TREATMENT OF AORTIC DISSECTION

AORTIC DISSECTION/INTRAMURAL HAEMATOMA/PENETRATING AORTIC ULCER
on CT aortogram

MOVE PATIENT TO RESUS
+ inform ED CIC/NIC

REFER

- **Type A/proximal to left SCA to CARDIOTHORACICS SpR (bleep ****)**
- **Type B/distal to left subclavian artery to VASCULAR SpR (bleep ****)**
- **Both types to INTENSIVE CARE SpR (bleep ****)**

INITIATE MEDICAL THERAPY
Goal is to minimise aortic wall shear stress/propagation of dissection flap by reducing HR and BP

GIVE IV ANTIEMETIC (e.g. metoclopramide) AND IV OPIATES (e.g. morphine)
Pain drives HR and BP up and must be treated aggressively
Consider fentanyl 25-50 mcg boluses if pain morphine-resistant

CONTROL HR & BP WITH IV LABETALOL (OR METOPROLOL)
+ SODIUM NITROPRUSSIDE (use with caution)*
AIM FOR HR <60/min and SBP 100-120 mmHg
Beta blocker therapy must be established first; SNP may cause a damaging reflex tachycardia if used alone
If an inter-arm BP differential exists, titrate to the higher BP

DO NOT DISCHARGE A PATIENT IN WHOM AD HAS BEEN SERIOUSLY CONSIDERED WITHOUT FIRST DISCUSSING WITH THE ED CONSULTANT
(REPEAT IMAGING IS OCCASIONALLY REQUIRED)

AT ALL TIMES, ESCALATE CONCERNS TO CIC/NIC

*Do not give GTN – GTN increases aortic shear stress and may extend the dissection.
If beta-blockers contraindicated, consider IV verapamil.