Early management of myocardial infarction

The challenge for GPs is to change

EDITOR,—At the same time as Hazel Wyllie and Francis Dunn were doing their study on use of aspirin in cases of chest pain in the north sector of Glasgow,[1] the first part of an audit was carried out among general practitioners in all of Glasgow over a period of a year. Half of those involved in 156 incidents of chest pain carried aspirin routinely, a fifth gave aspirin to patients with chest pain suspected of being myocardial infarction. The preliminary results were shown at the Scottish National GP Audit Symposium. Since then (and since Wyllie and Dunn's study) the results have been presented at meetings attended by Glasgow general practitioners and the need for aspirin discussed and emphasised. More meetings are planned.

Chest pain at home can be difficult to diagnose and manage. Most chest pain is not cardiac in origin, and the presentation of myocardial infarction may not be classical. General practitioners tend to be concerned with assessing the patient, relieving symptoms, handling anxious relatives, and arranging for patients to be transferred to hospital and given thrombolysis as soon as possible. Doubts over diagnosis may have inhibited use of aspirin in the past, and it is not long since aspirin was being pilloried for its side effects. Intravenous analgesia in the patient's home is not always without hazard. In a city like Glasgow with "immediate" ambulances patient transfer is quick.

Wyllie and Dunn's study depended on the recollections of patients who were unwell. Our study depended on the general practitioners accurately recording their actions. Both these methods may lead to some bias.

The challenge is to change. Publishing papers in academic journals seems to be of limited effect; implementing change is more likely to work if the difficulties perceived by general practitioners are addressed. General practitioners in Glasgow have already taken action to improve management of this situation. There is no room for complacency, but future audits should show a rise in the administration of aspirin and appropriate drug therapy.

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1 Wyllie H, Dunn F. Pre-hospital opiate and aspirin administration in patients with suspected myocardial infarction. *BMJ* 1994;308:760-1. (19 March.)

Paramedics should give an opiate

EDITOR,—In their guidelines for the early management of myocardial infarction C F M Weston and colleagues state that ambulance staff do not give opiates.[1] Although they recommend that ambulance services should develop protocols for the administration of oxygen, nitrates, and aspirin, they make no such recommendations about opiate analgesia. They do, however, acknowledge that this can be given safely.

In 1992 some paramedics of the then Plymouth division of Devon ambulance service who had been trained by the NHS Training Directorate were, after additional training, allowed to give nalbuphine not only to patients with myocardial infarction but also to patients with isolated fractures and burns. This achieved good pain relief with no important side effects.[2] The service was not the first ambulance service to give the drug in Britain. Because of the success in Plymouth the drug is now being introduced throughout the Westcountry Ambulance Service Trust.

A combined response by the ambulance service and general practitioner to a patient with chest pain is an ideal, but when this is not possible patients should not be deprived of the benefits of analgesia: trained ambulance staff should give an opiate as well as oxygen, aspirin, and nitrates.

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1 Weston CFM, Penny WJ, Julian DG on behalf of the British Heart Foundation Working Group. Guidelines for the early management of patients with myocardial infarction. *BMJ* 1994;308:767-71. (19 March.)
2 Chambers JA, Guly HR. Prehospital intravenous nalbuphine administered by paramedics. *Resuscitation* (in press).

Senior staff should see all emergencies

EDITOR,—The guidelines for the early management of patients with myocardial infarction raise several points and highlight some deficiencies in the care of emergencies in Britain.[1] It is important to differentiate between treatment required by patients who present with cardiac arrest and that required by patients who present with symptoms of chest pain suggestive of myocardial infarction.

The best chance of survival after cardiac arrest in the community occurs when a bystander gives immediate and effective basic life support and this is followed by early advanced cardiopulmonary resuscitation and then evacuation to hospital.[2] Advanced resuscitation is currently most readily provided by paramedics working independently.

On the other hand, if a patient has chest pain suggestive of myocardial infarction a response by both the general practitioner and the ambulance service seems ideal. This combines the diagnostic and treatment skills of the general practitioner with the equipment and rapid, safe route to hospital provided by the paramedic. After brief initial assessment and treatment with analgesia, aspirin, nitrates, and oxygen the main priority must be prompt evacuation to hospital, particularly in urban settings, where the time taken to reach hospital is short. In a rural environment, where the time taken to reach hospital is prolonged, further investigation and treatment, including thrombolytic treatment given by the general practitioner, may be of benefit.[3]

When the patient arrives at the hospital direct admission to the coronary care unit or fast tracking through the accident and emergency department for assessment by experienced clinicians can reduce delays to the administration of thrombolytic treatment.[4,5] Unfortunately, although these benefits are known, most patients who present to hospital as an emergency are still initially managed by junior staff. Indeed, most accident and emergency departments in Britain are staffed by senior house officers holding six month posts. Too often in hospital, emergencies are regarded by senior clinicians as an interruption to the smooth running of ward rounds and routine out patient clinics. The resulting delegation of initial assessment to junior staff leads to unacceptable delay in definitive treatment, unnecessary investigation, and, in some cases, inappropriate management.

A radical shake up is required throughout the medical profession such that all patients presenting as an emergency—not just those with myocardial infarction—are primarily dealt with by interested, competent, senior staff. Only then will prompt, effective, definitive care be delivered to those who require it.

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1 Weston CFM, Penny WJ, Julian DG, on behalf of the British Heart Foundation Working Group. Guidelines for the early management of patients with myocardial infarction. *BMJ* 1994;308:767-71. (19 March.)
2 European Resuscitation Council Basic Life Support Working Group. Guidelines for basic life support. *BMJ* 1993;306:1587-9.
3 GREAT Group. Feasibility, safety, and efficacy of domiciliary thrombolysis by general practitioners: Grampian region early trial. *BMJ* 1992;305:445-8.
4 Pell ACH, Miller HC, Robertson CE, Fox KAA. Effect of "fast track" admission for acute myocardial infarction on delay to thrombolysis. *BMJ* 1992;304:83-7.
5 Burns JMA, Hogg KJ, Rae AP, Hills WS, Dunn FG. Impact of a policy of direct admission to a coronary care unit on use of thrombolytic therapy. *Br Heart J* 1989;61:322-5.

Presentation is often pain free in elderly patients

EDITOR,—Regrettably, guidelines for timely administration of thrombolytic agents in suspected myocardial infarction[1] fail to take cognisance of the fact that about a third of elderly patients with this diagnosis have a pain free presentation, characterised by sudden onset breathlessness, mental confusion, or collapse.[2] The time of onset of these symptoms, accurately identified, is equivalent to time of onset of chest pain for the purposes of thrombolytic treatment if the diagnosis is subsequently confirmed by electrocardiography. The indications for treatment would be similar to those already in use for patients presenting with chest pain.[1]

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1 Weston CFM, Penny WJ, Julian DG. Guidelines for the early management of patients with myocardial infarction. *BMJ* 1994;308:767-71. (19 March.)
2 Bayer AG, Chandra JS, Farag RR, Pathy MSJ. Changing presentation of myocardial infarction with increasing age. *J Am Geriatr Soc* 1986;34:263-6.

Confirm diagnosis before giving thrombolytic treatment

EDITOR,—The British Heart Foundation has produced guidelines for the early management of patients with acute myocardial infarction, emphasising the importance of reducing the "call to needle time."[1] We agree with these recommendations, but believe that the diagnosis of acute myocardial infarction should be as certain as possible before thrombolysis can be given safely.