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www.reachmd.com
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(866) 423-7849

Managing Acute PE: Updates from the 2026 AHA/ACC Guideline

Dr. Leuchars:

This is *Heart Matters* on ReachMD. I'm your host, Dr. Mary Leuchars, and today I'm joined by Dr. Mark Creager to review the 2026 American Heart Association and American College of Cardiology Guideline on the evaluation and management of acute pulmonary embolism. In addition to serving as chair of the writing committee for this guideline, Dr. Creager is also a Professor of Medicine and Professor of Surgery at the Geisel School of Medicine at Dartmouth.

Dr. Creager, welcome to the program.

Dr. Creager:

Well, thank you very much, Mary. It's a pleasure to be here.

Dr. Leuchars:

Well, Dr. Creager, let's start with the most significant update in the guideline: the new PE clinical categories, which replace the traditional low-risk, submassive, and massive PE classifications. What prompted the development of this new framework?

Dr. Creager:

It's really been quite a few years since other PE guidelines have been published, and there's new information available. There's been really significant advances in our understanding of pulmonary embolism and treatments to effectively manage this condition.

So the classifications that you mentioned—low risk, submassive, and massive—came out over 10 years ago from an American Heart Association scientific statement. But the European Society of Cardiology actually updated these, particularly in 2019, and proposed a classification of low risk, low-intermediate risk, high-intermediate risk, and high risk. And people have been using that a lot. But we've realized with the advances we've had in our understanding of the diagnosis and management of pulmonary embolism that we really need a characterization that's a bit more nuanced and in-depth to really help clinicians navigate these new advances to the most effective approaches to care for patients with acute pulmonary embolism.

So the new guideline and our classification includes patient treatment recommendations by care setting, including which patients can be discharged from the emergency department and managed as outpatients and which patients require hospitalization and need critical care. And the new AHA/ACC clinical categories really help clinicians drill down on those decisions.

Dr. Leuchars:

So as you said, the guideline introduces a more structured diagnostic approach. Aside from those changes that you've already mentioned, are there any other changes that will help clinicians evaluate these patients more efficiently?

Dr. Creager:

Well, the guideline is really quite detailed with a number of recommendations that really will help clinicians manage these patients. And it really includes how you make the initial diagnosis when patients present to the emergency department or their clinician's office and what tools they need to do a risk assessment. If the diagnosis is made, where they fit in this clinical characterization from our lowest risk, which we're characterizing as A, to our highest risk, which we characterize as E, and then depending on where they fit, what's the most effective therapy? So we do provide detailed recommendations about who can be managed effectively as outpatients, who requires hospitalization, who requires intensive care, and what the management should be acutely in terms of anticoagulant therapy, or more advanced therapy, such as catheter-based therapies or even surgical embolectomy.

And we give detailed recommendations about follow-up. And in terms of follow-up, it's when they should be seen, what management

strategy should be considered, and then what you do with a patient who has persistent symptoms. So all of that is in here. A lot of it is new. Much of it clinicians have been doing for years, but it really puts it together in a comprehensive format.

Dr. Leuchars:

That's really helpful. And as you say, not every patient with acute PE is going to require hospitalization, but it sounds like the new recommendations will help clinicians determine the most appropriate setting for care.

In terms of your training for clinicians, people work in different settings in different-sized cities and different-sized institutions. Is there any detail in the guidelines to help those clinicians who might be in more remote settings?

Dr. Creager:

Oh, there absolutely is. First, I want to reinforce the fact that, although I was privileged to chair the guidelines, we really had a terrific writing committee that represented a broad swath of clinicians who manage patients with acute pulmonary embolism. So in terms of your question, we had emergency department physicians on it who really understand the approach from the emergency room. We had pulmonary and critical care doctors who understand the approach to patients who end up in an intensive care unit. We had interventionalists involved, those individuals who apply advanced therapies, hematologists to help guide the discussion on anticoagulant therapy, and cardiac surgeons to help us consider what happens in patients who may require surgical embolectomy. So we really had input from a wider range of specialists.

And in terms of managing these patients, we do drill down and focus on, what should the emergency department do when a patient presents there? What does a hospitalist have to do if the patient's admitted to the hospital? How are we going to manage these patients as outpatients? And the type of clinician that will be taking care of them. So we really provide information that is fit for virtually every setting in which a patient with acute pulmonary embolism is managed initially and then during follow-up.

Dr. Leuchars:

For those just tuning in, you're listening to *Heart Matters* on ReachMD. I'm your host, Dr. Mary Leuchars, and I'm speaking with Dr. Mark Creager about the updated guidelines on the management of acute pulmonary embolism.

So, Dr. Creager, turning back to treatment and the details that you've already given us about who was involved in creating the guidelines, how can these new recommendations help us tailor therapy to each individual patient's level of risk?

Dr. Creager:

These guidelines really provide considerable detail for each patient. And we mentioned at the outset of this podcast that we have a new clinical categorization, which we call the AHA/ACC acute pulmonary embolism clinical categories that really range from five major categories. We letter them A, B, C, D, and E, and within some of these categories, there are subcategories, and they go from low-risk to more high-risk patients. And as one reads the guidelines, you can see we have specific, almost prescriptive recommendations on how these patients could be managed.

So let me give you an example. Our lowest risk categories are category A and B. Category A is subclinical. These are incidental findings of pulmonary embolism. Someone might get a chest CT scan for cancer surveillance, and a pulmonary embolism is seen in a segmental artery.

Category B is patients who are symptomatic. They present to the emergency department, but when we do a clinical severity score, they're low down on the score. So these are patients we feel are low risk, and they can be managed as outpatients.

Symptomatic patients, based on whether they have elevated biomarkers or RV dysfunction, fit into one of the subcategories. These patients are typically hospitalized and managed with either anticoagulant therapy or, in the worst cases, other more advanced therapies may be considered.

In category D, these people are very ill. They have incipient cardiopulmonary failure or actually are in shock. And those patients typically are considered for more advanced therapies.

So throughout the guideline, we really talk about how one would manage patients who really fit into these categories. Again, can they be managed with oral anticoagulants as an outpatient? Do they require hospitalization for initial therapies? Do they require advanced therapies?

Dr. Leuchars:

The guideline also recognizes that caring for patients with PE doesn't end at hospital discharge. What are the biggest challenges patients face after the acute event, and how do the new recommendations help clinicians support recovery over the long term?

Dr. Creager:

Well, I'm so glad you brought that up, Mary, because it's incredibly important. The guideline strongly emphasizes continuity of care. So we really talk about a timeline of how to follow up these patients to make sure they stay within the healthcare system and get the appropriate care they need.

We recommend that one week after discharge, someone contacts them either by phone, a telehealth visit, or an office visit to really go over with them what has happened to them and what initial management is being recommended for them. And then we also recommend an in-office visit with someone who is knowledgeable about pulmonary embolism at about the two to three-month period to review how they're doing, reinforce the recommendations that were made, and make sure that they're on the appropriate therapy.

Then, depending on how well the patient is doing, they do require long-term follow-up. Whether it's with their primary care provider or whether it's someone with more specific expertise in pulmonary embolism is dependent on the specific situation, the specific patient, and the clinical course that they're experiencing.

Dr. Leuchars:

With that in mind, I want to thank my guest, Dr. Mark Creager, for joining me to share this updated guidance on the evaluation and management of acute pulmonary embolism.

Dr. Creager, it was a pleasure having you on the program.

Dr. Creager:

Well, thank you very much, Mary. It was really my pleasure.

Dr. Leuchars:

For ReachMD, I'm Dr. Mary Leuchars. To access this and other episodes in this series, visit *Heart Matters* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.