Hospital Name:_____
ED Physician:_____
Date:_____

MaineHealth®

AMI / PCI PATHWAY
Care Protocol & Data Collection Tool

Patient Label

Patient Arrival (Record Time)

Stat ECG (Record Time)

For patients who appear likely to require transfer, consider early initiation of transfer process

Monitor V/S
Adm. O2, ASA, NTG, MSO4
Start 2 PIVs (per local CP protocol)
Obtain old records

Identify Patient's Cardiologist or Preference

Attention: Record times for quality improvement

ECG shows ST elevation? No Yes
ECG shows new LBBB? No Yes

NO → ECG shows ST depression, nonspecific changes uninterpretable or is normal → Follow local practice guideline for chest pain or R/O MI

Any YES

Chest pain < 12 hrs? (Record time of onset)

NO → Consult local cardiologist / internist

YES

Contraindication to lytic tx? (Relative Contraindications on back)

Any prior intracranial hemorrhage	No	Yes
Known structural cerebrovascular lesion (e.g. AVM)	No	Yes
Known malignant intracranial neoplasm	No	Yes
Ischemic stroke within 3 mos (EXC within 3 hrs)	No	Yes
Suspected aortic dissection	No	Yes
Active bleeding or bleeding diathesis (EXC menses)	No	Yes
Significant closed head trauma (see back)	No	Yes
Uncontrolled HTN (SBP >175; DBP >110)	No	Yes
Current use of anticoagulants	No	Yes

Any YES → Any YES: Consider Primary PCI

All NO → Review relative contraindications (see back of this page)

Evaluate for lytics; administer lytic therapy according to local lytic protocol (If lytic admn'd, record time)

TIMI Risk Score: Any of the following defines "not low risk"
- Previous MI
- Anterior Infarct
- Systolic BP <100
- Sinus tachycardia (>100)
- Atrial flutter or fib
- Age > 70 yrs
- Killip Class ≥ II (see definitions on back)

Lytic + Not-Low Risk MI: → YES: Consider PCI

Lytic + Low Risk MI → **Observe 60 mins.** → **>60 min post lytic**

Lytic Failure?

<50% ST seg resolution	No	Yes
Fluctuating ST changes	No	Yes
Unimproved chest sx	No	Yes
Worsening hemodynamic status	No	Yes

Any YES: Consider Rescue PCI

All NO → Admit to facility per local AMI protocol

Appropriate for PCI? (Definition on back)

Pt appropriate for aggressive interventions?	No	Yes
Pt/family willing to consider cath, PCI, or potential CABG?	No	Yes
Absence of prior anaphylactoid contrast reaction	No	Yes
Adequate femoral or brachial vascular access	No	Yes
Weight <350 lbs	No	Yes

Any NO → Unclear if patient is candidate for rapid MI transport, consult MMC interventionalist through REMIS (871-2950).

All YES → **Initiate AMI Rapid Transport**

Call REMIS: 871-2950
Give following info:
- Call back number
- Patient name
- Referring hospital
- Pt's MMC cardiologist (see back of page), OR identify if no prior MMC cardiologist

ED Attending receives call from Interventionalist

ED Arranges Transport to MMC

Administer Plavix 300mg po, beta-blocker, heparin bolus

ED physician obtains targeted history for report to Interventionalist:

Bleeding disorder	No	Yes
CVA	No	Yes
Renal Failure	No	Yes
HTN	No	Yes
Recent Surgery (2 wks)	No	Yes
Bleeding	No	Yes
Hx of PVD	No	Yes
Diabetes	No	Yes

ED DATA
Symptom Onset DATE/TIME_____
Patient Arrival to ED TIME_____
1st diagnostic 12lead ECG TIME_____
Treatment decision time:_____
❑ Primary PCI
↳ Time Transport Arrived:_____
↳ Time Left ED:_____
❑ Lytic + PCI
↳ Time lytic given_____
↳ Time Transport Arrived:_____
↳ Time left ED_____
❑ Lytic + Observation
↳ Time lytic given_____
↳ Time decision RE: lytic failure_____
↳ Time Transport Arrived:_____
↳ Time left facility_____

CATH LAB DATA
↳ Cath Lab Arrival Time:_____
↳ Balloon Inflation Time:_____

ED Nursing & EMS Personnel: Please keep this report with the patient in the RAPID TRANSPORT FOLDER
Please return to Cardiac Database Coordinator (R8)

Copyright MaineHealth 2004

Contraindication Definitions:

Significant closed head trauma

Significant closed head trauma includes patients with (1) any head injury with loss of consiousness within the previous 24 hours; or (2) a moderate to severe closed head injury within the previous 3 months as defined by an initial Glasgow coma scale score of 12 or less, or a head injury associated with more than a transient loss of consciousness, amnesia, alteration of consciousness, or other focal neurologic signs.

Relative contraindications for lytic therapy:

- History of chronic severe poorly controlled hypertension
- History of prior ischemic stroke (NOTE: ischemic stroke *within prior 3 months* is an a*bsolute* contraindication to lytic therapy – see front)
- Dementia or known intracranial pathology not covered in absolute contraindications - see front
- Recent trauma (within 2-4 weeks), including head trauma
- Traumatic or prolonged CPR (greater than 10 minutes)
- Recent major surgery (less than 3 weeks)
- Recent internal bleeding (within 2-3 weeks)
- Non-compressible vascular punctures
- For streptokinase/anistreplase: prior exposure to one of these agents (especially within past 5 days – 2 years) OR prior allergic reaction to one of these agents
- Pregnancy
- Active peptic ulcer

Appropriate for PCI

Inappropriate patients are those with limited life expectancy due to end-stage comorbid illness (eg. metastatic cancer), limiting dementia, and/or those unwilling to undergo cardiac surgery, CPR, or intubation if necessary.

Killip Classification*

Class I: no heart failure
Class II: rales, increased jugular venous distension (JVD); or S3 gallop
Class III: pulmonary edema
Class IV: cardiogenic shock

*Killip T 3rd, Kimball JT. Treatment of myocardial infarction in a coronary care unit. A two year experience with 250 patients. Am J Cardiol. 1967; 20:457-464

Cardiology Physician List

Cardiovascular Consultants of Maine

Scarborough
Warren D. Alpern, M.D.
Craig M. Brett, M.D.
Andrew C. Corsello, M.D.
William A. Dietz, M.D.
John P. Driscoll, M.D.
Peter J. Higgins, M.D
Charles S. Hoag, D.O.
Mirle A. Kellett, Jr., M.D.
Karen Kurkjian, M.D.
John C. Love, M.D.
John C. Lualdi, M.D.
Paul D. McGrath, M.D.
John F. Moloney, M.D.
John R. O'Meara, M.D.
Thomas J. Ryan, M.D.
Peter K. Shaw, M.D.
Paul W. Sweeney, M.D.
Edward J. Teufel, M.D.

Portland --Forest Ave. Office
Charles S. Hoag, D.O.

Augusta
David T. Frost, M.D.
Edward J. Teufel, M.D.
Lesley S. West, M.D.

Lewiston
David Abisalih, M.D.
Alan B. Langburd, M.D.
Dervilla McCann, M.D.
Robert J. Weiss, M.D.

Waterville
Wayne A. Kruithoff, M.D.

Maine Cardiology Associates

Portland
David C. Burkey, M.D.
David. W. Butzel, M.D.
Charles M. Carpenter, M.D.
Mylan C. Cohen, M.D.
D. Joshua Cutler, M.D.
Joel E.Cutler, M.D.
Marco N. Diaz, M.D.
Mary C. Fahrenbach, M.D.
Jennifer Hillstrom, M.D.
Frederick K. Poulin, Jr., M.D.
James B. Powers, M.D.
Jeffrey A. Rosenblatt, M.D.
Karl C. Sze, M.D.
Lisa Thomas, M.D.
George N. Welch, M.D.
Joseph N. Wight, M.D.

Lewiston
James Parker, M.D.
Roy Ulin, M.D.

Augusta/Waterville
George Petropoulos, M.D.
Enrique J. Rivas, M.D.

Rockport
Louis C. Coyle, D.O.
Ralph C. Hamill, M.D.

Southern Maine Cardiology
Paul G.Meadows, M.D.
Edward J. Quinlan, III, M.D.
Howard B.Sherman, M.D.

Mid Coast Cardiology
Scott D. Mills, M.D.
R. Scott Schaefer, M.D.
Paul R. Burns, M.D.
Ellen M. Simon, M.D.

Copyright MaineHealth 2004