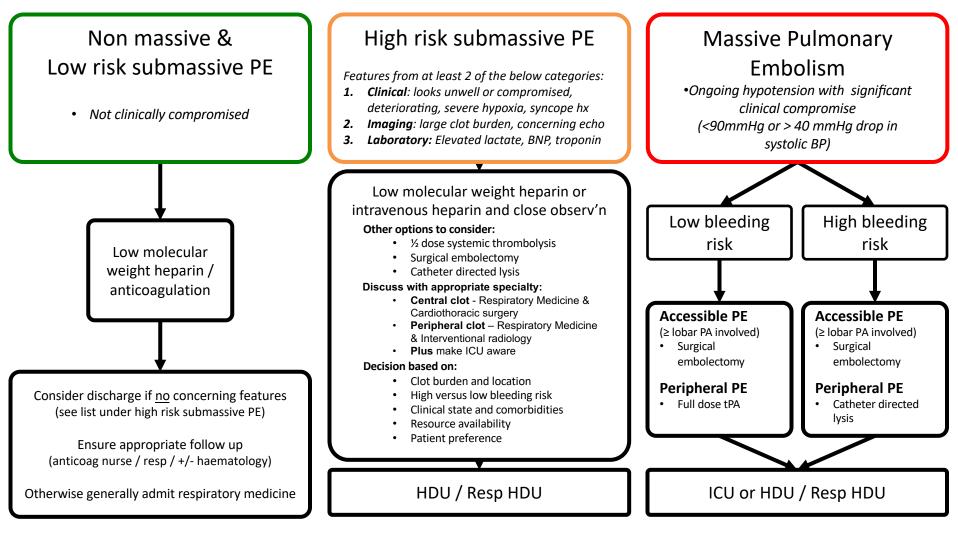


Sir Charles Gairdner Hospital

Pulmonary Embolism Advanced Care Pathway

A senior clinician should be involved in the assessment of patients with pulmonary embolism, and discussion between emergency medicine, respiratory medicine, cardiothoracic surgery and interventional radiology is encouraged. These are only guidelines, patients are unique, there is a broad and complex spectrum of presentation, and definitive evidence is limited.



Designed in collaboration and with agreement from Emergency Medicine, Respiratory Medicine, Interventional Radiology and Cardiothoracic Surgery Reference: Modified from the EMCrit.org website May 2015. <u>http://i2.wp.com/emcrit.org/wp-content/uploads/2014/07/Orens-PE-Algo.jpg</u>



Sir Charles Gairdner Hospital

Pulmonary Embolism Advanced Care Pathway – additional information

High bleeding risk and contraindications to thrombolysis

Absolute	Relative
Known allergy / hypersensitivity / adverse reaction to thrombolytics or allergy to	Age more than 75 years Uncontrolled hypertension on presentation
Gentamicin (a trace residue from the manufacturing process)	Current anticoagulant use (if on warfarin (Systolic >180 or diastolic >110mmHg)
Active or recent internal bleeding within 14 days (excludes menstruation)	only thrombolyse if INR <2.0) • Ischaemic stroke over 3 months ago
Significant closed head, facial or other severe trauma within past 3 months	Non compressible vascular puncture within Dementia or known intracranial pathology
Suspected aortic dissection or pericarditis	past 10 days • Pregnancy or recent delivery
Prior intracranial haemorrhage within past 6 months	Recent major surgery (within 3 weeks) Reduced GCS
Ischaemic stroke within 3 months or previous haemorrhagic stroke	Traumatic or prolonged CPR (for more than Haemorrhagic ophthalmic conditions
Known structural cerebral vascular lesion (AVM or aneurysm)	10 minutes) • Active peptic ulcer or other ulcerative
Known malignant intracranial or intraspinal neoplasm	Recent internal bleeding (within 2-4 weeks) conditions (i.e. Crohn's disease)
Known severe bleeding disorder	History severe chronic poorly controlled Advanced kidney or liver disease
Recent (within past 2 months) intracranial or intraspinal surgery)	Hypertension Prior Streptokinase / Alteplase / Reteplase

Consideration of imaging for source of PE and need for IVC filter

In patients with suspected massive or high risk submassive PE, CTPA with concurrent CTV down to popliteal veins is recommended.

• Where CTV is not prospectively performed ultrasound of the lower limbs is an alternative and strongly recommended if considering major Rx (lysis, cath, embolectomy).

- IVC filter is placed in patients who have undergone surgical pulmonary embolectomy and in whom there remains significant lower limb thrombus.
- IVC filter is considered in patients with submassive PE, in whom there remains significant lower limb thrombus, particularly if it appears unstable.
- · Advice on the use of TED stockings is available on the SCGH ED DVT pathway

Administration of thrombolysis for pulmonary embolism

Full dose thrombolysis

Alteplase (tPA)

- > 65kg 10mg IV bolus, followed by 90mg IV infusion over 2 hours
- < 65kg adjust dose so it does not exceed 1.5mg/kg; give 10mg IV bolus then the remainder of the dose over 2 hours

Half dose thrombolysis

Alteplase (tPA)

> 65kg 10mg IV bolus, followed by 40mg IV infusion over 2 hours

< 65kg adjust dose so it does not exceed 0.75mg/kg; give 10mg IV bolus then the remainder of the dose over 2 hours

Follow the Alteplase 2 hour infusion with anticoagulation with unfractionated heparin via IV infusion as per anticoagulation chart protocol.

Catheter directed thrombolysis

Alteplase (tPA) as directed by interventional radiology