Acute Aortic Syndromes

REFERRAL PATHWAY
THEATRE SOP
ACCU CARE PATHWAY

Surname………………………………………… **First Name**……………….………………

Medical Record No. ………………………….. **NHS Number**…………………………….

Date of admission ……………………………

Diagnosis: Type A AD ☐ **Type A IMH** ☐ **Type B AD** ☐ **Type B IMH** ☐

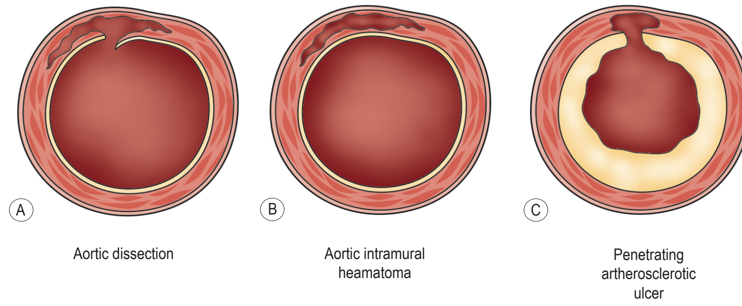
PAU ☐ **Impending rupture** ☐

Management plan: Conservative ☐

Surgery ☐ ……………………………………………………………..

Endovascular ☐ ...……………………………………………………

Responsible Consultant ………………………………………………………………



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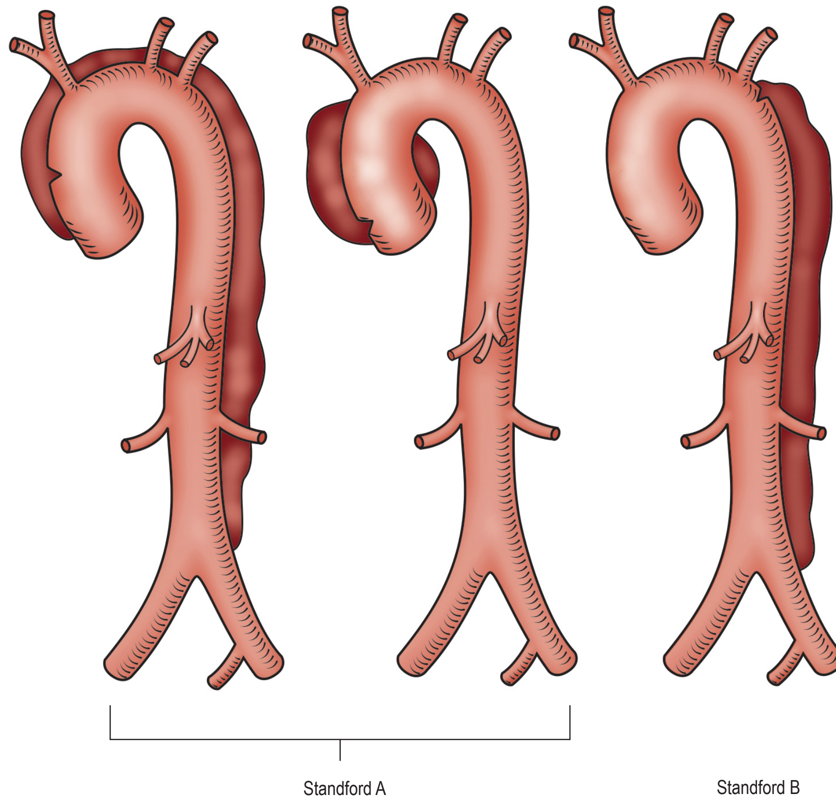

TYPE A AAS

Surgical indication

EMERGENCY SURGERY for:

- AD
- IMH with pericardial effusion

URGENT SURGERY for:

- IMH without effusion
- PAU

TYPE B AAS

Conservative management

- BP control
- Pain management

Urgent intervention if:

- Uncontrolled BP
- Persistent pain
- Malperfusion
- Expanding aortic diameters

TEVAR (preferred in acute setting) vs. Open surgical repair (if no endovascular option)

Acute Type A Aortic Dissection Referral Pathway

Cardiac SpR Receives Referral Call:

- Note history, diagnosis, review of imaging (if not on PACS, rapid image transfer), contact details of referring clinician.
- Discuss with oncall Aortic Surgery Consultant

Cardiac SpR Accept Referral:

- Call referring team and ask for patient to be transferred to Cardiac Theatres, 1st Floor, KGV Building, St Bartholomew's Hospital
- Take patients Name, Date of Birth, NHS Number and Allergies
- IV access, IV labetalol aim SBP <110mmHg, 15min obs

Cardiac SpR Informs the following:

- Anaesthetic SPOC - 07525 618 514 who will inform Consultant
- Theatre Team + Perfusion via Swithboard
- ICU Bed Coordinator who will also register patient and print name bands
- Cardiac SpR to print blood labels and prepare consent form

Team Brief in Theatre prior to arrival of patient

On arrival in theatre:

- Rapid assessment by Surgeon and Anaesthetist
- Consent form signed
- Arterial line inserted and bloods immediately drawn
- HCSW to take bloods to lab
- Anaesthesia commenced
- Procedure will start with "emergency blood" until cross match available

Department of Aortic Surgery, St Bartholomew's Hospital, February 2021

Acute Type A Aortic Dissection Referral Pathway - Checklist

Patients name:

Date of Birth:

NHS Number:

Allergies:

Referring Clinician Name and Phone:

Hospital:

Date of Referral: / / Time:

Presentation: Chest Pain / Back Pain / Abdo Pain / Malperfusion (limb, abdominal, NRL, coronaries) / Incidental

BP: / (Both L and R arms initially and manage higher BP) (On Nil / Labetalol / GTN)

Lactate: Stroke: Yes / No Limb Ischaemia: Yes / No Aortic valve regurgitation: Yes / No

Extent dissection: Root / Ascending / Arch / Descending / Visceral / Iliacs Dissection / IMH / PAU

Significant Medical History

Images Reviewed: Yes / No PACS / Whatsapp Time:

Pericardial effusion: Yes / No

Accepting Aortic Consultant: Oo / Uppal / Yap / Lall / DiSalvo / Adams / Lopez-Marco Time:

Referring Hospital Informed to send patient to Barts: ☐ Time:

Anaesthetic SPOC informed: ☐

Theatre Team Informed: ☐

ICU Coordinator Informed: ☐

Wristbands printed and taken to theatre: ☐

Bloods labels printed and taken to theatre: ☐

Consent form prepared and taken to theatre: ☐

Team Brief Performed: ☐ Time:

Bloods Taken to Lab: ☐ Time

Acute Type B Aortic Dissection Referral Pathway

Cardiac SpR Receives Referral Call:

- Note history, diagnosis, review of imaging (if not on PACS, rapid image transfer), contact details of referring clinician.
- Discuss with oncall Aortic Surgery Consultant
- Discuss with ITU Bed Coordinator

Cardiac SpR Accepts Referral:

- Call referring team and ask for patient to be transferred to HDU/ITU 1st Floor, KGV Building, St Bartholomew's Hospital
- Take patients Name, Date of Birth, NHS Number and Allergies
- IV access, IV labetalol aim SBP <120mmHg

On arrival in ITU:

- Assessment by Cardiac SpR
- Ensure analgesia + BP control (sBP < 120 mmHg - Labetalol (neat) +/- GTN if needed
- Arterial line + CVC line inserted by Anaesthetic team if not present already
- Hourly obs: Cardiovascular, Neuro, Lower limbs, UO. Frequent ABGs

Conservative management plan:

- Conservative treatment if not complicated
- Repeat CT Aorta 48h after admission
- Request TTE
- Early referral to BP consultant (Dr Melvin Lobo / Dr Vikas Kapil) and next planned Aortic MDT
- Discharge from ITU/HDU once 24h without IV BP medication
- Follow-up in Aortic Clinic with repeated CT scan in 4-6 weeks

Escalate to Aortic Consultant if complications:

- Refractory pain or uncontrollable BP
- Signs of malperfusion and/or ischaemia
- Rapid aortic expansion
- For Ad-Hoc MDT discussion +/- Urgent/Emergency intervention (Endovascular or Open Surgery)
- Prepare Cross match, Consent Form and inform relevant teams

Acute Aortic Syndromes Emergency Admission Pathway	
Common admission guidelines to HDU/ITU	
Invasive monitoring	• Central line • Arterial line • Urinary catheter with temperature monitoring • PA sheath +/- PA catheter (if indicated) • ECG
Investigations on admission	Infection control • MRSA screen • CRO screen • COVID19 screen • Urinalysis • Send sputum, urine, faeces for MC&S if clinically indicated Blood tests • FBC, U&E, Coagulation, X-match, hourly ABGs Imaging • Chest x-ray • CT aorta • TTE 12 lead ECG
Observations	Usual level 2/3 clinical observations - Escalate if changes in BP - New chest/back/abdominal pain - New neurological or vascular symptoms - Deterioration in UO, ABGs Hourly neurovascular observations – potential lower limb ischemia or paraplegia Fluid balance – potential oliguria/anuria
Clinical aims	Systolic <120mmHg with Labetalol* (first line) +/- GTN if required Fluid resuscitation if indicated Document plan for re-imaging or intervention planned
Drug chart	MRSA protocol Stop oral anticoagulation & commence systemic heparin when indicated
General	Routine admission documentation Update family liaison hub Surgical consent form and Crossmatch when surgery indicated NBM, Clip chest, abdominal, both groins and legs on morning of surgery

*Consider administering labetalol (neat) via a centra line, especially if expected to be required for >6h or high doses required as high volume of dilution for peripheral labetalol my lead to fluid overload/electrolyte disturbance i.e. hyponatraemia

TYPE B ACUTE AORTIC SYNDROME (AD, IMH, PAU)	

Management plan	• Clear documentation in the notes about management plan. Options:
	  ○ Conservative treatment (BP and pain control): First line
	  ○ Endovascular repair: If complications occur
	  ○ Open repair: If complications occur and there is no endovascular option
	
	• Plan for repeating imaging and additional requests
	  ○ Repeat whole CT Aorta in 48hrs (earlier if clinical deterioration)
	  ○ TTE on admission – repeat if clinically indicated
	  ○ CTCA if plan for surgery
	  ○ CT Head / Limbs when clinically indicated
	
	• Documentation of Responsible Consultant (Cardiac or Vascular Surgeon) and contact number for escalation

Blood pressure	• Keep systolic <120mmHg with Labetalol* (First line) +/- GTN infusion • To remain in HDU/ITU setting until > 24hrs without need for IV anti-hypertensives • Established on oral anti-hypertensives at least 48hrs prior to discharge home • Refer to Blood Pressure Consultant

Complications	Management of complications
Complications may include • Uncontrolled blood pressure • Persistent Pain • Expanding aortic diameters • Malperfusion	**Escalation process:** 1. Cardiac Surgery Registrar On-Call 2. Aortic Surgery Consultant 3. ACCU Consultant if spinal drain alarming, not draining CSF or if one required

*Consider administering labetalol (neat) via a centra line, especially if expected to be required for >6h or high doses required as high volume of dilution for peripheral labetalol my lead to fluid overload/electrolyte disturbance i.e. hyponatraemia

Post op management of Type A AAS with Frozen Elephant Trunk (FET)	
ET tube	Extubate as per normal cardiac surgical pathway
Blood pressure	MAP >80-85mmHg with fluid expansion, and judicious use of noradrenaline +/- vasopressin if vasoplegia present Consider CO monitoring (PA catheter) and TOE if unstable/escalating inotropic and/or vasopressor requirement **Paramount to minimise risk of paraplegia**
Arterial line	Usually radial & femoral arterial line in situ. Remove one of them on Day 1.
PA sheath	If inserted leave in situ for a minimum of 24hrs
VasCath	Citralock vascath - RRT if indicated
Bloods	Send FBC, coagulation, U & E on admission Baseline TEG 6S (Global Coagulation Cartridge) to correct coagulopathy – repeat as clinically indicated
Rewarm	Yes. Use bair hugger if needed
Chest drains	No routine removal. Follow Aortic Team instructions only
Neurovascular Obs	Full neurovascular observations - Use Aortovascular observation chart **Escalate ASAP if lower limbs lack movement or perfusion issues.** Emergency spinal drain insertion
Fluid Balance	Expect at least positive fluid balance of 1-2 Litres in first 24 hours. Significant fluid administration often required.
Sedation	Early sedation-hold to assess lower limb movement (Max. 2h after ITU admission) Escalate if no movement as might indicate SCI and require emergency insertion of spinal drain
Cerebral NIRS	Until extubated
VTE	As normal – no specific need for anticoagulation based on FET (refer to aortic valve indication)
Mobilise	Encouraged when possible

Post op management of Type A AAS without Frozen Elephant Trunk	
ET tube	Extubate as per normal cardiac surgical pathway
Blood pressure	MAP >65-70mmHg with fluid, and inotropes as instructed Consider CO monitoring (PA catheter) and TOE if unstable/escalating inotropic and/or vasopressor requirement
Arterial line	Usually radial & femoral arterial line in situ. Remove one of them on Day 1.
PA sheath	If inserted leave in situ for a minimum of 24hrs
VasCath	Citralock vascath - RRT if indicated
Bloods	Send FBC, coagulation, U & E on admission Baseline TEG 6S (Global Coagulation Cartridge) to correct coagulopathy – repeat as clinically indicated
Rewarm	Yes. Use bair hugger if needed
Chest drains	No routine removal. Follow Aortic Team instructions only
Neurovascular Obs	Full neurovascular observations - Use Aortovascular observation chart Escalate if lower limbs lack movement or perfusion issues.
Fluid Balance	Expect at least positive fluid balance of 1-2 Litres in first 24 hours Significant fluid administration often required
Sedation	Sedation-hold when clinically possible
Cerebral NIRS	Until extubated
VTE	As normal – need for anticoagulation based on aortic valve indication
Mobilise	Encouraged when possible

Neurological Assessment Chart

Date																										
Time																										
Pset																										
MAP																										
ICP (Pcsf)																										
CPP (MAP – ICP)																										
RASS/GCS score			**RASS/GCS assessment at same time as Motor/Sensation Assessment - Document on ACCU observation chart**																							
Cerebral O_2 Sats %		**L**																								
		R																								
Spinal O_2 Sats %		**L**																								
		R																								
Pupil size & reaction			**Pupil assessment at same time as Motor/Sensation Assessment - Document on ACCU observation chart**																							
Motor Power & Movement Assessment Score 0 - 5	**Left Leg Score 0 - 5**	Point toes																								
		Flex foot																								
		Bend knee																								
	Patient unable to obey commands. Moves left leg spontaneously																									
	Unable to assess due to RASS/GCS. No spontaneous left leg movement																									
	Right Leg Score 0 - 5	Point toes																								
		Flex foot																								
		Bend Knee																								
	Patient unable to obey commands. Moves right leg spontaneously																									
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Sensation - Normal (N), Impaired (I) or Absent (A)	**Left Leg**	**Thigh** Normal Impaired Absent																								
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		Foot Normal Impaired Absent																								
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Signature																										

Peripheral Neurovascular (Limb perfusion) Assessment (√ as appropriate)

		Date																								
		Time																								
Limb Pain Assessment	Pain at rest	None/mild																								
		Moderate																								
		Severe																								
	On passive movement	None/mild																								
		Moderate																								
		Severe																								
	Pain since last analgesia	No pain/ Pain has improved																								
		Is the same																								
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Barts Health NHS
NHS Trust

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Motor Power & Movement Assessment Score 0 - 5	Left Leg Score 0 - 5	Point toes																								
		Flex foot																								
		Bend knee																								
	Patient unable to obey commands. Moves left leg spontaneously																									
	Unable to assess due to RASS/GCS. No spontaneous left leg movement																									
	Right Leg Score 0 - 5	Point toes																								
		Flex foot																								
		Bend Knee																								
	Patient unable to obey commands. Moves right leg spontaneously																									
	Unable to assess due to RASS/GCS. No spontaneous right leg movement																									
Sensation - Normal (N), Impaired (I) or Absent (A)	Left Leg	**Thigh** Normal Impaired Absent																								
		Calf Normal Impaired Absent																								
		Foot Normal Impaired Absent																								
	Unable to assess due to RASS/GCS																									
	Righ t Leg	**Thigh** Normal Impaired Absent																								
		Calf Normal Impaired Absent																								
		Foot Normal Impaired Absent																								
	Unable to assess due to RASS/GCS																									
		Signature																								

Peripheral Neurovascular (Limb perfusion) Assessment (√ as appropriate)

		Date	
		Time	
Limb Pain Assessment	Pain at rest	None/mild	
		Moderate	
		Severe	
	On passive movement	None/mild	
		Moderate	
		Severe	
	Pain since last analgesia	No pain/ Pain has improved	
		Is the same	
		Has worsened	
	Unable to assess √		
	IF unable to assess limb pain due to RASS/GCS – Document CPOT scores on ACCU observation chart		
Pulse	Left lower limb	Normal	
		Weak	
		Doppler	
		Absent	
	Right lower limb	Normal	
		Weak	
		Doppler	
		Absent	
	Left upper limb	Normal	
		Weak	
		Doppler	
		Absent	
	Right upper limb	Normal	
		Weak	
		Doppler	
		Absent	
Colour & capillary refill	Left lower limb	No skin colour change &/or CRT ≤2 sec	
		Pale, cyanotic, mottled &/or CRT ≥ 2 sec	
	Right lower limb	No skin colour change &/or CRT ≤2 sec	
		Pale, cyanotic, mottled &/or CRT ≥ 2 sec	
	Left upper limb	No skin colour change &/or CRT ≤2 sec	
		Pale, cyanotic, mottled &/or CRT ≥ 2 sec	
	Right upper limb	No skin colour change &/or CRT ≤2 sec	
		Pale, cyanotic, mottled &/or CRT ≥ 2 sec	
NIRS	O_2Sats %	Left calf	
		Right calf	
Warmth	Left lower limb	Warm	
		Hot/Cool	
		Cold	
	Right lower limb	Warm	
		Hot/Cool	
		Cold	
	Left upper limb	Warm	
		Hot/Cool	
		Cold	
	Right upper limb	Warm	
		Hot/Cool	
		Cold	
Signature			