Vascular, Stroke, VTE and Anticoagulation Reference

Course 03 · Cardiovascular, Vascular and Hematology · October 2026

PAD and aortic emergencies

• Typical claudication: exertional calf discomfort relieved with rest; ABI <=0.90 supports PAD.

• ABI >1.40 can reflect noncompressible vessels; toe-brachial index can help.

• Painful cold pulseless limb or pain at rest/ulceration: emergency or expedited limb assessment as severity warrants.

• Acute tearing chest/back pain and pulse deficit: emergency aortic syndrome evaluation.

TIA and stroke

• FAST deficits or sudden visual loss require emergency activation even if transient.

• Document last-known-well, symptoms, glucose and anticoagulant history.

• IV thrombolysis commonly considered within 4.5 hours in eligible patients; imaging-based options may extend treatment in selected cases.

• Stroke-team imaging and endovascular thrombectomy selection may extend to 24 hours in selected patients.

DVT/PE testing

• Determine clinical probability before testing; use D-dimer mainly to exclude VTE in selected low-risk settings.

• Suspected DVT: compression ultrasound when indicated; suspected PE: CTPA or suitable alternative when indicated.

• Unstable patient with possible PE: emergency assessment rather than delayed outpatient testing.

Anticoagulation safety

• Distinguish antiplatelets from anticoagulants; each has different indications.

• DOACs often preferred in suitable AF/VTE patients; mechanical valves and rheumatic mitral stenosis usually require warfarin.

• Check kidney function, interactions, pregnancy, bleeding history and procedure plans.

• Melena, hematemesis, severe headache, hypotension or focal deficits while anticoagulated require urgent evaluation.

AHA/ACC — 2024 Peripheral Artery Disease Guideline

Canadian Stroke Best Practices — Acute Ischemic Stroke Treatment

AHA/ACC — Atrial Fibrillation Clinical Practice Guideline

Canadian Cardiovascular Society — Guidelines Library

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