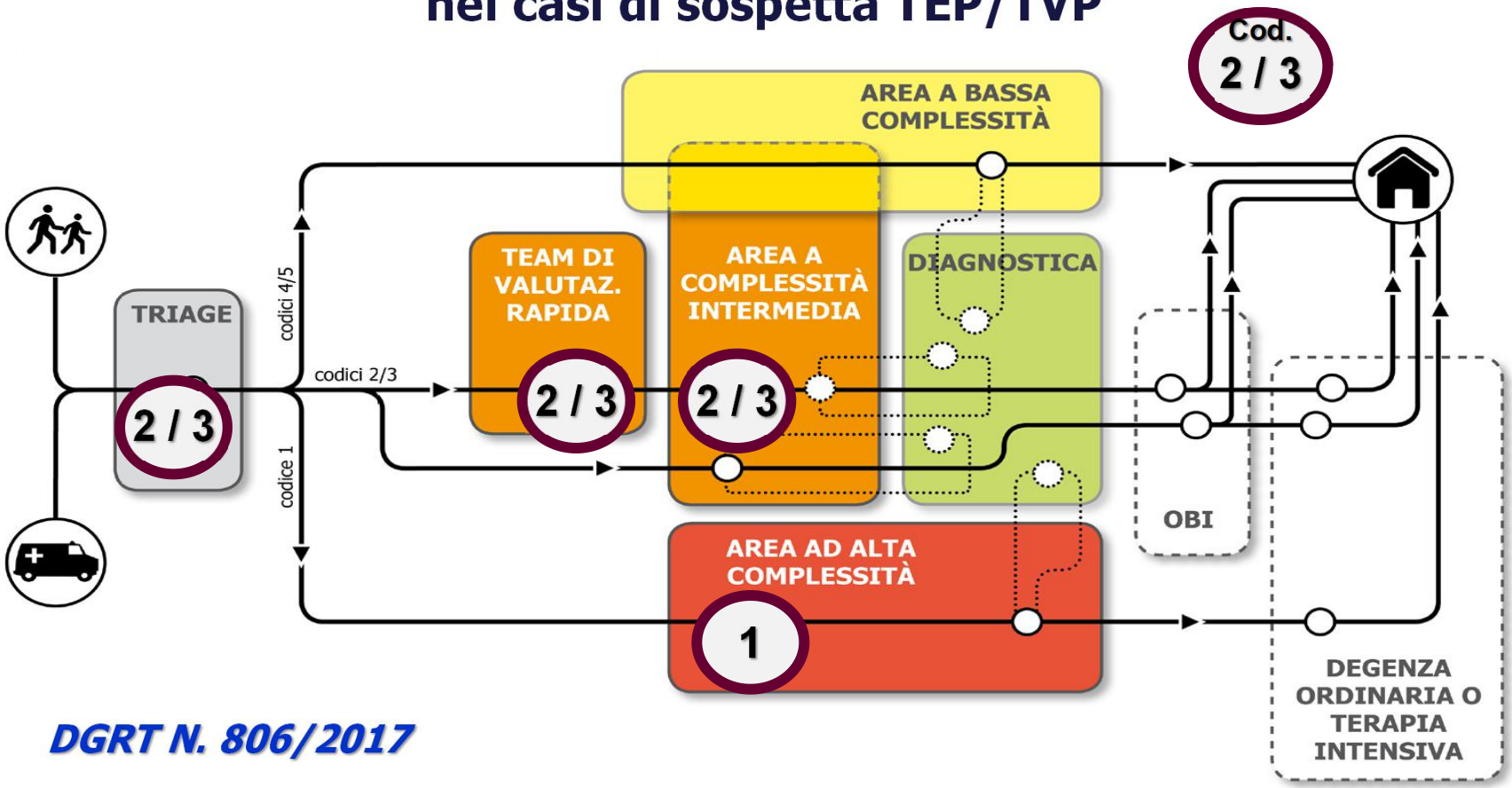
La Dimissione Del Paziente Con Embolia Polmonare dal PS: *Chimera o Realtà?*

Giuseppe Pepe, MD, PhD

Dipartimento Emergenza Urgenza e Terapie Intensive
UOC Medicina d'Urgenza e Pronto Soccorso
Ospedale Unico Versilia
Azienda USL Toscana Nord Ovest

XI congresso nazionale simeu
ROMA 24-26 MAGGIO 2018

La *NOVITA'* LOGISTICA dei percorsi di diagnosi e stratificazione nei casi di sospetta TEP/TVP



DGRT N. 806/2017

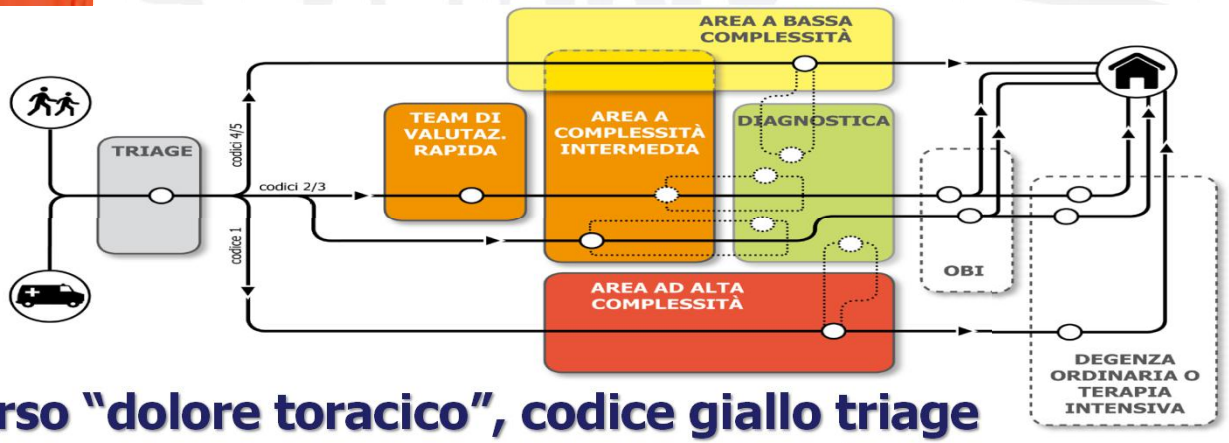
Un caso clinico

F.L. - Maschio 56 anni

Accesso in PS per dolore toracico da circa 6 ore

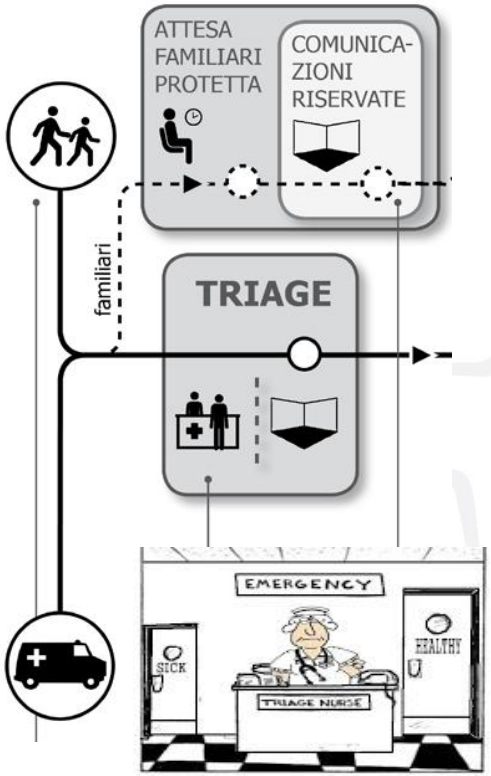
Il dolore è continuo, in peggioramento, che si esacerba con gli atti del respiro

Non c'è febbre né tosse



Percorso "dolore toracico", codice giallo triage

Un caso clinico



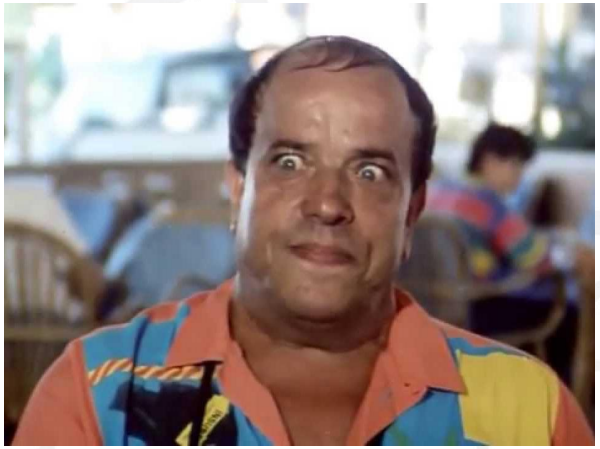
Pressione arteriosa: 135/90 mmHg

Frequenza cardiaca: 80 bpm

SatO2 97% in aa

TC 36.5

Un caso clinico

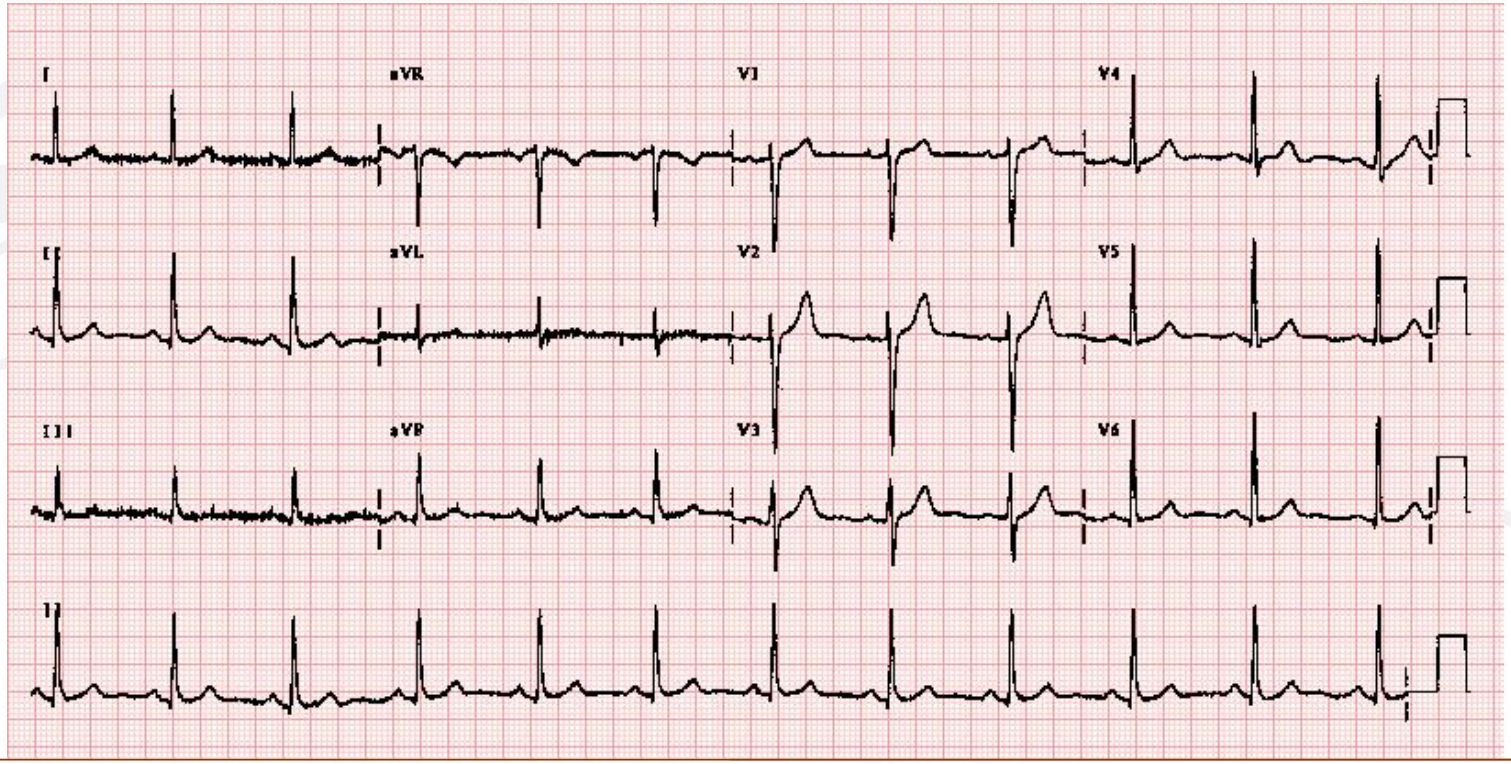


Anamnesi patologica:

Diabete mellito, ipertensione arteriosa in terapia discontinua
No allergie

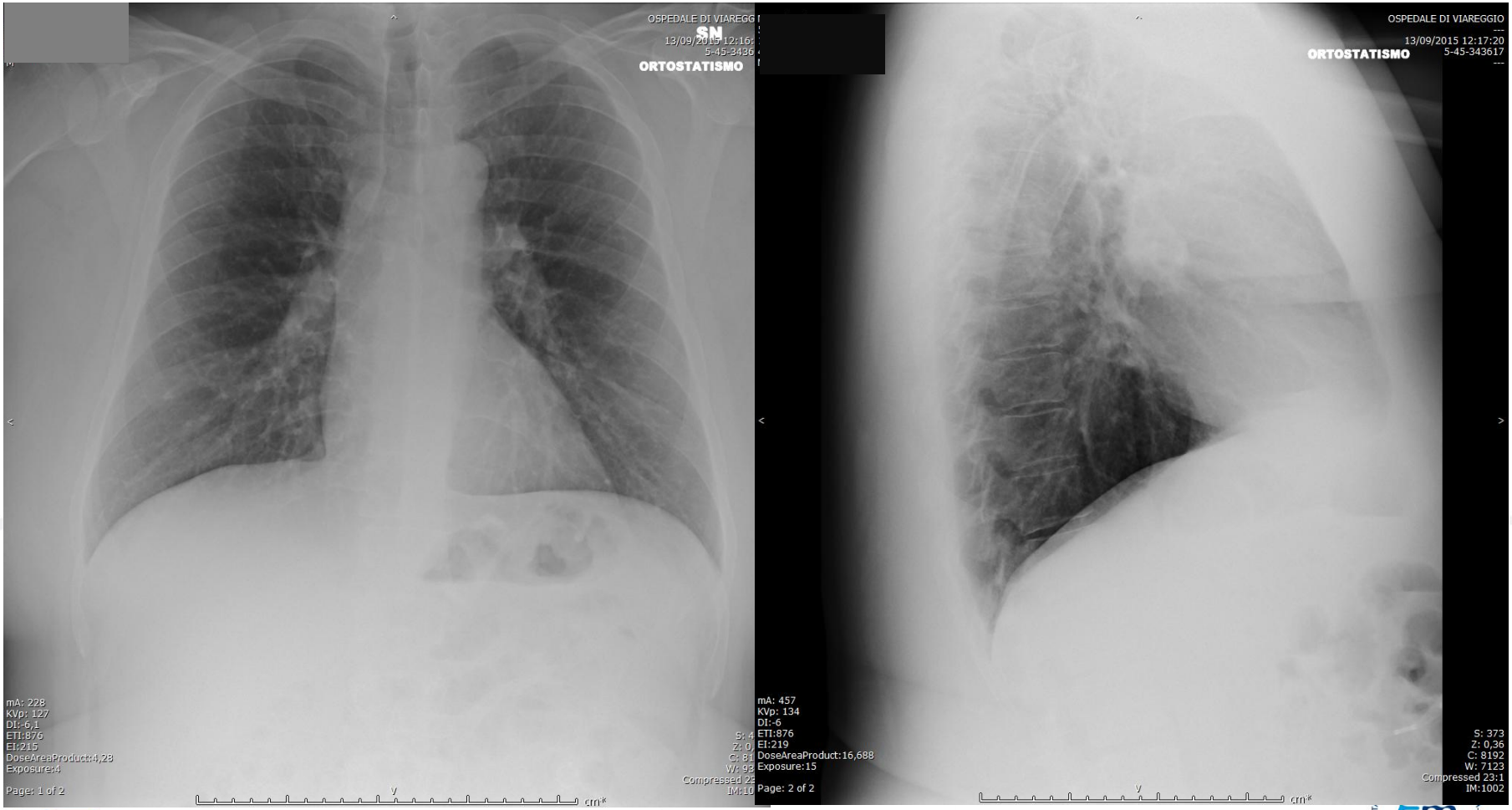
TD: metformina 1000 x 3, ASA 100 mg, altro non ricorda

ECG (AVR)



LAB: Troponina 4.6 pg/ml (0-14)

RX torace (2 pr.)



Un caso clinico

SCA non ancora esclusa, il paziente deve rimanere in PS per *proseguire "le troponine"*

Intanto si pensa alla diagnosi alternativa

Lab (1)

Glicemia 110

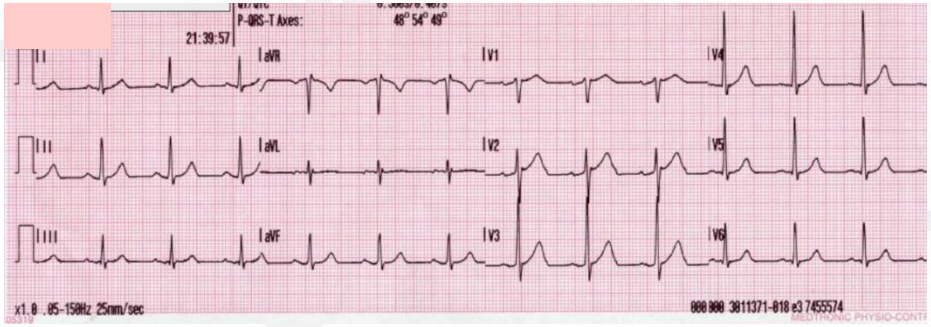
GB 9.01
GR 5.90
Hb 15.8
HTC 48
PTL 190.000

Creatinina 0.74
GOT 21 (0-45)
GPT 23 (0-45)

Rivalutazione a 3 ore

Il paziente è stabile

Il dolore è ancora presente, immodificato



LAB (2°): Troponina 3.9 pg/ml (0-14)

→ Paracetamolo 1 gr per os

Rivalutazione a 3 ore

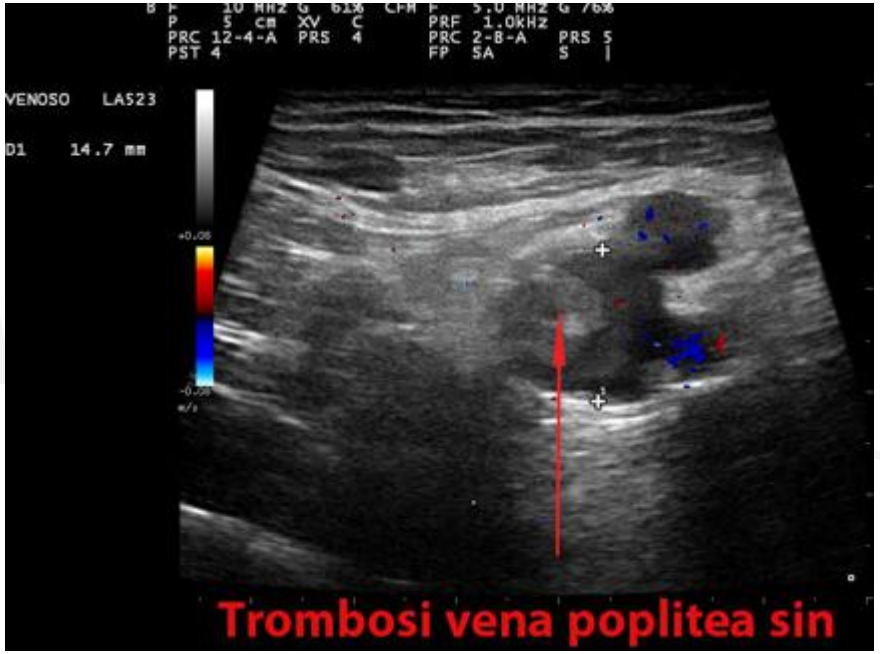
EGA
pH 7.465
pO2 75
pCO2 37
satO2 96%

Lattati: 0.5

D-dimero: 1980 (<250)

PCR 1.3

CUS arti inferiori

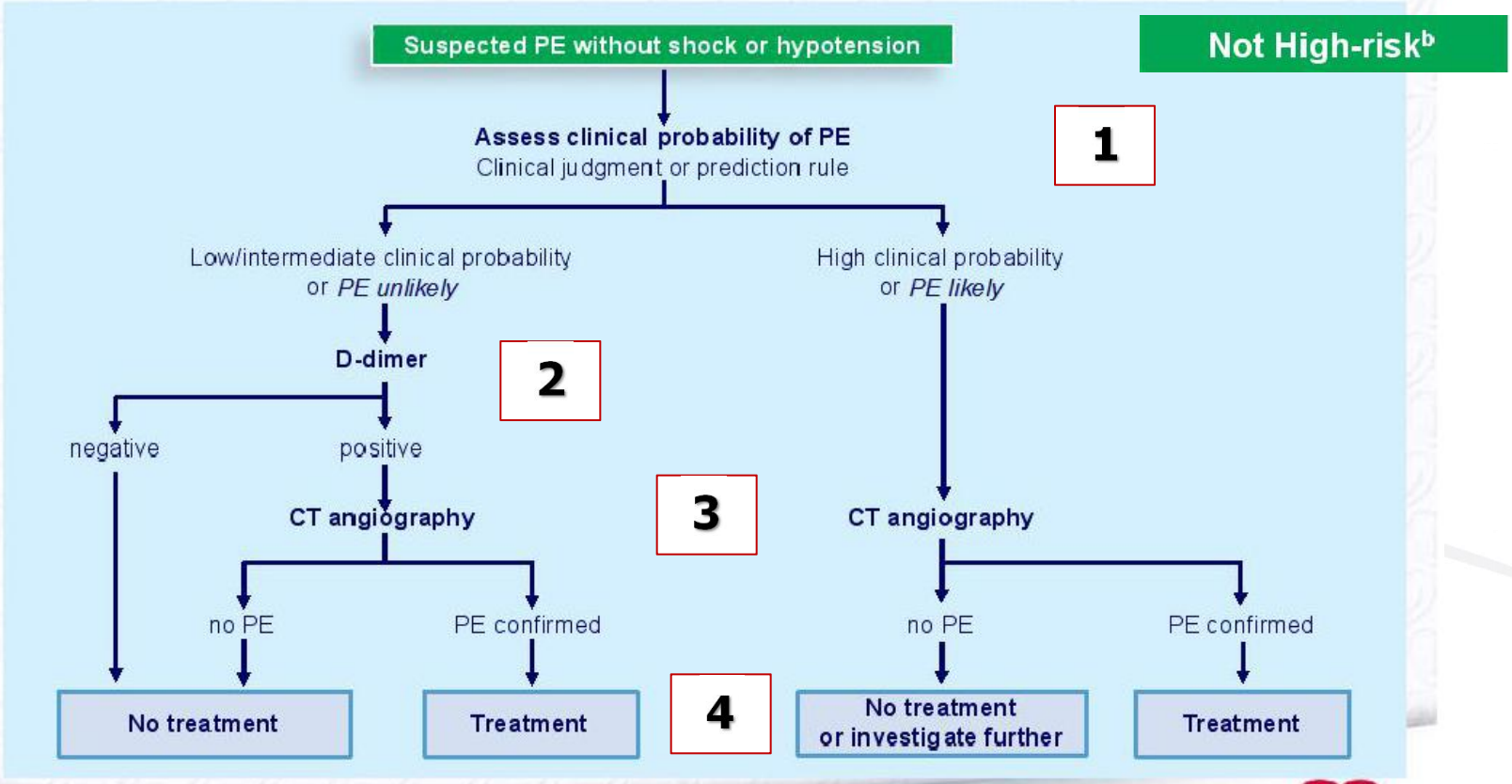


Un caso clinico

E’ fatta diagnosi “clinica” di **embolia polmonare**

Si somministra prima dose di **EBPM** (dosaggio terapeutico)

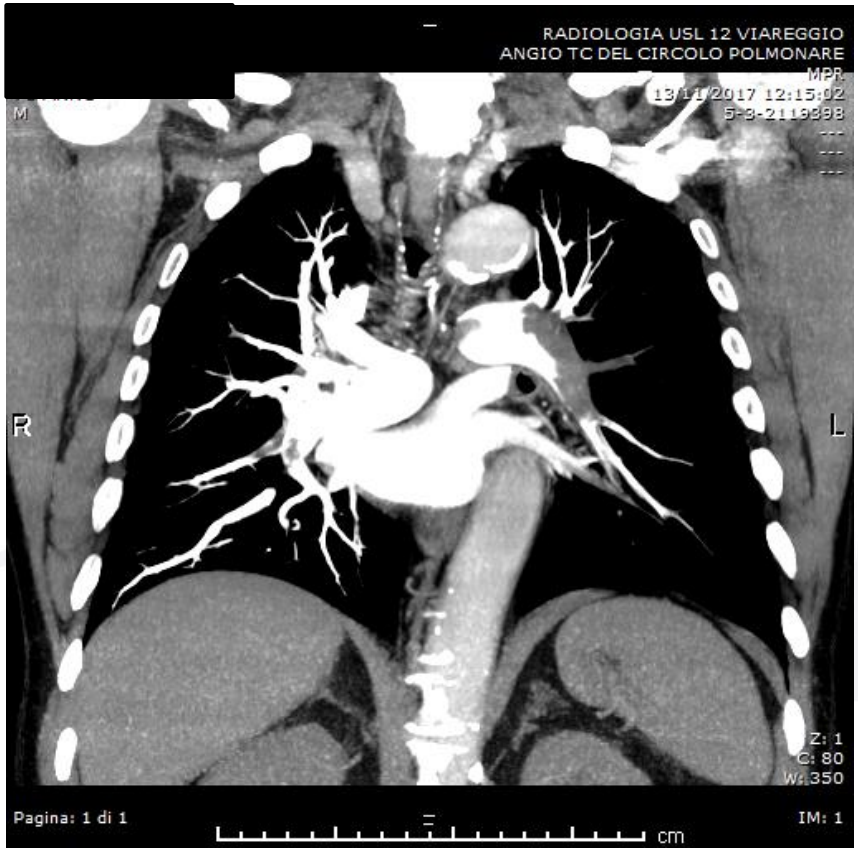
Diagnostic algorithm: not high-risk PE

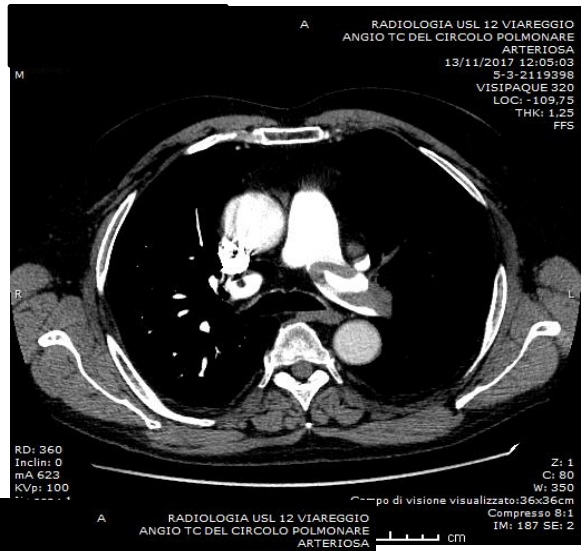


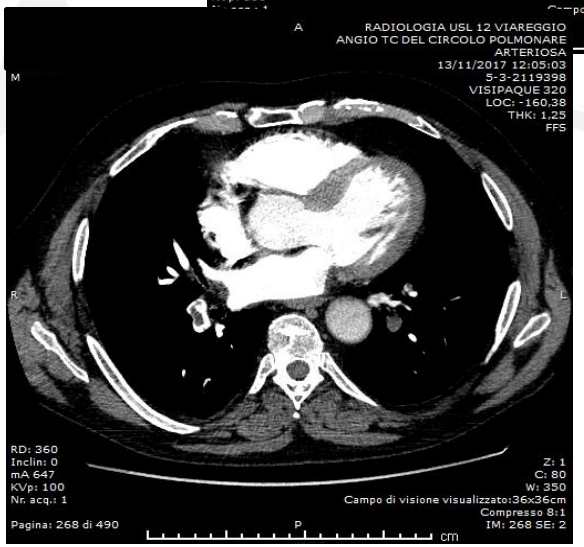
www.escardio.org/guidelines

European Heart Journal (2014):doi:10.1093/eurheartj/ehu283

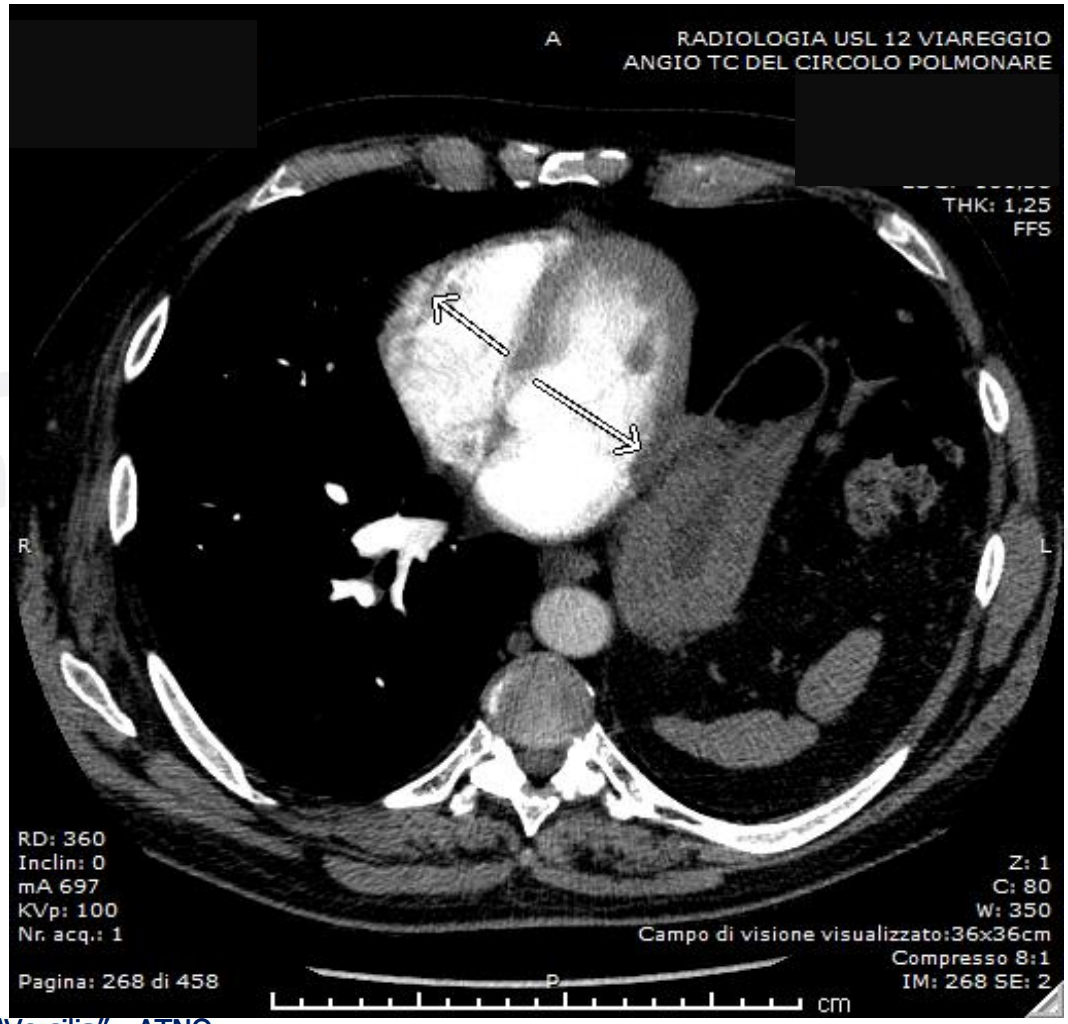
Angio TC polmonare







Angio TC polmonare



PE: anatomical extent of PE as defined in NOACs trials

- Limited extent
  - ≤25% of the vasculature of a single lobe
- Intermediate extent
  - >25% of vasculature of a single lobe or multiple lobes with ≤25% of entire vasculature
- Extensive extent
  - multiple lobes with ≥25% of entire vasculature

The Hokusai-VTE Investigators. N Engl J Med 2013

La Dimissione EP in PS

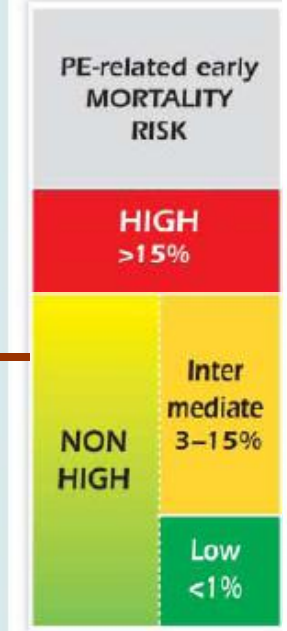
G. Pepe

Risk- and Severity-Adjusted Strategy

European Heart Journal (2008) **29**, 2276–2315
doi:10.1093/eurheartj/ehn310

2008 ESC GUIDELINES

Severity of PE should be understood as an individual estimate of PE-related ea mortality risk, rather than anatomic burden, shape and distribution intrapulmonary emboli. Therefore current guidelines suggest replacing potentia misleading terms such as "massive, sub-massive, non-massive" with the estimat levels of risk of PE-related early death.



- ***Abbandonare i termini embolia polmonare "massiva", "sub-massiva" e "non massiva",***
- ***Adottare i livelli di rischio di mortalità "precoce" correlata ad EP, basati sulla presenza di markers di rischio (clinici, ecocardiografici, bio-umorali).***

Domanda

Nel nostro paziente, confermata la diagnosi di TEP alla angioTC polmonare valutiamo se possibile una gestione domiciliare ?

A) Si, lo dimetto senza fare altro;

B) Si, ma eseguo prima una stratificazione del rischio;

C) No, non vi ancora abbastanza consenso tra i colleghi per questa responsabilità e faccio cosa dice lo specialista

D) non lo so, lo ricovero e basta.

PE: home treatment

	Aujesky et al	Zondag et al	Agterof et al	Otero et al	HoT PE ongoing
Design	Open-label, RCT	Prospective cohort	Prospective cohort	Open-label, RCT	Prospective cohort, phase IV
Eligibility criteria					
Systolic BP	≥100 mmHg	≥100 mmHg	≥90 mmHg	≥90 mmHg	≥100 mmHg
Clinical prediction rule	PESI class I or II	Hestia	-	Uresandi 0-2	Modified Hestia
Biomarkers	No	No	NT-proBNP	Troponin T	No (analysis planned)
Absence of RVD	No	No	No	TTE	CT or TTE
Renal function	CrCl ≥30	CrCl ≥30	Creatinine <150 umol/L	No	CrCl ≥15
Platelet count	≥75 000/mm^3	-	-	-	-
Body weight	≤150 kg	-	-	BMI <30 kg/m^2	
Respiratory function	SaO_2 ≥90%, or PaO_2 ≥60 mmHg	SaO_2 >90% in air	SaO_2 >90% in air	SaO_2≥ 93%; NYHA I or II; severe COPD	SaO_2 >90% in air
Others	No history of HIT	No history of HIT; no hepatic impairment	-	No surgery <15 days	No history of HIT; no severe hepatic impairment
Time of discharge	<24 h vs inpatient management	<24 h	<24 h	3- to 5-day vs inpatient	≤48 h of admission

Classification of early mortality risk

Early mortality risk		Risk parameters and scores			
		Shock or hypotension	PESI Class III-V or sPESI ≥1	Signs of RV dysfunction on an imaging test	Cardiac laboratory biomarkers
High		+	(+)	+	(+)
Intermediate	Intermediate-high	–	+	Both positive	
	Intermediate-low	–	+	Either one (or none) positive	
Low		–	–	Assessment optional; if assesed, both negative	

www.escardio.org/guidelines

European Heart Journal (2014):doi:10.1093/eurheartj/ehu283

EUROPEAN SOCIETY OF CARDIOLOGY®

SOCIETÀ ITALIANA DI MEDICINA D'EMERGENZA-URGENZA · SIMEU ·

Il medico d'emergenza-urgenza *si innervosisce* quando deve pronunciarsi sul "*early mortality risk*" nei pazienti che intende dimettere a domicilio (outpatients)

ED evolution in the years

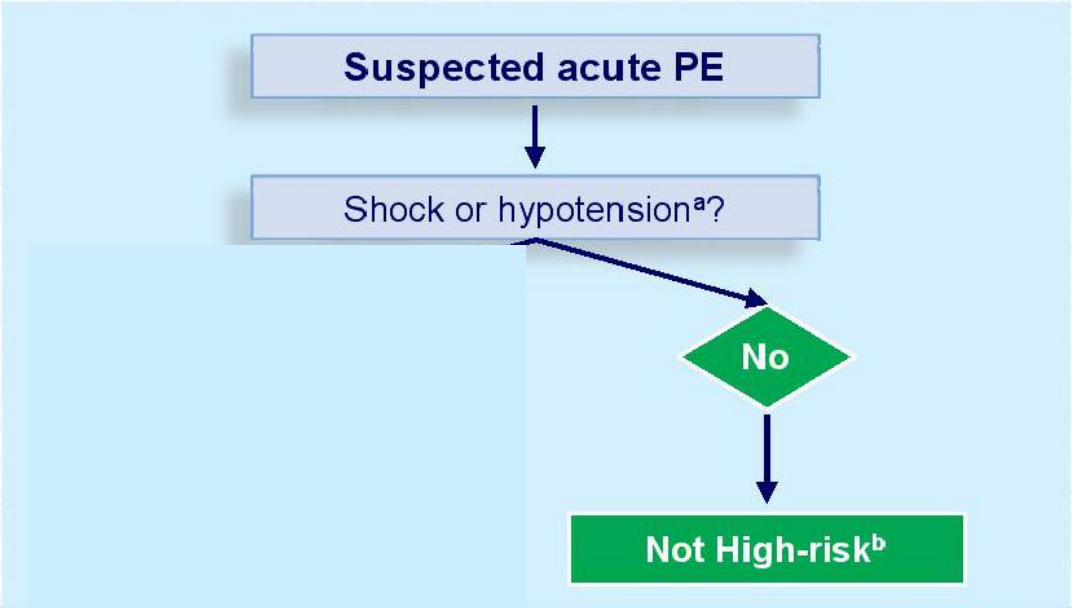
Nineties	2000	2014
"Admit to work up"	"Work up to admit "	"Work to discharge"

2018

"Certified discharge"

"Emergency Room"

Initial risk stratification of acute PE



Dimissione precoce "certificata" da stratificazione + competenza

Stratificazione del rischio "reale" - scores

	IMPACT	PESI	sPESI	Hestia
Mortality in low risk (%)	0.4	0.6	0	0
Sensitivity (95% CI)	95.2 (7.41-99.8)	90.5 (68.2-98.3)	100 (80.8-100)	100 (80.8-100)
Specificity (95% CI)	29.1 (26-32.5)	39.1 (35.6-42.6)	31.8 (28.6-35.2)	26.8 (23.8-30.1)
PPV (95% CI)	3.5 (2.2-5.4)	3.8 (2.4-6.0)	3.8 (2.4-5.8)	3.5 (2.2-5.4)
NPV (95% CI)	99.6 (97.2-100)	99.4 (97.4-99.9)	100 (98.1-100)	100 (97.8-100)

IMPACT= In-hospital Mortality for Pulmonary embolism using Claims data

HESTIA Criteria

	Hestia
Mortality in low risk (%)	0
Sensitivity (95% CI)	100 (80.8-100)
Specificity (95% CI)	26.8 (23.8-30.1)
PPV (95% CI)	3.5 (2.2-5.4)
NPV (95% CI)	100 (97.8-100)

IMPACT= In-hospital Mortality

TABLE 2: HESTIA CRITERIA

If any of the below are answered "Yes," the patient should NOT be treated as an outpatient.

1. Hemodynamically unstable?
2. Thrombolysis or embolectomy necessary?
3. Active bleeding or high risk of bleeding?
4. Oxygen supply to maintain oxygen > 90% > 24 hours?
5. Pulmonary embolism diagnosed during anticoagulant treatment?
6. In severe pain needing IV pain medication > 24 hr (or multiple doses in the ED)?
7. Medical or social reason for treatment in hospital > 24 hr?
8. Creatinine clearance less than 30 mL/min?
9. Severe liver impairment or disease?
10. Pregnant?
11. Documented history of heparin-induced thrombocytopenia?

Se risposta sempre "NO" il pz è un basso rischio

Original and simplified pulmonary embolism severity index

sPESI

Parameter	Simplified version
Age	1 point (if age >80 years)
Male sex	–
Cancer	1
Chronic heart failure	1
Chronic pulmonary disease	
Pulse rate ≥110 b.p.m.	1
Systolic blood pressure <100 mmHg	1
Respiratory rate >30 breaths per minute	–
Temperature <36°C	–
Altered mental status	–
Arterial oxyhaemoglobin saturation <90%	1

" Emerg. Phisicians Love the simplified tools..."

www.escardio.org/guidelines

European Heart Journal (2014):doi:10.1093/eurheartj/ehu283

EUROPEAN SOCIETY OF CARDIOLOGY

Severity index *by "sPESI – triage/TVR"*

- ***Age***
- ***Cancer***
- ***Chronic pulmonary & heart disease***
- ***Pulse rate b.p.m.***
- ***SBP mmHg***
- ***Sat.O2 %***

Severity index *by "sPESI – triage/TVR"*

- ***Age***
- ***Cancer***
- ***Chronic pulmonary & heart disease***
- ***Pulse rate b.p.m.***
- ***SBP mmHg***
- ***Sat.O2 %***

sPESI = 0

Franco, 56 anni
Iperteso
Diabetico
PR 80 bpm
PAS 140/70 mmHg

SatO2 97%

Original and simplified pulmonary embolism severity index (PESI)

Parameter	Original version	Simplified version
	Risk strata	
	Class I: ≤65 points very low 30-day mortality risk (0-1.6%) **Class II: 66-85 points** low mortality risk (1.7-3.5%) **Class III: 86-105 points** moderate mortality risk (3.2-7.1%) **Class IV: 106-125 points** high mortality risk (4.0-11.4%) **Class V: >125 points** very high mortality risk (10.0-24.5%)	**0 points** = 30-day mortality risk 1.0% (95% CI 0.0%-2.1%) **≥1 point(s)** = 30-day mortality risk 10.9% (95% CI 8.5%-13.2%)

sPESI = 0

sPESI ≥1

www.escardio.org/guidelines

European Heart Journal (2014):doi:10.1093/eurheartj/ehu283

EUROPEAN SOCIETY OF CARDIOLOGY

DEA Versilia, ATNO

Dal 1.1.2017 al 31.12.2017

La malattia trombo-embolica venosa (TVP + EP):

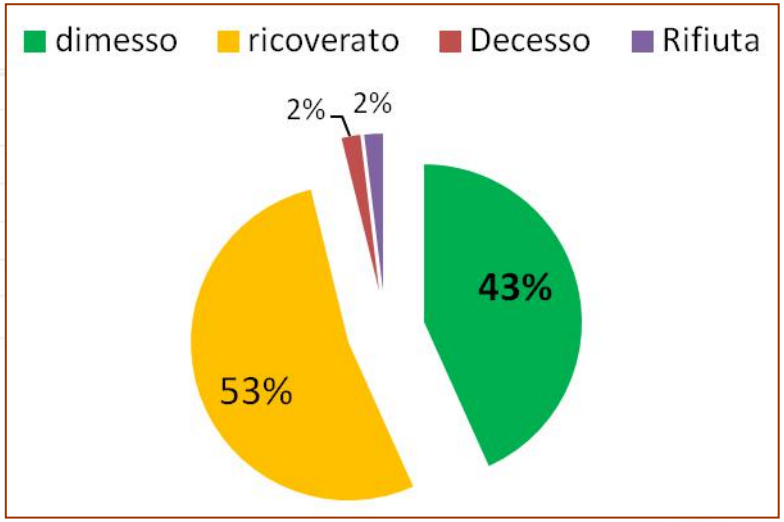
N=218

- **114 TVP**
- **104 EP**

Intervallo temporale di selezione: **01/01/2017 - 31/12/2017**

Condizioni: **Diagnosi principale: EMBOLIA POLMONARE**

Esito Intervento
Esito Finale
Dimesso
Ricoverato
Deceduto in P.S.
Rifiuta il ricovero
Rifiuta osservazione
Totali



DEA Versilia, ATNO

Dal 1.1.2017 al 17.11.2017

La malattia trombo-embolica venosa (TVP + EP):

- **104 EP** → Sperimentazione **follow-up telefonico** (7 gg) **e clinico** (30 gg)

La Dimissione EP in PS

G. Pepe

Thrombosis Research xxx (2018) xxx-xxx

Contents lists available at ScienceDirect

Thrombosis Research

journal homepage: www.elsevier.com

ELSEVIER

Full Length Article

Early discharge of patients with pulmonary embolism in daily clinical practice: A prospective observational study comparing clinical gestalt and clinical rules

Simone Vanni[a,*], Cecilia Becattini[b], Peiman Nazerian[a], Carlo Bova[c], Valerio Teodoro Stefanone[a], Ludovica Anna Cimini[b], Gabriele Viviani[a], Cosimo Caviglioli[a], Michela Sanna[d], Giuseppe Pepe[d], Stefano Grifoni[a]

[a] Department of Emergency Medicine, Azienda Ospedaliero-Universitaria Careggi, Firenze, Italy
[b] Internal and Cardiovascular Medicine - Stroke Unit, University of Perugia, Italy
[c] Department of Medicine, University Hospital of Cosenza, Cosenza, Italy
[d] Department of Emergency Medicine, Ospedale Versilia, Lido di Camaiore, Italy

ARTICLE INFO

ABSTRACT

Objectives: To estimate the efficiency and safety of clinicians' gestalt in the identification of patients with pulmonary embolism (PE) candidates for early discharge and to compare the efficiency and safety of clinical gestalt with that of the Pulmonary Embolism Severity Index (PESI), the simplified PESI (sPESI) and the Hestia criteria (HC).

Methods: Consecutive adult patients presenting to the emergency department of four Italian hospitals with confirmed diagnosis of PE were included. Data for PESI, sPESI and HC assessment were prospectively collected. Patients were managed according to the clinical gestalt of the attending physician, independent of the results of PESI, sPESI and HC. Efficiency was defined as the prevalence of candidates to early discharge. The primary safety measure was the incidence of a composite of venous thromboembolic recurrence, major haemorrhage or all-cause mortality within 30 days.

Results: Out of 547 included patients, 178 (32.5%) were judged to be at low risk and discharged within 48 h from presentation. HC identified a higher proportion (41.7%) whereas both PESI (24.1%) and sPESI (18.3%) identified a lower proportion of candidates for early discharge when compared to clinical gestalt ($P < 0.01$ for all). The incidence of the safety outcome was 2.8% in early-discharged patients according to clinical gestalt and 2.3%, 3.0% and 2.6% in candidates to early discharge according to PESI, sPESI and HC, without differences between strategies.

Conclusions: In our cohort, clinical gestalt identified one-third of PE patients for early discharge. Among different strategies HC showed the highest efficiency sharing similar safety with the other strategies.

1. Introduction

International guidelines on the diagnosis and management of patients with pulmonary embolism (PE) [1–3] suggest considering early discharge and outpatient treatment for patients judged to be at low risk of short-term adverse outcome. However, scarce data are available on the early discharge of PE patients in clinical practice [4]. In recent years several clinical rules have been published and at least three have been validated for the identification of low-risk patients who could be candidate for home treatment, the Pulmonary Embolism Severity Index (PESI) [5,6], the simplified PESI (sPESI) [7] and the Hestia criteria (HC) [8]. Data about their efficiency and safety in every-day clinical practice are lacking and recent metaanalyses [9–11] suggest that more data are needed to confirm the feasibility and the impact of this strategy in the real word. Moreover, whether scores or clinical rules can identify candidates to early discharge better than clinical gestalt is controversial [9].

The aim of this study was to prospectively estimate the efficiency and safety of clinicians' gestalt to identify PE patients as suitable candi-

* Corresponding author at: Emergency Department, AOU-Careggi, Largo Brambilla 3, 50139 Firenze, Italy.
Email address: simonevanni@alice.it (S. Vanni)

https://doi.org/10.1016/j.thromres.2018.05.008
Received 25 March 2018; Received in revised form 23 April 2018; Accepted 6 May 2018
Available online xxx
0049-3848/

La Dimissione EP in PS

G. Pepe

Early discharge of patients with pulmonary embolism in daily clinical practice: A prospective observational study comparing clinical gestalt and clinical rules

Simone Vanni[a,*], Cecilia Becattini[b], Peiman Nazerian[a], Carlo Bova[c], Valerio Teodoro Stefanone[a], Ludovica Anna Cimini[b], Gabriele Viviani[a], Cosimo Caviglioli[a], Michela Sanna[d], Giuseppe Pepe[d], Stefano Grifoni[a]

[a] *Department of Emergency Medicine, Azienda Ospedaliero-Universitaria Careggi, Firenze, Italy*
[b] *Internal and Cardiovascular Medicine - Stroke Unit, University of Perugia, Italy*
[c] *Department of Medicine, University Hospital of Cosenza, Cosenza, Italy*
[d] *Department of Emergency Medicine, Ospedale Versilia, Lido di Camaiore, Italy*

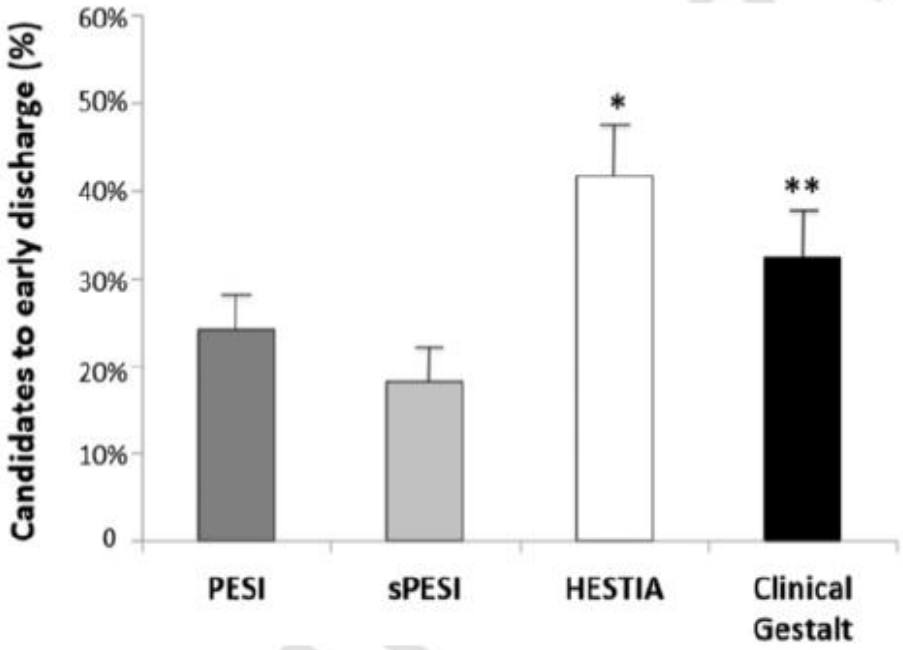


Fig. 2. Efficiency of clinical gestalt, PESI, sPESI and Hestia Criteria (HC) in the identification of candidates for early discharge. *$P = 0.004$ *vs* clinical gestalt, $P < 0.001$ *vs* PESI and sPESI. **$P = 0.004$ *vs* HC and $P = 0.008$ *vs* PESI and $P < 0.001$ *vs* sPESI.

La Dimissione EP in PS

G. Pepe

Early discharge of patients with pulmonary embolism in daily clinical practice: A prospective observational study comparing clinical gestalt and clinical rules

Simone Vanni[a,*], Cecilia Becattini[b], Peiman Nazerian[a], Carlo Bova[c], Valerio Teodoro Stefanone[a], Ludovica Anna Cimini[b], Gabriele Viviani[a], Cosimo Caviglioli[a], Michela Sanna[d], Giuseppe Pepe[d], Stefano Grifoni[a]

[a] *Department of Emergency Medicine, Azienda Ospedaliero-Universitaria Careggi, Firenze, Italy*
[b] *Internal and Cardiovascular Medicine - Stroke Unit, University of Perugia, Italy*
[c] *Department of Medicine, University Hospital of Cosenza, Cosenza, Italy*
[d] *Department of Emergency Medicine, Ospedale Versilia, Lido di Camaiore, Italy*

Table 3
Details of different distribution of candidates for home treatment in sPESI and Hestia criteria.

Patients with sPESI ≥ 1 in those with Hestia criteria = 0	
Total	165
Cancer	89 (62%)
Age > 80	62 (40%)
COPD/CHF	57 (37%)
HR ≥ 110	28 (18%)
Sat02 < 90%	5 (3%)
SBP < 100	3 (2%)
Patients with sPESI = 0 in those with Hestia criteria ≠ 0	
Total	35
Medical or Social reason	19 (54%)
PE during anticoagulation	6 (17%)
Thrombolysis or embolectomy	5 (14.3%)
Oxygen supplementation	3 (10%)
Need of pain medications IV	2 (6%)
CrCl < 30 ml/min	2 (6%)
Pregnancy	1 (3%)
Active bleeding/high bleeding risk	1 (3%)
Heparin induced thrombocytopenia	1 (3%)

Abbreviations: sPESI, simplified Pulmonary Embolism Severity Index. COPD, Chronic obstructive pulmonary disease; CHF, Chronic heart failure; HR, heart rate; IV, intravenous; CrCl, Creatinine Clearance; PE, pulmonary embolism; SBP, systolic blood pressure.

La Dimissione EP in PS

G. Pepe

Early discharge of patients with pulmonary embolism in daily clinical practice: A prospective observational study comparing clinical gestalt and clinical rules

Simone Vanni[a, *], Cecilia Becattini[b], Peiman
Ludovica Anna Cimini[b], Gabriele Viviani[a],

[a] Department of Emergency Medicine, Azienda Ospedaliero-Universitaria Ca
[b] Internal and Cardiovascular Medicine - Stroke Unit, University of Perugia,
[c] Department of Medicine, University Hospital of Cosenza, Cosenza, Italy
[d] Department of Emergency Medicine, Ospedale Versilia, Lido di Camaiore,

S. Vanni et al.

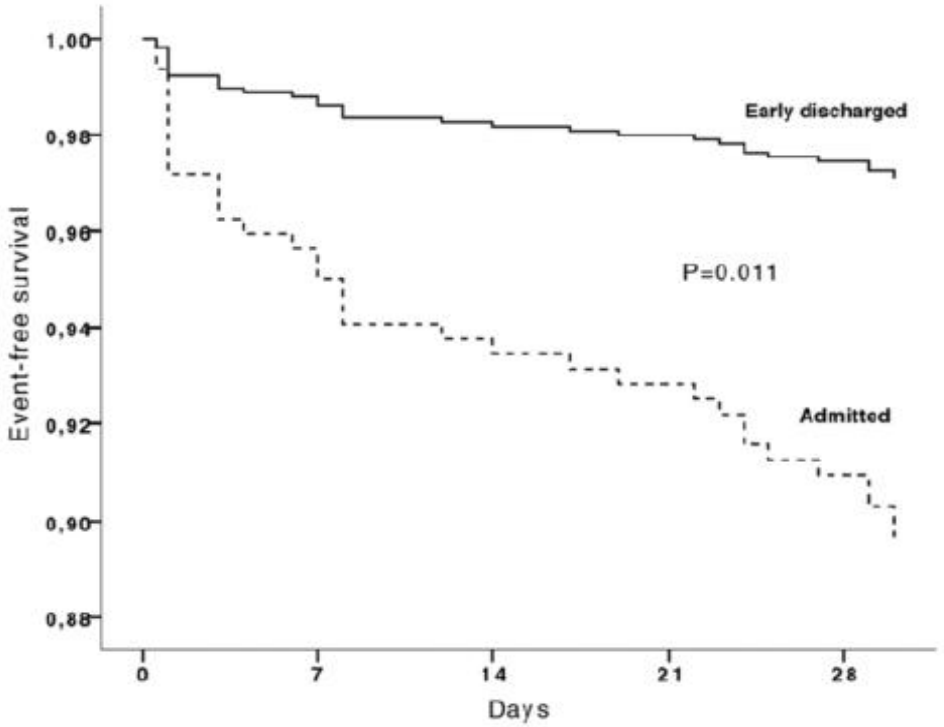
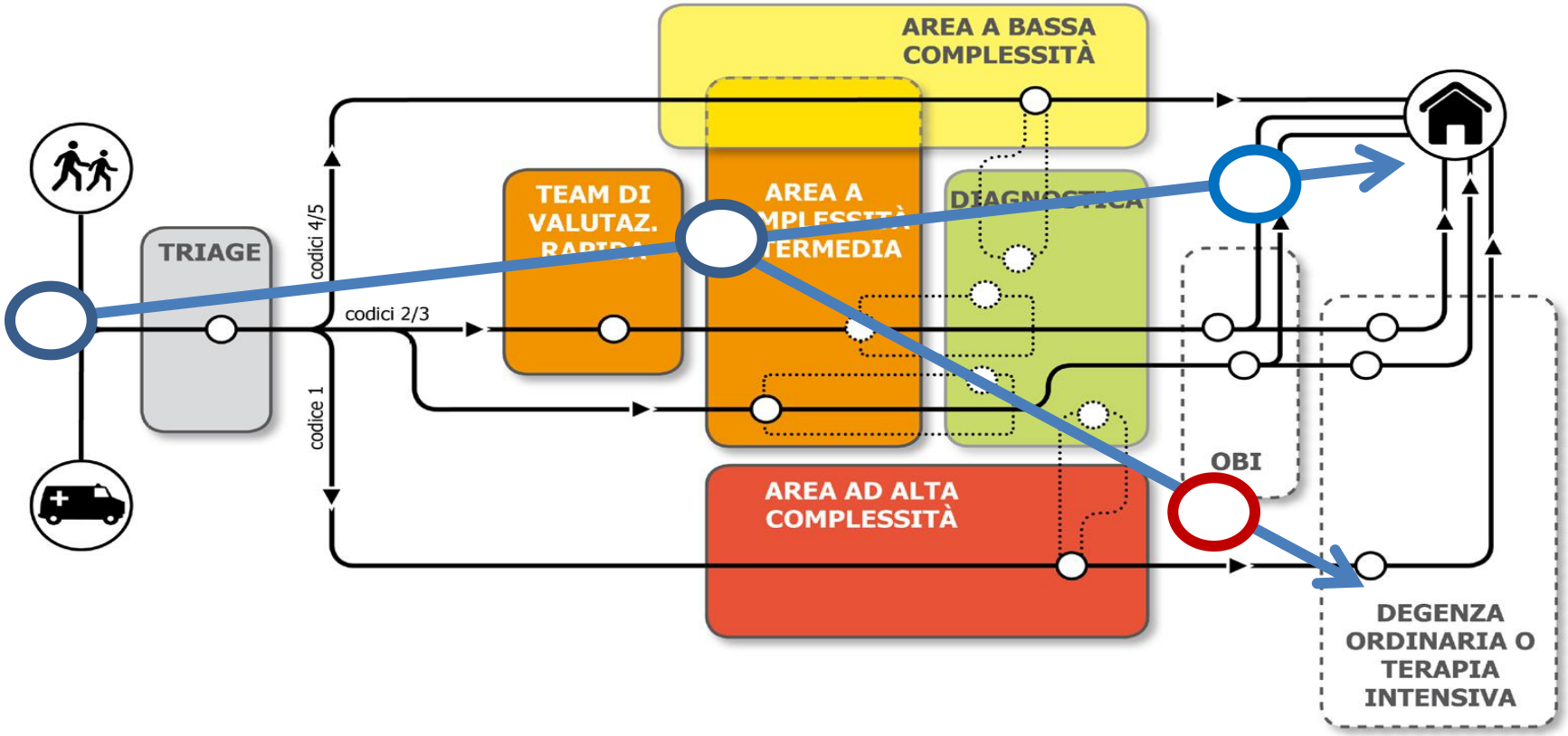
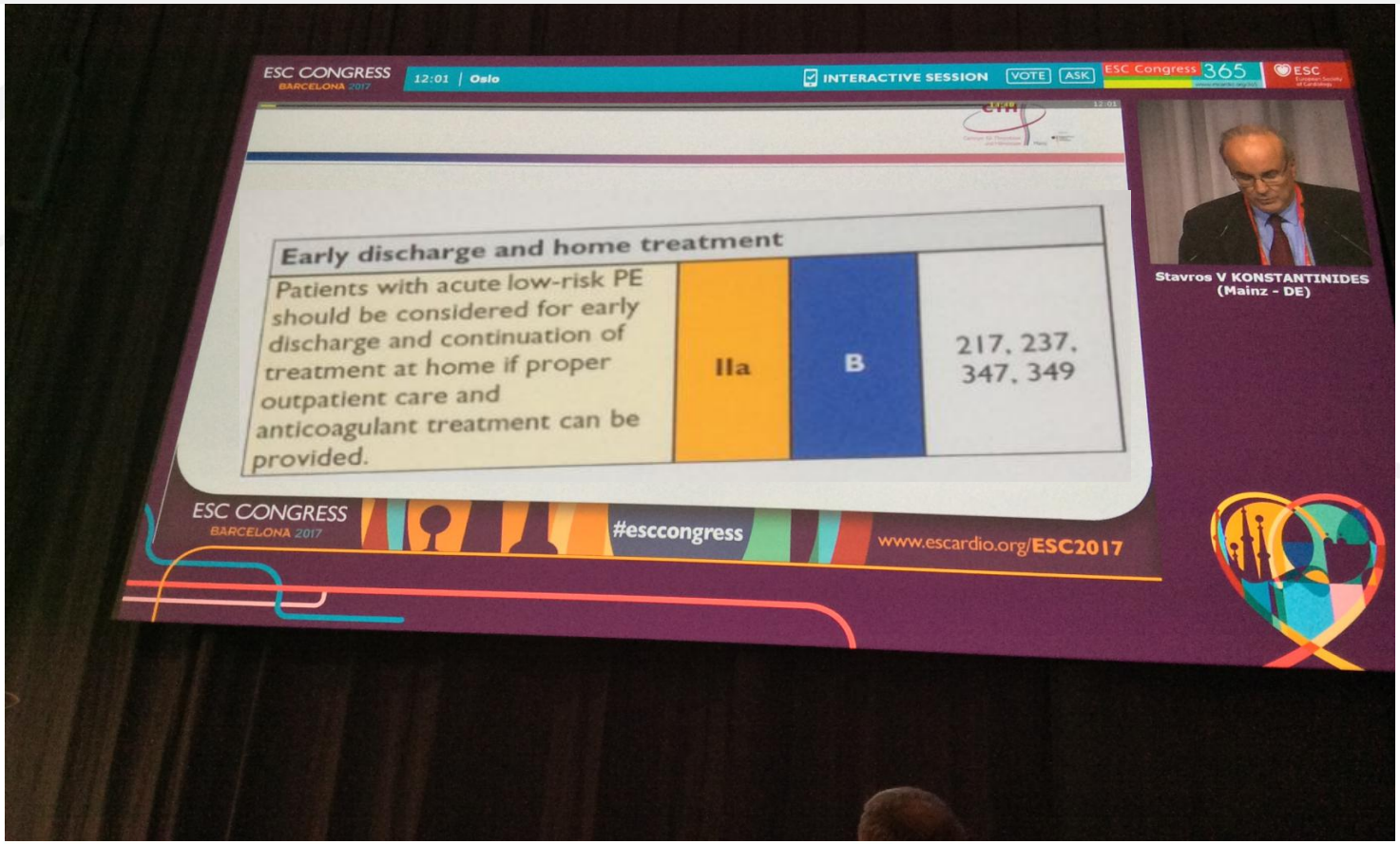


Fig. 3. Event-free survival curves of patients early discharged *vs* admitted patients according to the multivariate Cox regression analysis.This difference was significant also when comparing early discharged patients to those admitted to the hospital without overt hemodynamic instability, RVD or cardiac troponin elevation ($P = 0.042$) (Table 4).

Diagnosi + stratificazione prognostica → esito
in Pronto Soccorso del tromboembolismo venoso



"La dimissione (dal PS) del paziente con embolia polmonare è possibile"



ACCP Guidelines 2016

Antithrombotic Therapy for VTE Disease
CHEST Guideline and Expert Panel Report

CHEST

Clive Kearon, MD, PhD; Elie A. Akl, MD, MPH, PhD; Joseph Ornelas, PhD; Allen Blaivas, DO, FC(
David Jimenez, MD, PhD, FCCP; Henri Bounameaux, MD; Menno Huisman, MD, PhD;
Christopher S. King, MD, FCCP; Timothy A. Morris, MD, FCCP; Namita Sood, MD, FCCP;
Scott M. Stevens, MD; Janine R. E. Vintch, MD, FCCP; Philip Wells, MD; Scott C. Woller, MD;
and COL Lisa Moores, MD, FCCP

We suggest that patients who satisfy all of the following criteria are **suitable for treatment of acute PE out of the hospital**:

1. clinically stable with good cardiopulmonary reserve;
2. no contraindications such as recent bleeding, severe renal or liver disease, or severe thrombocytopenia;
3. expected to be compliant with treatment;
4. the patient feels well enough to be treated at home.

Clinical decision rules such as the Pulmonary Embolism Severity Index (PESI), the simplified form with score of 0, can help to identify low-risk patients who are suitable for treatment at home.

ACCP Guidelines 2016

Antithrombotic Therapy for VTE Disease
CHEST Guideline and Expert Panel Report

CHEST

Clive Kearon, MD, PhD; Elie A. Akl, MD, MPH, PhD; Joseph Ornelas, PhD; Allen Blaivas, DO, FC(
David Jimenez, MD, PhD, FCCP; Henri Bounameaux, MD; Menno Huisman, MD, PhD;
Christopher S. King, MD, FCCP; Timothy A. Morris, MD, FCCP; Namita Sood, MD, FCCP;
Scott M. Stevens, MD; Janine R. E. Vintch, MD, FCCP; Philip Wells, MD; Scott C. Woller, MD;
and COL Lisa Moores, MD, FCCP

Treatment of Acute PE Out of the Hospital

***20. In patients with low-risk PE and whose home circumstances are adequate, we suggest treatment at home or early discharge over standard discharge (eg, after the first 5 days of treatment)** (Grade 2B).

BTS Guidelines 2018 – *draft version*

British Thoracic Society

British Thoracic Society Guidelines for the outpatient management of pulmonary embolism
Summary of recommendations

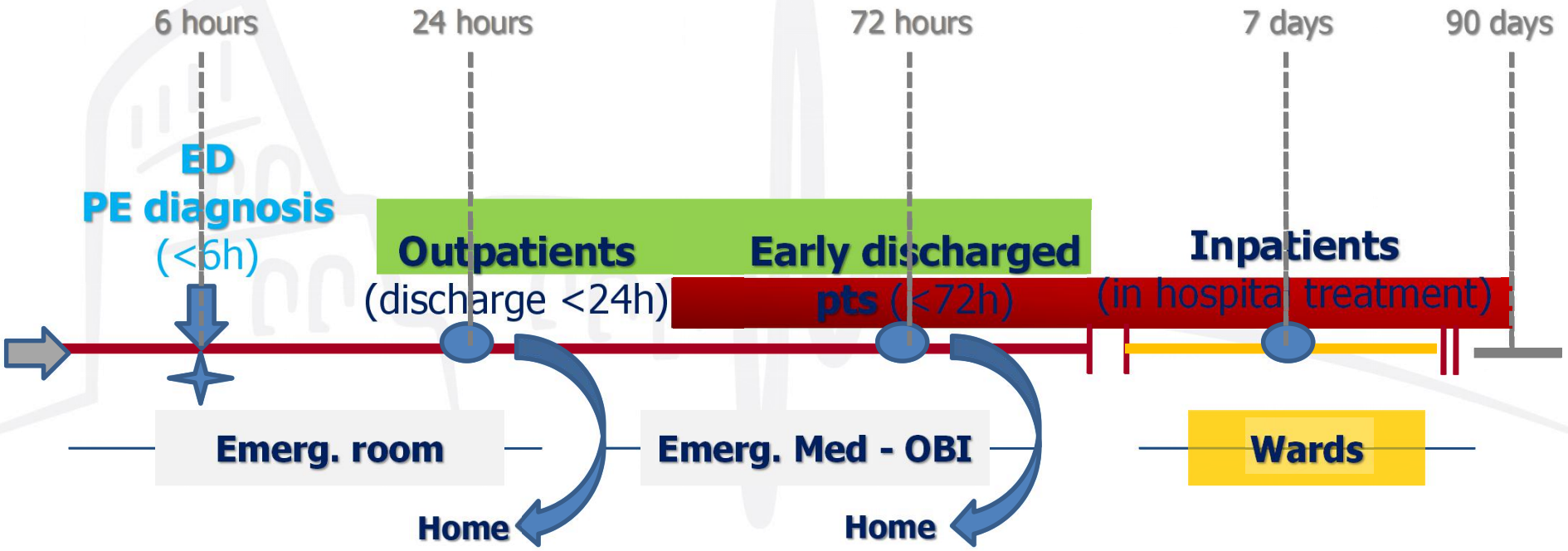
Outcomes of Outpatient Care for Low-Risk Pulmonary Embolism
Recommendation

- Patients with pulmonary embolism should be assessed for suitability for management in an ambulatory care setting. **Grade B**
- Those patients assessed as low risk and suitable for outpatient management should be offered treatment in an outpatient setting where a robust pathway exists for follow-up and monitoring. **Grade B**

Inclusion and exclusion criteria for outpatient management or early discharge
Recommendations

- Patients with confirmed pulmonary embolism should be risk-stratified using a validated clinical risk score. **Grade B**
- Patients in PESI Class I/II, sPESI 0 or meeting the Hestia criteria should be considered for outpatient management of PE. **Grade B.**
- Where PESI or s-PESI is used, a set of exclusion criteria should be applied to patients being considered for outpatient management of confirmed pulmonary embolism. **Grade B**

PE ,"phenotypes", timing and setting



LMWH-Fondaparinux (5 days)

Anticoagulants: VKA/NAO (90 days)

Realtà o chimera ?

« [...] Era il mostro di origine divina,
leone la testa, il petto capra, e drago
la coda; e dalla bocca orrende vampe
vomitava di foco: e nondimeno,
col favor degli Dei, l'eroe la spense [...] »
(*Iliade*, VI, 180-184)

La Dimissione EP in PS

G. Pepe


IL TIRRENO

In manette il serial-ladro

Dopo 20 colpi ai distributori automatici di sorvegliare

Concorsi-disastro? I giovani non sanno scrivere

Oggi Sposi

LA BUONA SANITÀ

«Io, salvato dai medici del Versilia»

David ha avuto un'embolia polmonare: vivo grazie al pronto soccorso

PIETRASANTA

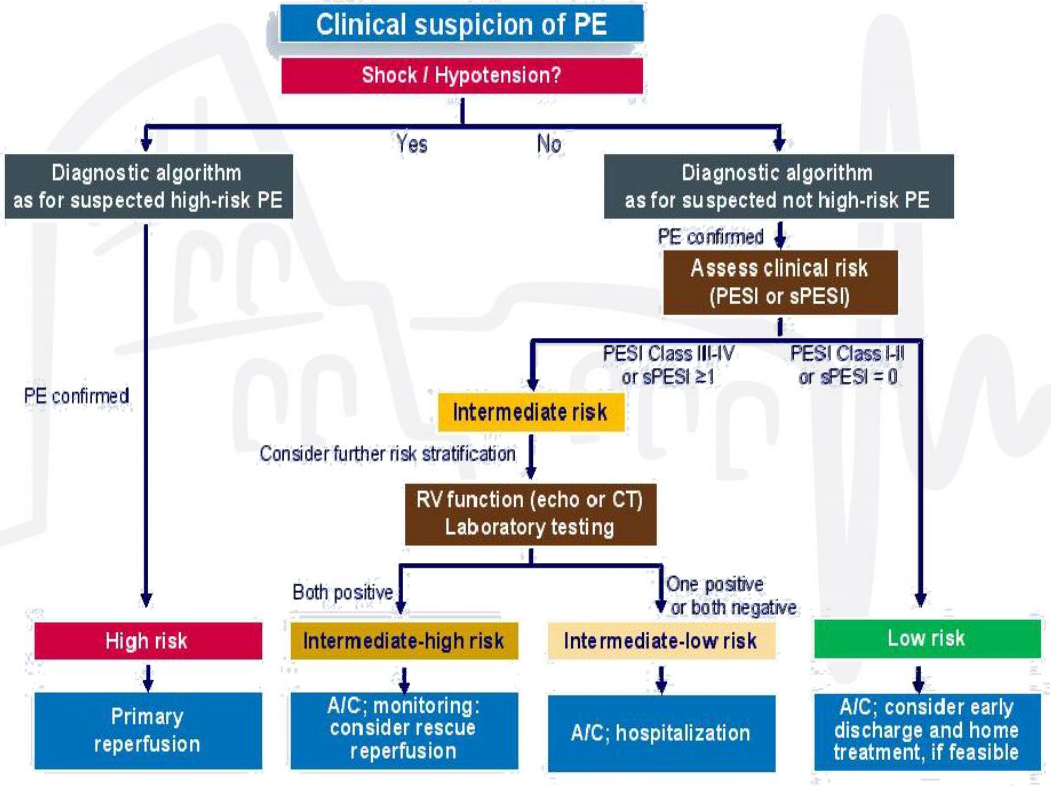
Oggi, David, 52 anni, sta meglio. Decisamente meglio. «Ma quando sono stato trasportato d'urgenza, in codice rosso, al pronto soccorso del Versilia, ho veramente pensato il peggio. Respiravo con difficoltà e avevo tutta una serie di problematiche: mi è stata subito diagnosticata un'embolia polmonare. Insomma, sono stati momenti difficili».

Ma David vuole raccontare la sua esperienza soprattutto per elogiare «i medici del pronto soccorso e tutto il reparto, anche infermieristico della medicina d'urgenza, che con il sottoscritto si sono comportati in modo professionale ed umano. Posso solamente ringraziarli. Spesso mi capita di leggere di critiche al sistema sanitario del Versilia: non so che dire. Io posso, come detto, solo parlarne bene: se oggi sono a casa mia dove continuo a seguire una terapia perché quello che ho passato non è stata proprio una sciocchezza, lo devo a loro. Ma l'importante è poterla raccontare e, soprattutto, potere ringraziare chi, in soli sei giorni, mi ha curato e seguito ora dopo ora per poi dimettermi, come il primario **Giuseppe Pepe**, la dottoressa **Maria del Mar Olivan Roldan**, il dottor **Vincenzo Berti** e più in generale tutto lo staff medico ed infermieristico del pronto soccorso. È stata – prosegue David – un'esperienza drammatica, ma nella sfortuna ho potuto toccare con mano la competenza e l'umanità dei nostri medici». *(l. b.)*

L'ingresso del pronto soccorso dell'ospedale Versilia

Grazie

Le Linee Guida e la buona pratica



*Si presuppone che il medico che opera con **prudenza** sappia scegliere il modo più opportuno e tempestivo per attuare il proprio intervento, e soprattutto, sia in grado di **prevedere** quali possano essere le conseguenze del suo operato…*

Screening "base" per TVP/TEP non provocata in DEA

- Rx Torace
- Eco addome completo

Screening "base" differibili urgenti

- PSA
- Mammografia / ecografia ginecologica

- Markers neo (???)

La Dimissione EP in PS

G. Pepe

La Dimissione EP in PS

G. Pepe