**IS WELLS’ SCORE ALWAYS WELL?**

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| Introduction: Pulmonary embolism is not uncommon, with its probability determined by clinical gestalt or risk stratification tools such as Wells’ score.  Case description: A 58-year-old man, underlying diabetic nephropathy with nephrotic syndrome, presented with breathlessness and fever. He was tachypneic, tachycardic, hypoxic, and febrile with lung crepitations. Electrocardiography (ECG) showed sinus tachycardia with T inversion over lead V1-V3. Bedside echocardiography revealed dilated right ventricle with septal flattening. Arterial blood gas showed hypoxia, metabolic acidosis with wide A-a gradient. Calculated Wells’ score fell into ‘PE unlikely’ category. Nevertheless, urgent computed tomography pulmonary angiography was done in view of high probability according to clinical gestalt and multiple episodes of transient hypotension, which reported bilateral main pulmonary artery thromboembolism and pneumonia. He was diagnosed with unprovoked intermediate-high-risk pulmonary embolism (elevated troponin), and treated with subcutaneous enoxaparin and intravenous antibiotics. Subsequently, he underwent catheter-directed thrombolysis and aspiration thrombectomy with removal of 80% of clot burden. He was discharged with oral anticoagulant.  Discussion: Risk stratification of pulmonary embolism can occur by clinical gestalt or a risk stratification tool such as Wells’ score [1]. However, whether to use a risk stratification tool or clinical gestalt is a topic of debate [1]. A meta-analysis of prospective studies found that the sensitivity of clinical gestalt was comparable to risk stratification tools [1]. Wells’ score has pitfalls in which it excludes other persistent risk factors (besides active malignancy), ECG and echocardiographic findings within its criteria. Clinical gestalt can be used alternatively for risk stratification. Nephrotic syndrome is under-recognized as a risk factor of thromboembolism, which is related to increased synthesis of prothrombotic factors, urinary loss of antithrombotic proteins, hypoalbuminemia, impaired fibrinolysis, and intravascular volume depletion leading to hypercoagulability and blood stasis [2]. Interventional therapy may be considered as reperfusion strategy in intermediate-risk pulmonary embolism with hemodynamic and respiratory deterioration [3].  Conclusion: High index of suspicion with use of Wells’ score or clinical gestalt is required for diagnosis of pulmonary embolism. The presence of another pathology (pneumonia) does not rule out pulmonary embolism. Timely recognition with prompt treatment will lead to favourable outcome.  Keywords: Pulmonary Embolism, Clinical Gestalt, Wells’ Score |