**Suspected Pulmonary Embolus Pathway for Adults**

**Eligible patients must have:**
- Basic bloods (FBC, U&E, LFT, clotting)
- ECG
- CXR
- Senior decision maker (ST4+) to commence on pathway

**Exclusions to pathway:**
- Age <16 years
- Pregnant (see separate pathway)
- Haemodynamic instability

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**Calculate Well's score for PE (BOX 1)**

<table>
<thead>
<tr>
<th>Signs and symptoms of DVT</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE most likely diagnosis</td>
<td>3</td>
</tr>
<tr>
<td>HR &gt;100 bpm</td>
<td>1.5</td>
</tr>
<tr>
<td>Immobilisation &gt; 3 days, or surgery within the last 4 weeks</td>
<td>1.5</td>
</tr>
<tr>
<td>Previous objectively diagnosed DVT/PE</td>
<td>1.5</td>
</tr>
<tr>
<td>Haemoptysis</td>
<td>1</td>
</tr>
<tr>
<td>Malignancy (treatment within last 6 months or palliative)</td>
<td>1</td>
</tr>
</tbody>
</table>

**TOTAL**

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**BOX 1: Well’s score for PE**

- **0-1.5**
  - Any positive PERC criteria?
    - Age ≥50 yrs
    - HR >110 bpm
    - SpO₂ on air <95%
    - Unilateral leg swelling
    - Haemoptysis
    - Trauma or surgery within previous 4 weeks (requiring general anaesthesia)
    - Previous DVT/PE
    - Oestrogen-containing hormone use
  - No
  - PE excluded, consider alternative diagnosis

- **2-4**
  - Bleed patient and request D-dimer
  - sPESI = 0 (BOX 2)
    - Patients may be transferred to ACC if open prior to result. For patients definitely requiring admission, request MAU bed if not already done so.
  - D-dimer greater than 500 ng/dl or age x 10 (if patient ≥50 years)? e.g. 85 year old = d-dimer cut off of 850 ng/dl
  - Yes
  - Start LMWH 1 mg/kg BD if no contraindication
  - No
  - Suitable for outpatient care
    - ACC referral if patient in ED
    - ACC to request imaging (see BOX 4)
    - Give safety net advice
  - Yes
  - Admit under medical team. Does the patient need escalation to HDU/ICU?

- **4.5+**
  - sPESI ≥ 1 (BOX 2) or other contradiction to discharge (Box 5)
  - Admit under medical team. Does the patient need escalation to HDU/ICU?

**BOX 2: sPESI score**

Not suitable for outpatient care if ANY of the following:
- Tachycardia >110 bpm
- Systolic BP <100 mmHg
- SpO₂ <90%
- Age >80 years
- Chronic lung or heart disease
- Cancer (history or active)
**BOX 3: Anticoagulation**

Patients awaiting imaging should receive anticoagulation while awaiting imaging unless imaging is available immediately or there is a major contraindication to anticoagulation (e.g. active bleeding, inherited or acquired clotting disorder, very low platelet count) – in which case seek expert (consultant) advice.

**Enoxaparin 1mg/kg BD** if no contraindication (altered dosing in renal impairment, pregnancy and extremes of weight - check BNF/discuss with pharmacist).

**Prescribing advice for all anticoagulation**

- See BNF for drug interactions
- If the patient is at risk of bleeding but has a high clinical probability of PE, immediate imaging should be organised (see Box 4) so the risks vs benefits can be weighed, and expert advice sought.

**BOX 4: Imaging**

**Timing:**

- All patients with suspected PE in whom radiological imaging is required after initial assessment should be imaged within 24 hours.
- Stable patients assessed out of normal working hours should be imaged on the first available list the following day. Unstable patients, or high clinical probability cases where there is concern re: anticoagulation, should ideally be imaged within 1 hour.
- Where a patient’s need for imaging is considered urgent, a senior clinician should discuss the case with the radiologist on-call.

**Imaging modality:**

- Age under 50 and no significant co-morbid cardiorespiratory disease with a normal chest radiograph: VQ SPECT scan if available (not out of hours).
- Age over 50 or significant co-morbid cardiorespiratory disease, or abnormal chest radiograph: CTPA.
- Impaired renal function or previous reaction to contrast: discuss with radiologist.

**Box 5: Do not discharge the following groups of patients being treated with anticoagulation for suspected pulmonary embolus**

- Active bleeding or risk of major bleeding
- On full dose anticoagulation at the time of the suspected PE
- Severe pain (requiring IV opioids)
- Other medical comorbidities requiring hospital admission
- Chronic kidney disease (CKD) stage 4 or 5 or severe liver disease
- Heparin induced thrombocytopenia within the last year and where there is no alternative to repeating heparin treatment
- Social reasons which may include inability to return home, inadequate care at home, lack of telephone communication or concern over treatment compliance.