Archives of the Balkan Medical Union
vol. 61, no. 2, pp. 244-252
June 2026
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ORIGINAL PAPER

ACUTE CORONARY SYNDROME AT THE PREHOSPITAL STAGE: DIAGNOSTIC APPROACH AND RISK STRATIFICATION

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Received 20th Apr 2026, Accepted 23rd May 2026
https://doi.org/10.31688/ABMU.2026.61.2.12

Abstract

Introduction. Acute coronary syndrome (ACS) remains one of the leading causes of cardiovascular mortality worldwide and requires rapid diagnosis and early reperfusion therapy. The prehospital stage plays a critical role in reducing delays and optimizing patient outcomes.
The objective of the study was to evaluate the diagnostic approach and risk stratification of patients with suspected ACS in the prehospital setting in the Republic of Moldova.
Materials and methods. A retrospective observational study was conducted using national data provided by the Prehospital Emergency Medical Service of the Republic of Moldova for the period 2023–2025. A comparative statistical analysis of cardiovascular emergencies, ACS cases, tele- Electrocardiographic activity, therapeutic window management, and ST-segment elevation myocardial infarction (STEMI)-related mortality was performed using Chi-square trend analysis. A p-value <0.05 was considered statistically significant.

Résumé

Syndrome coronarien aigu au stade préhospitalier: approche diagnostique et stratification des risques

Introduction. Le syndrome coronarien aigu (SCA) demeure l'une des principales causes de mortalité cardiovasculaire dans le monde et nécessite un diagnostic rapide ainsi qu'une thérapie de reperfusion précoce. La phase préhospitalière joue un rôle essentiel dans la réduction des délais thérapeutiques et l'optimisation du pronostic des patients.
L'objectif de l'étude avait pour objectif d'évaluer l'approche diagnostique et la stratification du risque chez les patients présentant une suspicion de syndrome coronarien aigu au stade préhospitalier en République de Moldova.
Matériels et méthodes. Une étude observationnelle rétrospective a été réalisée à partir des données nationales fournies par le Service d'Assistance Médicale Urgente Préhospitalière de la République de Moldova pour la période 2023–2025. Une analyse statistique comparative des urgences cardiovasculaires, des cas de

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Results. Cardiovascular emergencies represented the leading category of emergency calls and increased significantly during the study period, from 24.8% in 2023 to 26.2% in 2025 (p<0.05). Non-ST-segment elevation (NSTE)-ACS remained the predominant ACS presentation in the prehospital setting. Tele-ECG contributed to increased identification of ACS cases, with STEMI detection increasing from 1.2% to 1.6% and NSTEMI/NSTE-ACS from 0.5% to 1.0% (p<0.05). Although the total number of ACS cases increased progressively, the proportion of patients managed within the therapeutic window declined to 48.1% in 2025 (p<0.05). STEMI-related mortality remained relatively stable during the study period (p>0.05).
Conclusions. The implementation of standardized prehospital diagnostic algorithms, telemedicine-assisted ECG interpretation, and structured risk stratification may contribute to improved early ACS recognition and patient triage. However, organizational barriers continue to limit timely reperfusion therapy, highlighting the need for further optimization of the prehospital chain of survival.

Keywords: acute coronary syndrome, prehospital emergency care, telemedicine, electrocardiography, risk stratification.

List of abbreviations:
ABCDE – Airway, Breathing, Circulation, Disability, Exposure
AMU – Ambulance Medical Unit
AHA – American Heart Association
NCPEMC – National Centre for Prehospital Emergency Medical Care
EMS – Emergency Medical Services
EMTs – Emergency Medical Teams
ESC – European Society of Cardiology
WHO – World Health Organization
ACS – Acute coronary syndrome
STEMI – ST-segment elevation myocardial infarction
NSTEMI – Non-ST-segment elevation myocardial infarction
NSTE-ACS – ACS without ST-segment elevation
ECG – Electrocardiogram

Résultats. Les urgences cardiovasculaires représentaient la principale catégorie d'appels d'urgence et ont augmenté de manière significative au cours de la période étudiée, passant de 24,8% en 2023 à 26,2% en 2025 (p<0,05). Les SCA sans sus-décalage du segment ST (NSTE-ACS) sont demeurés la forme prédominante de présentation du SCA au stade préhospitalier. Le télé-ECG a contribué à une meilleure identification des cas de SCA, avec une augmentation de la détection des STEMI de 1,2% à 1,6 % et des NSTEMI/NSTE-ACS de 0,5% à 1,0% (p<0,05). Bien que le nombre total de cas de SCA ait augmenté progressivement, la proportion de patients pris en charge dans la fenêtre thérapeutique optimale a diminué jusqu'à 48,1% en 2025 (p<0,05). La mortalité liée au STEMI est restée relativement stable durant la période étudiée (p>0,05).
Conclusions. La mise en œuvre d'algorithmes diagnostiques standardisés au stade préhospitalier, l'interprétation assistée de l'ECG par télémédecine et une stratification structurée du risque peuvent contribuer à améliorer la reconnaissance précoce du SCA et l'orientation des patients. Toutefois, des obstacles organisationnels continuent de limiter l'accès rapide à la thérapie de reperfusion, soulignant la nécessité d'optimiser davantage la chaîne de survie préhospitalière.

Mots-clés: syndrome coronarien aigu, assistance médicale urgente préhospitalière, télémédecine, électrocardiographie, stratification du risque.

Introduction

Acute coronary syndrome (ACS) remains one of the leading causes of mortality and morbidity worldwide and represents a major medical emergency requiring rapid diagnosis and timely reperfusion therapy. According to the World Health Organization, cardiovascular diseases are responsible for approximately 17.9 million deaths annually, with a substantial proportion related to ischemic heart disease and its complications, including ACS[1]. Beyond its impact on mortality, cardiovascular disease is a major contributor to disability, reduced quality of life, and increasing healthcare expenditures worldwide[2].

Despite significant advances in cardiovascular prevention and treatment, myocardial ischemia continues to represent an important public health challenge associated with considerable morbidity and mortality. Acute myocardial infarction, particularly ST-segment elevation myocardial infarction (STEMI), remains one of the most severe clinical manifestations of coronary artery disease. Although mortality from ischemic heart

disease has declined in several European countries during recent decades, coronary pathology still accounts for nearly 1.8 million deaths annually in Europe, representing approximately 20% of total mortality[3,4].

Recent epidemiological studies have demonstrated important changes in the incidence patterns of myocardial infarction. The incidence of STEMI has progressively declined, whereas NSTEMI has become increasingly prevalent. These changes are associated with improved primary and secondary cardiovascular prevention strategies, broader use of antiplatelet therapy and statins, and enhanced diagnostic sensitivity due to the implementation of high-sensitivity cardiac troponin assays[5].

Clinical presentation and prognosis of ACS vary according to age, sex, and comorbidities. STEMI occurs more frequently in younger male patients, while elderly individuals and women more often present with NSTEMI or atypical symptoms, which may delay diagnosis and treatment initiation[6]. Furthermore, mortality associated with STEMI is influenced by multiple factors, including age, diabetes mellitus, renal dysfunction, severity of heart failure, extent of coronary artery disease, left ventricular dysfunction, and particularly delays in reperfusion therapy. Nevertheless, advances in primary percutaneous coronary intervention (PCI) and modern antithrombotic therapy have significantly improved short- and long-term outcomes.

The prehospital stage plays a fundamental role in the early recognition and management of ACS. Suspected ACS represents one of the most common reasons for emergency medical service activation. Under prehospital conditions, clinical decision-making regarding direct transfer to PCI-capable centers frequently occurs under substantial time constraints. In the absence of standardized diagnostic and triage protocols, patients with high-risk non-ST-segment elevation acute coronary syndrome (NSTE-ACS) may experience delayed diagnosis, inappropriate referral, and postponed invasive management[7].

Contemporary international literature emphasizes the importance of integrating prehospital electrocardiography, telemedicine, rapid cardiac biomarker assessment, and validated clinical risk scores into ACS evaluation pathways[6]. Current European Society of Cardiology (ESC) guidelines recommend an integrated and coordinated approach to chest pain management, ensuring continuity of care between prehospital emergency systems, emergency departments, and specialized cardiology services[8]. In this context, structured prehospital algorithms contribute to reducing treatment delays, improving diagnostic accuracy, and optimizing patient triage.

In the Republic of Moldova, recent reforms in prehospital emergency medical care and the consolidation of the national regulatory framework have contributed to improved coordination between emergency medical teams and specialized hospital centers. These developments have facilitated more efficient transfer pathways for time-dependent emergencies such as ACS and acute stroke[9]. However, nationwide implementation of standardized ACS risk stratification tools, prehospital diagnostic protocols, and treatment checklists remains incomplete. Moreover, national studies addressing ACS management in the prehospital setting remain limited and are predominantly based on descriptive retrospective analyses, highlighting the need for further analytical evaluation of emergency medical service performance and patient management strategies.

The objective of the study was to evaluate the diagnostic approach and risk stratification of patients with suspected ACS in the prehospital setting in the Republic of Moldova, with emphasis on electrocardiography, telemedicine, and standardized risk assessment tools.

Materials and methods

A retrospective observational study was conducted using nationwide operational data extracted from the National Centre for Prehospital Emergency Medical Care (NCPEMC) of the Republic of Moldova for the period 2023 – 2025. The ethical approval was obtained from the Research Ethics Committee of the Nicolae Testemitanu State University of Medicine and Pharmacy (approval no. 109, dated 24th November 2025).

The study included all prehospital emergency calls coded as cardiovascular emergencies and acute coronary syndrome-related diagnoses registered during the study period.

The analysed variables included:

- total number of emergency calls,
- cardiovascular emergency calls,
- ACS cases,
- STEMI and NSTE-ACS cases,
- tele-ECG activity,
- cases managed within the therapeutic window,
- STEMI-related mortality.

Descriptive statistics were used to summarize the data. Categorical variables were expressed as absolute numbers and percentages. Comparative statistical analysis between years was performed using the Chi-square test for trend. A p-value <0.05 was considered statistically significant. Statistical analysis was performed using SPSS version 26.0 (IBM Corp., Armonk, NY, USA).

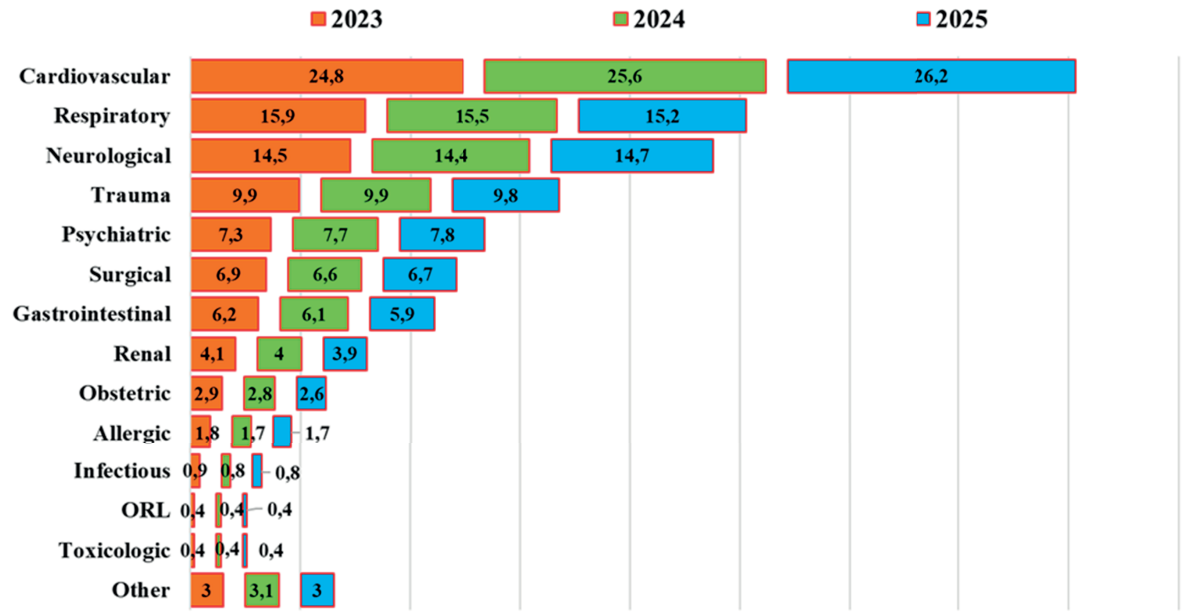


Figure 1. Comparative distribution of prehospital emergency calls by nosological categories in the Republic of Moldova, 2023–2025
Note: Data are presented as percentages (%)
Source: developed by the authors based on NCPEMC data[10-12]

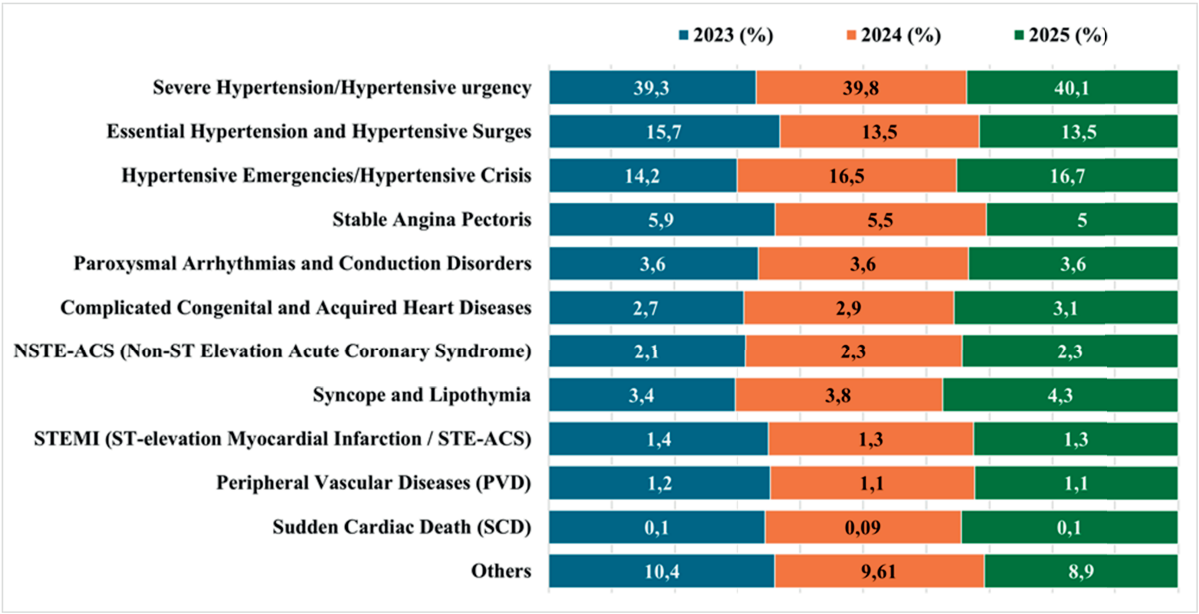


Figure 2. Comparative distribution of prehospital cardiovascular emergency calls in the Republic of Moldova, 2023–2025
Note: Data are presented as percentages (%)
Source: developed by the authors based on NCPEMC data[10-12].

Results

The analysis of nationwide emergency medical service data demonstrated that cardiovascular conditions represented the leading category of prehospital emergency calls throughout the study period (2023–2025). A statistically significant upward trend was observed, with cardiovascular emergencies increasing from 24.8% in 2023 to 26.2% in 2025 (Chi-square test for trend, $p<0.05$) (Figure 1). This evolution indicates a progressive increase in cardiovascular-related demand within the prehospital emergency system rather than random annual variation.

Respiratory emergencies accounted for 15.9% in 2023 and 15.2% in 2025, demonstrating a non-significant downward trend, while neurological

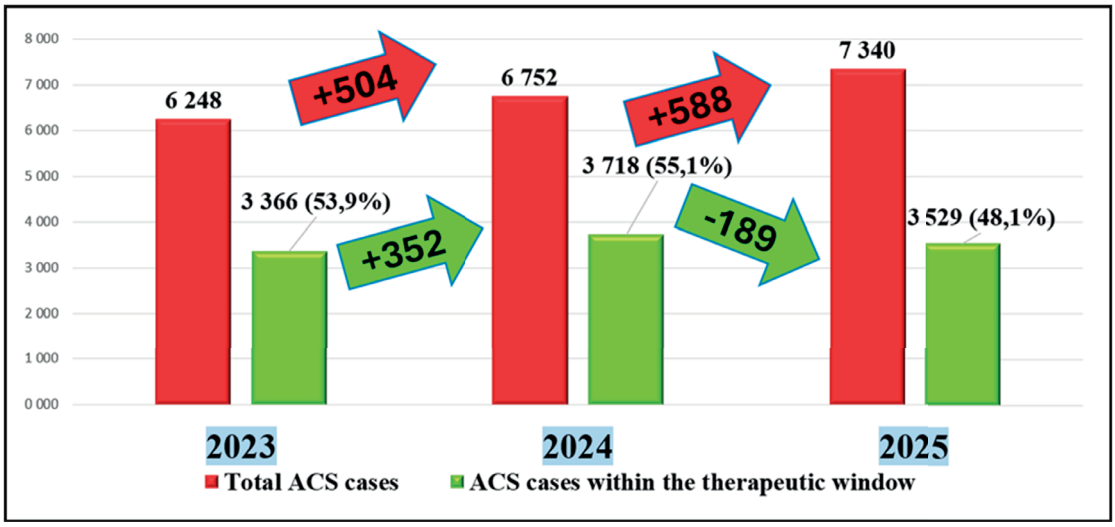


Figure 3. ACS cases managed within the therapeutic window in the Republic of Moldova, 2023–2025
Note: Data are presented as absolute numbers (n) and percentages (%)
Source: developed by the authors based on NCPEMC data[10-12].

emergencies remained stable at 14.5% and 14.7%, respectively[10-12].

Within the cardiovascular subgroup, ACS cases showed a stable temporal distribution across the study period. STEMI remained consistently low, with proportions of 1.4% in 2023, 1.3% in 2024, and 1.3% in 2025, indicating no significant temporal variation. NSTE-ACS demonstrated a slight upward trend from 2.1% in 2023 to 3% in 2025, without statistical significance (Figure 2).

Analysis of tele-electrocardiography (tele-ECG) activity demonstrated a progressive reduction in the total number of ECGs transmitted and interpreted over the study period, from 65,149 in 2023 to 48,798 in 2025[10-12]. The decline followed a near-linear pattern, suggesting a systematic reduction in utilization rather than episodic fluctuation.

Emergency medical personnel performed most ECG acquisitions (>99% across all years), while physician involvement remained marginal and declined from 0.4% to 0.1%, reflecting increased procedural standardization within prehospital teams. Despite the reduction in total ECG volume, diagnostic yield for ACS increased. STEMI detection rose from 1.2% in 2023 to 1.6% in 2025, while NSTEMI/NSTE-ACS increased from 0.5% to 1.0%. Cardiac arrhythmias remained the most frequent diagnostic category (35.4–37.0%), demonstrating stable arrhythmic burden within the prehospital population.

A substantial proportion of ECGs (31.4–34.4%) showed no acute pathological changes, confirming the dual role of tele-ECG in both early identification of life-threatening conditions and exclusion of acute pathology, thereby supporting triage efficiency and reducing unnecessary hospital transport[10-12].

Overall, tele-ECG demonstrated stable operational capacity with increasing diagnostic efficiency for ischemic events, indicating improved targeting of clinically relevant cases rather than increased system workload.

The total number of ACS cases increased progressively from 6,248 in 2023 to 7,340 in 2025 (Figure 3)[10–12]. This upward trend was statistically significant (Chi-square test for trend, $p<0.05$), suggesting a sustained increase in ACS burden within the prehospital system.

The proportion of patients managed within the optimal therapeutic window increased from 53.9% in 2023 to 55.1% in 2024, followed by a significant decline to 48.1% in 2025 ($p<0.05$). This pattern indicates an initial improvement in system efficiency followed by deterioration in 2025, consistent with possible saturation of prehospital response capacity or increased systemic delays (Figure 3).

From a system performance perspective, these findings demonstrate a divergence between increasing ACS incidence and declining treatment timeliness in the final year of observation, suggesting reduced resilience of the prehospital care pathway under increased demand.

STEMI-related mortality among patients managed in the presence of emergency medical teams remained low and stable throughout the study period, with minor fluctuations and no statistically significant temporal trend ($p>0.05$) (Figure 4).

The total number of STEMI cases increased from 2,442 in 2023 to 2,681 in 2025, indicating a persistent upward trend in absolute case burden. The proportion of patients of working age remained stable with minor fluctuations (112 cases in 2023, 115

Indicator	2023	2024	2025
Total STEMI cases	2442	+128 2570 +111	2 681
▪ including working-age patients	112	115	103
Total deaths due to STEMI	60 (2,5%)	53 (2,1%)	58 (2,2%)
▪ including working-age patients	15	11	14

Figure 4. STEMI deaths in the presence of the emergency medical team in the Republic of Moldova, 2023–2025
Note: Data are presented as absolute numbers (n) and percentages (%)
Source: developed by the authors based on NCPEMC data[10-12].

Table 1. HEART Score

Component	0 points	1 point	2 points
History	nonspecific	moderately suggestive	typical of angina
ECG	normal	nonspecific changes	ischemic changes
Age	<45 years	45–65 years	>65 years
Risk factors	no risk factors	1–2 risk factors	≥3 or atherosclerotic disease
Initial troponin	normal	1–3× normal	>3× normal

in 2024, and 103 in 2025), without a consistent directional pattern[13].

Mortality rates showed limited variation, decreasing from 2.5% in 2023 to 2.1% in 2024, followed by a slight increase to 2.2% in 2025, with no statistically significant trend. Despite stable mortality, the persistence of deaths underscores the time-dependent nature of STEMI outcomes and the continued vulnerability of prehospital care pathways to delays in activation, transport, and coordination.

Overall, these findings indicate that while diagnostic capacity and case identification have improved, prehospital outcomes remain highly sensitive to system-level constraints, reinforcing the need for continuous optimization of the chain of survival for acute coronary syndrome patients.

Discussion

Recent evidence from international prehospital studies emphasizes that structured risk stratification strategies, including clinical scoring systems, cardiac biomarkers, and standardized diagnostic pathways, significantly improve early recognition of ACS and reduce delays to reperfusion therapy. The HEART score remains one of the most validated tools for early risk stratification in patients with suspected non-ST-elevation ACS, improving triage accuracy and reducing unnecessary hospital admissions in prehospital settings[14] (Table 1).

In the present study, national EMS data demonstrated a progressive increase in ACS case detection, from 6,248 cases in 2023 to 7,340 cases in 2025 ($p<0.05$). This upward trend suggests a combined effect of improved diagnostic capacity within the prehospital system and an increasing cardiovascular burden in the population. However, this improvement in case identification was not accompanied by a proportional enhancement in treatment timeliness, as the proportion of patients managed within the optimal therapeutic window decreased to 48.1% in 2025 ($p<0.05$). This divergence indicates a growing imbalance between demand and system capacity, suggesting emerging structural constraints within the emergency medical system[6].

Tele-ECG findings further support this interpretation. Although the total number of ECGs performed decreased over time, diagnostic yield improved, with increased detection of STEMI and NSTEMI/NSTE-ACS cases. This indicates better targeting of clinically relevant patients and improved prehospital decision-making. Nevertheless, the persistently high proportion of ECGs without acute pathological changes (approximately one-third of all recordings) confirms that chest pain remains a frequent but diagnostically non-specific presentation, reinforcing

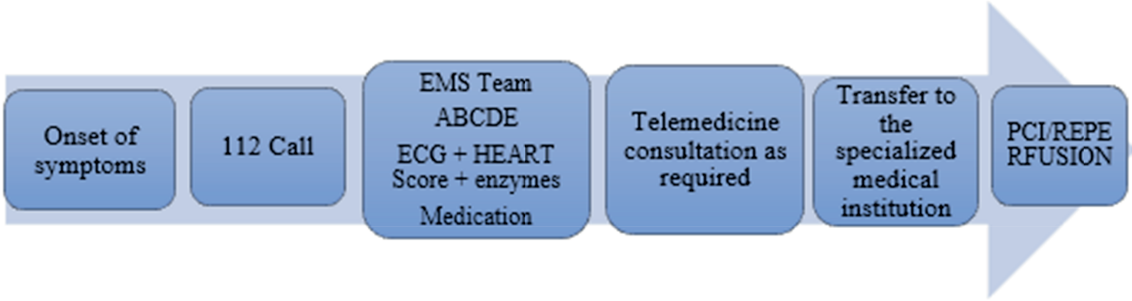


Figure 5. Prehospital Chain of Survival and rapid transfer to reperfusion in patients with ACS
Source: *elaborated by the authors based on ESC Guidelines*[3,4]

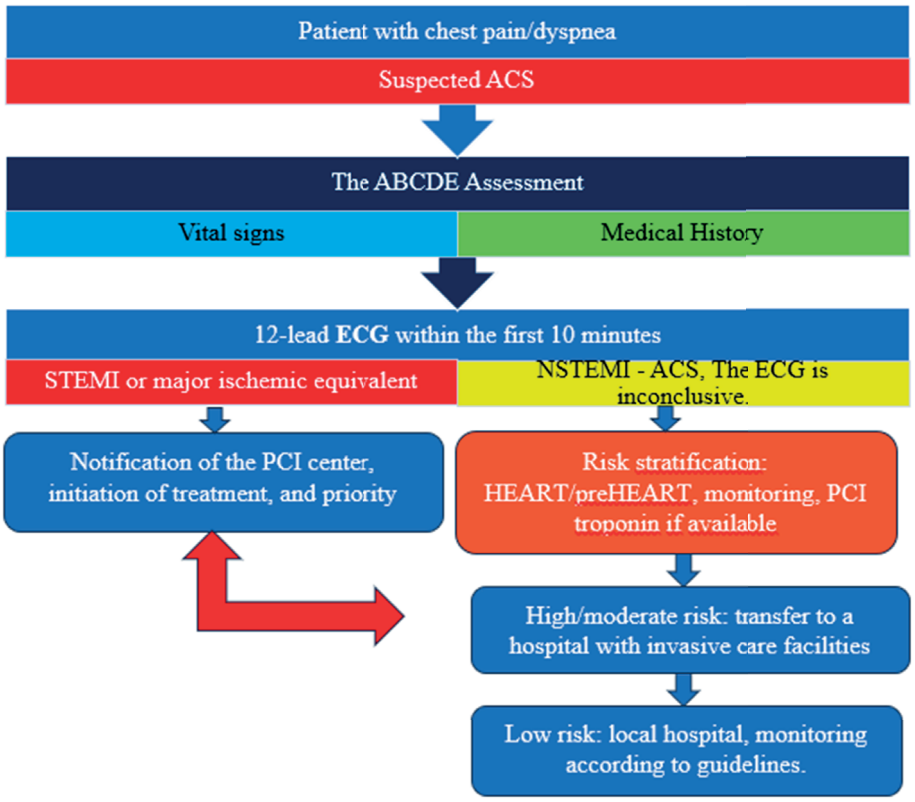


Figure 6. Algorithm for the diagnosis and treatment of ACS in the prehospital setting.
Source: *elaborated by the authors based on ESC Guidelines*[3,4]

the need for enhanced risk stratification strategies at the prehospital level.

The predominance of NSTE-ACS over STEMI aligns with global epidemiological trends. Despite stable mortality rates, STEMI outcomes remain highly time-dependent and sensitive to prehospital delays.

The temporal pattern observed in treatment efficiency, characterized by improvement in 2024 followed by deterioration in 2025, suggests a non-linear response of the system to increasing workload. This may reflect short-term gains following procedural optimization, followed by saturation of EMS operational capacity under sustained demand. Similar patterns have been described in other European emergency systems, where improvements in diagnostic algorithms do not always translate into sustained gains in treatment timeliness due to logistical and organizational limitations.

From a systems perspective, these findings highlight a persistent gap between diagnostic improvement and therapeutic execution. While tele-ECG implementation and standardized assessment protocols enhance early ACS recognition[3,4], delays in reperfusion remain a critical bottleneck in the prehospital chain of survival. These findings highlight a persistent gap between diagnostic improvement and therapeutic execution. Strengthening coordination between EMS, telemedicine centers, and PCI-capable hospitals is essential to optimize the chain of survival (Figure 5).

Overall, the results of this study support the implementation of integrated prehospital ACS management[3] pathways combining telemedicine, structured risk stratification tools, and standardized diagnostic algorithms (Figure 6).

However, the observed variability in treatment timeliness underscores the need for continuous monitoring and adaptive system-level optimization to ensure sustained improvements in clinical outcomes.

Limitations of the study

The retrospective design and reliance on nationwide registry data limited access to individual clinical variables, including comorbidities, treatment details, and long-term outcomes. In addition, the study evaluated operational EMS indicators rather than patient-level therapeutic interventions. Nevertheless, the use of nationwide data provides an important overview of ACS management trends in the prehospital setting of the Republic of Moldova.

Conclusions

This study demonstrates a progressive increase in the burden of ACS within the prehospital emergency system in the Republic of Moldova, where cardiovascular emergencies remain the leading cause of ambulance calls, rising from 24.8% in 2023 to 26.2% in 2025. The predominance of NSTE-ACS and the relatively low proportion of STEMI cases reflect ongoing challenges in early recognition and timely patient presentation at the prehospital level.

The integration of standardized diagnostic tools, including the HEART score, high-sensitivity cardiac biomarkers, and tele-electrocardiography, supports more accurate early identification and improved clinical decision-making in suspected ACS cases. However, despite these diagnostic improvements, the proportion of patients managed within the optimal therapeutic window declined in the final year of observation, indicating a mismatch between increasing system demand and prehospital treatment capacity.

These findings underscore the need for strengthening coordinated prehospital ACS pathways, with emphasis on rapid triage, improved transport logistics, and expansion of telemedicine-supported decision-making to optimize time-dependent outcomes

Author's Contributions:

N.C., N.M. and M.P. conceived and drafted the article. T.M. and L.R. participated in the design of the study. N.C. and M.P. revised it critically for important intellectual content. All the authors have read and agreed with the final version of the article.

Compliance with Ethics Requirements:

"The authors declare no conflict of interest regarding this article"

"All procedures performed in this study were in accord-ance with the ethical standards of the institutional and/or national research committee(s) and with the Helsinki Declaration (as revised in 2013), as well as the national law. Informed consent was obtained from the patients included in the study"

"No funding for this study"

Acknowledgements:

None

References

1. World Health Organization. Cardiovascular diseases (CVDs). Geneva: WHO; 2023. Available from: https://www.who.int/health-topics/cardiovascular-diseases#tab=tab_1
2. Negruta L, Raevschi E. Evaluation of costs and benefits in the healthcare system – ensuring efficient use of resources [in Romanian]. *Moldovan Journal of Health Sciences*. 2024;11(3 Suppl 2):123. Available from: https://ibn.idsi.md/sites/default/files/imag_file/p-123_6.pdf
3. Ibanez B, James S, Agewall S, et al. 2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation. *European Heart Journal*. 2018;39(2):119–177. doi:10.1093/eurheartj/ehx393
4. Collet JP, Thiele H, Barbato E, et al. 2020 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation. *European Heart Journal*. 2021;42(14):1289–1367. doi:10.1093/eurheartj/ehaa575
5. Van Dongen DN, Tolsma RT, Fokkert MJ, et al. Pre-hospital risk assessment in suspected non-ST-elevation acute coronary syndrome: a prospective observational study. *European Heart Journal Acute Cardiovascular Care*. 2020;9(1 Suppl):5–12. doi:10.1177/2048872618813846
6. Demandt J, Koks A, Sagel D, et al. Prehospital risk assessment and direct transfer to a percutaneous coronary intervention centre in suspected acute coronary syndrome. *Heart*. 2023. Available from: https://pubmed.ncbi.nlm.nih.gov/38040452/
7. Catanoi N, Rabovila A, Scurtov N, Pestereanu M. Hypertensive emergencies: challenges and achievements in the prehospital stage [in Romanian]. *Buletinul Academiei de Ştiinţe a Moldovei. Medical Sciences*. 2020;2(66):150–153. Available from: https://ibn.idsi.md/ro/vizualizare_articol/168259
8. Kubica J, Adamski P, Ładny JR, et al. Pre-hospital treatment of patients with acute coronary syndrome: recommendations for medical emergency teams. *Medical Research Journal*. 2022;7(1). Available from: https://journals.viamedica.pl/medical_research_journal/article/view/MRJ.2022.0013/66656
9. Catanoi N, Rezneac L, Mocanu N. Protocols for the diagnosis of urgent neurological pathologies in the pre-hospital stage. *Arch Balk Med Union*. 2025;60(1):140–147.
10. National Center for Prehospital Emergency Medical Care (CNAMUP). Activity report for 2023 [in Romanian]. Available from: https://ambulanta.md/storage/uploads/

Rapoarte%20%C8%99i%20statistici/09.02.2024%20Raport%20activitate%20pentru%202023.pdf
11. National Center for Prehospital Emergency Medical Care (CNAMUP). Activity report for 2024 [in Romanian]. Available from: https://ambulanta.md/storage/uploads/Rapoarte%20%C8%99i%20statistici/CNAMUP_21.02.2025_Raport%20activitate%20pentru_2024.pdf
12. National Center for Prehospital Emergency Medical Care (CNAMUP). Activity report for 2025 [in Romanian]. Available from: https://ambulanta.md/storage/uploads/Despre%20Noi/Rapoarte%20si%20Statistici/CNAMUP%20Raport%20activitate%20pentru_2025..pdf
13. Ministry of Health, Labour and Social Protection of the Republic of Moldova. Order no. 430 of 03.04.2019 regarding the Prehospital Emergency Medical Service [in Romanian]. Available from: https://ambulanta.md/storage/uploads/Acte%20legislative%20si%20normative/Ordin-nr.-430-din-03.04.19-Cu-privire-la-Serviciul-de-AMUP-din-RM_compressed-1.pdf
14. Anwar I, Sony D. HEART score: prospective evaluation of its accuracy and applicability. *Indian Journal of Critical Care Medicine*. 2024;28(8):748–752. Available from: https://www.ijccm.org/doi/pdf/10.5005/jp-journals-10071-24773