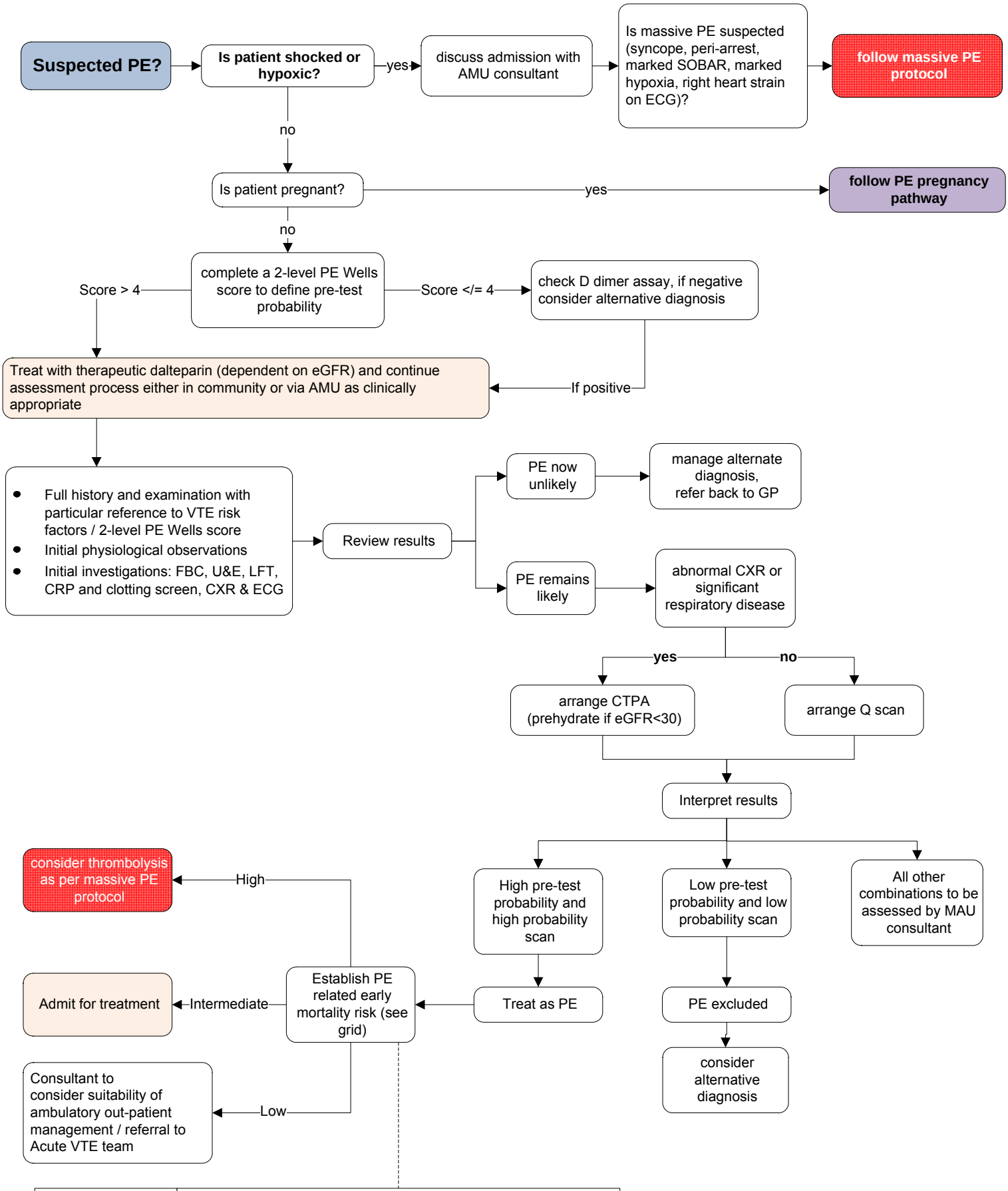


PE-related early Mortality Risk	Risk Markers		
	Clinical (shock or hypotension)	RV dysfunction	Myocardial injury
HIGH >15%	+	(+)*	(+)*
Intermediate 3 – 15%	-	+	+
		+	-
		-	+
Low <1%	-	-	-

*in the presence of shock or hypotension it is not necessary to confirm RV (right ventricle) dysfunction/injury to classify as high risk of PE-related early mortality

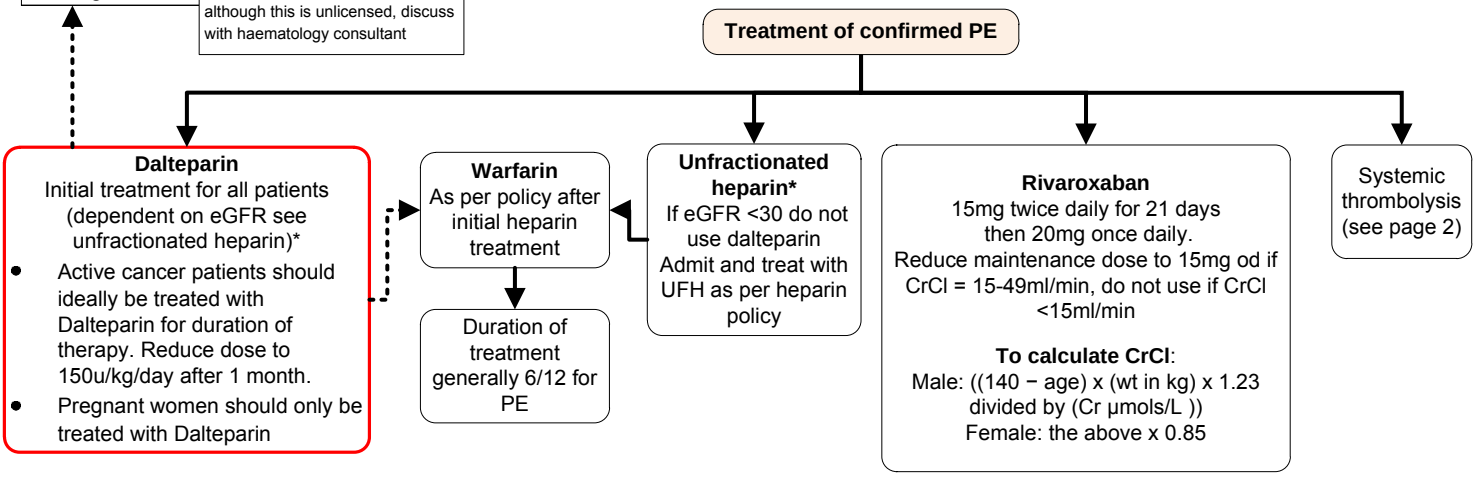
Reference: ESC guidelines 2008

Two-level Wells Score for pulmonary embolism (PE)

Clinical feature	Points
Clinical signs and symptoms of DVT (minimum of leg swelling and pain with palpation of the deep veins)	3
An alternative diagnosis is less likely than PE	3
Heart rate > 100 beats per minute	1.5
Immobilisation for more than 3 days or surgery in the previous 4 weeks	1.5
Previous DVT/PE	1.5
Haemoptysis	1
Malignancy (on treatment, treated in the last 6 months, or palliative)	1
Clinical probability simplified score	
	PE likely more than 4 points
	PE unlikely 4 point or less

Systemic thrombolysis - refer to massive PE protocol

Body weight kg	Dalteparin dose (units)
Under 46	7500 once daily
46 – 56	10000 once daily
57 – 68	12500 once daily
69 – 82	15000 once daily
83 and over	18000 once daily
>110kg	You may wish to give a higher dose although this is unlicensed, discuss with haematology consultant



Follow-up

- Contact anticoagulant team who can advise on ongoing treatment and initiate or direct to GP if the practice concerned self-manages warfarin.
- FBC must be checked Day 4 & Day 7-10 in all patients on unfractionated heparin and in patients with cancer continuing on Dalteparin to look for a fall in platelet count which might herald Heparin induced thrombocytopenia with thrombosis (HITT) – a >50% fall from baseline must be discussed with consultant haematologist.
- Underlying cause for PE must be considered with investigations normally done by GP (e.g. further investigations for cancer in all patients aged over 40 years with a first unprovoked PE who do not have signs or symptoms of cancer such as CXR, USS, abdomino-pelvic CT scan (and a mammogram for women)
- Thrombophilia clinic review for patients with unprovoked or recurrent PE (if appropriate). Do NOT send blood tests for heritable thrombophilia screening whilst the patient has active thrombosis. You may send bloods for investigation of antiphospholipid syndrome screening if warfarin has not been started (anticardiolipin antibodies & lupus anticoagulant).