MEDIBEATS
The Medical Bulletin

In Critical Care

1. Bronchial embolization is the initial treatment of choice for most patients with massive hemoptysis.

2. Clinical findings, including laboratory and EKG results, are neither sensitive nor specific for the diagnosis of PE. CT chest angiography or V/Q scan is necessary to confirm the diagnosis.

3. Duration of therapy in an unprovoked PE in a low-risk bleeding patient is at least 3 months, with a recommendation for life-long anticoagulation and annual reassessment of the risk versus benefit of long-term anticoagulation.

4. Clinical assessment of volume status and perfusion is critical in treatment of acute decompensated heart failure.

5. Valve replacement is the only treatment for symptomatic severe aortic stenosis. No medical options have been shown to be effective.

6. It is important to distinguish hemodynamically unstable arrhythmias that need immediate cardioversion/defibrillation from more stable rhythms.

7. In patients with out-of-hospital cardiac arrest who have recovered a perfusing rhythm but have neurologic deficits, therapeutic hypothermia has been shown to dramatically improve outcomes.

8. Aortic dissection carries high morbidity and mortality if untreated and should be suspected in a patient presenting with acute onset severe chest, back, or abdominal pain.

9. All patients presenting with aortic dissection should be immediately evaluated by a surgeon. Type A dissections require emergent open repair. Type B dissections complicated by end-organ ischemia, rupture, rapidly expanding dissection or aneurysm, or intractable pain or hypertension require surgery; endovascular repair is preferable if possible.

10. Pericardial tamponade is a medical emergency, diagnosed based upon clinical physiology and treated by emergent pericardiocentesis or drainage

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