Pulmonary embolic disease is associated with greater mortality in the elderly (4,6), emphasising the importance of a timely diagnosis and instituting early appropriate management. Supportive measures should be considered in all patients, including analgesia, oxygen and fluid replacement (7).

Patients presenting with a massive PE and showing evidence of circulatory collapse should be considered for thrombolysis (7). Most studies suggest there is no significant difference in the bleeding risk associated with thrombolysis between elderly and younger patients (17,18), although one study does show the converse (19). Nonetheless massive PE carries a particularly poor prognosis in the elderly (20) such that any bleeding risks are more than likely outweighed by the potential benefits.

In patients with a massive PE anticoagulation is the treatment of choice (7). Elderly patients are often anticoagulated without incident for a number of other diagnoses and thus age per se should not be seen as a contraindication to warfarin therapy (21). A study of nonagenarians (ie >90yrs) presenting with pulmonary embolism showed that the risk of fatal PE (5.9%) was greater than the risk of fatal bleeding (2.2%) suggesting that the benefits of treatment potentially outweigh the risks even in this extreme age group.

In patients in whom anticoagulation is absolutely contraindicated an IVC filter can be considered as an alternative approach to treatment (7). A recent population-based study from the US showed that IVC filters were predominately used in the elderly, presumably as there were more contraindications to anticoagulation in this group (23). Long term mortality was worse in those with an IVC filter alone suggesting that formal anticoagulation remains the preferred treatment option.

CONCLUSIONS

Pulmonary embolic disease presents both a diagnostic and a management challenge in the elderly. With an appropriate level of suspicion however, diagnosis is timely and treated in much the same way as younger patients.

REFERENCES

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