Management of Acute Type B Aortic Dissections Guideline

Haemodynamic targets (initial)

- Systolic BP 100-120 mmHg
- MAP <80 mmHg
- Targets should be changed ONLY after consultation with Vascular team

If patient develops leg weakness, the Vascular surgeon and Vascular anaesthetist must be contacted immediately. ***Potential*** interventions for spinal cord ischaemia

- Increasing target BP to avoid potential spinal cord infarction
- Emergency CSF drain
- Repeat CT or MRI imaging

Early medical management: Aggressive BP control, analgesia and anti-emetics

Analgesia

- **Morphine** (1-10mg) IV titrated to effect

Then

- **Morphine PCA** 1mg bolus 5 min lockout

*If the patient has **renal impairment,** morphine can be replaced with **fentanyl** 10 microgram bolus 5 min lockout*

- Regular **Paracetamol** (unless contra-indications)

Anti-emetics

- **Ondansetron** 4mg IV every 8 hours
- Supplemental cyclizine 50mg IV every 8 hours and metoclopramide 10mg IV every 8 hours may be used

BP control

Intravenous therapy

1. **Labetalol** (first choice)
    a. Administer IV bolus injections for initial control of blood pressure (10mg slow IV bolus injections at 2 minute intervals to a maximum of 200mg per course of boluses).
    b. AND ALSO start an IV infusion to maintain blood pressure control.
        i. Concentration 5mg/ml for CVC use OR 1mg/ml for PVC use
        ii. Dose – Start at 15mg/hr and titrate to clinical effect, but often 10-60mg/hour.
2. **Nicardipine** (second line in addition to labetalol, or first line if contra-indications to beta-blocker)
    a. IV infusion *(change IV infusion site every 12h if peripherally administered)*
        i. Concentration 25mg made up to 250ml (5% glucose) = 100micrograms/ml
        ii. Dose – titrated to clinical effect
        iii. Start at 50ml/hour (5mg/hour). The rate may be increased every 10 mins by 25ml/hour to a maximum of 150ml/hour (15mg/hour).
        iv. Once target BP is achieved reduce dose gradually, usual maintenance dose 2-4mg/hour

3. **Hydralazine** (third line) **NB OFF LICENCE USE – Consultant directed use only**
   PATIENT MUST BE RATE CONTROLLED BEFORE COMMENCING HYDRALAZINE
   a. IV bolus – 5mg slow IV injection bolus at 20 minute intervals to a usual maximum of 20mg
   b. IV infusion
      i. Concentration 60mg made up to 60ml (0.9% sodium chloride) = 1mg/ml
      ii. Dose – titrated to clinical effect
      iii. Start at 3ml/hr (50micrograms/min). The rate may be increased every 10 mins by 3ml/hour to a maximum of 18ml/hour (300micrograms/min).

Oral therapy – <u>Start as soon as possible (Day 1 unless contra-indicated)</u>
<u>Titrate first line drug to maximum tolerated dose before introducing next line drugs</u>

1. **Bisoprolol** (first choice)
   a. 2.5-20mg once daily
2. **Amlodipine** (second line in addition to bisoprolol, or first line if contra-indications to beta-blocker)
   a. 5-10mg once daily
3. **Doxazosin** (third line in addition to bisoprolol and amlodipine)
   a. 1-16mg once daily

NB ACE Inhibitors and diuretics should be avoided initially while the kidneys are at risk.

References

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Think **DISSECTION**

The Management of Acute Type B Aortic Dissections

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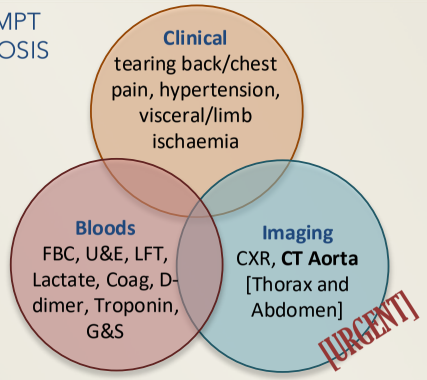
1 RESUSCITATION

A B C D E

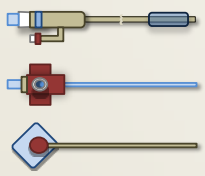
Early anticipation of critical care involvement

2 PROMPT DIAGNOSIS



Hypotension may be due to myocardial ischaemia, tamponade, aortic root incompetence, or an aortic bleed. These warrant urgent investigations.

3 SYSTEMIC MONITORING



Urinary Catheter
Invasive BP
ECG Rhythm

Urgent Critical Care opinion regarding Level 2 bed (HDU)

4 ANALGESIA AND ANTI-EMETICS

Morphine 1 – 10mg IV titrated to effect;
Morphine PCA 1mg bolus; 5min lock out;
Fentanyl 10µg IV bolus 5min lock out [renal failure]
Paracetamol 1g QDS (unless contraindicated)

Ondansetron 4mg IV every 8 hours OR
Cyclizine 50mg IV PRN 8 hourly OR
Metoclopramide 10mg IV PRN 8 hourly

TYPE A → **Urgent Cardiothoracic Opinion** [bleep: 1682]

TYPE B → **Urgent Vascular Surgery** [via switchboard] **and Critical Care** [bleep: 2306] **Opinion**

5 BLOOD PRESSURE CONTROL

Systolic BP target:	**100 -120mmHg**
MAP target:	**<80mmHg**
Heart rate target:	**50 – 60 bpm**
Urine output target:	**0.5 ml/kg/hr**

1 **Labetalol** 10mg IV bolus every 2 min [max 200mg]
THEN IV infusion 15mg/hr titrated to clinical effect.
Concentration: 1mg/ml [PVC] or 5mg/ml [CVC].

2 **Nicardipine** 25mg in 250ml [100µg/ml]
Add to Labetalol, or 1st line if intolerant to β-blockers
Start at 50ml/hour (5mg/hour).
Increase every 10 min by 25ml/hour;
Max 150ml/hour (15mg/hour).
Once target BP is achieved reduce dose gradually, usual maintenance dose 2-4mg/hour

3 **Hydralazine** 5mg slow IV bolus every 20min [max 20mg] (in addition to previous agent)
THEN IV infusion 1mg/ml titrated to clinical effect;
Start at 3ml/hr (50µg/min).
Increased every 10 mins by 3ml/hour.
Max 18ml/hour (300 µg/min).

6 LONG-TERM MANAGEMENT

CONVERT TO ORAL BLOOD PRESSURE CONTROL AS EARLY AS TOLERATED

Target **BP** 120/80 mmHg
Repeat CT before discharge (usually at 48 hours)
Follow-up CT at 1, 6 and 12 months.
Outpatient follow-up at 8 weeks post discharge, unless indicated sooner.

1	**Bisoprolol**	2.5 – 20mg once daily
2	± **Amlodipine**	5 – 10mg once daily
3	± **Doxazosin**	1 – 16mg once daily

HIGH RISK FEATURES OF TYPE B DISSECTIONS !

Visceral / **limb** ischaemia
Entry tear **≥10mm**
Inner curve entry tear
Aortic diameter **≥4cm**
On-going **Pain** or **HTN**
Retrograde dissection
False lumen (FL) **≥22mm**
Partial FL **thrombosis**
Fusiform index ≥0.64
Grow **≥1cm/yr** or **≥5.5cm**