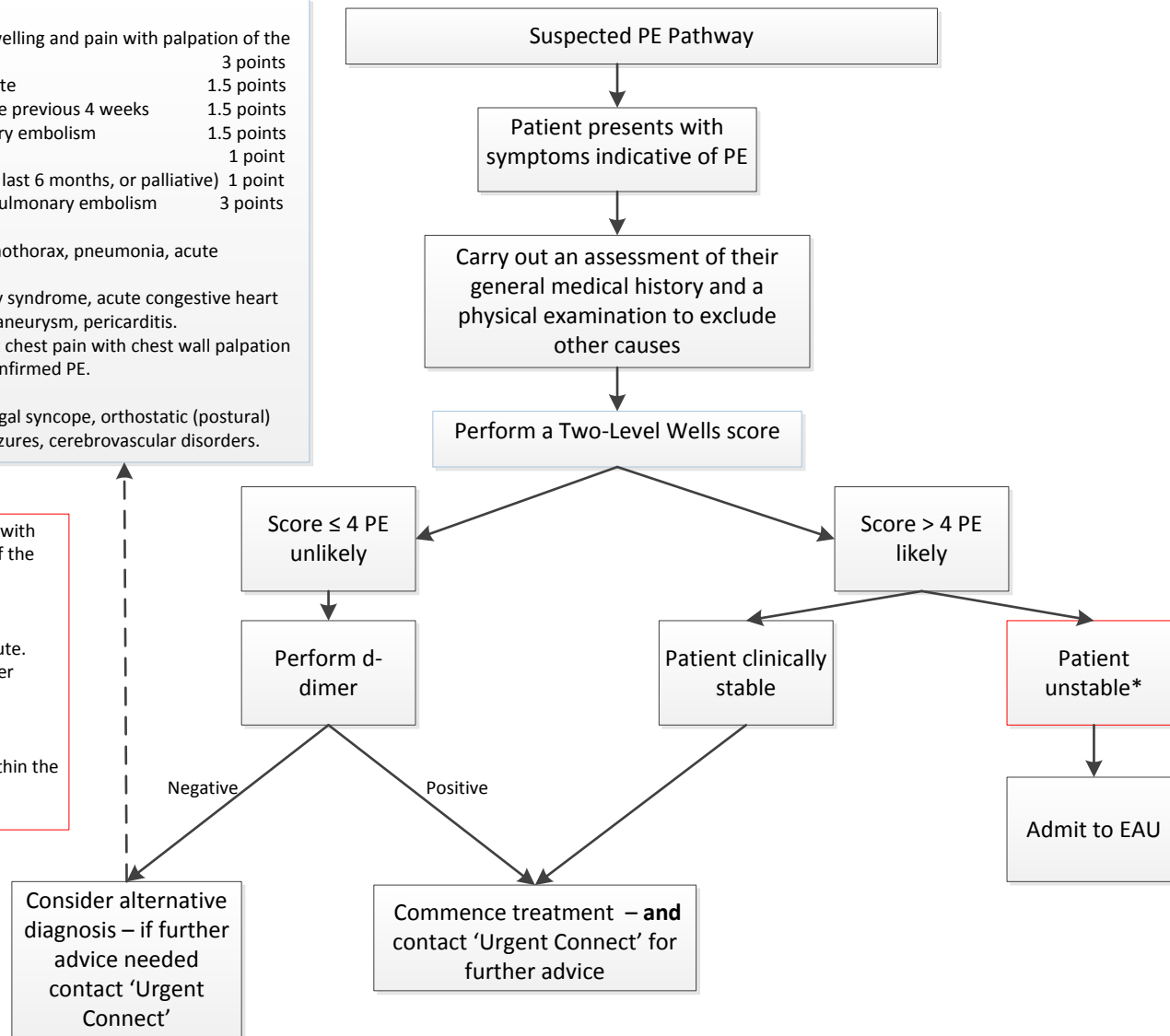


Two-level PE Wells score;
Clinical features of DVT (minimum of leg swelling and pain with palpation of the deep veins) 3 points
Heart rate greater than 100 beats per minute 1.5 points
Immobilization for > 3 days or surgery in the previous 4 weeks 1.5 points
Previous deep vein thrombosis or pulmonary embolism 1.5 points
Haemoptysis 1 point
Cancer (receiving treatment, treated in the last 6 months, or palliative) 1 point
An alternative diagnosis is less likely than pulmonary embolism 3 points

Alternative conditions to consider include:

- Respiratory conditions such as pneumothorax, pneumonia, acute exacerbation of chronic lung disease.
- Cardiac causes such as acute coronary syndrome, acute congestive heart failure, dissecting or rupturing aortic aneurysm, pericarditis.
- Musculoskeletal chest pain. Note that chest pain with chest wall palpation occurs in up to 20% of people with confirmed PE.
- Gastro-oesophageal reflux disease.
- Any cause for collapse such as vasovagal syncope, orthostatic (postural) hypotension, cardiac arrhythmias, seizures, cerebrovascular disorders.

* Arrange immediate admission for people with suspected pulmonary embolism with any of the following features:
Altered level of consciousness.
Systolic BP of less than 90 mmHg.
Heart rate of more than 130 beats per minute.
Respiratory rate of more than 25 breaths per minute.
Oxygen saturation of less than 91%.
Temperature of less than 35°C.
If they are pregnant, or have given birth within the past 6 weeks.



Recommended treatment options for the management of PE

Treatment should generally be continued for 3-6 months as per individual clinical picture

- short term/modifiable risks consider 3 months treatment,
- long term risks consider 6 months treatment.
- If recurrent event consider long term treatment

N.B. If the patient is known to have active cancer on-going Low Molecular Weight Heparin (LMWH) may be the most appropriate option.

Standard Treatment

LMWH (Enoxaparin) 1.5mg/kg by subcutaneous injection every 24 hours until adequate oral anticoagulation is established. **Warfarin 5mg** loading regimen as per local guideline (ORAL ANTICOAGULANT, Vit K antagonist only, MANAGEMENT GUIDELINES) -*hyperlink to guideline to be added once updated*

Or consider use of a novel agent

Apixaban - 10 mg taken orally twice daily for the first 7 days followed by 5 mg taken orally twice daily.

[See SPC for full list of cautions/contra-indications](#)

Dabigatran – 150mg twice daily following treatment with a parenteral anticoagulant for at least 5 days. For special groups see below

[See SPC for full list of cautions/contra-indications](#)

Dabigatran dose should be reduced to 110mg twice a day in the following groups:

- Patients aged 80 years or above
- Patients who receive concomitant verapamil

Dabigatran 110mg twice a day may also be appropriate in the following groups dependent on an individual assessment of the thromboembolic risk and the risk of bleeding:

- Patients between 75-80 years
- Patients with moderate renal impairment
- Patients with gastritis, esophagitis or gastroesophageal reflux
- Other patients at increased risk of bleeding

Edoxaban - 60 mg once daily following treatment with a parenteral anticoagulant for at least 5 days

[See SPC for full list of cautions/contra-indications](#)

Rivaroxaban - 15 mg twice daily for the first three weeks followed by 20 mg once daily for the continued treatment

[See SPC for full list of cautions/contra-indications](#)

Authors: Dr H Chowhan Clinical Lead, NEECCG & Dr Vivien Toh Consultant Haematologist, CHUFT.

Approved by: North East Essex Medicines Management Committee December 2017

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