Monash Prac Fellowship Exam June 2016
Guide to Q 23 long answer (PE)
M. Mee

1. First choice of definitive imaging to diagnose/exclude PE, in female , 41 yo (<55), stable patient, with at least moderate risk according to info given:

Would usually be VQ, given lower radiation dose to breast tissue and hence decreased long term risk of breast ca. However this can be site specific.

I still gave points for CTPA if it was well justified, which usually people had trouble doing. Eg might be justified if abnormal CXR or smoking history turns out to be heavy, or if asthma/COPD. Also gave some credit to argument of it being less likely to be indeterminant. Or some informed discussion re spec/sens compared with VQ.

Some interpreted this as first choice of non definitive imaging eg CXR, which I gave points for because the question design was suboptimal post editing. I wanted to assume CXR/ECG already done!

2. Criteria for safe transfer to imaging (CT) for this unstable patient with suspected PE

Any of the following was given a point:

-staff for transfer with details: usually medical with anaesth experience and nursing escort
-haemodynamically stable, with some cut offs for obs/other comment. If each line just had a vital sign limit, I would give up to 2 points total only
-some comment re inotropes dose (eg low dose only?) would be helpful
-able to lie flat for CTPA (eg no NIV)
-no respiratory distress (similar to above)
-patent airway
-equipment with examples
-monitoring with details
-no potentially reversible cause untreated (eg PTx on EFAST/CXR) OK~

I DID NOT like ETT for transfer: this is VERY HIGH RISK procedure in unstable PE, with likely severe deterioration/arrest of patient as a result.

Better to go with next option of imaging for these patients if ongoing instability

3. definitive imaging if ongoing instability despite resus measures:

TTE Bedside: RV dilatation, +/- RV dysfunction

ok to write adjunct DVT US at bedside but not full points

Too many people diluted their answer with things like BNPs, Trops, ddimers and all sorts of extra stuff, may have lost points here for that, and definitely wasting precious time!
ECG plus findings OK but is not definitive

4. Factors influencing decision to thrombolyse PE:

Any of the following OK, but remember to give at least one example or appropriate detail. Thrombolysis more likely if:

-haemodynamic instability ONGOING despite _____ (eg despite low dose inotropes)
-Even if she stabilizes, RV strain on imaging can be factor, controversy.
-No alternate Rx preferred (eg embolectomy, clot retrieval, anticoag without thrombolysis)
-Contraindications not present eg:
*No bleeding diathesis (eg pl) BUT remember, most patients who get thrombolysis GET CONCURRENT heparin so it is not absolute contraindication to be on warfarin!
*Her recent surgery: she is on the cusp of having CI given chole 3 weeks ago! Not many people remembered to mention this
* up to 2 points total for list of appropriate CI
-Input of Resp/Haem unit
-Patient consents
-availability of ICU/HDU post thrombolysis
-adequate staff experience local ED factors with regards to thrombolysis procedure/availability