PE Case Study
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Case Study

- 64 yr old female transferred on 10/18/2018
- PE – saddle, hypotension, hypoxemic resp failure → intubated
- Systemic lysis at the outlying hosp → Hypotension improved, off pressors. Now on IV heparin
- DUS – ACUTE DVT of LPTV, peroneal and popliteal
- Recent PMHx:
  - In and out of Hosp over 3 months for L2-L5 Laminectomy and complications → pyloric ulcer perf → Ex-Lap and patch repair → Abcess

TTE

- Moderate left ventricular systolic dysfunction with RWMA
- LVEF is 40% (finding is suggestive of ischemic cardiomyopathy)
- Saline agitated bubble study is negative.
- Right ventricle is mildly dilated with normal systolic function

Decreased sedation → Left hemiparesis

+ Thrombosis of the right MCA near the bifurcation with large evolving acute ischemic infarct of the posterior right frontal lobe without any evidence of hemorrhage or mass-effect.
Vascular Service Consulted

Next steps

Labs

- APTT and INR baseline – Mild elevation
- Platelets – 140k, 5 months ago 200s K
- LFTs/ Creat – normal range

- What next?
- Started on Argatroban and sent of PF4 antibodies
- TEE ordered

...wait

- Follow up CT → Cerebral edema, without hemorrhagic conversion
- NS consulted → No surgical intervention

TEE – Large PFO

Following days

- CT stable
- PF4 negative
- Switched to back to IV heparin and then to DOAC
  - PTT and anti-Xa correlated – Match!
  - DRV/VT indeterminate and Hex Phase indeterminate
  - ACA/ B2Gp – WNL
- After all – Whole thing was situational VTE with a PFO

lead in vascular care