

LETTERS TO THE EDITOR

Chest Pain Units and Emergency Departments

To the Editor:

As emerges from the articles by Drs. Pastor et al¹ and Sanchís et al,² it seems that, fortunately, chest pain units (CPU) have begun to get interesting results from the patient care point of view. Thus, the fact that approximately 80% of low-risk patients with chest pain can be discharged with safety from hospital emergency departments (HED) within 24 hours, following performance of ergometry, means a significant decrease in the number of hospital admissions and, therefore, in the pressure on emergency rooms, and better bed rotation in the emergency room observation units, especially in those with the monitoring facilities and nursing staff to manage patients in an emergency situation.^{3,4} In addition, the detection of almost 20% of cases who require admission enormously decreases the possibility of erroneous discharge,⁵ benefiting both the patients and the emergency room physician who attended them.⁶ Even with the biases of transience and selection alluded to by the authors, we agree that with the findings of these studies we may assume that there has been a change in mentality with regard to the management of chest pain in the emergency room.

Nevertheless, we deduce from both studies that, by limiting ergometry and evaluation by the CPU cardiologist to the hours of the usual hospital work day, we are still far from the standards of the Sociedad Española de Cardiología (Spanish Society of Cardiology)⁷ by not guaranteeing these tests are performed within the first 24 hours of care (including weekends and holidays) and that, in addition, a not inconsiderable number of patients will continue to be under supervision, if not the direct responsibility, of emergency room physicians.^{8,9}

It is important, on the other hand, that both studies have been carried out on functional units that are fully integrated into the HED and not in specific physical units, which in our opinion the most adequate for optimization of healthcare resources, maximizing these in the current setting of a deficit in medical personnel and nursing staff, equipment, and space from which HEDs suffer.¹⁰ Emergency medicine deals with not only the care of chest pain but cerebrovascular accidents sensitive to thrombolysis, intoxication by tricyclic antidepressants, slight to moderate cranial trauma, etc. There is no doubt that the best place for treatment of cardiovascular or cerebral disease would be a specific physical space and adequately trained personnel who are exclusively dedicated to it, but the reality is that the Spanish healthcare systems and our hospitals do not appear to be able to provide themselves with such luxuries. Faced with this situation, we must be careful not to broadcast ideas such as everyone for themselves in the current overcrowded hospital emergency rooms, which are surely far from the idea of creating CPUs, but which could distract managers and healthcare authorities from what, in

our opinion, should be their final objective: improving the care of all emergency room patients.

Extrapolar experiences of other countries so different from ours in their organization and healthcare financing do not appear to be entirely adequate.¹¹ The reality is that Spanish healthcare, particularly with regard to emergency rooms, needs to include continuous availability of care, normal and special emergency room services, and pre-hospital emergency systems (with medical coordination centers); the latter need to be implemented quickly and have magnificent availability of material and human resources.¹² All these healthcare devices are key pieces for the identification and initial treatment of chest pain and, in spite of its progressive improvement, the management of patients with ischemic cardiopathy in general has not reached yet adequate standards.¹³

It is, thus, absolutely necessary that the protocols for chest pain do not only include hospital emergency rooms, but all the pre-hospital care mechanisms. Their exclusion may possibly lead to an even higher saturation of HED¹⁴ resources which will, in turn, prevent the achievement of other standards, such as the performance of an ECG within 10 minutes⁷ or the early administration of acetylsalicylic acid.¹³ We also must improve the intrahospital care of ischemic cardiopathy,¹⁵ as well as the integration of other specialists who, in not a few hospitals, treat this illness. We agree with the requirements for management of patients with suspected acute coronary syndrome proposed in the editorial by Alegría y Bayón:⁶ «The only things needed are: *a*) a defined protocol...; *b*) better reorganization and use of existing resources; *c*) good coordination between the cardiology and emergency room services, as well as adequate hierarchical organization, and *d*) the will.»

The Sociedad Española de Medicina de Urgencias y Emergencias (Spanish Society of Urgent and Emergency Medicine) congratulate the authors for studies such as these,^{1,2} performed with scientific rigor and an eagerness for integration,⁶ and hope that the manifest spirit of collaboration that shines through^{5,11} is expressed in guidelines, recommendations, and shared protocols¹⁶ that definitively improve the care of urgent patients, whatever their illness or the site where care is provided.

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