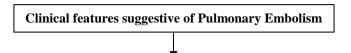
13. Pulmonary Embolism Algorithm

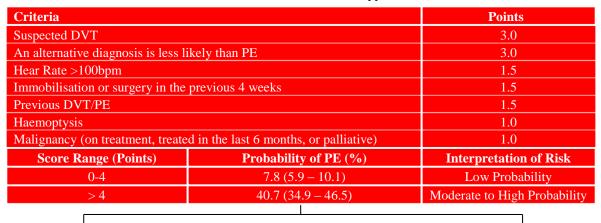
This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.



- Monitor, support ABCs in **Resuscitation room** (ER). Be prepared to provide CPR and ?Thrombolysis¹
- Obtain/review 12-lead ECG Consider ACS see 12. Chest Pain (Acute Coronary Syndrome) Algorithm.

 Features of PE on ECG; Sinus Tachycardia, T wave inversion in III & V1, V3 or S1, Q3, T3 pattern. A normal ECG can be seen in 30% of patients
- Check vital signs (BP, PR, RR, SPO₂, T°C, RBS)
- Start Oxygen IF SPO₂ < 94% or if patient is dyspnoeic. Maintain SPO₂ \geq 94%
- Establish IV Access and send blood samples for FBC, UEC, & Coagulation screen
- Perform brief, targeted history, physical exam

Clinical Gestalt or Validated clinical decision support tool (Wells score)

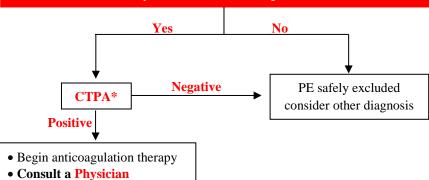


Haemodynamically stable, Low Probability for PE

Pulmonary Embolism Rule-Out Criteria (PERC)

- 1. Is the patient > 49 years of age?
- 2. Is the pulse rate > 99 beats per minute?
- 3. Is the pulse oximetry reading < 95% while the patient breathes room air?
- 4. Is there a present history of haemoptysis?
- 5. Is the patient receiving exogenous oestrogen?
- 6. Does the patient have a prior diagnosis of venous thromboembolism?
- 7. Has the patient had recent surgery or trauma requiring endotracheal intubation or hospitalization in the previous 4 weeks?
- 8. Does the patient have unilateral leg swelling (visual observation of asymmetry of the calves)?

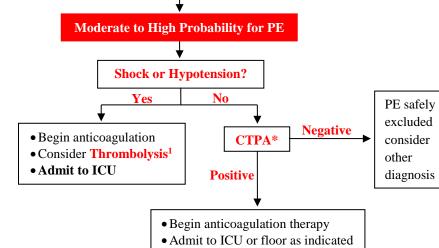




¹Indications for Thrombolysis in PE (rule out contraindication to Thrombolysis)

- Cardiac Arrest
- SBP <90 mmHg for >15 minutes, if not caused by new-onset arrhythmia, hypovolaemia, or sepsis

Consult a Physician
Consider immediate transfer to an appropriate facility



- * Compression ultrasound of lower extremities can be performed as the initial diagnostic imaging modality in any of the following situations;
- no CT scan available
- patients with obvious signs of deep vein thrombosis (DVT) for whom venous ultrasound is readily available
- patients with relative contraindications for CT scan (e.g., borderline renal insufficiency, CT contrast agent allergy)
- in pregnant patients
- patients with a moderate to high clinical risk of PE with a negative or inconclusive CTPA or an inconclusive V/Q scan.

A **positive finding** in a patient with symptoms consistent with PE can be considered evidence for diagnosis of VTE disease and potentially eliminate the need to expose the patient to the radiation from either a CTPA or V/Q scan.