Recognition of ST elevation by paramedics

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Objective: To define the ability of UK paramedics to recognise ST segment elevation using a prehospital 12 lead electrocardiogram (ECG).

Methods: Analysis of the diagnostic ability of seven paramedics 12 months after a two day training course, using interpretation of a 12 lead ECG by two cardiologists as the criterion standard. Comparison of paramedic and A&E SHO diagnosis to determine accuracy, specificity, sensitivity, negative predictive value, and positive predictive value of paramedic interpretation.

Results: Paramedics showed a median accuracy of 0.95 (95% CI 0.88 to 0.98), a specificity of 0.91 (95% CI 0.53 to 1.0), a sensitivity of 0.97 (95% CI 0.94 to 0.99), a PPV of 0.77 (95% CI 0.62 to 0.92) and a NPV of 0.99 (95% CI 0.92 to 1.0). This was not significantly different from a group of experienced A&E SHOs.

Conclusions: UK paramedics can recognise ST elevation using a 12 lead ECG. Radio transmission of an ECG may not be necessary to pre-alert the hospital.

RESULTS

Of the 10 paramedics initially trained seven remained at the same ambulance station after a year and were tested. The sensitivity, specificity, accuracy, negative predictive value (NPV) and positive predictive value (PPV) of paramedic and SHO classifications are shown in table 1.

DISCUSSION

Prehospital recognition of patients who may benefit from thrombolysis is not an established part of prehospital care in the UK. The role of prehospital diagnosis (if any) has yet to be defined. There are two questions that need to be answered: (1) Is prehospital recognition practical? (2) Is prehospital recognition worthwhile?

Table 1 Overall performance (95% confidence intervals) for paramedics and SHOs

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<th>Paramedic</th>
<th>A&amp;E SHO</th>
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<tr>
<td>Sensitivity</td>
<td>0.97 (0.94 to 0.99)</td>
<td>0.97 (0.96 to 0.99)</td>
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<tr>
<td>Specificity</td>
<td>0.91 (0.53 to 1.0)</td>
<td>0.67 (0.58 to 0.73)</td>
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<tr>
<td>Accuracy</td>
<td>0.95 (0.88 to 0.98)</td>
<td>0.93 (0.90 to 0.94)</td>
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<td>Negative predictive value</td>
<td>0.77 (0.62 to 0.92)</td>
<td>0.85 (0.77 to 0.92)</td>
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<tr>
<td>Positive predictive value</td>
<td>0.99 (0.92 to 1.0)</td>
<td>0.93 (0.91 to 0.95)</td>
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Abbreviations: AMI, acute myocardial infarction; ECG, electrocardiogram; PPV, positive predictive value; NPV, negative predictive value.
The transmission of a prehospital diagnosis before the arrival of the patient enables the hospital to “gear up” to provide a swift response once the patient arrives. Several studies have shown that this decreases the door to needle time. A prehospital diagnosis is also required if prehospital thrombolysis is contemplated. These studies have shown that prehospital recognition of patients who may benefit from thrombolysis is worthwhile in the American systems examined. A similar benefit could be expected in Britain.

There are many differences in training between British and American paramedics. This study shows that British paramedics, after a short training course, are able to recognise significant ST elevation on a 12 lead ECG. This study was performed using a group of well motivated and enthusiastic paramedics from a single ambulance station with a close connection to a teaching hospital. The same results might not be obtained if all paramedics were trained in this skill.

Some skills are performed so infrequently by paramedics that there are major concerns about skill retention. As patients with both non-cardiac chest pain and AMI are common, prehospital diagnosis is a skill that will be frequently practised. There is therefore likely to be good skill retention. As the ambulance service works closely with A&E staff, immediate feedback is available to paramedics, which may make re-training unnecessary. The need for re-training could be easily assessed using a similar method to that used in this study.

There is little difference between paramedics and SHOs in this study apart from the trend towards lower specificity in the SHO group. Decision making is influenced by the perceived risks and benefits of different outcomes. A&E SHOs may be rather afraid of missing an AMI and therefore be more suspicious of marginal ST changes, leading to a larger number of false positives and a lower specificity. The doctors may also be unconsciously answering the question “Does this patient have an acute myocardial infarction?” rather than “Does this ECG show ST elevation?”, or using a different set of ST segment elevation criteria for the diagnosis of AMI.

These data are useful in planning a system for alerting the hospital prior to arrival of a patient with AMI. Diagnosis by paramedic may remove both the need for transmission of ECGs and the requirement that a senior doctor is immediately available to interpret the transmitted document. This would reduce both the cost and the organisational change required for prehospital diagnosis. The equipment change required is already occurring, with new cardiac monitors being able to record a 12 lead ECG. The training requirement would be a short course for all paramedics. No change would be required to the current system for transmitting messages from ambulance crews to the hospital.

These data are also useful in the debate about paramedic administration of prehospital thrombolysis, as the ability to recognise significant ECG changes has been defined. However, it is important to emphasise that this study did not examine the ability of a paramedic to diagnose AMI. Diagnosis of AMI is more complex than simply identifying ST elevation on a 12 lead ECG. Much more work would have to be done before any statement could be made about the diagnostic abilities of a paramedic. In particular the probable number of diagnostic errors must be known before any risk/benefit calculation can be made about prehospital thrombolysis.

The effect of widespread introduction of prehospital recognition of ST elevation has not been established. It can be argued that if there was an efficient in hospital response to every patient a prehospital diagnosis would be unnecessary, however many hospitals still give a less than ideal response to these patients. No single intervention will universally provide early thrombolysis. All parts of the chain of care from initial symptoms onwards should be optimised to provide early treatment. This study has shown that prehospital identification of ST elevation by paramedics is possible in the UK. The effect of the introduction of this technique now requires assessment.

This study has shown that prehospital recognition of ECG criteria for thrombolysis by paramedics is practical. UK paramedics can recognise significant ST elevation in a prehospital ECG with a sensitivity of 97% and a specificity of 91%. This information contributes to the analysis of the role of prehospital diagnosis in the treatment of patient with AMI. Only relatively small changes in ambulance training and equipment would be required to enable routine prehospital identification of patients with chest pain and significant ST changes.

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Contributors: Mark Whibread initiate the study, discussed core ideas, participate in protocol design, taught the paramedics, oversaw data collection and assisted with writing of the paper. Vicki Leah discussed core ideas, participate in protocol design, taught the paramedics, participated in data analysis and assisted with writing the paper. Tim Bell participated in data collection, assisted in data analysis and editing of the paper. Tim Coats discussed core ideas, participate in protocol design, oversaw data analysis and wrote the paper. Tim Coats is the guarantor of the paper.

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