

UWMC (Adapted from HMC) Off-Hours Triage of Requested Echocardiograms:

Triage	Clinical Concern
<p>Emergency/STAT (Includes weekday nights 5PM to 8AM. Includes weekends all day and night.)</p> <p>*****</p> <p>RESTRICT TO CASES WHERE ECHO RESULT WILL SUBSTANTIALLY CHANGE MANAGEMENT</p> <p>*****</p>	<p><u>Acute chest pain:</u></p> <ol style="list-style-type: none"> 1. Evaluate acute chest pain with suspected myocardial ischemia and non-diagnostic ECG/enzymes (perform during pain) 2. Evaluate patients with hemodynamic instability unresponsive to simple therapeutic measures. 3. Evaluate chest pain in patients with suspected acute aortic syndromes when CT is not feasible or possible myopericarditis 4. Evaluate patients with suspected bleeding in the pericardial space (e.g. trauma, perforation) 5. Guidance and monitoring of emergency pericardiocentesis for tamponade. 6. Evaluate cardiac transplant recipients for acute rejection. <p><u>Acute dyspnea:</u></p> <ol style="list-style-type: none"> 1. Distinguish cardiac vs. non-cardiac etiology of severe acute dyspnea where clinical/laboratory findings are ambiguous. 3. Evaluate for tamponade. 4. Evaluate for severe valve regurgitation and/or prosthetic valve dysfunction (may need TEE) 5. Evaluate suspected complication of ACS, such as acute MR, VSD, cardiac rupture, RV involvement, severe heart failure. 6. Evaluation cardiac transplant recipients for acute rejection. <p><u>Hemodynamic instability/shock</u></p> <ol style="list-style-type: none"> 1. Distinguish cardiac vs. non-cardiac etiology of the cause of hypotension or shock. 2. Rapid identification of pericardial effusion, LV/RV dysfunction, and acute valvular dysfunction. 3. Rapid assessment of intravascular volume status. 4. Assess LVAD function, cannula velocities, ventricular function in patient with mechanical circulatory support 5. Identify(unexpected) cause of cardiac arrest in order to guide CPR
<p>Prioritized to first study group next avail weekday (M-F) 7:00AM</p> <p><i>Rationale:</i></p> <p>-Complete study -Better quality -Expedited Formal interpretation -Rested Sonographer</p>	<p><u>Acute chest pain:</u></p> <ol style="list-style-type: none"> 1. In STABLE patients with suspected pericardial disease. 2. Evaluate acute chest pain in patients with known underlying cardiac disease (valvular, pericardial, or primary myocardial) 3. Evaluation of LV function/wall motion <p><u>Dyspnea:</u></p> <ol style="list-style-type: none"> 1. Assess LV size, shape, global/regional function with suspected diagnosis NEW heart failure or NEW pulm hypertension <p><u>New murmur:</u></p> <ol style="list-style-type: none"> 1. In patients with cardiac murmurs and symptoms or signs of or suggestive of heart failure, myocardial ischemia/infarction, syncope, thromboembolism, infective endocarditis, or clinical evidence of structural heart disease. 2. Detection of valve vegetations or new leaflet pathology <p><u>Arrhythmia:</u></p> <ol style="list-style-type: none"> 1. Assess LV size, shape, global/regional function with suspected diagnosis NEW heart failure or NEW pulm hypertension
<p>Transesophageal Echo NPO 6h, includes tube feeds</p> <p>Patient or family designate available for consent</p> <p>Plt count \geq 50k, PTT or INR in therapeutic range</p> <p>Patient must be in ICU or PACU for night/weekend studies.</p> <p>Anesthesia support as needed per UWMC</p> <p>Moderate Conscious Sedation Guidelines</p>	<p><u>Acute chest pain:</u></p> <ol style="list-style-type: none"> 1. Evaluate chest pain with suspected acute aortic syndromes when CT is not feasible or possible myopericarditis 2. Evaluate acute chest pain with suspected myocardial ischemia and non-diagnostic ECG/enzymes <p><u>Hemodynamic instability/shock</u></p> <ol style="list-style-type: none"> 1. Distinguish cardiac vs. non-cardiac etiology of the cause of hypotension or shock. 2. Rapid identification of pericardial effusion, LV/RV dysfunction, and acute valve dysfunction. 3. Rapid assessment of intravascular volume status. 4. Assess LVAD function, cannula velocities, ventricular function in patient with mechanical circulatory support 5. Identify(unexpected) cause of cardiac arrest in order to guide CPR <p><u>Acute dyspnea:</u></p> <ol style="list-style-type: none"> 1. Distinguish cardiac vs. non-cardiac etiology of severe acute dyspnea where clinical/laboratory findings are ambiguous. 2. Evaluate for tamponade. 3. Evaluate for severe valve regurgitation and/or prosthetic valve dysfunction <p><u>Arrhythmia:</u></p> <ol style="list-style-type: none"> 1. Left atrium for thrombus prior to DC cardioversion
<p>To next business day (M-F)</p>	<p><u>Source of Embolus:</u> CVA, TIA, peripheral embolus</p> <p><u>Follow-up of stable patient with known cardiac diagnosis</u></p> <p><u>Elective TTE in a medical/surgical patient with possible secondary cardiac diagnosis:</u> Atrial fibrillation, CHF,</p>

---Adapted from the 4/30/2014 document by Ted Gibbons, MD:

Douglas, PS et al. ACCF/AHA/ASA/ASNC/HFSA/HRS/SCAI/SCCM/SCCT/SCMR 2011 Appropriate Use Criteria for Echocardiography (J Am Soc Echocardiogr 2011;24:229-67.)

Neskovic AN et al. Emergency echocardiography: the European Association of Cardiovascular Imaging Recommendations. Eur Heart J – Cardiovascular Imaging (2013) 14, 1–11