**ASSESSMENT OF ACUTE AORTIC DISSECTION**

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| **A. Demographics** |

1. **Are you:**  Male  Female
2. **Have you seen any patients in the last year with acute aortic dissection?**  Yes  No
3. **How many years have you been practicing medicine?** \_\_\_\_\_\_\_ Years
4. **How many years of residency training?** \_\_\_\_\_\_\_ Years
5. **On average how many patients do you see per week?** \_\_\_\_\_\_\_ # Patients/week
6. **In what setting do you perform MOST of your clinical activities? Tick one box**
7. Teaching Hospital
8. Community / District General Hospital: Teaching
9. Community / District General Hospital: Non-Teaching
10. Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **B. Need and priority of a decision aid** |

1. **Do we need a clinical decision aid/tool for acute aortic dissection?** Yes  No  Unsure
2. **Should the priority be**
   1. reduce unnecessary imaging  or reduce miss rate or equally important
3. **Which is more important?** The ability to rule out acute aortic dissection..

The ability to rule in acute aortic dissection.….

Equally important……………………………………………………………

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| **C. Components of proposed decision aid/tool** |

1. **Please provide your opinion on the importance of each of the following variables in the proposed score to determine which patients are at risk for Acute aortic dissection**

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| **Pain Descriptors** | Very Important | Important | Less Important | Never Important |
| 1. Thunderclap pain (acute onset chest, back, abdominal, flank pain reaching max intensity within 1 hour) |  |  |  |  |
| 1. Migrating pain |  |  |  |  |
| 1. Tearing/ripping pain |  |  |  |  |
| 1. Pleuritic pain |  |  |  |  |
| 1. Pain - dull, pressure, burning |  |  |  |  |
| **Past medical history** |  |  |  |  |
| 1. History of aortic aneurysm 2. Hypertension |  |  |  |  |
| 1. Ischemic heart disease |  |  |  |  |
| 1. Diabetes |  |  |  |  |
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| **Physical Exam** |  |  |  |  |
| 1. New cardiac murmur |  |  |  |  |
| 1. Pulse deficit |  |  |  |  |
| 1. Neurological deficit (including syncope) |  |  |  |  |
| 1. Hypotension |  |  |  |  |
| **Clinical suspicion for acute aortic dissection** |  |  |  |  |
| **Clinical suspicion for an alternative diagnosis** |  |  |  |  |

1. **If the proposed risk score is validated to accurately risk stratify patients for Acute aortic dissection will you incorporate this tool in your clinical practice? Yes**   **Likely**  **Unlikely**   **No**

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| D. **Optimal Cut point for Risk Strata** | | |
| 1. Based on an individual patient’s risk score, we would like to classify the patient as “Low”, “Medium”, or “High” risk. |

1. **What is an acceptable miss rate for acute aortic dissection** **<1%** **1-5%** **5-10%**  **other \_\_\_\_\_\_\_\_\_\_**
2. **What is an acceptable percentage of positive computed tomographic scans (yield) for acute aortic dissection? 2-5%** **5-10%** **10-20%**  >20%  **other \_\_\_\_\_\_\_\_\_\_**
3. **What is an acceptable number of missed cases of acute aortic dissection at your hospital?**

**1 missed case/ year**

**1 missed case every 2 years**

**1 missed case every 3 years**

**1 missed case every 5 years**

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|  | **E. Tests available in your hospital** | | | | |  | | | |
| 1. Do you have 24 hour access to Computed tomography  Yes No Sometimes 2. Do you have D-dimer available at your institution?  Yes No 3. Would you be comfortable using D-dimer to rule out AAS in a low risk group?  Yes No Maybe | | | | | |  | |  | |  | |
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| **F. Comments** | |  | |  | |  | |  | | | |