Simplification of the Revised Geneva Score for Assessing Clinical Probability of Pulmonary Embolism

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Background: The revised Geneva score is a fully standardized clinical decision rule (CDR) in the diagnostic workup of patients with suspected pulmonary embolism (PE). The variables of the decision rule have different weights, which could lead to miscalculations in an acute setting. We have validated a simplified version of the revised Geneva score.

Methods: Data from 1049 patients from 2 large prospective diagnostic trials that included patients with suspected PE were used and combined to validate the simplified revised Geneva score. We constructed the simplified CDR by attributing 1 point to each item of the original CDR and compared the diagnostic accuracy of the 2 versions by a receiver operating characteristic curve analysis. We also assessed the clinical utility of the simplified CDR by evaluating the safety of ruling out PE on the basis of the combination of either a low-intermediate clinical probability assessed recently.2 Correct implementation of CDRs in the clinician in diagnostic decision making.2 Correct implementation of CDRs in diagnostic strategies has been proven to decrease the need for expensive, time-consuming, and invasive diagnostic imaging procedures. Moreover, the venous thromboembolism failure rate is acceptably low in patients in whom PE is ruled out by various diagnostic criteria including a CDR and when anticoagulant treatment is withheld.3-5

Although 2 CDRs for the pretest probability of PE have been extensively validated, ie, the Wells rule and the Geneva score,6-10 both have practical limitations.7-10 A fully standardized rule exclusively based on objective clinical items, the revised Geneva score, has been developed and validated recently.9,10 The revised Geneva score is independent of physicians' implicit judgment, which makes this CDR objective and easily reproducible.10 The score consists of 8 different variables with different individual weights (Table 1), which might lead to miscalculations in acute patient care. Also, a more complicated score may be less likely to be used by clinicians or remembered correctly.11 Therefore, we evaluated whether a simplified version of the revised Geneva score in which each variable would be attributed 1 point (Table 1) would retain its diagnostic accuracy and clinical useful-
nography that showed deep venous thrombosis received anti-
mobility, plasma D-dimer levels (VIDAS D-Dimer Exclusion Test; 
considered to be excluded if the diagnosis of PE was unlikely (Wells 
clinical probability. The revised Geneva score comprises 4 variables 
29 patients in the unlikely clinical probability group as assessed by the simplified 
results in missing D-dimer data for 69 patients in the low- and 
results of both studies were combined in a single database. Optimal cutoff points for the 
were attributable to a heart rate of 95 beats/min or more.

Abbreviations: DVT, deep vein thrombosis; PE, pulmonary embolism.

Table 1. Scoring of the 8 Variables in the Original and Simplified Revised Geneva Score

<table>
<thead>
<tr>
<th>Variable</th>
<th>Original</th>
<th>Simplified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt;65 y</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Previous DVT or PE</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Surgery (under general anesthesia) or fracture (of lower limbs) within 1 mo</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Active malignant condition (solid or hematologic, currently active or considered cured &lt;1 y)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Unilateral lower-limb pain</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Hemothysis</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Heart rate, beats/min</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>75-94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;95</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pain on lower-limb deep venous palpation and unilateral edema</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2. Scoring of the 7 Variables of the Wells Rule

<table>
<thead>
<tr>
<th>Variable</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical signs and symptoms of DVT (minimum of leg swelling and pain on deep venous palpation)</td>
<td>3</td>
</tr>
<tr>
<td>Alternative diagnosis is less likely than PE</td>
<td>3</td>
</tr>
<tr>
<td>Heart rate greater than 100 beats/min</td>
<td>1.5</td>
</tr>
<tr>
<td>Immobilization or surgery in the previous 4 wk</td>
<td>1.5</td>
</tr>
<tr>
<td>Previous DVT/PE</td>
<td>1</td>
</tr>
<tr>
<td>Hemothysis</td>
<td>1</td>
</tr>
<tr>
<td>Malignant neoplasm (patient receiving treatment, treated in past 6 mo, or receiving palliative care)</td>
<td>1</td>
</tr>
</tbody>
</table>

Abbreviations: DVT, deep venous thrombosis; PE, pulmonary embolism.

To test this hypothesis, we retrospectively compared the performance of the original and the simplified revised Geneva scores in 2 large patient cohorts.3,4

METHODS

PATIENTS

Data from 2 large prospective diagnostic trials that included patients with suspected PE were used and combined for the validation of the simplified revised Geneva score.3,4

In the first trial (study A), consecutive patients with suspected PE admitted to the emergency department of 3 teaching hospitals (Geneva University Hospital, Geneva, Switzerland; Angers University Hospital, Angers, France; and Hôpital Européen Georges-Pompidou, Paris, France) between August 1, 2002, and November 30, 2003, were eligible for inclusion.3 In study B, D-dimer tests were performed only in patients with a Wells score of 4 or less. This resulted in missing D-dimer data for 69 patients in the low- and intermediate-probability group and for 29 patients in the unlikely clinical probability group as assessed by the simplified revised Geneva score.

ASSESSMENT OF THE REVISED GENEVA SCORE

In study A,3 the data collection form was identical to that used in the derivation study of the revised Geneva score, allowing retrospective calculation of the simplified revised Geneva score for each patient. In study B,4 the Wells rule was used for assessing clinical probability. The revised Geneva score comprises 4 variables not included in the Wells rule: age, unilateral lower-limb pain, heart rate, and signs of deep venous thrombosis (pain on lower-limb deep venous palpation and unilateral edema). The 4 variables absent from the original database were extracted from the medical charts in a prespecified standard way by 2 independent observers after blinding of the diagnosis (PE or no PE) by a third person not involved in the data extraction. Lower-limb pain and signs of deep venous thrombosis were routinely recorded in patient charts in the setting of a clinically suspected PE. Therefore, there were no missing data.

In the simplified revised Geneva score, all variables were given 1 point if present (Table 1). Because of the weight of heart rate in the original score, we attributed 1 point to a heart rate between 75 and 94 beats/min and an additional point for a heart rate of 95 beats/min or more.

DATA ANALYSIS

Patient characteristics and outcomes of both studies were combined in a single database. Optimal cutoff points for the simplified Geneva score were determined by a receiver operating
characteristic (ROC) analysis. To account for the existence of both 3-level (low, intermediate, or high clinical probability) and 2-level (PE unlikely or likely) schemes in clinical practice, we set cutoff points for both schemes. Accuracy of the simplified revised Geneva score and the revised Geneva score was compared by means of the area under the curve (AUC) in ROC analyses of the continuous score and of the 3-level classification scheme. Comparing the AUC for the continuous scores was designed to compare the original and simplified rule more precisely, using all possible point scores. However, the continuous score is not meant for clinical use. We studied the clinical course of patients with a normal D-dimer result in different clinical probability categories using the simplified revised Geneva score. Statistical analysis was performed by using SPSS software (SPSS for Windows 14.0.2; SPSS Inc, Chicago, Illinois). P < .05 was considered statistically significant.

Results

Study A included 756 outpatients. They had a mean (SD) age of 60 (19) years, and 454 were female (60.1%). The overall prevalence of PE in this cohort was 25.6% (194 patients). However, owing to missing values mainly for heart rate, the revised Geneva score could not be computed in 7 patients, leaving 749 for the present analysis, including 192 patients with PE (25.6%). Three hundred patients in study B with suspected PE were included in the present study. These patients were 47 (16) years old at time of diagnosis, 181 were female (60.3%), and 289 were outpatients (96.3%). The overall prevalence of PE in this cohort was 16.3% (49 patients). Taken as a whole, the complete study population consisted of 1049 patients with an overall prevalence of venous thromboembolism of 23.0% (241 patients).

In selecting the optimal cutoffs for the 3-level scheme, a low clinical probability was defined as a score of 0 or 1 point, an intermediate probability as 2 to 4 points, and a high probability as 5 points or more (Figure 1 and Figure 2). With the use of these cutoff points, 378 patients (36.0%) were assigned to the low clinical probability category (prevalence of PE, 7.7% [95% confidence interval (CI), 5.2%-10.8%]), 629 patients (60.0%) to the intermediate clinical probability category (prevalence of PE, 29.4% [26.9%-33.1%]), and 42 patients (4.0%) to the high clinical probability category (prevalence of PE, 64.3% [48.0%-78.5%]). The optimal cutoff for the 2-level scheme was 3 points, patients with a score of 0 to 2 being categorized as unlikely to have PE and those with a score of 3 or more as likely to have PE (Figure 1); 681 patients (64.9%) were designated unlikely to have PE (prevalence of PE, 12.9% [10.5%-15.7%]) and 368 patients (35.1%) were designated likely to have PE (prevalence of PE, 41.6% [36.3%-46.8%]). Flowcharts for both dichotomized and trichotomized rules are shown in Figure 3 and Figure 4.

We compared the AUC for the revised Geneva score and simplified revised Geneva score (Figure 2). The AUC of the continuous score was 0.75 (95% CI, 0.71-0.78) for the revised Geneva rule and 0.74 (0.70-0.77) for the simplified revised Geneva rule. The AUC of the 3-level classification scheme was 0.70 (0.66-0.74) for the revised Geneva score and 0.68 (0.64-0.72) for the simplified revised Geneva score.

Finally, we studied the clinical utility of the simplified revised Geneva score. Of all patients in the combined patient population with a normal result of the D-dimer test, in whom PE was excluded (n = 361), 2 patients were lost during follow-up and an additional 10 received anticoagulant therapy for reasons other than PE. These patients were excluded from the analysis. During 3 months of follow-up, no patient with a low (0 of 219 [0%; 95% CI, 0.0%-1.7%]) or intermediate (0 of 130 [0%; 0.0%-2.8%]) clinical probability score by the simplified revised Geneva score and a normal D-dimer result at inclusion was subsequently diagnosed as having venous thromboembolism (Figure 3). When the 2-level rule was used, no patient with an unlikely clinical probability (0 of 318 [0%; 0.0%-1.2%]) was subsequently diagnosed as having venous thromboembolism after the 3-month follow-up period (Figure 4).

This study shows that it is possible to simplify the revised Geneva score without decreasing the diagnostic accuracy of the rule. The distribution of the patient proportions by the simplified revised Geneva score in both dichotomized and dichotomized categories and the prevalence of PE in these categories were comparable to those of the original revised Geneva score as well as to 3 other validated CDRs: the Wells rule, the Geneva score, and the rule by Kline et al. The simplified revised Geneva score is clinically useful and might safely rule out PE when combined with a normal D-dimer result using a highly sensitive assay. Indeed, in this cohort, the venous thromboembolism failure rates were extremely low in patients with normal D-dimer results and a low-intermediate clinical probability (3-level scheme) or a “PE unlikely” as-
essment (2-level score). The simplified score would likely be easier to compute and may reduce computational errors in clinical practice in busy environments with a heavy workload.

Several studies have shown D-dimer assays to have a high negative predictive value and to be a sensitive but nonspecific marker of PE. However, different sensitivity for several D-dimer assays has been described in the literature. Less sensitive tests yield a lower negative predictive value for the same pretest probability of PE. Also, the negative predictive value of a normal D-dimer test result diminishes as disease prevalence rises. As a consequence, the proportion of patients with suspected PE in whom D-dimer testing can safely be used to exclude PE depends on both the prevalence of the disease and the sensitivity of the D-dimer assay. This is why we adopted 2 different schemes. Table 3 shows the posttest probability of PE for various combinations of clinical probability categories and D-dimer assays. The upper limit of the 95% CI of the 3-month thromboembolic rate after negative pulmonary angiography is 2.7%. Using this 3% as the upper posttest probability limit above which it is no longer safe to rule out PE by the combination of clinical probability and a negative D-dimer result, Table 3 shows that, with a 3-level score, a less sensitive D-dimer assay would exclude PE safely only in low-probability patients, whereas the same assay would still be safe in the patients in whom PE was unlikely by using the 2-level score. For this reason, a less sensitive assay would rule out PE in more patients and therefore be more useful in combination with the dichotomized rule because there are more patients categorized as PE unlikely than in the low clinical probability category (Figure 1). Conversely, the 3-level score would be more useful when a highly sensitive assay is used because it would safely rule out PE in both the low and intermediate probability groups, which would regroup a higher number of patients than the PE unlikely category. In the present study, a highly sensitive quantitative D-dimer assay with a reported sensitivity of 95% to 98% was used, and the out-

Figure 2. Receiver operating characteristic curves. A, Continuous revised Geneva score (RGS) and simplified RGS. B, Three-level categorized RGS and simplified RGS.

Figure 3. Flowchart of patients showing outcomes by 3-level simplified revised Geneva score. *One patient was lost to follow-up and 3 patients were treated with anticoagulant therapy for reasons other than pulmonary embolism (PE). †One patient was lost to follow-up and 7 patients were treated with anticoagulant therapy for reasons other than PE. CI indicates confidence interval.
come of 3-month follow-up was good in either low-intermediate probability or PE unlikely categories. However, a physician using the simplified revised Geneva score in combination with a D-dimer assay with a lower sensitivity should probably restrict its use to the low clinical probability category of the 3-level score to exclude PE.

The AUC of the ROC curve of the simplified score was not lower than that of the original score. Given that the original score assigned very different weights to the individual variables, at least some loss of predictive accuracy would have been expected, and this might therefore seem surprising. Because this is also true for the ROC curve using all the score values and not only 2 cutoff values, this observation is not due to cutoff selection in this particular population.

This study has limitations. We performed a retrospective analysis, which can be subject to various biases. We acknowledge that prospectively studying the clinical utility and outcomes in a new sample would be the best way of testing our hypothesis. Nevertheless, the revised Geneva score could be calculated in more than 99% of patients. Also, the original cohorts prospectively included consecutive patients with minimal loss to follow-up (0.5% in study A and 0.1% in study B). There were some differences in general characteristics between the 2 study populations, ie, mean age and prevalence of PE. However, the prevalence of PE according to the number of points in the simplified revised Geneva score was similar in the 2 groups (data not shown), which actually adds validity to the simplified score. Finally, by study design, D-dimer results were not available for all patients. Data were missing in 9 patients (2.4%) with low clinical probability, in 60 patients (9.5%) with intermediate clinical probability, and in 29 patients (4.3%) designated as PE unlikely.

In summary, our data indicate that simplification of the revised Geneva score does not decrease the score’s diagnostic accuracy and clinical utility. Prospective outcome studies are needed, however, to confirm our findings.

Accepted for Publication: April 25, 2008.

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Table 3. Posttest Probability of PE According to Sensitivity of DD and Clinical Probability Category as Assigned by Simplified Revised Geneva Score

<table>
<thead>
<tr>
<th>Clinical Probability, %</th>
<th>3-Level Scheme</th>
<th>2-Level Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Intermediate</td>
</tr>
<tr>
<td>Prevalence of PE</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>Posttest PE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly sensitive DDb</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Less sensitive DDc</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Low-sensitivity DDd</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

Abbreviations: DD, D-dimer test; PE, pulmonary embolism.

a Figures for sensitivity and specificity are extracted from Di Nisio et al.16
b Sensitivity, 97%; specificity, 40%.
c Sensitivity, 95%; specificity, 65%.
d Sensitivity, 85%; specificity, 65%.
REFERENCES


