British Thoracic Society Guidelines for the outpatient management of pulmonary embolism

Public consultation/Stakeholder comment form

Name: Prof Mark Strachan, Secretary

Organisation: Royal College of Physicians of Edinburgh

Please indicate if you are responding as an individual or on behalf of the organisation noted above:

Individual response: ☐

Organisation response: ☒

Please add comments to the following table noting the section number and page number to which your comment refers.

Note 'general' in the section column if your comments relate to the whole document.

Please note that the Summary of recommendations should be read in conjunction with the Full guideline.

Document Full Guideline or Summary of recommendations	**Page**	**Line #**	**Comment**
General			The College agrees that the guideline represents a step forward in the modern out patient management of pulmonary embolism. The recommendations are pragmatic, sensible and err on the side of safety. They cover a variety of day to day assessment and management problems and emphasize that evidence is sparse and experience limited in the use of the newer oral anticoagulants but offer very useful advice and algorithms. Fellows feel that clinicians will find this document very useful and the College welcomes its production. The use of a risk stratification tool is well needed and will help strengthen already existing outpatient pulmonary embolism pathways with some security and added governance which has so far been lacking in a robust fashion. This will also hopefully stimulate centres without outpatient pulmonary embolism pathways to develop such services and undoubtedly will result in fewer or shorter admissions. The guidance will also help to standardise management for audit and research purposes. The research presented is well interpreted to allow answers to many of the questions clinicians will have in developing or running this service.

			A few points of discussion raised by colleagues: some of these points are addressed to some extent in the guidance but may need clarification. It may be felt that some are beyond the remit of this guideline: The title could be a little misleading into thinking the guidance was for all patients' outpatient management (including follow up guidance of those who were admitted). Outpatient management is not actually discussed. Could this be made more specific? For example 'Guidance for safe management of PE out of hospital' 'Avoiding hospital admission in PE management' 'Facilitating early discharge in PE management' The use of the term DOAC. The term NOAC is still very common; does the use of various terminologies and the decision to use DOAC need a short explanation to clarify the choice and avoid confusion? The decision to use PESI/sPESI is pragmatic and the latter in particular is easy to use. However, it is not clear how this is superior to Hestia. All are well validated: the latter excludes pregnant patients but the former excludes cancer patients. The statement (line 885 – 886) that PESI removes the "ambiguous criterion of medical or social reason for treatment in hospital" is counteracted by the "clinical and social exclusion criteria" box in the guideline algorithm which is also open to interpretation. Many studies have used a combination of inclusion and exclusion criteria (e.g. Vali et al). Should there be a specific indicator to consider using HESTIA in a patient with cancer in the algorithm as sPESI automatically excludes these patients? There is little guidance for the "clinical and social exclusion criteria". Importantly the presence of renal impairment, pain and risk of bleeding are not specifically mentioned. Given that this is suggested to be used potentially by ANPs should this be more clearly specified? At least a note to what criteria should be considered? This could be derived and adapted locally. Many centres will not currently offer BNP or hsTropnin. The evidence for their use seems unclear and to add little to the risk stratification scores. Should these be included? The use of the risk stratification supports clinical decision making, but clinical experience will be required in reviewing some of the exclusions including bleeding risks, renal impairment etc. Should the guidelines take a more robust view on how and by whom the patient is reviewed? The guidelines provide a broad direction and while this provides local flexibility it may be open to interpretation. It is perhaps beyond the remit of this guideline, but as patients with RV impairment may be discharged home, should there be a comment on the use of ECHO follow up at 3 months?

Contrast lines 885-6 with lines 1360-1361			PESI/sPESI recommended as it does not exclude pregnant women. But it is not to be used in pregnant women? Perhaps needs clarification.
1322			What is the definition of these individuals? What is the evidence to support this recommendation? Is this required for follow up? It is likely that most patients will be managed and discharged in Acute Medical Units, EDs and ACUs. DGHs will have general respiratory consultants not all with a 'special interest in VTE'.
	6	162	Unnecessary hyphen -to
	7	193	Comments in brackets look like a note – should they be there?
	12	352	LMWH first use - ? expand
	23	633	ESC first use - ? expand
	40	1188	Extra 'in' "with in PESI…"?
	40	1221	Close bracket required
	40	1211	?extra 'in' "medical training in prior to…."

Please add rows to this table as required.

Please return the completed form to:
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Deadline: **5pm Friday 17 February 2017**