



UNITED STATES TRANSPORTATION COMMAND

508 SCOTT DRIVE
SCOTT AIR FORCE BASE, ILLINOIS 62225-5357

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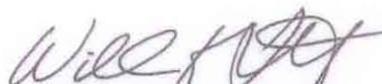
MEMORANDUM FOR (SEE DISTRIBUTION LIST)

FROM: USTRANSCOM SG

SUBJECT: Movement of Patients with Acute Coronary Syndromes

1. Standards of care for patients with acute coronary syndrome (ACS) continue to evolve. Acute coronary syndrome covers the spectrum of clinical conditions ranging from unstable angina to non-Q-wave myocardial infarction and Q-wave myocardial infarction.
2. Timelines for movement of ACS patients stated in the 10 Jun 2005 USTRANSCOM SG *Movement of Patients with Cardiac Diagnoses* policy letter and in AFI 41-307 *Aeromedical Evacuation Patient Considerations and Standards of Care* are no longer applicable, as we are now rapidly transporting ACS patients for percutaneous coronary intervention (PCI) and other treatment modalities.
3. Consultation between the referring physician and the validating flight surgeon is the foundation for developing a safe movement and care plan for all patients. We no longer require waiting 3 to 5 days post cardiac event to begin patient movement. When continuous cardiac monitoring or other critical care treatment modalities are required, the validating flight surgeon, in consultation with the referring physician, shall determine if a CCATT, physician, or ACLS trained nurse will accompany the patient.
4. The referring physician and validating flight surgeon should continue to work together to determine the appropriate aeromedical evacuation timeframe and clinical support requirements for ACS patients. The final decision for determining these requirements rests with the validating flight surgeon. The attached "*AE Cardiac Tool*" provides guidance for determining patient movement attendant and monitoring requirements.
5. This policy will remain in effect until AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, is updated, or an interim change is issued. My point of contact is the TRANSCOM Validating Flight Surgeon at DSN 229-5298.

Attachment
Approach to the Cardiac
Patient & AE


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Approach to the Cardiac Patient and AE			
		Usual AE Requirements	
Acute Coronary Syndrome / Myocardial infarction			
Low Risk			
Acute Coronary Syndrome	Low CAD pretest probability (<10%)	AE crew	
	Less than 3 of the following: active smoker, hypertension, hypercholesterolemia, family history of premature CAD		
	Negative cardiac markers (troponin, etc)		
	No pathologic ECG changes		
	Intermediate Risk		
	Intermed CAD pretest probability (10-90%)	Recommend/Consider:	
	No High Risk likelihood features		
	Diabetes Mellitus		
	Negative cardiac markers (troponin, etc)		
	Fixed Q waves		
Abnormal ST segments or T waves	CCATT MAY be considered		
Extracardiac vascular disease			
High Risk			
High CAD pretest probability > 90%	At the least: Cardiac Monitor Medical Attendant		
Pathologic ECG changes of ischemia			
Hemodynamic instability			
Pulmonary edema (SaO2<92% on room air)			
Known history of coronary disease			
EF < 50% (if able to test)			
Sustained VT			
Any positive cardiac marker (troponin, etc)	CCATT SHOULD be considered		
Valvular Disease			
Low Risk			
Valvular Disease	Asymptomatic	AE Crew	
	No dysrhythmia		
	EF > 50% (if able to test)		
	No evidence CHF/Pulmonary edema	ACLS Medical Attendant Cardiac Monitor	
	Intermediate Risk		
	Exertional symptoms only, no rest symptoms (syncope, chest pain, dyspnea)		
	High Risk		
	Symptoms at rest (syncope, chest pain, dyspnea)	CCATT	
	Any signs of CHF or pulmonary edema		
	Requirement for IV pressors/diuretics/rate controllers		

Dysrhythmias			
Dysrhythmias	Low Risk		
	Stable, rate controlled, asymptomatic SVT, A-fib, A-flutter	AE Crew	
	WPW pattern on ECG (delta wave, short PR)		
	1st degree AVB, 2nd degree AVB (Wenkebach/Mobitz I)		
	Pre-existing BBBs, asymptomatic	ACLS Medical Attendant Cardiac Monitor	
	Intermediate Risk		
	Recurrent PSVT requiring IV meds		
	EF < 50% (if able to test)		
	Newly dx SVT, afib/flutter; rate controlled with PO medications or cardioversion within 48 hours		
	Newly identified asymptomatic BBB, w/out evidence of MI	CCATT	
High Risk			
Wide complex tachycardia			
CHF or pulmonary edema			
Symptomatic bradycardia			
Heart blocks requiring rate control/pacing			

CAD Pre-test probability**	
Estimating the Pretest Probability of Coronary Artery Disease	
Step 1: Categorize the nature of the chest pain symptoms	
Coronary symptoms can be reliably characterized by using three clinical questions:	
1. Is the chest pain substernal?	
2. Are the symptoms precipitated by exertion?	
3. Is there prompt relief within 10 minutes with rest or nitroglycerin?	
Typical (classical) angina: all 3 present	
Atypical angina: any 2 present	
Nonanginal chest pain: 0-1 present	
Step 2 Estimate the pretest probability of coronary artery disease based on age,	
Low Probability (<10%)	
• Asymptomatic men and women of all ages	
• Women < 50 years with atypical chest pain	
Intermediate Probability (10%-90%)	
• Men of all ages with atypical angina	
• Women ≥ 50 years with atypical angina	
• Women 30-50 years with typical angina	
High Probability	
• Men ≥ 40 years with typical angina	
• Women ≥ 50 years with typical angina	
**Content from MKSAP 14, Cardiovascular Medicine.	

