroglycerine cannot be administered, give:

   ► *Morphine Sulfate: 5 mg (or 4 mg carpuject) IV, may repeat once after approximately 3 minutes* (hold if BP less than or drops below 90 systolic)
   OR
   Fentanyl 50 mcg IV, may repeat once after approximately 3 minutes for continued pain (hold if BP less than or drops below 90 systolic).
7. For nausea or vomiting and not known or suspected to be pregnant:

   ► *Ondansetron (Zofran®): ODT 8 mg (two 4 mg tablets) orally to dissolve inside of cheek, once;*
   OR,
   4 mg IV, may repeat 4 mg IV in approximately 3 minutes if symptoms persist.
8. Contact Base Hospital if acute MI (STEMI) for CVRC Destination or if acute MI not suspected, paramedic escort to an appropriate ERC.

CAUTION: AN ECG THAT IS "NORMAL" OR NEGATIVE FOR STEMI DOES NOT RULE OUT AN ACUTE MI OR SERIOUS ANGINA.

TREATMENT GUIDELINES:

- The following 12-lead monitor interpretations should be triaged to a CVRC :
  1. ***ACUTE MI***
  2. ***STEMI***
  3. Acute ST Elevation Infarct
  4. Probable Acute ST Elevation Infarct
  5. Acute Infarction
  6. Infarct, Probably Acute
  7. Infarct, Possible Acute

- Do not administer nitroglycerin if Viagra® (sildenafil), Levitra® (vardenafil), or Cialis® (tadalafil) were used by the patient in the past 24 hours.

- Intraosseous lines should be avoided for potential CVRC patients because such lines may allow for uncontrolled bleeding without the ability to compress the bleeding site if a patient receives thrombolytics.

- Angina equivalent symptoms can include, but are not limited to:
  - Unexplained sweating or diaphoresis
  - Sudden onset of general weakness
  - Unexplained shortness of breath
  - Anxiety, or vague feeling of panic

- Chest discomfort presenting as heartburn, pleuritic, or musculoskeletal pain does not rule out heart disease or acute MI. A field 12-lead ECG should be obtained as soon as possible, preferably prior to leaving scene, on any adult 45 years-old or greater who complains of the following symptoms:
  - Known history of heart disease with chest pain, chest discomfort, shortness of breath, or syncope-weakness.
  - Chest pain or chest discomfort (unrelated to injury or strain) as chief symptom.
  - Radiation of chest pain or chest discomfort to arm, shoulder, neck, jaw or back.
  - Diaphoresis.

- Base hospital contact should be made prior to leaving scene for all patients who have a 12-lead performed and elect to sign out AMA.

- If a patient is wearing a LifeVest®
  - Proceed with standard evaluation and treatment measures.
  - CPR can be performed as long as the device is not broadcasting, "press the response buttons," or "electrical shock possible, do not touch patient," or "bystanders do not interfere."
  - If external defibrillation is available, remove the LifeVest® and monitor/treat the patient with the external equipment. Providers can defibrillate with the vest in place AFTER disconnecting the battery.
  - To remove the LifeVest®, first pull out the battery, then remove the garment from the patient.
  - Take vest, modem, charger, and extra battery to the hospital.