Pulmonary embolism treatment

- Challenges in Pulmonary Management after Traumatic Brain and Spinal Cord Injury
- Postoperative Initiation of Thromboprophylaxis in patients with Cushing's Disease (PIT-CD): a randomized controlled trial
- Symptomatic venous thromboembolism after transsphenoidal surgery in Cushing's disease: incidence and risk factors
- Validating Khorana Risk Score in gastric cancer patients on immune checkpoint inhibitors and chemotherapy
- Two decades of trends in nontraumatic intracerebral hemorrhage care: A nationwide analysis
- Relationship between Tranexamic Acid Use and Safety in Patients with Acute Brain Injury: A Systematic Review and Meta-analysis of Mortality and Thromboembolic Events
- Effect of Cold Saline Pre-Washing on Cement Leakage in Vertebroplasty: A Novel Approach
- Assessing the impact of perioperative allogenic blood transfusion in spinal surgery: a comprehensive systematic review, meta-analysis, and meta-regression analysis

If the diagnosis is seriously entertained, start heparin – unless contraindicated – without waiting for the results of diagnostic studies. For an average 70 kg patient, begin with 5000–7500 unit IV bolus, followed by 1000 U/hr drip (less for smaller patients). Follow PTT and titrate drip rate for PTT 1.5 to 2 × control. The use of heparin shortly after surgery and in patients with brain tumors is controversial, and vena cava interruption may be an alternate consideration (e.g. Greenfield filter). Patients with massive PEs may be hemodynamically unstable. They usually require ICU care, often with PA catheter and pressors.