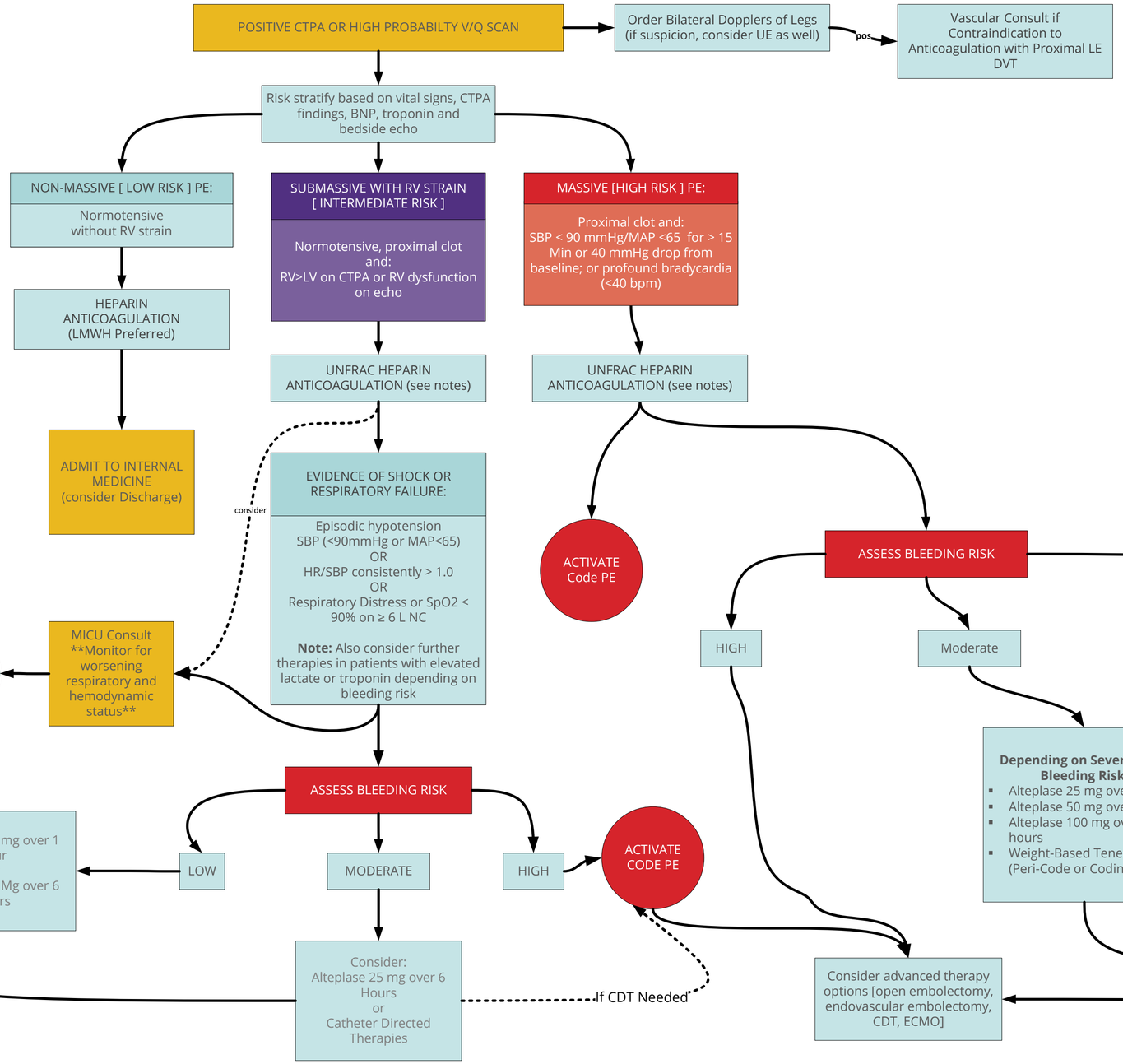
EMCrit RACC Pulmonary Embolism Pathway

HIGH BLEEDING RISK:

1. Any Prior ICH
2. Known structural intracranial cerebrovascular disease (e.g., avm)
3. Known malignant intracranial neoplasm
4. Ischemic stroke within the past 3 months
5. Suspected Aortic Dissection
6. Active, non-compressible bleeding
7. Known inherited or acquired bleeding disorder, e.g., hemophilia, platelet count <50,000/uL, or liver failure with prothrombin time abnormal (INR > 1.7)
8. Surgery that required opening of the chest cavity, peritoneum, skull, or spinal canal within the previous 14 days
9. Recent significant closed-head or facial trauma with radiographic evidence of bony fracture or brain injury

MODERATE BLEEDING RISK:

1. Age >70 years (AHA uses >75)
2. Current use of anticoagulation
3. Pregnancy (Consult OB)
4. Noncompressible vascular punctures
5. Traumatic or prolonged cardiopulmonary resuscitation (>10 minutes)
6. Recent internal bleeding (within 2 to 4 weeks)
7. Remote (>3 months) ischemic stroke
8. Major surgery within 3 weeks.
9. Uncontrollable hypertension: SBP>180 or DBP > 100, despite anti-hypertensive treatment
10. Metastatic cancer (consider Head CT in any cancer patient)
11. Head trauma causing loss of consciousness within previous 7 days (Get a Head CT)
12. Large Pericardial Effusion



Notes:

- Proximal clot=Filling defect in lobar or more proximal artery
- RV dysfunction on echo findings include: dilated and/ or hypokinetic RV, septal flattening or bowing
- If IV thrombolysis or catheter-directed treatment anticipated, prefer UFH administration and if you know you will be contemplating thrombolysis, consider holding initial heparin
- Stop heparin drip during administration of tPA. Recheck PTT immediately after tPA infusion is complete. When PTT < 2 x ULN, restart heparin drip WITHOUT bolus at same rate as before tPA was started. Consider waiting until fibrinogen returns to normal levels as well before restarting heparin.

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Inspired by North Carolina Medical Center Protocol