**Pleuritic Chest Pain**

from BTS guidelines + statement from BTS Care Standards Group **Dec 2006**

Patients in whom a diagnosis of PE is a ***REASONABLE*** diagnosis and ***AFTER*** a decent PA CXR has been done to look for alternative diagnosis, score as follows:

Is PE more likely than any alternative +1

Is there a major* risk factor for VTE +1

2= High 1=Intermediate 0=low.

After review by 'experienced middle grade doctor' d-dimer is indicated for low/intermediate groups. If negative, PE ruled out. High risk groups OR high d-dimers in other groups should have a CTPA as the first line investigation.

(VQ only in departments which have them on site, normal CXR, no intercurrent chronic chest conditions and the ability to do CTPA in positive/non-diagnostic VQ's)

*MAJOR risk factors

| | |
|---|---|
| Surgery | abdo/pelvic., post op ICU, knee/hip ops |
| Obstetrics | late pregnancy/puerperium/Caeserian section |
| Malignancy | advanced/mets, abdo/pelvic |
| Immobilisation | hospitalised/institutionalised |
| Lower limb | long bone fracture/varicose veins |
| Previous PE's | |

(smoking not risk factor. Travel, OCP/HRT/occult malignancy/obesity etc =MINOR risk factors)

So pleuritic chest pain with no risk factors/tachycardia/tachypnoea/hypoxia/ECG changes/ normal calves with tender chest wall or green sputum/fever etc which are NOT thought to be PE's therefore don't need all the above. The statement released in Dec 06 was because of the fact that many more patients were having investigations (& radiation) and most were negative-the opposite effect that the BTS original guidelines were designed to do because of excess r/o PE with d-dimers being done.