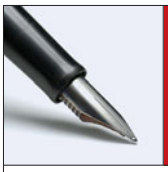


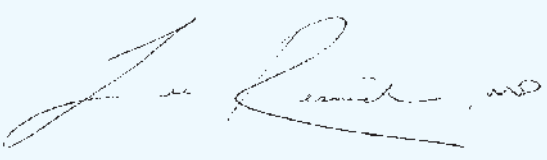
LETTER FROM THE EDITOR-IN-CHIEF

Evaluating Chest Pain in Urgent Care—"Catch 22 and the Three Bears": Part 1

What can Joseph Heller and Goldilocks teach us about managing no-win situations in urgent care? As it turns out, if you look under the covers of Baby Bear's bed, you might find something meaningful, perhaps even something that's "just right." Take the classic no-win situation when patients present to urgent care with chest pain. Without a definitive and reliable test to guide our decision making, we are stuck with the ultimate "damned if you do, damned if you don't" moment: Either send everyone with chest pain to the emergency department (ED) or roll the dice and send some of them home. Neither option is very good. One is "too hot" and one is "too cold." We cannot continue to ignore the problem; nor can we continue to complain about it.

Alternatively, there may be an approach that's "just right," or at least "just right enough." The fact is that the behavior and decision making of most clinicians is driven by the desire to eliminate risk, an idyllic fantasy that simply does not exist. In the absence of risk elimination, we would all agree that risk reduction with a realistic eye toward minimizing false positives and false negatives is our ultimate goal. So what does the evidence tell us, and how can we apply the evidence to our daily routine in a way that reflects best practice? Although most rejectionists among us would say that there is no evidence that defends a balanced approach to managing chest pain in urgent care, the reality reflects otherwise. Several clinical decision tools, along with a few diagnostic tests, can minimize the risk of bad outcome and the risk associated with false alarms. Consider the following approach:

- **Step 1: The first step to evaluating patients with a complaint of chest pain in urgent care is to actually evaluate them.** As absurd as that may sound, the practice of "pre-triaging" patients with chest pain to the ED before completing an evaluation is commonplace in urgent care. Patients are told by front-desk personnel that "we don't see chest pain" and are then referred directly to the ED. In an unrealistic effort to eliminate risk, the urgent care has taken on immeasurable risk by not providing a clinical evaluation. If the patient collapses on the way to the ED or gets into an accident, what will be your defense then? All patients presenting to an urgent care should have an evaluation that is reasonable for their clinical condition.
- **Step 2: Determine whether the patient is stable or unstable.** A patient with chest pain who is clinically unstable (e.g., the patient has altered responsiveness, has significant bradycardia or hypoxia, has hypotension) should trigger the initiation of emergency protocols regardless of underlying cause. If, on the other hand, the patient is clinically stable, then a reasonable and systematic evaluation should follow without bias or emotion.
- **Step 3: Decide whether a transfer is necessary.** There should, of course, be several hard stops in the evaluation that will trigger urgent or emergency transfer. These will vary on the basis of the equipment and testing available but would include things like ST-segment elevation myocardial infarction and an elevated level of cardiac enzymes (e.g., troponin I). It should also be clear that all patients with "typical" chest pain and/or evidence of ischemic changes on electrocardiograms belong in the ED or catheterization laboratory.
- **Step 4: Decide whether the patient can go home.** This is perhaps the most challenging step of them all. Although it may be easy to identify patients who obviously belong in the ED (as described in step 3), it is, conversely, extremely challenging to determine which of the remaining chest-pain presentations can be managed more routinely on an outpatient basis. In next month's column, I will examine this step in detail, including an evidence-based paradigm for sending some chest-pain patients home safely and according to a reasonable standard of care. ■



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