American Heart Association.

Top Take-Home Messages for the Emergency Physician

Adapted from: 2026 ACC/AHA/ACCP/ACEP/CHEST/SCAI/SHM/SIR/SVM/SVN Guideline for Evaluation and Management of Acute Pulmonary Embolism in Adults

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1. Clinical Assessment of Adults

In adult patients with suspected PE, who have a low or intermediate clinical probability of PE, an age-adjusted D-dimer value below the threshold (age × 10 μ g/L for fibrinogen equivalent units assays) effectively excludes PE and the need for imaging.

(Section 3.1.1).

2. Clinical Assessment of Pregnant Adults

In pregnant adults, it may be reasonable to use pregnancy adapted YEARS criteria to identify patients who do not need imaging for PE.

(Section 3.1.1).

3. Biomarkers for Risk Stratification

Lactate should be measured in patients with acute PE AHA/ACC PE Categories C-E, to risk stratify for short-term complications and/or mortality.

(Section 3.2.3).

4. Suitability for Outpatient Management of PE

In patients diagnosed with acute PE in AHA ACC PE Categories A and B, it is reasonable to use a decision tool such as the Hestia, PESI or sPESI score to identify suitability for outpatient treatment.

(Section 4.1.1).

5. Anticoagulation Therapy Initiation

In patients with acute PE who do not have an absolute contraindication to anticoagulation therapy, anticoagulation therapy should be immediately initiated to reduce the risk of recurrent VTE and death.

(Section 4.2.1).

6. Anticoagulation Therapy Administration

It may be beneficial to administer therapeutic anticoagulation when imaging is delayed or not immediately accessible, in patients suspected of having acute PE Category C2 or higher and in whom the bleeding risk is low.

(Section 4.2.1).

7. Sedation and Ventilatory Strategies

Deep sedation and mechanical ventilation should be avoided in patients with acute PE in AHA/ACC PE Categories C-E, to prevent hemodynamic collapse.

(Section 4.2.3).

8. Follow-Up Care for Acute Pulmonary Embolism

When discharging a patient with acute PE from the emergency department, it is beneficial to have clinical follow-up within a week to provide patient education, address barriers to anticoagulation therapy, ensure adherence to prescribed medications, and detect bleeding complications.

(Section 5.1.1).