and disposition decision and identify factors driving the discordance. Secondary outcome measures included comparing 30-day readmission rate, 30-day and 90-day mortality between the discordant PESI groups. **Results:** 365 patients were diagnosed with PE in the study period with 60% being admitted and 40% discharged. The median PESI score in admitted patients was 85 (26-172) vs. 68 (20-163) in discharged patients. 51% of admitted patients had a low-risk PESI score and 24% of the discharged patients were high-risk PESI. 30-day readmission rate was 22.9% vs. 5.3% ($p = 0.002$) in discharged patients with high-risk PESI vs. discharged patients with low-risk PESI. Hypoxemia was the most common (62%) justification for admission in low-risk PESI groups. Among discharged patients we noted an 8.6% 90-day mortality in the high-risk vs. 0% in the low-risk PESI groups. **Conclusion:** Discharging a PE patient from the ED with a high PESI score carries a significant risk of ED revisit and readmission. Hypoxia was the reason for admission in majority of low risk PE patients.

Keywords: pulmonary embolism severity index, acute pulmonary embolism

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Pain free laceration repairs using intra-nasal ketamine: DosINK 1- A dose escalation clinical trial

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Introduction: Laceration is common in children presenting to the emergency department (ED). They are often uncooperative related to pain and distressed during repair. Currently, there are wide variations regarding sedation and analgesia practices when sutures are required. There is a growing interest in the intranasal (IN) route for procedural sedation and pain control because of its effectiveness potential and ease of administration. Few studies have evaluated IN ketamine for procedural sedation in children with reported doses ranging from 3 to 9 mg/kg. The objective is to evaluate the optimal IN ketamine dose for effective and safe procedural sedation for laceration repair in children aged 1 to 12 years. **Methods:** A dose escalation clinical trial with an initial dose of 3 mg/kg of IN ketamine up to a maximum dose of 9 mg/kg in children 1 to 12 years old, using a 3+3 trial design. For each tested dose, 3 patients are enrolled. Escalation to the next dose is permitted if sedation is unsuccessful in at least one patient without serious adverse event (SAE). Regression to prior dose is warranted in the occurrence of two or more SEAs. This process is repeated until effective sedation for 6 patients at two consecutive doses is achieved with a maximum of 1 SAE or if regression occurs. The primary outcome is the optimal dose for successful procedural sedation as per the PERC/PECARN consensus criteria. Secondary outcome, namely, pain and anxiety levels, parent, patient and provider satisfaction, recovery time, length of stay in the ED, side effects and adverse event are recorded. **Results:** Nine patients have been recruited from March to December 2017 with median age of 2.9 years-old and with laceration length of 2 to 5 cm and with facial involvement in 55% of cases, respectively. Sedation was successful in 1/3, 1/3 and 3/3 of patients at doses of 3, 4, 5 mg/kg respectively, without any SAE. Median time from ketamine administration to return to baseline status and discharge were 35 and 98 min, respectively. We expect to complete patient recruitment in March 2018. **Conclusion:** The results from our trial is a groundwork for future dose-finding study. Pending study completion, a multicentric dose validation trial, is set up to further validate the optimal dose from dosINK1 trial. IN ketamine has the potential to improve the field of procedural sedation for children by introducing an effective IN agent with respiratory stability but without the need for an IV line insertion not otherwise needed.

Keywords: intranasal, ketamine, procedural sedation

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Rapid hepatitis C virus screening and diagnostic testing for high-risk patients in an urban emergency department: a pilot project

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Introduction: Hepatitis C virus (HCV) infection represents a significant public health problem in Canada and it is estimated that nearly half of individuals with chronic hepatitis C infection are unaware of their disease status. Previous studies of urban emergency department (ED) based screening programs have shown a prevalence ranging from 7.3 to 26% in high risk patients presenting to the ED . The advent of new treatment regimens with high rates of virologic cure strengthens the case for identifying the optimal setting for screening and testing individuals who may benefit from treatment. The proposed pilot project of ED-based screening for hepatitis C virus will aim to determine the prevalence of undiagnosed HCV infection and to link patients with chronic HCV infection to appropriate specialized follow-up care. **Methods:** We will be conducting a prospective cohort study of patients presenting to an urban emergency department between March and May 2018. Patients will be screened using high risk criteria for HCV infection as per national guidelines. Eligible patients will be offered and consented for a rapid point of care antibody test. Individuals with a positive antibody screen will have confirmatory testing and be linked to hepatology follow-up. The primary outcome will be the prevalence of hepatitis C virus among tested patients. Secondary outcomes will include the proportion of high risk patients without a primary care MD or access to alternate care settings where screening may occur, as well as the proportion of HCV-positive patients who are successfully linked to care. **Results:** We expect to screen approximately 2000 participants during the study period leading to an estimated 400 rapid antibody tests. Based on published results from other centres, we estimate that a significant proportion of screened patients will test positive for chronic HCV infection ($>$ 10%). Descriptive analyses will be performed for all variables using proportions with 95% confidence intervals. **Conclusion:** To our knowledge, no emergency department in Canada has undertaken protocoled HCV screening using rapid antibody testing in the ED. Results will inform the future development of integrated ED-based screening programs in novel settings more likely to be accessed by the at-risk population. Linking patients with chronic HCV infection to appropriate care will decrease the number of individuals developing HCV-related cirrhosis and hepatocellular carcinoma, thereby improving patient outcomes and reducing the future impact on our health care system.

Keywords: screening, public health, hepatitis C virus

P121

Derivation of a clinical decision tool for predicting adverse outcomes among emergency department patients with lower gastrointestinal bleeding

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Introduction: Lower gastrointestinal bleeding (LGIB) can result in serious adverse events, including recurrent bleeding, need for intervention

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