



Read the complete 2015 AHA Guidelines at this link:
<https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/>

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Prehospital STEMI? Go to PCI!

Prehospital recognition of STEMI with ED or Cath Lab notification decreases time to reperfusion. Inexperienced interpreters may benefit from computer analysis in conjunction with their interpretation. Field thrombolysis carries a risk of bleeding, so PCI is favoured.

No cath lab? Transfer all STEMI's out.

When timely transfer to PCI cannot be executed, fibrinolysis then transfer may be appropriate. Since PCI has become readily available in many places, quick transfer without fibrinolysis improves reperfusion and decreases risk of bleeding. If unable to transfer, fibrinolytic therapy with routine transfer for angiography is acceptable as an alternative.



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TIMI 0 or 1 OR Vancouver rule "low risk" AND negative HSTi = discharge

When risk stratification and high sensitivity Troponin i at 0 and 2 hours are combined, a less than 1% risk of Major Acute Coronary Event (MACE) at 30 days can be determined.

Find the sweet spot: Avoid hypoxemia and hyperoxia.

Oxygen should be titrated to ensure SpO₂ of 94% or greater when a patient is not in respiratory distress.



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Field anticoagulation isn't necessary

Prehospital STEMI may be treated with heparin, bivalirudin or enoxaparin, but may be given on arrival at the PCI lab or ED instead.

From: <https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/>
* For more Canadian content by the HSFC, check out <http://goo.gl/fHu8lc>

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