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Myocardial Infarction: Sex Differences in Symptoms Reported to Emergency Dispatch

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Abstract

Background

Emergency management of myocardial infarction (MI) is time critical, because improved patient outcomes are associated with reduced time from symptom onset to definitive care. Previous studies have identified that women are less likely to present with chest pain.

Objective

We sought to measure the effect of sex on symptoms reported to the ambulance dispatch and ambulance times for MI patients.

Methods

The Western Australia Emergency Department Information System (EDIS) was used to identify patients with emergency department (ED) diagnoses of MI (ST-segment elevation MI and non-ST-segment elevated MI) who arrived by ambulance between January 1 2008 and October 31 2009. Their emergency telephone calls to the ambulance service were transcribed to identify presenting symptoms. Ambulance data were used to examine ambulance times. Sex differences were analysed using descriptive and age-adjusted regression analysis.

Results

Of 3,329 MI patients who presented to Perth EDs, 2,100 (63.1%) arrived by ambulance. After pre-defined exclusions, 1,681 emergency calls were analysed. Women (n=621, 36.9%) were older than men ($p<0.001$) and even after age-adjustment were less likely to report chest pain (Odds Ratio [OR]=0.70; 95% Confidence Interval [CI] 0.57, 0.88). After age-adjustment, ambulance times did not differ between male and female patients with chest pain. Women with chest pain were less likely than men to be allocated a 'priority 1' (lights and sirens) ambulance response (Men 98.3% vs. Women 95.5%; OR=0.39; 95% CI 0.18, 0.87).

Conclusion

Ambulance dispatch officers (and paramedics) need to be aware of potential sex differences in MI presentation in order to ensure appropriate ambulance response.

Key words

Emergency medical services; myocardial infarction; symptoms; sex differences; emergency medical dispatch

Background

Current guidelines^{1,2} recommend prompt activation of the emergency medical service (EMS) if a person is experiencing symptoms suggestive of a myocardial infarction (MI). The emergency ambulance is usually the quickest mode of transport to hospital, especially in urban areas. In addition, paramedics are trained to initiate treatment and equipped to treat life threatening cardiac arrhythmias should they occur. The time from onset of MI symptoms to treatment in a hospital influences survival, and rapid reperfusion of an obstructed coronary artery is associated with reduced mortality.³ Additionally, current Australian and American College of Cardiology and American Heart Association (ACC/AHA) guidelines for the treatment of ST-segment elevation myocardial infarction (STEMI) recommend the time from first medical contact to percutaneous coronary intervention (PCI) to be as-soon-as-possible⁴ or less than 90 minutes,^{5,6} with suggestions that EMS to PCI time should be less than 90 minutes as well.^{5,7} Many studies have investigated reasons for underuse of emergency ambulances^{8,9} and delay in seeking treatment^{10,11} in MI patients. Research has shown that pre-hospital median delays range from 84 to over 400 minutes.¹⁰

However, no studies were found that have investigated symptoms of MI reported during the telephone call to emergency dispatch as a possible source of delay. Correct recognition of symptoms of a MI is crucial for the ambulance dispatcher to allocate a "priority 1" (lights and sirens) ambulance response. Most ambulance dispatch systems are primed to rapidly respond to mention of chest pain as a symptom, but not all MI patients experience chest pain as a symptom.¹² Previous studies have identified that women are less likely to present with chest pain^{13,14} and have prolonged prehospital delays.^{10,15} Our primary aim was to compare symptoms, in particular chest pain, reported during the emergency telephone call for men and women with MI. We also compared the relationship between symptoms reported and ambulance responses in men and women, with adjustment for age.

Methods

Study Setting and Cohort

This retrospective cohort study reviewed emergency telephone calls of all adult patients with an emergency department (ED) discharge diagnosis of MI transported by St John Ambulance (SJA) in Western Australia (WA) to one of the seven Perth metropolitan EDs between January 1, 2008 and October 31, 2009. The Perth metropolitan area covers an area over 5,000 square kilometers¹⁶ and has a population of 1.7 million, with 9.2% aged ≥ 65 years and 3% aged ≥ 75 years.¹⁷ Two and a half per cent of the population are indigenous (Aboriginal and Torres Strait Islander), with the overseas born population largely of Asian (23%) and European (19%) descent.¹⁷ SJA-WA is the single provider of prehospital emergency care and transport for WA and is staffed by paramedics who attend over 200,000 calls per year.¹⁸ In WA (as for the whole of Australia) the emergency

telephone number is “triple zero” (0-0-0).¹⁸ Calls are answered by an operator who asks whether the emergency requires “police, fire or ambulance”. Calls requesting ‘ambulance’ are immediately transferred to the Ambulance Operations Centre located at SJA-WA headquarters in Perth. All telephone calls are recorded and stored permanently.

At the time of the study SJA-WA ambulance dispatch operators completed a two- week in-house course in dispatch and prioritizing ambulances. The dispatch operators were not medically trained. The dispatch operator followed a written in-house protocol asking a series of scripted questions that establish location of the incident, phone number of the caller, chief complaint, and other complaint-specific questions. A computer-aided dispatch (CAD) System automatically records the time the call was received, the time the call was dispatched to the ambulance, and the time the ambulance arrived on scene, departed the scene, and arrived at the hospital. A priority is allocated to each call: “Priority 1” (lights and sirens) response represents an emergency, “Priority 2” response represents an urgent call, and “Priority 3” response represents a non-urgent call.¹⁸ Priority responses were assigned by the dispatch operator based on a list of predefined conditions for each priority level, e.g. “chest pain” was allocated as a priority 1. Priority allocation from scene to hospital is determined by the paramedic, based on patient’s clinical status. During the study period, current practice of paramedics did not include acquisition of a 12-lead electrocardiogram or direct transfer to a percutaneous coronary intervention laboratory.

All adult patients with an ED discharge diagnosis of MI (STEMI and non-STEMI) who were transported to ED by SJA-WA during the study period were identified from the Perth Emergency Department Information System (EDIS). EDIS is a real-time patient- tracking system containing utilization and patient disposition data for each ED in Perth.¹⁹ The principal clinical diagnosis is a mandatory field entered by clinical staff on patient discharge from the ED. The clinical diagnosis is electronically mapped to the *International Classification of Diseases and Related Problems, 10th Revision, Australian Modification* (ICD-10-AM) codes.²⁰

Patient details identified from EDIS were used to retrieve the emergency phone call made to SJA-WA, which was saved as a “.wav” file. Patient symptoms, as described by the caller, were transcribed verbatim by one author (LLC). To assess transcription accuracy a random sample of 200 phone calls were reviewed by the same author (LLC). Of the 200 phone calls, 197 were accurate indicating 98.5% data-entry accuracy. Initial lists of possible symptoms of MI were created from an extensive literature search and clinical expertise, with additional symptoms added as required from the telephone transcripts. Symptoms were coded “yes” if stated in the telephone call or “no” if declared absent or not stated. Multiple symptoms for individual patients were possible. Additional information pertaining to the call was collected, including sex of the caller and their relationship to the patient, and location of the call.

The SJA-WA patient database contains computerised records of all cases attended by ambulances in WA from the CAD system and the paramedic-completed patient care record (PCR), which includes dispatch priority, clinical problem codes, and clinical management. The EDIS data were linked to the SJA-WA database, together with the transcribed symptoms from the emergency phone call to SJA. Only the index hospital admission was included for patients who subsequently transferred to a second hospital. Patients were excluded if they arrived by private transport, Royal Flying Doctor Service, helicopter, or other voluntary transport services.

Statistical Methods

Data were presented as frequencies with percentages, or means \pm standard deviations.

Ambulance times were described using means, standard deviations, medians and inter-quartile ranges. Comparisons of baseline characteristics between men and women were performed using chi-square tests for categorical variables, the Mann-Whitney test for medians, and Student's *t* tests for continuous variables.

For each symptom of MI, logistic regression was used to estimate the odds ratio (OR) and its 95% confidence interval (CI) for the symptom being reported by women compared with men. Models were subsequently adjusted for age (as a continuous variable) and age-sex interaction was tested. For the symptom "chest pain", a stratified analysis that dichotomised age into < 70 years and ≥ 70 years, with men aged < 70 years as the comparison group was also conducted. Age 70 years was selected as the cutoff based on previous research demonstrating that presentation with chest pain is less common in individuals over 70 years of age.^{21,22}

Linear regression was used to model sex differences in ambulance times for patients with chest pain and patients without chest pain. Because model residuals were skewed, time intervals were log transformed. Beta coefficients (and 95% CIs) that estimate the difference in mean log time were reported. For patients with chest pain and patients without chest pain logistic regression was used to compare the odds of women being dispatched as a priority 1 ambulance response with those of men. Both linear and logistic regression modeling included adjustment for age (as a continuous variable) and testing for age-sex interaction.

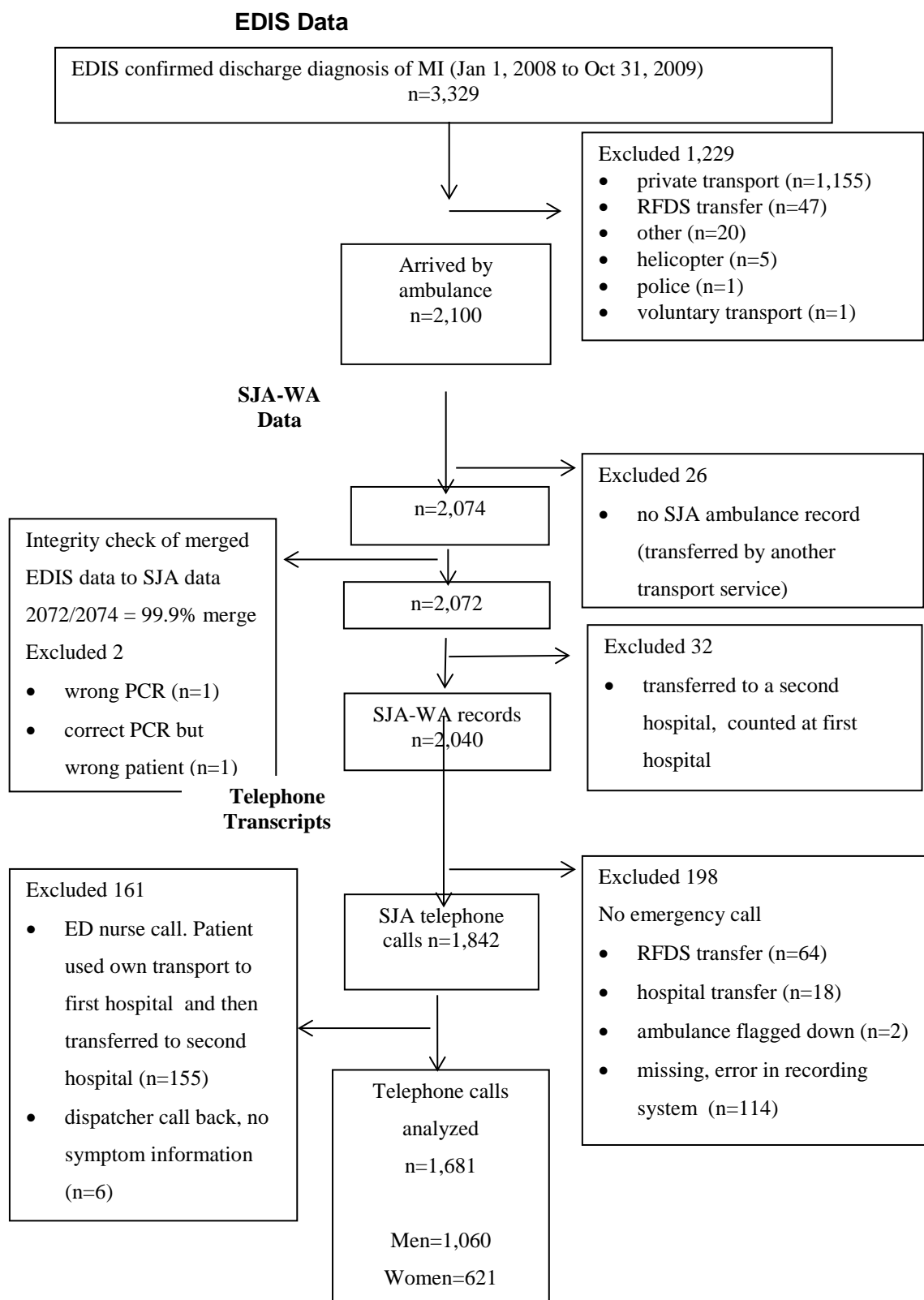
All statistical analyses were performed in PASW Release Version 17.0 (IBM SPSS Inc., 2008, Chicago, IL, www.spss.com). Two-sided p-values < 0.05 were considered significant. Ethics approval was obtained for this study from the University of Western Australia, number RA/4/1/2428.

Results

During the study period, January 2008 to October 2009, of the 3,329 (women, n = 1115; men, n = 2214) patients who were discharged from a Perth ED with a diagnosis of MI, 63.1% (women, n = 759; men, n = 1341) arrived by ambulance. More women (68%) than men (60%) arrived by ambulance ($p < 0.001$). Following exclusions, as detailed in Figure 1, 1,681 emergency telephone calls to SJA-WA were analyzed. Of these, 621 (36.9%) were for female patients.

Women were older than men (mean age 77.6 vs. 69.1 years, $p < 0.001$). Differences in the relationship of caller to patient and the location of patient at time of the emergency call were found between men and women (Table 1).

Figure 1 Study flow diagram



EDIS, Emergency Department Information System; MI, Myocardial Infarction; RFDS, Royal Flying Doctor Service; SJA-WA, St John Ambulance-Western Australia; PCR, Patient Care Record; ED, Emergency Department

Table 1 Sex Differences in the Descriptive Characteristics of the Emergency Phone Calls for Patients with Myocardial Infarction

Characteristic	Men (patients) n=1060	Women (patients) n=621	p-value
Mean Age, years (\pm SD), years	69.1 (14.4)	77.6 (12.8)	<0.001*
Duration of Phone Call - median (IQR), seconds	80.4 (67.8, 123.3)	79.2 (65.4, 123.6)	0.13
Sex of Caller, n (%)			
Male	322 (30.3)	179 (28.8)	0.50
Female	738 (69.7)	442 (71.2)	
Relation of Caller to Patient			
Self	129 (12.2)	59 (9.5)	0.09
Spouse	294 (27.7)	48 (7.7)	<0.001*
Family / Friend	226 (21.3)	204 (32.8)	<0.001*
Professional†	321 (30.3)	252 (40.6)	<0.001*
Other	13 (1.2)	8 (1.3)	0.91
Bystander	27 (2.6)	11 (1.8)	0.30
Unsure	50 (4.7)	39 (6.3)	0.17
Location of Patient at time of emergency call			
Home	714 (67.4)	403 (64.9)	0.18
Relative / Friend / Work	53 (5.0)	17 (2.7)	0.02*
Medical Centre	127 (12.0)	46 (7.4)	0.002*
Nursing home‡	89 (8.4)	133 (21.4)	<0.001*
Other	61 (5.7)	19 (3.1)	<0.001*
Unsure	16 (1.5)	3 (0.5)	0.68

Data are expressed as n (%) unless otherwise specified.

*Statistical significant difference.

†Includes health professional, medical receptionist and security personnel.

‡ Includes residential care facilities.

IQR = inter-quartile range; SD = standard deviation.

Sex Differences in Chest Pain Reported for Patients with Myocardial Infarction during the Emergency Telephone Call

As shown in Table 2, women were less likely than men to report chest pain (54% vs. 69%; OR=0.54; 95% CI 0.44, 0.67; $p<0.001$), even after age adjustment (OR=0.70; 95% CI 0.57, 0.88; $p=0.002$). There was no significant interaction between sex and age ($p=0.10$); however, in age-

stratified analysis, men aged ≥ 70 years (OR=0.48; 95% CI 0.37, 0.63; $p < 0.001$) and women aged ≥ 70 years (OR=0.28; 95% CI 0.22, 0.37; $p < 0.001$) were less likely to have reported chest pain when compared with men aged < 70 years.

Table 2 Sex Differences in Symptoms Reported for Patients with Myocardial Infarction during the Emergency Telephone Call.

Symptom *	Women n= 621 n (%)	Men n=1,060 n (%)	Unadjusted OR (95% CI)	p-Value	Age-Adjusted OR (95% CI)	p-Value
Chest Pain	338 (54.4)	728 (68.7)	0.54 (0.44, 0.67)	<0.001†	0.70 (0.57, 0.88)	0.002†
Left arm pain	90 (9.7)	105 (9.9)	0.97 (0.70, 1.36)	0.87	1.26 (0.89, 1.80)	0.19
Right arm pain	40 (6.4)	114 (10.8)	0.57 (0.39, 0.83)	0.003†	0.70 (0.48, 1.04)	0.08
Jaw / throat / neck pain	26 (4.2)	39 (3.7)	1.14 (0.69, 1.90)	0.60	1.39 (0.82, 2.37)	0.22
Sweatiness or clamminess	51 (8.2)	136 (12.8)	0.61 (0.43, 0.85)	0.004†	0.71 (0.50, 1.01)	0.06
Shortness of breath	176 (28.3)	273 (25.8)	1.14 (0.91, 1.42)	0.25	1.05 (0.84, 1.33)	0.66
Abdominal / epigastric pain	19 (3.0)	24 (2.3)	1.38 (0.76, 2.50)	0.29	1.02 (0.55, 1.91)	0.94
Nausea	31 (5.0)	43 (4.0)	1.24 (0.78, 1.99)	0.37	1.35 (0.82, 2.22)	0.23
Vomiting	46 (7.4)	52 (4.9)	1.55 (1.03, 2.34)	0.04†	1.57 (1.02, 2.41)	0.04†
Syncope / collapse / unconscious	54 (8.7)	67 (6.3)	1.35 (0.93, 1.92)	0.11	1.42 (0.96, 2.10)	0.08
Weakness	34 (5.5)	28 (2.6)	2.14 (1.28, 3.56)	0.004†	1.62 (0.95, 2.75)	0.08
Back pain	28 (4.5)	30 (2.8)	1.62 (0.96, 2.74)	0.07	1.62 (0.93, 2.81)	0.09
Unwellness	42 (6.7)	47 (4.4)	1.56 (1.02, 2.40)	0.04†	1.28 (0.82, 2.00)	0.29
Fall	51 (8.2)	37 (3.5)	2.47 (1.60, 3.82)	<0.001†	1.40 (0.89, 2.21)	0.15
Confusion	26 (4.2)	20 (1.9)	2.27 (1.26, 4.11)	0.007*	1.59 (0.86, 2.94)	0.14

*Multiple symptoms possible.

† OR significantly different from 1.

CI = confidence interval; OR = odds ratio (men as reference group).

Differences in Other Symptoms Reported for Patients with Myocardial Infarction during the Emergency Telephone Call

As shown in Table 2, women were more likely than men to present with vomiting (7.4% vs. 4.9%; OR=1.55; 95% CI 1.03, 2.34; $p=0.04$), even after age adjustment (OR=1.57; 95% CI 1.02, 2.41; $p=0.04$). Greater odds of vomiting in women persisted in subgroup analyses of chest pain only patients, but not in patients who did not report chest pain.

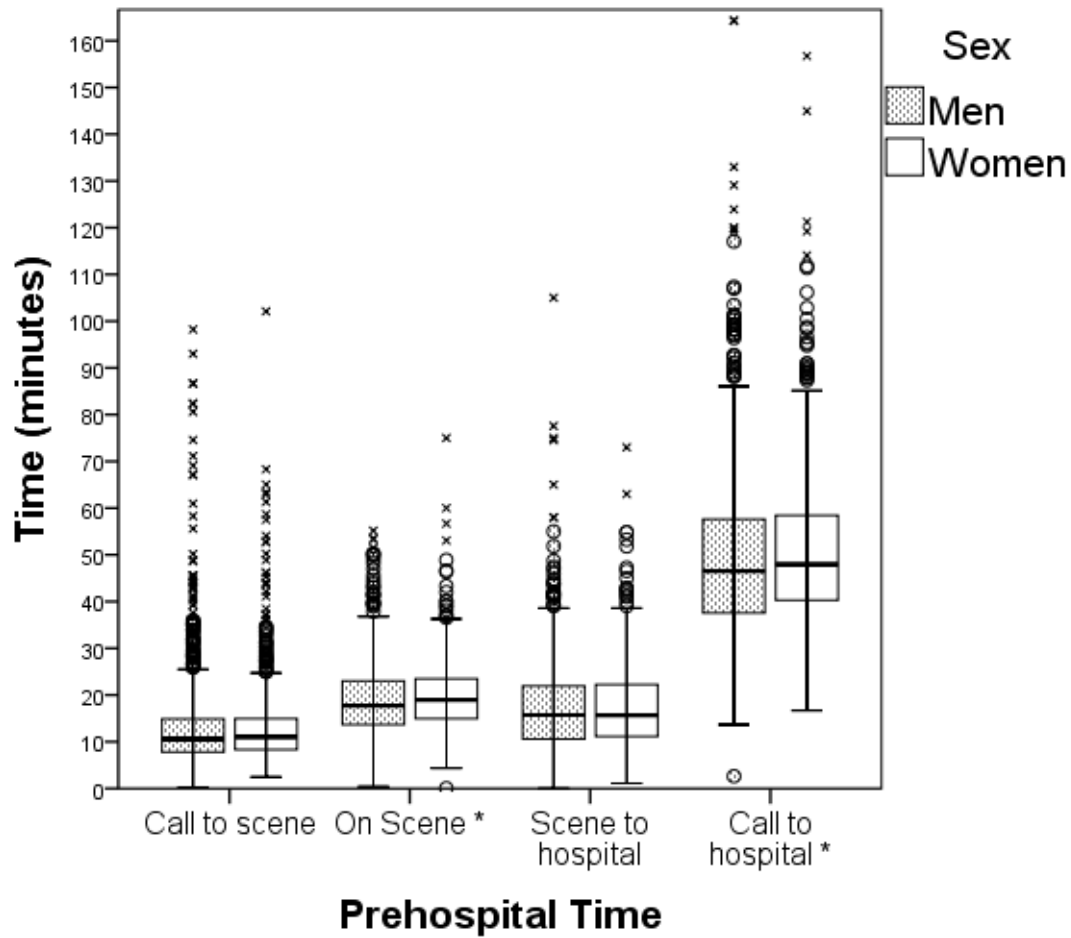
In a subgroup analysis of patients who did not report chest pain there were no statistically significant differences between other reported symptoms. The most common symptoms in this subgroup included shortness of breath (38% women vs. 32% men); a fall (17% women vs. 11% men); syncope, collapse or unconsciousness (17% women vs. 18% men); feeling unwell (11% women vs. 8% men); weakness (9% women vs. 7% men); confusion (8% women vs. 5% men); and vomiting (8% women vs. 8% men).

Sex Differences in Ambulance Times

As shown in Figure 2, compared with men, women had statistically significantly longer median on-scene time (19 vs. 17.7 minutes; $p<0.001$) and call to hospital time (48 vs. 46.5 minutes; $p=0.009$). The greatest component of pre-hospital time for both men and women was on-scene time.

As shown in Table 3, there were no sex differences in any component of ambulance times, except for on-scene time for the subgroup of MI patients with chest pain. The mean on-scene time for women was 1 minute longer than it was for men ($p=0.001$), but after age-adjustment, mean on-scene time did not differ by sex.

Figure 2 Boxplot showing sex differences in times for each component of prehospital time for men and women (n=1681)



*Statistically significant difference, the Mann-Whitney test was used to examine differences in prehospital time. Box encloses the middle 50% of times (the IQR); the horizontal line marks the median. ^oOutlier, value is between 1.5 and 3 IQR (box lengths) from the end of the box. Extreme outlier; value is more than 3 IQR from the end of the box. Data on one extreme outlier not shown, 'Scene to hospital' (180 minutes) and 'Call to hospital' (220 minutes).

Table 3 Sex Differences in Ambulance Times for Patients with Myocardial Infarction Who Had Chest Pain and Those Who Did Not Have Chest Pain

Ambulance Time Interval	PATIENTS WITH CHEST PAIN				PATIENTS WITHOUT CHEST PAIN			
	Men (n=729)		Women (n=337)		Men (n=331)		Women (n=284)	
	Time (minutes)		Unadjusted Beta	Age-adjusted	Time (minutes)		Unadjusted Beta	Age-adjusted Beta
	Mean (±SD)	Median (IQR)	Coefficient* (95% CI) p-Value	Beta Coefficient* (95% CI) p-Value	Mean (±SD)	Median (IQR)	Coefficient* (95% CI) p-Value	Coefficient* (95% CI) p-Value
Call to on-scene								
Men	11.8(8.7)	10.1(7.5, 13.2)	-0.02(-0.08, 0.04)	-0.02(-0.08, 0.05)	16.7(13.3)	12.8(8.8, 19.8)	0.02(-0.08, 0.12)	-0.04(-0.14, 0.06)
Women	11.2(6.5)	10.0(7.6, 12.6)	0.52	0.60	16.8 (12.8)	12.5(9.1, 20.0)	0.67	0.44
On-scene								
Men	18.1(7.2)	17.3(13.4, 22.4)	0.09(0.03, 0.14)	0.04(-0.02, 0.09)	20.4(9.3)	18.8(14.3, 24.8)	0.04(-0.05,0.12)	-0.02(-0.10, 0.07)
Women	19.1(5.9)	18.7(14.9, 22.6)	0.001†	0.18	21.1(9.4)	19.7(14.8, 26.2)	0.40	0.74
On-scene to hospital								
Men	17.6(10.2)	16.0(10.8, 22.6)	0.01(-0.07, 0.08)	0.02(-0.06, 0.10)	16.7(12.6)	14.9(9.8, 21.1)	0.10(-0.01, 0.19)	0.09(-0.02, 0.19)
Women	17.7(9.5)	15.7(11.3, 22.9)	0.80	0.66	17.2(9.1)	15.3(11.1, 21.7)	0.06	0.10
Call to hospital								
Men	47.6(16.6)	45.4(37.3, 54.3)	0.02(-0.02, 0.06)	0.01(-0.04, 0.05)	53.8(21.2)	50.1(39.7,64.6)	0.04(-0.02, 0.10)	-0.01(-0.06,0.06)
Women	48.0(13.6)	46.5(38.8, 56.1)	0.29	0.79	55.1(20.0)	49.8(42.1, 64.4)	0.20	0.92

*Ambulance times are log transformed.

† Beta- coefficient significantly different from 0 (men as reference group).

CI = confidence interval; IQR = inter-quartile range; SD = standard deviation.

Sex Differences in Priority Allocation Total Time from Emergency Call to Hospital for Each Priority Response

As shown in Table 4, women with chest pain were less likely than men to be allocated a priority 1 ambulance response after age-adjustment (98.3% vs. 95.5%; OR=0.39; 95% CI 0.18, 0.87; $p=0.02$). Also shown in Table 4, there were no sex differences in total time from emergency call to hospital for each priority response for patients with and without chest pain. However, there was an increase in total call-to-hospital time for both men and women who were allocated a priority 2 or 3 response compared with a priority 1 response.

Table 4 Sex differences in Ambulance Priority Response and Total Time from Call to Hospital for Patients with Myocardial Infarction Who Had Chest Pain and Those Who Did Not Have Chest Pain

Priority Response	PATIENTS WITH CHEST PAIN				PATIENTS WITHOUT CHEST PAIN			
	Men (n=729)		Women (n=337)		Men (n=331)		Women (n=284)	
	No. of events n (%)	Age-adjusted OR (95% CI) p-value	Total time Call to Hospital Time (minutes)		No. of events n (%)	Age-adjusted OR (95% CI) p-value	Total time Call to Hospital Time (minutes)	
			Mean (SD)	Median (IQR)			Mean (SD)	Median (IQR)
Priority 1								
Men	717 (98.3)	0.39 (0.18, 0.87)	47.2 (15.9)	45.2 (37.2,54.2)	175 (52.9)	1.01 (0.72, 1.42)	47.8 (15.7)	44.9 (36.5, 57.5)
Women	322 (95.5)	0.02*	47.5 (13.3)	46.1 (38.8, 55.5)	132 (46.5)	0.94	48.3 (12.9)	46.6 (40.0, 54.6)
Priority 2								
Men	6 (0.8)	4.77 (1.74, 13.08)	53.7 (20.8)	55.3 (36.4, 70.7)	104 (31.4)	1.06 (0.75, 1.51)	55.6 (18.2)	52.2 (44.6, 69.5)
Women	13 (3.9)	0.002*	57.0 (17.0)	57.8 (44.5, 67.8)	104 (36.6)	0.74	56.5 (20.6)	51.1 (44, 64.6)
Priority 3								
Men	6 (0.8)	0.56 (0.11, 2.91)	79.0 (47.1)	60.8 (45.2, 114.8)	52 (15.7)	0.89 (0.57,1.39)	70.6 (31.4)	68.1 (54.6, 76.3)
Women	2 (0.6)	0.49	64.7 (22.1)	64.7 (49.1, 80.3)	48 (16.9)	0.60	70.6 (25.2)	71.6 (49.9, 88.4)

*OR significantly different from 1.

CI = confidence interval; IQR = inter-quartile range; OR = odds ratio (men as reference group); SD = standard deviation.

Discussion

To our knowledge, this is the first study to analyze sex differences in symptoms reported during the emergency telephone calls for (ED confirmed) MI patients. Even after age-adjustment women were much less likely than men to report chest pain. Additionally, women were less likely than men to have a priority 1 ambulance response. Also, the median total time from emergency call to hospital for men and women who were allocated a priority 2 or 3 ambulance response was longer. Finally, less than two-thirds of MI patients utilized EMS for transport to the hospital. Other studies that have examined emergency telephone calls either have not focused on confirmed MI cases or have not investigated sex differences. We believe these findings add to the literature on MI patients transported by EMS and offer an opportunity to improve care by stimulation awareness of potential sex differences in MI presentation.

Sex Differences in Chest Pain

The reasons why women with MI experience less chest pain and are more likely to report vomiting than men are not entirely understood. Numerous studies have examined sex differences in symptom presentation of MI, but most have abstracted data from medical records or interviewed patients after MI. Recent studies^{14,23} found that women were less likely than men to experience chest pain. Men and women with MI may have different locations of obstructing lesions,^{24,25} and women have been reported to have less obstructive coronary disease at angiography.²⁶⁻²⁸ This may lead to different combinations of sympathetic and vagal stimulation, resulting in differences in the reporting of pain and vomiting.^{29,30} Also, it is well known that women with MI are older^{14,26,29} and have more co-morbid conditions such as diabetes,^{14,26,29} hypertension^{14,26,31} and heart failure,^{14,26,31} and these conditions have been associated with MI without pain.^{29,32,33}

For patients who did not report chest pain, there were no sex differences in the symptoms reported, possibly due to insufficient statistical power due to small numbers. The most common non-chest pain symptoms for both men and women were shortness of breath, a fall, or collapse, syncope or unconsciousness. These symptoms are similar to those found in a study¹² from a large multi-centre prospective trial of patients presenting to ED with suspected acute coronary syndrome but without chest pain. The two most common symptoms at presentation in this study were shortness of breath and syncope.¹²

Sex Differences in Ambulance Times

Although on-scene time and total ambulance time intervals were statistically significantly longer in women compared with men, this is unlikely to be clinically significant. Other studies analysing ambulance times have found the longest component of pre-hospital time is on-scene time.³⁴⁻³⁶

Only one study³⁵ reported sex differences in ambulance times and found women were delivered to hospital 2.3 minutes slower on average than men.

Sex Differences in Priority Allocation

For patients with chest pain, even after age adjustment, women were less likely than men to be allocated a 'priority 1' ambulance response. Other studies have found women with MI were less likely than men to be allocated an Advanced Life Support ambulance (76% vs. 92%)³⁷ or a 'priority 1' ambulance (67% vs. 81%).³⁸ As to be expected irrespective of chest pain status we have shown both men and women with MI who were not allocated a 'priority 1' ambulance response had longer median total time from emergency call to hospital. Further research is required to investigate strategies to better identify patients who do not present with classic MI symptoms, otherwise they are unlikely to be allocated to a high priority response and thus will have increased delay to definitive treatment.

On closer analysis of specific phone calls, the reason why some of the patients with chest pain were not allocated a priority 1 ambulance response was they were not experiencing chest pain at time of the emergency call. Some had experienced chest pain, they had taken sublingual nitrate, and their chest pain had resolved. Several had experienced chest pain earlier and had consulted their general practitioner, who had identified changes on the electrocardiogram or a positive test for troponin. While telephone dispatchers were instructed to ask whether the patient was experiencing chest pain at time of the call, some dispatchers allocated a priority 2 response to patients if their chest pain had resolved, contrary to existing SJA-WA policy. Even though allocating a priority 2 response was incorrect, after these 19 calls were removed from the analysis, we found no difference in 'priority 1' response between men and women. Recently, SJA-WA has introduced dispatch protocols (Medical Priority Dispatch System³⁹ – Version 12 AUE-std) with specific scripted dispatcher-asked questions, which ensures that all patients who have had chest pain are allocated a priority 1 response.

Finally, this study found a persistent underuse of emergency ambulance for the whole cohort (63%), with significantly more women (68%) than men (60%) using an ambulance. This finding is comparable to the 53% to 70% of MI patients transported by emergency ambulances in other studies.^{8,9} Also, consistent with other studies, women were more often transported by ambulance than men, possibly a reflection of the fact women tended to be older.^{9,40} Nonetheless, reasons that more than 35% of all MI patients in Perth chose not to call an ambulance is of concern and warrants further exploration. It is recommended that all patients experiencing symptoms of an MI call the emergency ambulance.^{1,2}

Limitations

The strength of our study is that it is a population-based cohort of patients with ED-confirmed MI (STEMI / non-STEMI), drawn from all public hospital EDs in the Perth metropolitan area. Whilst we are confident in sex differences found in the MI patients experiencing chest pain, some caution is required in the interpretation of sex differences in other symptoms, including vomiting. It is important to note that the ambulance dispatch officer did not attempt to elicit the full spectrum of symptoms experienced by the patient. If chest pain was mentioned, the need for a priority 1 response was established and further questioning about other symptoms was unlikely. As such, patients without chest pain were likely to report more of the other symptoms.

Also, SJA-WA had no formalised or routine call taker quality assurance program undertaken during the study period. Variations may have been caused by different subjective interpretations of the symptoms reported between dispatch operators. We also need to highlight the caller was often not a first party caller (i.e., self) and the majority of calls were from a second- or third-party caller. In three other studies,⁴¹⁻⁴³ first-party callers comprise 5 – 11%; as such, we would suggest our data is similar. The relationship of the caller to the patient and the location of the patient at the time of the emergency call were also different for male and female patients.

Another limitation is that we did not include MI patients for whom an ambulance was called but who were pronounced dead by the paramedics and not taken to an ED. Although unlikely, it is possible that such patients may have reported a different pattern of symptoms. Also, the ambulance record (n=26) and the emergency telephone call (n=198) were missing for a number of patients and could not be analyzed.

We were also unable to identify patient co-morbid conditions or location of the obstructed coronary artery that may be associated with atypical symptom presentation of MI. However, our primary research question was to determine sex differences in symptoms (particularly chest pain) during the emergency telephone call in MI patients and examine the effect of such differences on ambulance response.

Conclusion

During the emergency telephone call for an ambulance, women with an ED-confirmed diagnosis of MI were less likely than men to report chest pain as a symptom. Women with chest pain were also less likely to be allocated a priority 1 ambulance response. Overall, ambulance times did not differ between men and women, although women had a marginally longer on-scene time. Ambulance dispatch officers and paramedics need to be aware of the potential sex differences in MI presentation, in order to ensure appropriate ambulance response.

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