To: Station Captains for presentation to All providers Date: 12/03/01

From: Roger M. Stone, M.D, M.S. FACEP, FAAEM Please post
Medical Director, MCFRS Jurisdictional Program

Re: Helpful "Pearls" from Lessons Learned, 1st Instant Fax in a Series

1)When we take care of ALS patients, it's been well known that "not everything chest pain is Angina or cardiac", but with respect to that, the take home messages are:

* Risk factors include smokers, Diabetes, High BP, Family Hx, Cholesterol
* Attempts to diagnose non-cardiac chest pain at the provider level on the scene are fraught with risks, especially if the patient is leaning towards refusal of transport
* Relief w/ Maalox or pain on pressing the chest is not always reassuring

Did you know that the reverse sentence is also true, that is "not everything Angina or cardiac presents with chest pain"? The CLASSIC offending conditions which fool medics or other practitioners into not considering cardiac causes include:

- Diabetes Mellitus patient with symptoms other than chest pain
- Female with postmenopausal symptoms, or atypical pain
- Youth who was not asked about cocaine use

The classic cardiac symptoms that <u>diabetic patients</u> may confront medics with are:

- Shortness of breath alone
- Profuse nausea and vomiting (esp. with lack of other explanation)
- Jaw pain, arm heaviness, isolated back pain
- Profound dizziness, diffuse weakness, or syncope (watch for heart blocks!)

2) As protocols move towards giving us a little more guidance in immobilizing patients, there are criteria that cannot be ignored if we wish to hedge bets in our favor:

- Never fail to immobilize patients who actually complain of, or do not deny, neck or back pain, those with now resolved history of neck pain on the scene or afterwards, or neck pain with movement when you find them on the scene
- Never fail to immobilize patients with movement or sensory problem (deficit)
- Never fail to collar & board those with a compatible mechanism and notable distracting injury (fracture), which can drown out the patient's neck/back pain
- Always collar & board patients with tenderness in the neck or back area that you identify, even if the patient did not initially complain of pain
- All bets are off with intoxicated or head injured patients, or those with altered sensorium or loss of consciousness (LOC), so err on the side of caution

MORE MESSAGES TO COME AS WE IDENTIFY AREAS TO SHOWCASE