Acute Coronary Syndrome (ACS) encompasses a spectrum of conditions from unstable angina to acute myocardial infarction. ACS is usually associated with atherosclerotic plaque rupture, thrombosis and partial or complete occlusion of the infarct-related artery.

Paramedics must be alert for high risk atypical presentations which may occur in some patient groups (e.g. female, diabetic, renal failure, indigenous and the elderly).

Treatment:

- Perform 12 lead ECG within **10 minutes** of patient contact (where 12 lead capability permits)
- Patients must have continuous cardiac monitoring and increased physiological observations every 15 minutes until clinical handover is complete
- Treat per specific protocol
  - C12 – Cardiac Reperfusion Primary Angioplasty (PAPA)
  - C13 – Cardiac Reperfusion – Prehospital Thrombolysis (PHT)
- Administer (if indicated)
  - Aspirin (218) – See clinical notes
  - Glyceryl trinitrate (209)
  - Oxygen (221) – See clinical notes
  - Pain management (A6)
- Transport to ED – Provide comprehensive clinical handover (IMIST-AMBO) including progressive ECG’s

P5 Protocol Specific Exclusions:
- Confirmed or suspected cardiac chest pain and/or clinical suspicion of ACS

Clinical Notes

**Aspirin – Administration prior to paramedic arrival**
- NSW Ambulance Control Centres may have instructed the patient to self administer aspirin prior to paramedic arrival as part of the call taking procedure.
- If self-administered, prior to paramedic arrival, paramedics should confirm the medication, dose and route taken. Paramedics should make a clinical decision to either withhold further aspirin administration or administer aspirin based on this information.

**Oxygen**
- Routine oxygen administration is not indicated for treatment of ACS. Patients with an SpO₂ <94% should be administered titrated oxygen to achieve and maintain SpO₂ ≥94%