Determine the PQRST of the pain

P = Place of the pain. Determine its exact location.
Q = Quality of the pain. Rate it on a scale of 1 to 10 (10 being the worst), and ask the patient to describe it (e.g., sharp, dull, pressure, burning).
R = Radiation. Does the pain radiate to the jaw, shoulder, stomach, or back?
• Pain radiating to jaw or left shoulder is common with cardiac ischemia.
• Pain radiating to back should increase suspicion for aortic dissection.
S = Associated Symptoms. What makes the pain worse or better (e.g., bending over, walking up stairs, lying down, resting, eating, etc.)?
T = Timing. How long has the pain been present, or how long does it last when it occurs?
• Fainting pain that lasts seconds is typically musculoskeletal in origin.

Does the patient have any risk factors for myocardial infarction?
See Myocardial Infarction p. 16

Has the patient experienced any symptoms consistent with angina?
Exertional shortness of breath or chest pain

Has there been any trauma, heavy lifting, or heavy exertion?
More consistent with musculoskeletal chest wall pain

Determine the presence of cough, fever, or upper respiratory symptoms
More consistent with pneumonia, pleurisy, or costochondritis

Does the patient have a history of gastroesophageal reflux disease (GERD) or esophageal spasm?
Esophageal irritation from GERD or spasm can present as severe chest pain.
Typically, pain is either exacerbated or relieved by eating.

Does the patient have a history of chronic obstructive pulmonary disease/asthma?
Chest pain can be associated with acute exacerbations.

Obtain a social history
Document any recent drug or alcohol use. Cocaine use can cause acute chest pain.

Perform a general review of systems
This may help elicit any potential medical problems complicating the chest pain.

Perform a physical exam
Lungs: Note egophony, pleural rub, wheezing, or absent or decreased breath sounds.
Chest: Listen for murmurs, pericardial rub, irregular pulse, and S3 or S4 as signs of congestive heart failure.
Extremities: Note pedal edema, pain with range of motion of arm/shoulders.

Check the ECG
If there are signs of a myocardial infarction (e.g., ST-segment elevation), see Myocardial Infarction p. 16.

Obtain a CXR
Look for signs of infiltrate, pulmonary edema, pleural effusion, fractured ribs, or masses.

Check oxygen saturation
Low oxygen saturation on room air suggests pulmonary embolism, pulmonary edema, or pneumonia.

If there are multiple risk factors and/or an abnormal ECG, check cardiac enzymes
Approximately 10% to 25% of pts presenting to the ED can have a nondiagnostic ECG despite having a myocardial infarction.

Musculoskeletal Chest Wall Pain
- or-
Pleurisy
Inflammation of the pleura, usually occurring as a complication of a disease (e.g., pneumonia, viral illness)

Costochondritis
Anterior chest wall pain caused by an irritated joint between the rib and the sternum

Differential Diagnosis
- Myocardial infarction
- GERD/esophageal spasm
- Pneumonia
- Pulmonary embolism
- Pneumothorax
- Aortic dissection

Provide effective pain relief
NSAIDs work well on pain and the inflammatory response.
Narcotics pain relievers may be needed initially to control symptoms.

Encourage coughing and deep breathing exercises
Prevents atelectasis and secondary pneumonia when pts are splinting.

Musculoskeletal pain may respond to heat and stretching exercises
Educate pt
On the diagnosis and expected duration of illness

Ensure adequate follow-up with their primary care provider in the next week
Instruct pt to return to the ED for
Increased shortness of breath or chest pain
Fever greater than 102°F
Any other concerns or complaints