

Pulmonary embolism: a case report

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Introduction: Pulmonary embolism is obstruction of one or more branches of the pulmonary artery caused by a clot that most often forms in the veins of the legs or pelvis and reaches the lungs through the bloodstream. It is a condition that requires immediate diagnostic workup and therapy. CT angiography of the pulmonary arteries is a gold standard when diagnosing pulmonary embolism. Symptoms and signs are dyspnea accompanied by chest pain and cough, tachycardia and headache. One of the possible and at the same time the most serious complications is sudden cardiac arrest. Fainting and convulsions occur due to the reduced ability of the heart to deliver a sufficient amount of oxygenated blood to the brain and other organs. Standard treatment is anticoagulant therapy and/or fibrinolytics, the use of oxygen and supportive therapy such as analgesics and sedatives. It is important to inform the patient about possible complications in a timely manner.¹⁻³ In this paper, we will present the case of the patient with a massive pulmonary embolism.

Case report: A 40-year-old female patient was admitted to Intensive Cardiac Care unit after surviving out of hospital cardiac arrest. Patient recently had laparoscopic gynecological surgery due to menorrhagia and was on oral contraceptive therapy. Upon arrival at the emergency department the patient was unconscious and had no pulse, cardiopulmonary resuscitation was performed until spontaneous circulation was established. The patient was intubated and mechanically ventilated. MSCT pulmonary angiography showed bilateral massive pulmonary embolism. During the patient's stay in Intensive cardiac care unit, trained nurses monitored daily vital functions and recorded changes in them. Due to hemodynamic instability, vasopressors and inotropes were initiated. Due to a recent surgical procedure, a mechanical thrombectomy was performed through the right femoral vein, during which a significant amount of clots were removed. Due to recurrent and persistent hemodynamic instability after thrombectomy, alteplase fibrinolytic therapy was administered, which led to only temporary stabilization. Unfortunately, once again patient condition was getting worse and she was in cardiogenic shock that did not respond to medical therapy. ECMO circulatory support was instituted. After hemodynamic stabilization ECMO decannulation was performed three days later and patient was extubated the day after. This was followed spontaneous breathing with preserved consciousness and adequate contact with the environment. Given the complexity of the patient's condition, the nurses created an adequate health care plan and selected interventions to achieve the set goal as best as possible. The patient was stable and discharged home awaiting further rehabilitation.

Conclusion: In addition to patient care, nurses participate in education and psychological support. It is a serious and potentially fatal condition that requires quick and coordinated teamwork of healthcare professionals, which is crucial for quick diagnosis, adequate treatment and recovery of the patient.

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