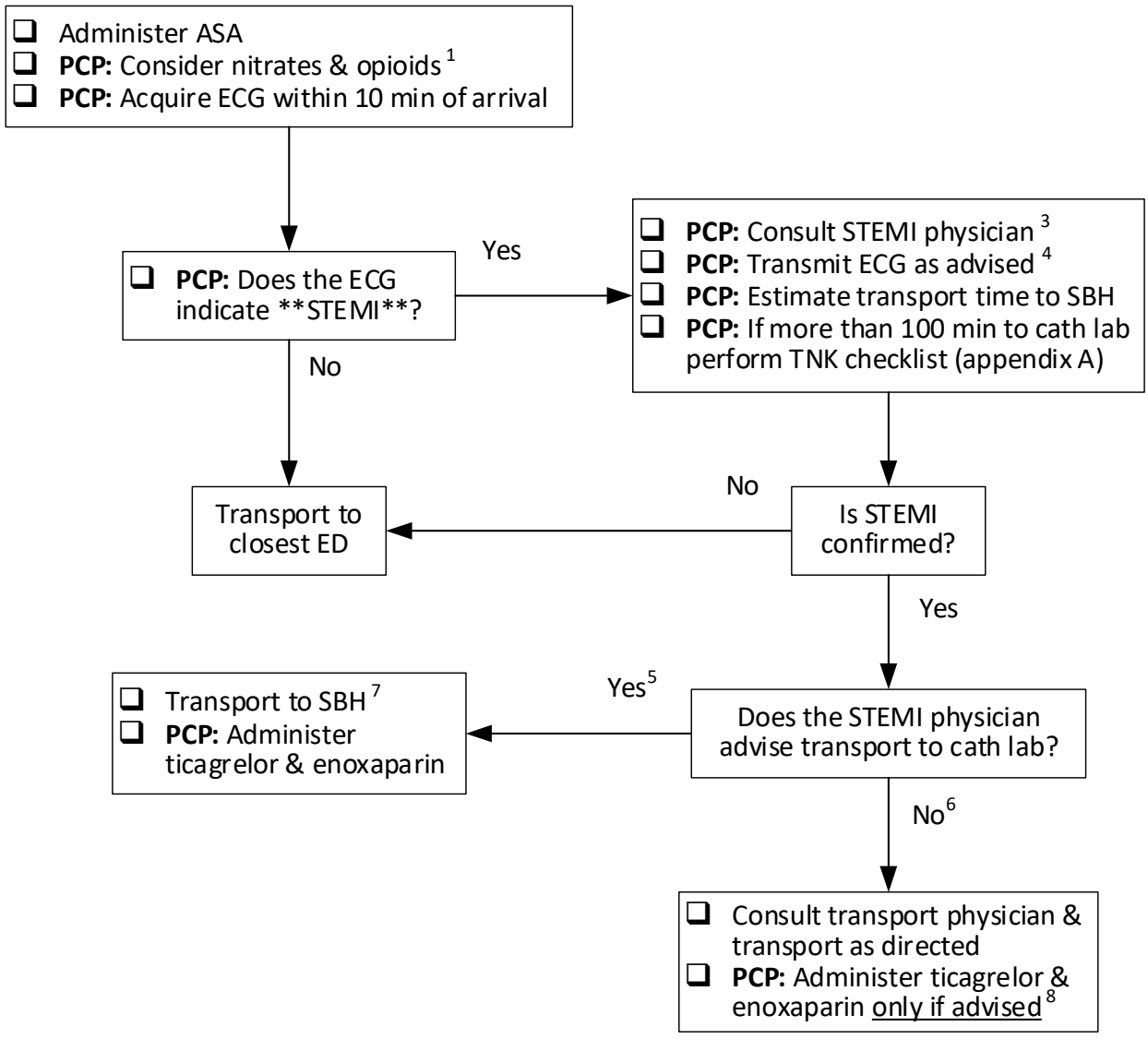
Shared health Soins communs Manitoba	E04 - ACUTE CORONARY SYNDROME & STEMI	
	17 years & older	MEDICAL
Version date: 2023-11-27		Effective Date: 2024-02-13 (0700)



IDENTIFIER:	EMR: EMR only	PCP: PCP & ICP	ICP: ICP only	None - All providers

INDICATIONS
• Chest discomfort, pain, pressure, or heaviness; and / or other symptoms consistent with or suspicious for an acute coronary syndrome (ACS)

CONTRAINDICATIONS
• Not applicable

NOTES

1. Patients with right ventricular infarction (RVI) may be sensitive to right ventricular filling to maintain adequate cardiac output. Use nitrates and opioids with caution. If hypotension develops, hold / discontinue medications, and administer boluses of intravenous crystalloid solution (repeat as required).
2. The Zoll X-series monitor can determine the presence of ST-segment elevation myocardial infarction (STEMI) with a high degree of accuracy and will indicate ****STEMI**** on the automated interpretation.
3. Contact the Medical Transportation Coordination Center (MTCC) to determine who is the on-call **Code-STEMI physician** that day, regardless of your geographic location. Then, contact the STEMI physician directly.

   Communication with the STEMI physician should include the patient's name, age, and gender; time of symptom onset; relevant medical history, medications, and allergies; current vital signs and relevant physical findings; and estimated transport time to the cath lab at St. Boniface Hospital (SBH), and any contraindications to tenectaplase (appendix A).
4. When transmitting an ECG obscure or cover the patient's identifying data.
5. If the STEMI physician confirms the diagnosis and the patient can arrive at the cath lab within 100 minutes of EMS arrival, they will pre-alert the cath lab, direct transport to SBH, and authorize administration of antithrombotic therapy (enoxaparin & ticagrelor).
6. If the STEMI physician confirms the diagnosis but the patient cannot arrive at the cath lab within 100 minutes, contact MTCC and request to speak to the **Provincial transport physician** regardless of your geographic location.

   The STEMI physician will determine the reperfusion plan, while the transport physician will determine the transport strategy (including possible air intercept).

   - The STEMI physician may direct transport directly to SBH, even beyond the 100-minute window. The transport physician will determine if air intercept will save time.
   - The STEMI physician may direct transport to a local emergency department for fibrinolysis, followed by interfacility transport (IFT) to the cath lab. Paramedics will remain with the patient until released by the transport physician.
7. If the patient is stable on arrival at SBH proceed directly to the cath lab unless otherwise advised. If they are unstable, go to the ED first. Ensure appropriate pre-arrival notification of receiving ED staff.
8. Ticagrelor and enoxaparin are contraindicated before tenectaplase (TNK). Do not administer if TNK is being considered.

9. If the patient becomes unstable during transport, such as a rhythm disturbance or hemodynamic compromise, contact VECTRS and continue / redirect advised.

LINKS	
M03.1 - MORPHINE	M37.1 - ASA
M03.2 - FENTANYL	M37.2 - TICAGRELOR
M21 - NITROGLYCERIN	M43 - ENOXAPARIN

APPROVED BY	
	
EMS Medical Director	EMS Associate Medical Director

VERSION CHANGES (refer to X05 for change tracking)
• TNK checklist should be performed earlier while waiting for the Code-STEMI physician • Modified flow chart • Identifier legend at bottom of flow chart replaces work scope statement in header

APPENDIX A: CHERCKLIST FOR FIBRINOLYSIS WITH TENECTAPLASE (TNK)

Inform the STEMI MD if the patient has / had any of the following.

- ☐ Current use of anticoagulant
- ☐ Active internal bleeding (excluding menses)
- ☐ Ischemic stroke within the last 3 months
- ☐ Prior intracranial hemorrhage
- ☐ Intracranial or intraspinal surgery or trauma within the last 2 months
- ☐ Major closed head or facial trauma within the last 3 months
- ☐ Intracranial neoplasm / tumor, arteriovenous malformation, or aneurysm
- ☐ Severe uncontrolled hypertension (any systolic BP greater than 180 mmHg during this encounter)
- ☐ Bleeding disorder
- ☐ Traumatic or prolonged (more than 10 minutes) CPR
- ☐ Suspected aortic dissection