



Heart attack and chest pain scenarios

Scenario 1 - Mr J

It is Friday afternoon and Mr J has had a busy day at the office. He is anxious about Monday morning's meeting. He works in a stressful job and has been overweight for a number of years.

On and off for a number of months he has had what he thought was indigestion. At 6 o'clock his 'indigestion' returns but the feeling is unbearable and is extending across his chest. He is finding it difficult to breathe and he is sweating. His friend, who has popped round to watch a DVD, notices the pain and anxiety on Mr J's face and calls the ambulance.

Scenario 2 - Mrs P

Mrs P has always been fit, walking and swimming every week. She is 65 and her family has a history of high cholesterol. One day Mrs P starts to feel a pain in her chest. She starts walking to a friend's house to get a lift to the shops. She stops to see if the pain goes off. After a few minutes she starts walking again but the pain is getting worse.

A passer-by notices Mrs P and asks if she needs some help. Mrs P refuses the offer of an ambulance, but calls a taxi. The taxi takes her to her local Accident and Emergency (A&E) department, but the symptoms appear to be dying off. Mrs P asks herself if she should be wasting the hospital's time.

Information for organisers to answer questions/give feedback on outlines of some of the proposed changes after workshops:

Below is an outline of some of the differences we would expect to see in a new region-wide system of care, with specialist centres and improved care throughout District General Hospitals. It contrasts some examples of the way things can happen now with the proposed improved scenarios.

1) Improvements through use of specialist centres:

A common current example:

Mr J: An ambulance arrives. A heart attack is suspected and an electrocardiogram (ECG) confirms the diagnosis. Treatment is given either by the ambulance team or after transfer to the local hospital. This includes immediate aspirin, pain relief and thrombolysis (a clot busting injection).

If the thrombolysis works Mr J will be discharged after 4-6 days and may be referred for rehabilitation.

Risk assessment in the cardiac clinic may be delayed for weeks and the possibility of further heart problems may not be clarified at this stage. In some centres coronary angiography (which shows up blockages in arteries) may be performed but only the minority of cases are fully investigated. A second admission for tests and possible PCI may then be required

Under the new proposals:

An ambulance arrives for Mr J and confirms he is having a heart attack. He is given immediate aspirin and pain relief. The local co-ordinator for heart attack care is contacted and Mr J is taken immediately to the closest specialist centre (which may be further away than the nearest hospital). An emergency team including a cardiologist, nurses and technicians will be assembled to provide an immediate assessment and usually a coronary angiogram (which shows up blockages in arteries).

The blockage will be opened and a meshwork tube (called a stent) will be inserted to "repair" the coronary artery that caused the heart attack. This will all be completed within two hours from the call for help and is called Primary Percutaneous Coronary intervention (PPCI).

The risk of death or further complications is reduced. Mr J is likely to be at home in three days and have a better longer term recovery, helped by early rehabilitation.

If, for any reason Mr J can't get to a specialist centre in time, he will be given thrombolysis. If this happens, Mr J will later have angiography to clarify the best on going treatment.

PPCI for Mr J means:

- Less heart damage
- Lower risk of death
- Less need for future treatments
- Earlier return home....
- Rehabilitation

2) Improvements through District General Hospitals (DGHs)

A common current example:

Mrs P has chest pain and goes to an A&E. On arrival she has an electrocardiogram (ECG – this measures the electrical activity in your heart) as well as blood tests. One blood test shows that there could be some heart damage. Mrs P is classed as mid to high risk of further heart damage and admitted to medical admissions unit under care of general medical team. Medication begins: she is likely to have beta-blockers, aspirin, statin and GTN (often called ‘angina spray’).

As her condition is stable with no angina for 48 hours the risk is now considered low. She is discharged with a recommendation for her GP to seek cardiology advice if there are further symptoms. However there is still a risk of recurrent angina or heart attack. This risk may be as high as 15-30%.

Under the new proposals:

Mrs P has chest pain and goes to an A&E. On arrival she has an electrocardiogram and blood tests. The scan and blood test results indicate she has a mid to high risk of damage to her heart. She is immediately referred to the specialist cardiology team.

Within 48 hours she has a more detailed risk assessment and is given PCI.

Once it is established that she is well enough, Mrs P is discharged and referred on to rehabilitation.

She and the rehabilitation team now have a clearer understanding of the risks and the best ongoing treatment.

Heart Attack & Chest Pain

Comment form for scenarios workshops

Which scenario are you commenting on ? (Please delete where applicable)

- Question 1 / Question 2

Questions (if you need more space please continue on a spare piece of paper marking clearly the date and which questions you are answering – see above):

1. What would you expect to happen at the scene (or A&E)?
2. Where would you expect to have/be taken for treatment?
3. If you have to travel further for specialist care what issues would we need to take into consideration?
4. If you have had to travel to a specialist centre, we want to be able to move you back to a local hospital for ongoing care once it is safe to do so. What issues do we need to think about to make sure this goes as smoothly as possible for you?
5. What information and support should be available for your family/carer while you are in hospital?
6. Would you like to give any further comments/raise any other issues around the proposals for changes to heart attack and chest pain care?