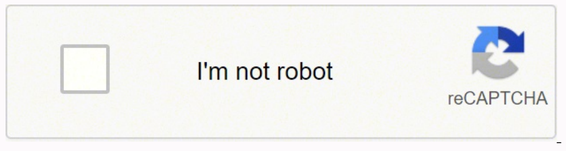

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Management of pulmonary embolism after recent intracranial hemorrhage

A case report

Wei-Chieh Lee, MD[a,b,*], Hsiu-Yu Fang, MD[a]

Abstract

Rationale: Venous thromboembolism may result from prolong immobilization following intracerebral hemorrhage. Massive pulmonary embolism with associated right heart failure is life-threatening, requiring treatment with anticoagulants or even thrombolytic agents. However, these drugs are contraindicated after a recent hemorrhagic episode, as they may induce further hemorrhage. There are no guidelines for treatment in these circumstances.

Patient concerns: A 57-year-old man experienced massive pulmonary embolism and shock 18 days after an intracerebral hemorrhage.

Diagnoses: Tachycardia and high D-dimer (21.27 mg/L fibrinogen-equivalent units) were noted. Chest computed tomography showed bilateral pulmonary trunk embolism.

Interventions: Heparinization were used and activated partial thromboplastin time therapeutic range was 50 to 70 seconds. Fortunately, shock status and shortness of breath improved two days later. Continuing high dose Rivaroxaban was administrated for three weeks.

Outcomes: There was no recurrent intracranial hemorrhage (ICH) following treatment for three-weeks with high-dose and one-year with standard dose of rivaroxaban. This report presents a treatment option in the management of these difficult clinical situations.

Lessons: The combination of unfractionated heparin infusion and continuing non-Vitamin K antagonist oral anticoagulants use could manage life-threatening pulmonary embolism following recent ICH. Theoretically, the use of NOAC is a safer strategy if the patient with previous history of major ICH.

Abbreviations: CT = computed tomography, DVT = deep vein thrombosis, ICH = intracranial hemorrhage, IVC = inferior vena cava, LV = left ventricle, NOAC = non-Vitamin K antagonist oral anticoagulant, PE = pulmonary embolism, RV = right ventricle, UFH = unfractionated heparin, VTE = venous thromboembolism.

Keywords: critical care, intracranial hemorrhage, non-Vitamin K antagonist oral anticoagulants, pulmonary embolism

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HYF has also equal contributon as correspondence author.

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Disclosures: None.

Human rights statements and informed consent: All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1964 and later revisions. The patient and her family agree to publish this case report.

All authors declare that they have no conflict of interest.

[a]Division of Cardiology, Department of Internal Medicine, [b]Division of Cardiology, Cardiac Care Unit, Kaohsiung Chang Gung Memorial Hospital, Chang Gung University College of Medicine, Kaohsiung, Taiwan, Republic of China.

[*]Correspondence: Wei-Chieh Lee, Division of Cardiology, Department of Internal Medicine, Kaohsiung Chang Gung Memorial Hospital, 123, Ta-Pei Road, Niao Sung District, Kaohsiung City, 83301, Taiwan, Republic of China (e-mail: leeweichieh@yahoo.com.tw).

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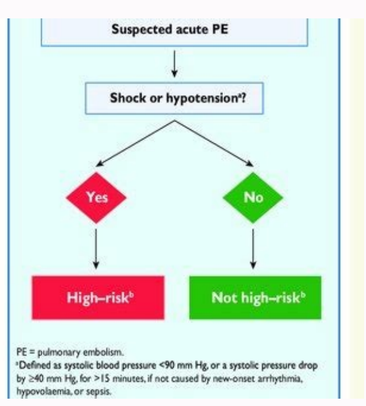
1. Introduction

A treatment dilemma exists in patients who experience life-threatening venous thromboembolism (VTE) following recent severe brain injury. Clinicians must decide which anticoagulants to use in patients who have had a recent cerebral hemorrhage. We report a case of severe pulmonary embolism with right heart failure and shock following recent intracranial hemorrhage without surgical intervention. A strategy of unfractionated heparin infusion and non-Vitamin K antagonist oral anticoagulants (NOAC) was used with good outcome, and did not result in secondary hemorrhagic events, or recurrent thromboembolism. All studies using NOAC for VTE and stroke prevention in patients with atrial fibrillation, showed a lower incidence of intracranial hemorrhage (ICH), than with heparin and warfarin.[1] Therefore, it is reasonable and safe to use NOAC to treat VTE in patients who have had a hemorrhagic episode recently.

2. Case presentation

A 57-year-old man experienced sudden onset of shortness of breath for several hours, requiring emergency intubation for impending respiratory failure with low oxygen saturation. Tachycardia and high D-dimer (21.27 mg/L fibrinogen-equivalent units) were noted. Electrocardiography showed new



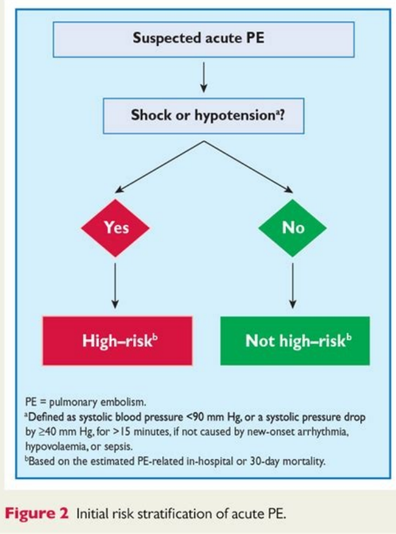


Figure 2 Initial risk stratification of acute PE.

Classes of recommendations	Definition	Suggested wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended/is indicated
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
Class IIa	*Weight of evidence/opinion is in favour of usefulness/efficacy.*	Should be considered
Class IIb	*Usefulness/efficacy is less well established by evidence/opinion.*	May be considered
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended

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Task Force Report

Guidelines on diagnosis and management of acute pulmonary embolism[1]

Task Force on Pulmonary Embolism, European Society of Cardiology[2]:
Core Writing Group: A. Torbicki (*Chairman*), E. J. R. van Beek (*Editor*), B. Charbonnier, G. Meyer, M. Morpurgo, A. Palla and A. Perrier
Members: N. Galie, G. Gorge, C. Herold, S. Husted, V. Jezek, W. Kasper, M. Kneussl, A. H. Morice, D. Musset, M. M. Samama, G. Simonneau, H. Sors, M. de Swiet and M. Turina
Internal reviewers: G. Kronik, J. Widimsky

Preamble

Presented Guidelines were prepared by the ESC Task Force on Pulmonary Embolism, as suggested by the nucleus of the Working Group on Pulmonary Circulation and Right Ventricular Function and approved by the ESC Board at its meeting on 17 June 1997 upon the recommendation of the Committee for Scientific and Clinical Initiatives.

This Task Force consists of 21 Members, including representatives of the European Respiratory Society, the European Association of Radiology, and an advisory Body consisting of two Internal Reviewers. The Members were appointed by the Board of the ESC upon suggestions from the Working Group and from the Boards of Scientific Societies, invited to contribute to the development of the guidelines on pulmonary embolism. The Chairman and seven of the Members of the Task Force formed a Core Writing Group (CWG), which included an Editor, responsible for preparation of the final document. The Task Force Members met in September 1998 in Vienna and the Core Writing Group in May 1999 in Warsaw and in January 2000 in Paris. In addition, controversial issues were presented and discussed with the Pulmonary Circulation Group of the European Respiratory Society during an open Workshop organized at the ERS annual Congress in Geneva, in September 1998.

Review of the literature and position papers were prepared by the Members according to their area of expertise. Their contributions were then posted on the Task Force WebBoard and submitted to discussion over the internet. A second phase consisted of preparation and editing of the consecutive versions of the Guidelines by the CWG, as discussed at the two consecutive meetings as well as over the internet. At the request of the Committee for Scientific and Clinical Initiatives, the Task Force Chairman reported to the Congress of the ESC in August 1999, indicating key points of the emerging guidelines.

Finally, the document was distributed for correction and endorsement to all Members and independently reviewed for consistency by Internal Reviewers. Effort was made to include all relevant evidence relating to the

Correspondence: A. Torbicki, Department of Chest Medicine, Institute of Tuberculosis and Lung Diseases, Warsawa, Poland.

[1]This document has been reviewed by members of the Committee for Scientific and Clinical Initiatives and by members of the Board of the European Society of Cardiology (see Appendix 1), who approved the document on 14 April 2000. The full text of this document is available on the website of the European Society of Cardiology in the section 'Scientific Information', Guidelines.

[2]For affiliations of Task Force Members see Appendix 2.

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Pulmonary embolism management guidelines sri lanka. Guidelines on the diagnosis and management of acute pulmonary embolism. Management of massive pulmonary embolism guidelines. Management of pulmonary embolism nice guidelines. Bts guidelines for the outpatient management of pulmonary embolism. 2014 esc guidelines on the diagnosis and management of acute pulmonary embolism. 2019 esc guidelines for the diagnosis and management of acute pulmonary embolism. Pulmonary embolism management guidelines pdf.

Comerota AJ, Throm RC, Mathias SD, Haughton S, Mewissen M. Hoeper Mm, Mayer E, Simonneau G, Rubin LJ. Subbiah R, Aggarwal V, Zhao H, Kolluri R, Chatterjee S, Bashir R. Table 2: absolute and relative contraindications to catheter-directed thrombolysis absolute contraindications active bleeding disorders recent CVA or TIA recent neurosurgery recent intracranial trauma absolute contraindication to anticoagulation relative contraindications recent recent abdominal, ophthalmic or obstetric cardiopulmonary resuscitation. Recent trauma (other than intracranial) Known intracranial tumor or vascular anomaly Uncontrolled hypertension: Systolic BP> 180 mm Hg, Diastolic BP> 110 mm Hg Recent known gastrointestinal bleeding Severe allergic or adverse reaction to thrombolytics Agent or contrast media (not controlled by steroid/antihistamine therapy) Known severe thrombocytopenia to right-to-left cardiac or pulmonary shunt or other condition that precludes ability to tolerate the procedure Suspected intracardiac thrombus suspected with Ridney Disease Act Infected suspects. IVE Severe pregnancy Severe liver disease Recent active infection = 0.9 Ventricular septal doubling from right to left Presence of enlargement of the right ventricle Ec Dilation of the right ventricle and hypokinesia Right ventricle diameter / Left ventricle diameter >0.9 Interventricular septal flattening and paradoxical left septal movement Presence of TR Presence of PH (maximum speed) trichospid jet greater than 2.6 m/s and loss of respirophysic hypokinesia of the free wall of the right ventricle) of; RV = right ventricle; LV = left ventricle TR = tricuspid regurgitation; HP = pulmonary hypertension; IVC = inferior vena cava Figure 1: Cumulative risk of death in acute PE Discontinuous line= hemodynamically stable. Ultrasound breaks down fibrin fibers in a reversible way. Venous claudication in iliofemoral thrombosis: long-term effects on venous hemodynamics, clinical status and quality of life. Zhonghua Yi Xue Za Zhi 2012;92:1343-5. Results after the use of the vena cava filter in non-cancerous patients with acute venous thromboembolism: a study Intern Emerg Med 2008;3:131-8. Eur J Vasc Endovasc Surg 2009;38:118-24. Venous Venous For iliofemoral vein thrombosis, the results of 10 years of a prospective randomized study. J am Coll Cardiol 2014; 63. J Vasc Grav Radiol 2011; 22: 330-5. Kaufman Ja, Rundback JH, Kee St, et al. Risk stratification ³ results in hemodinÃ mically stable patients with acute pulmonary embolism: a prospective, multi-metric cohort study with three months follow-up. Three key considerations must be factored into the decision ³ proceed with an endovascular approach: 1) Severity of disease and acuity; 2) probability of a major adverse bleeding event; and 3) specific patient considerations. The need for definitive evidence related to the use of IVCF in some of these circumstances has been recognized for a long time, although randomized control data continue to be missing.58 TrombectomÃa mecÃ ÃÃÃÃÃÃ o³ absolute contraindication to the thrombÃÃ ³ lysis. Neglanda P, Hollis KC, Olivier J, Raju S. Pengo V, Lensing Aw, Prins MH, et al. Kasirajan K, Gray B, Ouriel K. Unfractionated heparin should be used to maintain a clotting time ³ n> 250 seconds. A prospective cohort study in 1,626 patients. Improvements in pulmonary artery ³ and right ventricular n³t function after ultrasound-accelerated catÃ©-directed thrombolysis for the treatment of pulmonary embolism. 2014 ESC Guidelines on the diagnosis³ diagnosis and management³ n of acute pulmonary embolism. Hypertension³ n pulmonary thromboember³ lica crÃ ³ nica. JAMA INTERN MED 2014; 174: 1494-501. Troponin I and right ventricular dysfunction for risk assessment ³ patients with non-gastric pulmonary embolism in the emergency department in combination ³ a risk score based solely on the risk. Follow-up of eight patients with ,aj ,aj notsimro ,wp syurreS .odazirotaela oidutsE)aveuC raP eriodomluP eilobmE'd uD noitneverP(odaimerp oidutse le :ranomlup ailobme al ed n³Äicneverp al ne avac anev ed setnenamrep And, et al. The results of future directions for CDT are likely to improve with technological advances ³ endovascular therapies and, as the more³clinical improvements improve patient selection, careful risk assessment ³ standardization of peri³tic and post-processing monitoring³ n. Meissner MH, CAPS MT, Bergelin RO, MANZO RA, STRAKNESS DE. Deep vein thrombosis iliofemoral: aggressive therapy with thrombolysis directed by catÃ©. J Vasc Surg 1993; 18: 596-605. ClinicalTrials.gov: National Library of Medicine (USA) 2000 - 2016, 2016. Compression measures ³ prevent post-thromb syndromeÃ ³: a randomized placebo-controlled trial. An interventionist approach to managing both acute le-iliofemoral DVT and massive underwater PE holds great promise. This technique is rarely used as an independent procedure and carries a significant risk of distal and proximal embolization³ The postromb syndrome ³: prevention³ diagnosisÃ ³ and evidence-based treatment strategies: a scientific statement ³ the American Association ³ the Heart³ n. J Thromb Haemost 2009; 7: 938-44. CatÃ© Cardiovasc Inter 2010; 76: 316-25. Guidance ³ use of thromboembolic therapy for the treatment of venous thromboembolism. Systemic thrombosis ³ associated with lower all-cause mortality in patients with mass ³ education and should be the treatment of choice in this subset of patients.31,39 Current US social guidelines U.S. And Europe recommends endovascular treatment strategies in case of treatment failure in this subset. 32,40,41 An approach of the pulmonary embolism response team (PERT), so a multidisciplinary team determines the course of action ³ optimal ³ patients with chronic diseases with massive PE, 42 should be considered when oxygenation ³ dadilaicepse dadilaicepse ed ogseir le etnemavitacifingis atnemua orep ,dadilatrom ed oicifeneb nu noc adaicosa ¡Âtse acim©Âtsis sisil³Âbmort al ed osu le ,ovitatsujambus EP ne 44,34.adiv ed orroha ed savitanretla res edeup acigrºÂriuq ranomlup otneimanoiccelobme al o / y)OMCE(anarbmem al ed including intracranial hemorrhage39,45 For this subgroup of patients, the PCCA guidelines currently recommend systemic thrombotic therapy when cardiopulmonary deterioration is evident but hypotension has not occurred³ no overt. Deep venous insufficiency: the relationship ³ lysis and posterior reflux. Engelberger RP, Kucher N. Kuo WT, Banerjee A, Kim PS, et al. Vedantham S, Piazza G, Sista AK, Goldenberg NA. J Thromb Haemost 2011;9:2397-405. N English J Med 2014;370:1402-11. J Vasc Surg 2002;35:694-700. W M. Kline JA, Steuerwald MT, Marchick MR., HernÃndez-Nino J, Rose GA. J Thromb Haemost 2005;3:939-42. Patients with demonstrated acute PE should be immediately anticoagulated with intravenous unfractionated heparin with a bolus of 80 units per kilogram followed by infusionÃ ³ n. N English J Med 2011;364:1677-8. The ACC/AHA guidelines suggest that embolectom with catÃ© can be considered when evidence of cardiopulmonary deterioration or submassive PE is seen when patients have unique evidence of adverse prognosis³. The International Cooperative Pulmonary Embolism Registry (ICOPER) demonstrated mortality rates at 90 days of 58.3% in patients with massive PE versus 15.1% in patients with submassive PE.20 Several studies demonstrate short-term mortality rates of less than 2% in patients with low-risk PE.21-23 The characteristics suggesting an adverse prognosis ³ acute PE are listed in Table 2. RadiologÃa 1999;211;39-49 It is necessary to obtain a standard right scar catheterization with simultaneous mixed saturation ³ venous and systemic oxygen. Chatterjee S, Chakraborty A, Weinberg I, et al. Health-related quality of life after catÃ©-directed thrombolysis for deep vein thrombosis: secondary results from the randomized, non-blind, parallel-group CaVenT study. Follow-up echocardiography should be performed to confirm the best size and function of the VD Trombosis of the lower cava vena. Derivation and validation of a prognostic model of pulmonary embolism. This strategy has been been In the Ultima (ultrasound-assisted, catÃ©-directed thrombolysis for acute intermediate-risk pulmonary embolism) trial, 33 that demonstrated superiority to anticoagulation ³ only to improve hemodinÃ mica without a significant increase in bleeding complications. J Vasc Grav Radiol 2013; 24: 17-24. J Vasc, Radiol 2006; 17: 1043-9. None of the patients have an intracranial bleed, while one patient suffered a ³ major bleeding complication. Quality improvement guidelines for the performance of the placement ³ inferior vena cava filter for the prevention ³ pulmonary embolism. Conclusions VTE is increasingly recognized as a cause of significant morbidity and mortality in the United States. Paclitaxel balloon coating, a novel method for the prevention³ and therapy of restenosis. Scheller B, Speck u, Abramjuk C, Bernhardt U, Bohm M, Nickenig G. Determinants of the early and long-term efficacy of catÃ©Ã³ter-directed thrombosis in proximal deep vein thrombosis. BMJ open 2013; 3: E002984. For access to sick vasculature, we recommend the following approach recommended by the AHA/ACC guidelines.32 Get access through a 6F femoral venous sheath and advance a 6F angle pigtail catÃ© on each main pulmonary artery. Quality improvement guidelines for the treatment of deep vein thrombosis of the lower limb with the use of ³ endovascular thrombus elimination. Aklog L, Williams CS, Byrne JG, Goldhaber SZ. CatÃ©³directed thrombosis lysis for iliofemoral deep vein thrombosis improves health-related quality of life. Moderate pulmonary embolism treated with thrombÃ ³ lysis (from the "MOPETT" judgment). J Vasc Grav Radiol 2006; 17: 1099-104. Circulation ³ 2014; 130: 829-36. ³ late diagnosis and evolution ³ hemodinÃ nÃ nÃ mÃ nÃ mÎnÃ nÃ nÃ nÃ nÃ nÃ nÃ nÃ nÃ nÃ m y respiratory data. Haig Y, Ende T, Slagsvold Sandvik L, Sandset PM, Klow NE. Guanella R, Ducruet T, Johri M, et al. Currently, the benefit of using IVCF appears to be in reducing the risk of acute PE in patients who have a clear anticoagulation in the form of active bleeding.54,55 In the absence of such a contraindication, there does not seem to be a clear benefit and non-recovery of IVCF exposes the patient to the risk of recurrent VTE, PTSD and other mechanical complications such as filter fracture or migration56,54,19. High-quality evidence is lacking32,38,57,58 Notable examples of these disparate recommendations include free floating proximal DVT, acute PE in the presence of pre-existing IVF, non-compliance with medication, and the use of IVF as prophylaxis of VTE in the context of immobility, trauma, or major surgery. Comparative results of catheter-directed thrombolysis plus anticoagulation vs. anticoagulation alone to treat proximal deep vein thrombosis of the lower extremity. J Vasc Interv Radiol 2014;25:1317-25. Patient-specific considerations Patient preference should be fundamental in determining whether an endovascular treatment approach is appropriate. Incidence of chronic thromboembolic pulmonary hypertension after pulmonary embolism. Lancet 1997;349:759-62. The only exception are patients who have a large saddle plunger without adverse hemodynamics or right ventricular effects. In addition, this device can be used to forcefully infuse (Â"power pulseÂ") a thrombolytic agent such as r-tPA instead of saline solution, which is likely to improve thrombolytic efficacy. In J Med 2014;127:829-39. Thrombolysis for pulmonary embolism and risk of all-cause mortality, major hemorrhage and intracranial hemorrhage: a meta-analysis. McLafferty RB. Clinical Topics: Anticoagulation Management, Arrhythmias and Clinical EP, Cardiac Surgery, Cardiovascular Care Team, Dyslipidemia, Cardiovascular Failure and Cardiomyopathies, Angiography and Cardiovascular Intervention Invasive, Non-Invasive Imaging, Prevention, Hypertension and venous, venous thromboembolism, Medicine, Implantable Devices, Basic Science EP, SCD/Ventricular Arrhythmias, Atrial Fibrillation/Supraventricular Arrhythmias, CirugÃa AÃ ³ rtica, Cardiac Surgery and Arrhythmias, Cardiac Surgery and Heart Failure, Lupus Metabolism, New Agents, Statins, Acute Heart Failure Heart Failure and Cardiac Biomarkers, Pulmonary Hypertension, Interventions ³ and ImI Genes, Interventions and Structural Heart Disease, Interventions and Vascular Medicine, EcocardiografÃa/Ultrasonido, HypertensiÃ ³ n Keywords: Acute Renal Lesion³ Adenosine, Aminophylline, Globe Angioplasty, Anticoagulants, Antithrombins, Aspirin, Bed Rest, Biomarkers, Antithrombins, Platelets, Arterial Pressure³ Bradycardia, Brain, Band Blockage, Cardiac ³, Cardiopulmonary Resuscitation, Cause of Death, CrCare Disease, Dilation³ Management Systems³ Medication Products, Labeling of Medicines, Dyspnea, EchocardiografÃa, ElectrocardiografÃ a, EmbolectomÃ a, OxigenaciÃ n of ExtracorpÃ rea Membrane, Factor Xa, Vena Femoral, Fibrina, FibrinÃÃ gen, FibrinÃÃ lisis, FibrinolÃticos Agents, Follow-Up Studies, Goals, Heart Failure, Cardiac Venture, HemodinÃÃÃ mica, Hemoglobins, Hemostasis, Heparina Low Molecular Weight, Hyrudin, Hispanic American, Histamine Antagonists, Hospital Mortality, Hypersensitivity, Hypertension, Hypertension, Pulmonary, Hypertrophy, Hypertrophy, Ventricular Right, Hypotension, Hypotension, Hypotension, Hypertension, Inflammation, Informed Consent, Intensive Care Units, Intracranial Hemorrhages, Ischemic Attack, Transient, Life Expectancy, Hemorrhage Drug Adherence, Natriuretic Peptide, Brain, Neoplasms, Neurosurgery, Obstetrician Procedures, OxUgen, Partial Thromboplastin Time, Patient Preference, Patient Selection, Patient Fragments, Pharmaceutical Preparations, Patient's Count Pregnancy, Natriuretic Peptide, Brain, Natriuretic Peptides, Prognostic, Prospective Studies, Pulmonary Artery, Pregnancy Punctures, Quality of Life, Records, Records, Insufficiency, Chronicle, Risk Evaluation, Risk Factors, Rotation, Media, Compression, Stroke, Survivors, Tachycardia, Breast, Thrombelby, Thrombocytopenia, Thromble Therapy, Thrombosis, Ticlopidine, Tissue Plasminogen Activator, Tomography, Treatment Failure, Insufficiency of the valve TricÃºSpide, troponin, vena filters cava, vena cava, lower, venous thrombosis, ventricular dysfunction, right

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