



American Heart Association®

Target: Pulmonary Embolism

Clinical Fundamentals of Pulmonary Embolism Care

March 26, 2026 | 6-7PM CST / 7-8PM EST

Webinar Will Begin Shortly...



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Target: Pulmonary Embolism

Welcome!

Learn more at
heart.org/TargetPE

American Heart Association Team

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Objective & Learning Goal

- Provide a practical review of core clinical principles guiding the management of pulmonary embolism, from pathophysiology to treatment strategies and critical decision points across the PE care continuum.

Agenda

Introduction to Target: Pulmonary Embolism

2026 AHA/ACC Acute PE Guidelines Announcement

Epidemiology & Pathophysiology

How PE is Defined & Diagnosed

Current Evidence-Based Therapies & Treatments (Model Share)

Q & A

Upcoming Virtual Forum Announcement

Closing Remarks



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Target: Pulmonary Embolism

Initiative Overview

Goal: To improve PE care by closing gaps, strengthening systems, and advancing evidence-based, equitable, and patient-centered care

Impact: Improving patient outcomes and advancing a more consistent and evidence-based approach to PE care nationwide



Prevalence: PE is a type of venous thromboembolism (VTE), or blood clot in the veins. VTE (e.g., PE, DVT) is potentially life-threatening and contributes to up to 100,000 deaths per year in the U.S.



Need: PE-related mortality increased between 2008 and 2018, underscoring its persistent and growing impact as a leading cause of cardiovascular morbidity and mortality.



Areas of Opportunity: PE continues to be underdiagnosed, undertreated, and inconsistently managed across health systems.



Scan the QR code to learn more, see a map of participating sites, and stay informed about national education events!

Heart.org/TargetPE

Initiative Aims To:

- Build network of 20 diverse, multidisciplinary team members focused on creating a PE system of care.
- Address current gaps in the PE patient journey.
- Disseminate models for quality standards of care for the identification and management of PE care.
- Inform and guide clinical practice for PE patient care based on insights.



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Participating Sites





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Check out the press release!

Improving care for life-threatening blood clots

New American Heart Association effort will bring together diverse hospitals to create scalable models for timely, effective pulmonary embolism treatment



DALLAS, October 31, 2025 — Pulmonary embolism (PE), a type of blood clot in the lungs, sends more than half a million people to U.S. hospitals each year — and kills about one in five high-risk patients, according to the American Heart Association [2025 statistical update](#). PE is the third leading cause of cardiovascular death in the U.S.^[1] While progress has been made in PE care, pulmonary embolism remains underdiagnosed, undertreated and inconsistently managed.

To address these gaps in care, the American Heart Association, devoted to changing the future to a world of healthier lives for all, is launching a three-year quality improvement initiative, supported by Inari, now part of Stryker, to better understand barriers and advance best practices for pulmonary embolism diagnosis, treatment and follow-up care.

The [Pulmonary Embolism Quality Improvement Initiative](#) will convene a 20-site national learning collaborative representing urban, rural and under-resourced communities. These diverse care teams will share data, insights and experiences through an “all teach, all learn”

Related Images



Heart and lungs illustration

Human Chest Cavity illustration: Right lung, left lung, heart

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Addressing persistent gaps in PE care and strengthening systems of care nationwide



Pulmonary embolism (PE) is a type of venous thromboembolism (VTE), or blood clots in the veins. PE occurs when a blood clot breaks free, usually from a deep vein in the legs, and becomes lodged in the lungs. VTE is a potentially life-threatening condition that contributes to up to 100,000 deaths each year in the United States.



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Recent data show that PE-related mortality increased between 2008 and 2018, underscoring its persistent and growing impact as a leading cause of cardiovascular morbidity and mortality.²

Check out our website to stay up to date with the latest PE information!

[Heart.org/TargetPE](https://www.heart.org/TargetPE)



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Steven Pugliese, MD

Pulmonologist & Critical Care Specialist
Penn Medicine – Philadelphia, PA

PE Program Medical Director – Penn Medicine
PERT Director – Hospital of the University of Pennsylvania
Associate Professor, Clinical Medicine – University of Pennsylvania



American Heart Association:

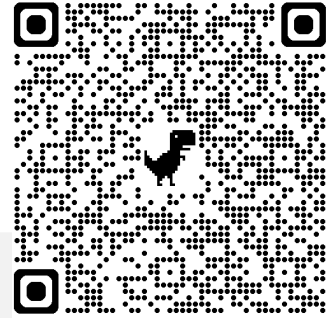
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2026 AHA/ACC Acute PE Guideline Announcement



AHA PE Guideline Announcement

Check it out here!



Highlights:

- The first clinical practice guideline on acute PE from the AHA and ACC introduces a **new Acute PE Clinical Category system** to define the severity of an acute PE and assist in developing a treatment strategy for adults with this condition.
- Details **risk factors** for acute PE, such as recent surgery or hospitalization, trauma, prolonged immobility, pregnancy, obesity, cancer + blood clotting disorders, among others.
- Includes comprehensive recommendations for **diagnostic strategies and treatment options** to improve outcomes for patients with acute PE, depending on the care setting — ED, inpatient setting or outpatient clinic — and availability of local resources.
- Provides **guidelines on follow-up care** after acute PE diagnosis and treatment, including safe physical activity, travel considerations and long-term use of anti-clotting medications.
- **A few new insights:** DOACs preferred over VKAs for most patients; LMWH preferred initial parenteral agent; PERT recommended/encouraged where available; structured follow-up and CTEPH screening

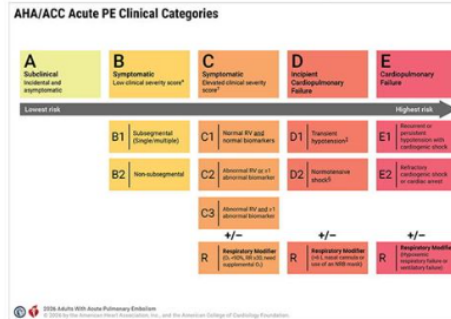


2026 AHA/ACC Acute PE Guidelines

2026 Guideline for the Evaluation and Management of Acute Pulmonary Embolism in Adults

Published: February 19, 2026

- A new clinical classification scheme is presented, entitled “Acute Pulmonary Embolism Clinical Categories,” with five categories (A–E) and subcategories, ranging from low to high risk for adverse outcomes, in order to enhance the precision of severity classification, prognosis assessment, and evidence-based therapeutic decision-making for patients presenting with acute PE.
- Symptomatic patients with acute PE and an elevated clinical severity score, including those with elevated biomarkers and/or right ventricular dysfunction (AHA/ACC PE Category C), incipient cardiopulmonary failure (AHA/ACC PE Category D), and those with cardiopulmonary failure characterized by persistent hypotension (AHA/ACC PE Category E) should be hospitalized to optimize treatment strategies.
- In patients with acute PE who are eligible for oral anticoagulation, direct oral anticoagulants (DOACs) are recommended over vitamin K antagonists (VKAs), unless contraindicated, to prevent recurrent venous thromboembolism (VTE) and reduce major bleeding.



REVIEW ARTICLE | Originally Published 19 February 2026 | [Check for updates](#)

2026
AHA/ACC/ACCP/ACEP/CHEST/SCAI/SHM/SIR/SVM/SVN Guideline for the Evaluation and Management of Acute Pulmonary Embolism in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Abstract

AIM

The “2026 AHA/ACC/ACCP/ACEP/CHEST/SCAI/SHM/SIR/SVM/SVN Guideline for the Evaluation and Management of Acute Pulmonary Embolism in Adults” is a de novo guideline that provides comprehensive recommendations for the evaluation, management, and follow-up of adult patients (≥18 years of age) with acute pulmonary embolism (PE). A key feature of this guideline is the introduction of the AHA/ACC Acute Pulmonary Embolism Clinical Categories, which enhance the precision of severity classification, prognosis assessment, and evidence-based therapeutic decision-making.

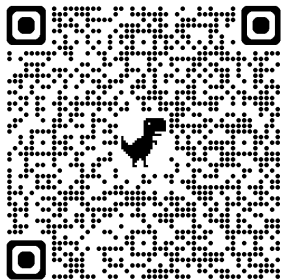
METHODS

A comprehensive literature search was conducted from February 2024 to October 2024 to identify clinical studies, reviews, and other evidence conducted on human subjects that were published in English from MEDLINE (through PubMed), EMBASE, the Cochrane Library, Agency for Healthcare Research and Quality, and other selected databases relevant to this guideline. Select key studies published until April 2025 were added by the guideline writing committee as appropriate.

STRUCTURE

The focus of this clinical practice guideline is an evidence-based and patient-centered approach for acute PE evaluation and management of the adult patient. This guideline encompasses the period from the onset of symptoms through clinical follow-up, focusing on risk outcomes assessment, clinical diagnosis of acute PE, appropriate use of adjunctive cardiovascular testing, and management in both the acute and early post-acute phases of PE. It addresses evidence-based diagnostic and management strategies (including pharmacological therapies, advanced interventional therapies, and in-hospital support) for acute PE and associated outcomes.

Check it out here!

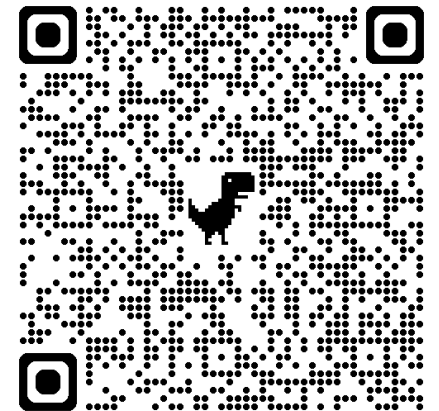




2026 AHA/ACC Acute PE Guidelines Resources:

- [Top Things to Know: 2026 Guideline for the Evaluation and Management of Acute Pulmonary Embolism in Adults](#)
- News Release: [First AHA/ACC Acute Pulmonary Embolism Guideline Prompt Diagnosis and Treatment are Key](#)
- [Acute Pulmonary Embolism Guideline Slide Set \(PPTX\)](#)
- [Acute Pulmonary Embolism Pocket Guide](#)
- [Top Take-Home Messages for the Emergency Physician \(PDF\)](#)
- [Key Patient Messages for Acute Pulmonary Embolism \(PDF\)](#)
- [Patient Resource: What is a Pulmonary Embolism Infographic \(PDF\)](#)
- [Patient Resource: Que es una Embolia Pulmonar Infographic Spanish \(PDF\)](#)

**All Guideline
Resources Here!**



Epidemiology & Pathophysiology of Pulmonary Embolism

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PE Program Medical Director

PERT Director

Associate Professor of Clinical Medicine



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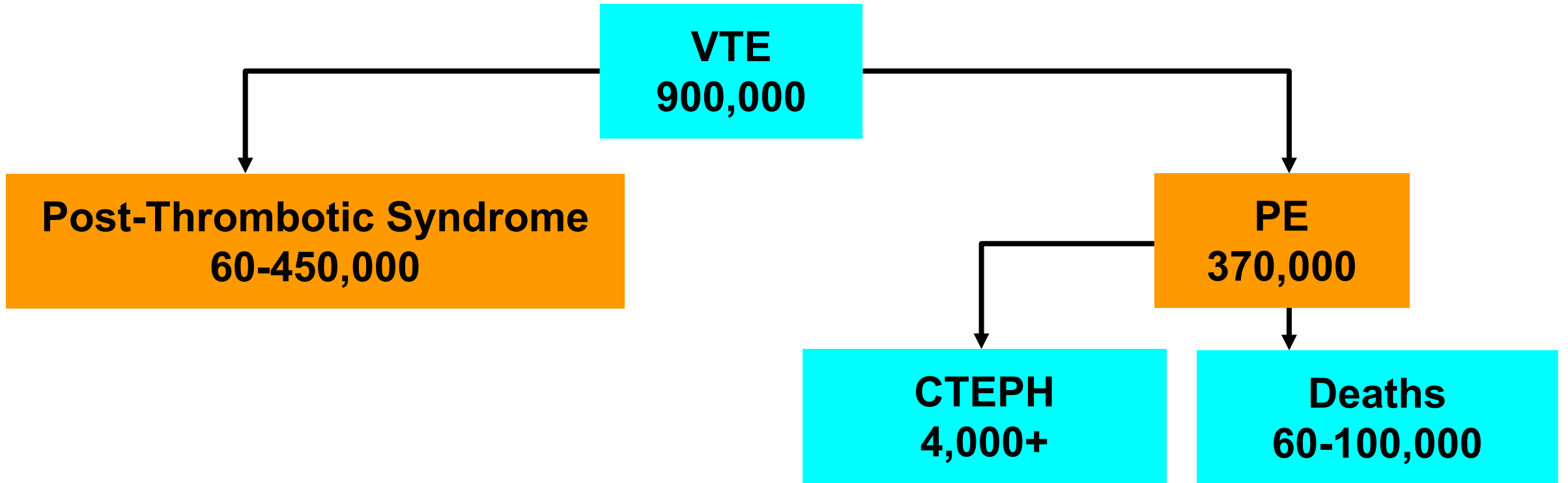
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VTE: Third Leading Cause of Cardiovascular Death

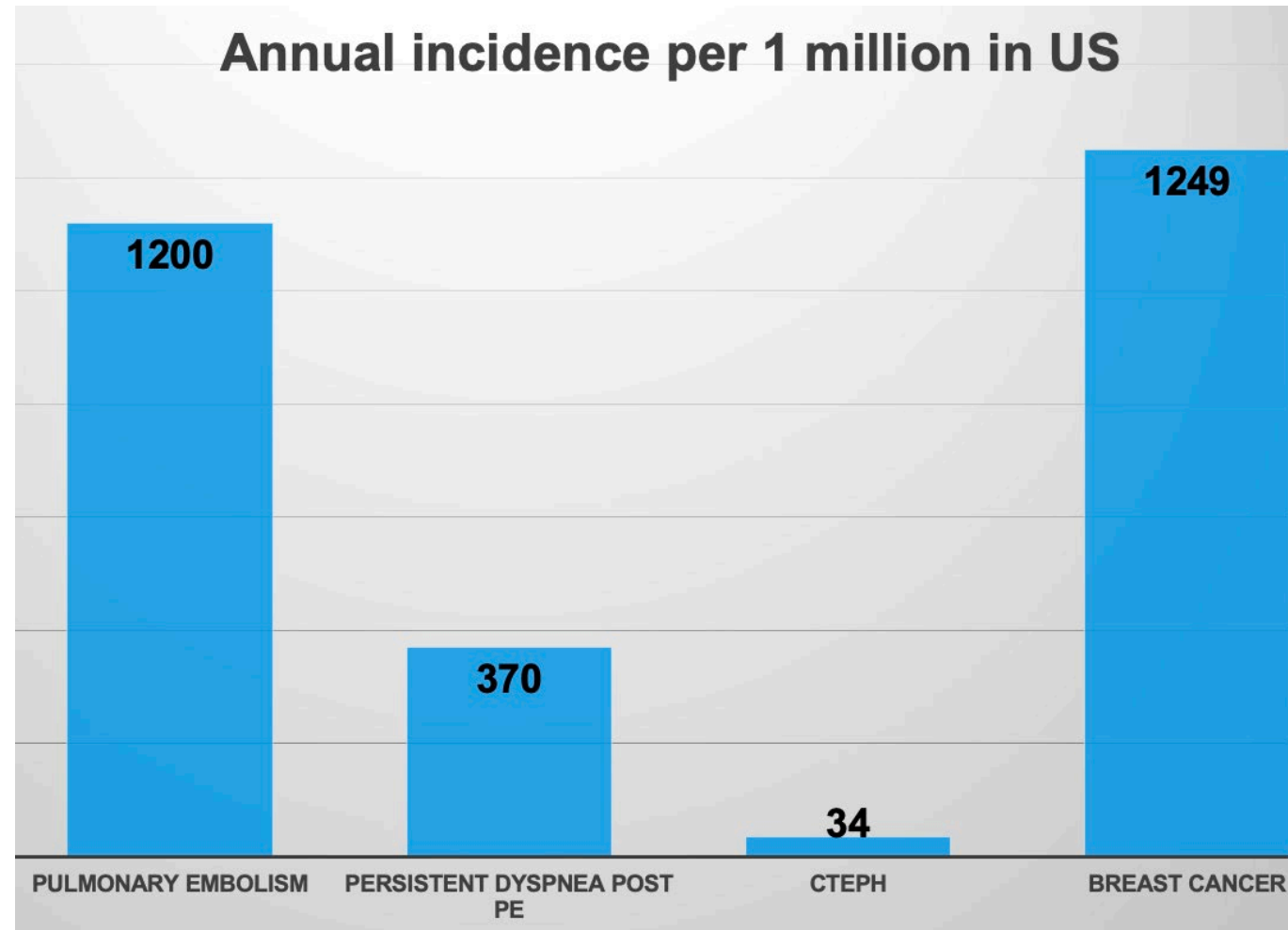


Estimated Cost of VTE Care \$2-10 Billion/year



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***Black Pts Higher VTE/PE Incidence and Mortality** *(Bell AJM 2016, Takahashi Circulation 2025)*



Table 9. Risk Factors for Venous Thromboembolism

Major Reversible Risk Factor	Minor Reversible Risk Factor	Persistent Risk Factor
Surgery with general anesthesia ≥ 30 minutes Hospitalization for acute medical illness ≥ 72 hours while confined to hospital bed Cesarean section Lower limb fracture	Surgery with general anesthesia < 30 minutes Hospitalization for acute medical illness < 72 hours Out-of-hospital acute medical illness ≥ 72 hours while confined to bed Estrogen therapy (hormone replacement or contraceptive) Peripartum period Trauma with decreased mobility ≥ 72 hours	Active cancer with or without ongoing treatment Autoimmune disease (eg, rheumatoid arthritis, systemic lupus erythematosus) Inflammatory bowel disease Chronic immobility Anatomic: • May-Thurner, Fibroids, Thoracic outlet syndrome

“Unprovoked VTE” Risk Factors

- Hereditary thrombophilia
- Age > 65
- Male sex
- Non-O blood type ($\uparrow$ WVF and Factor VIII?)*

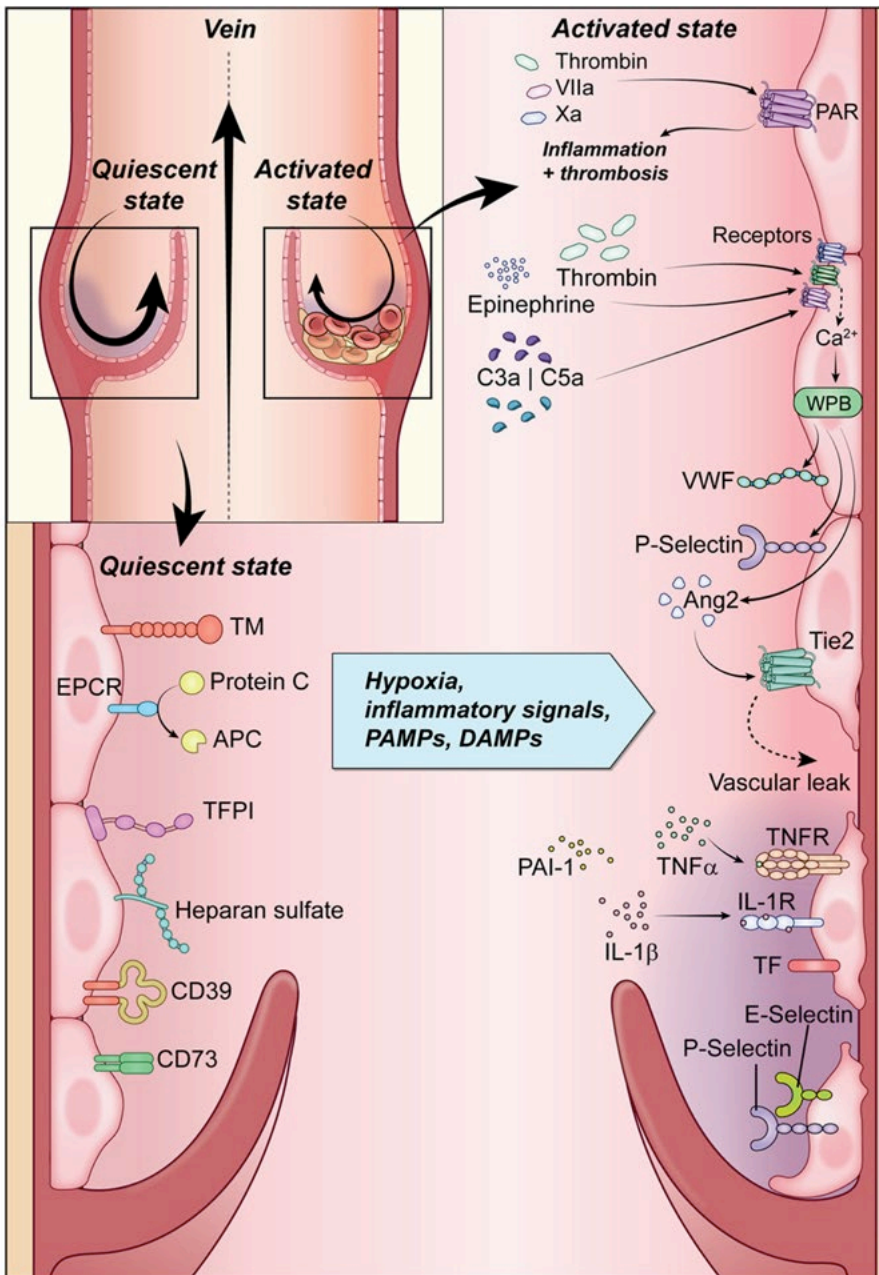
* = Not included as a risk factor in the 2026 guidelines



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Pathophysiology



Thrombo-Inflammation: It's More Than Just Clot

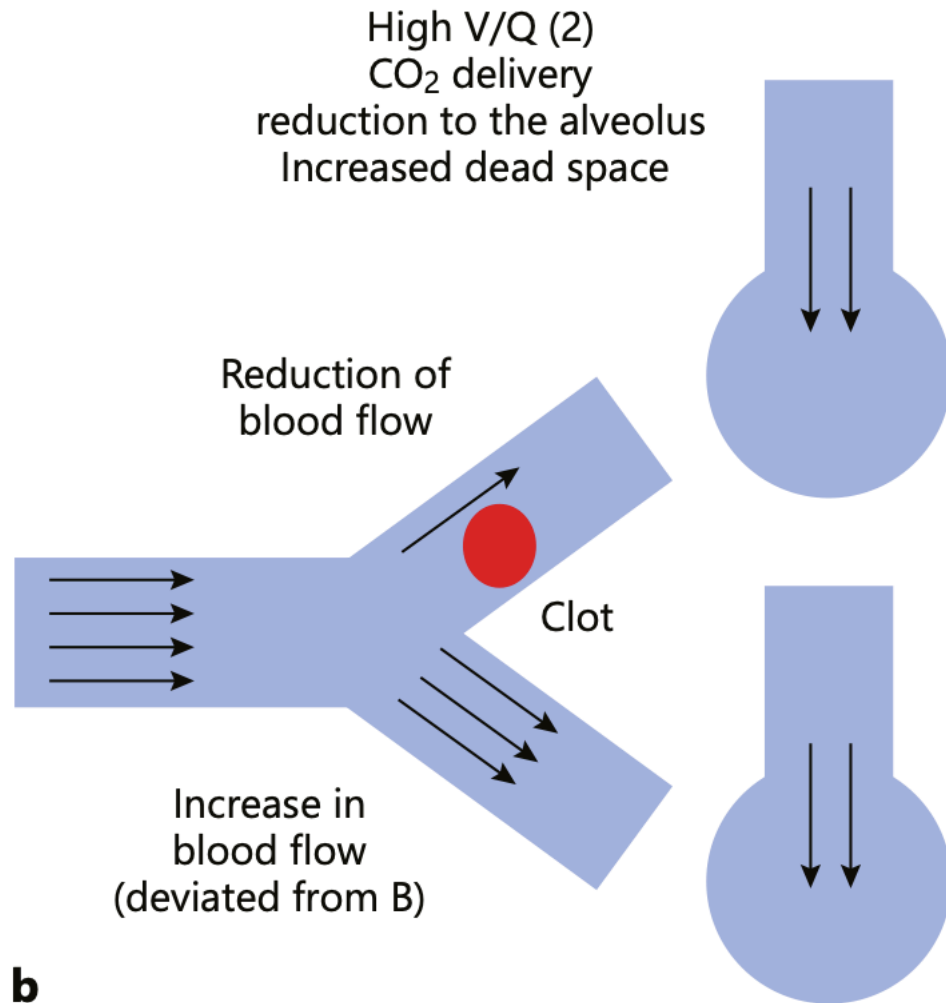
1. Inflammatory insult
2. Cytokine release
3. Endothelial dysfunction
4. Platelet activation
5. Thrombogenesis



- Vasoconstriction
- Systemic immune response



Gas Exchange



Deadspace: $\uparrow$ CO₂

1. Normal V
2. **No Q**

V/Q mismatch: $\downarrow$ O₂

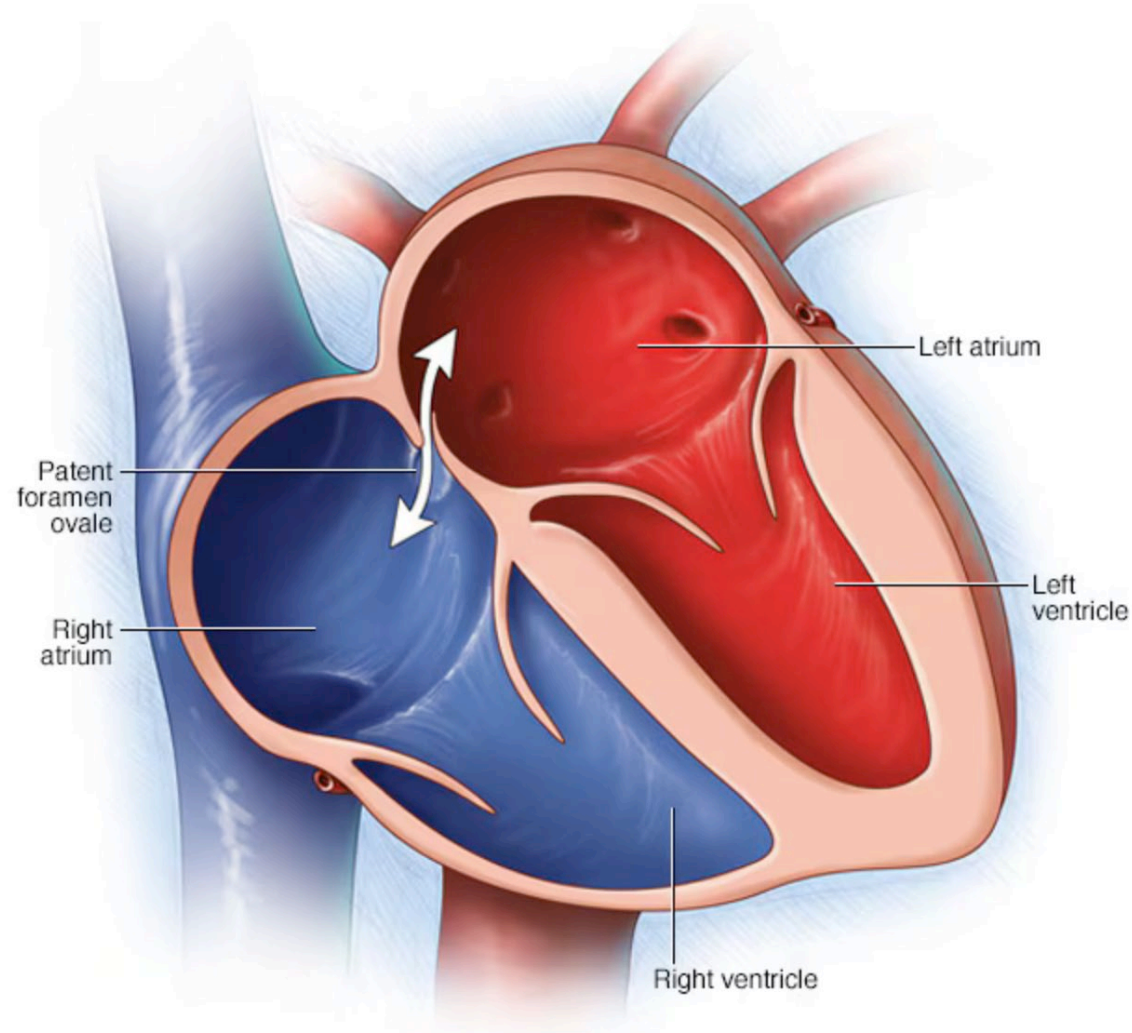
1. Normal V
2. **Increased Q**



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Patient Foramen Ovale: Rare but Severe



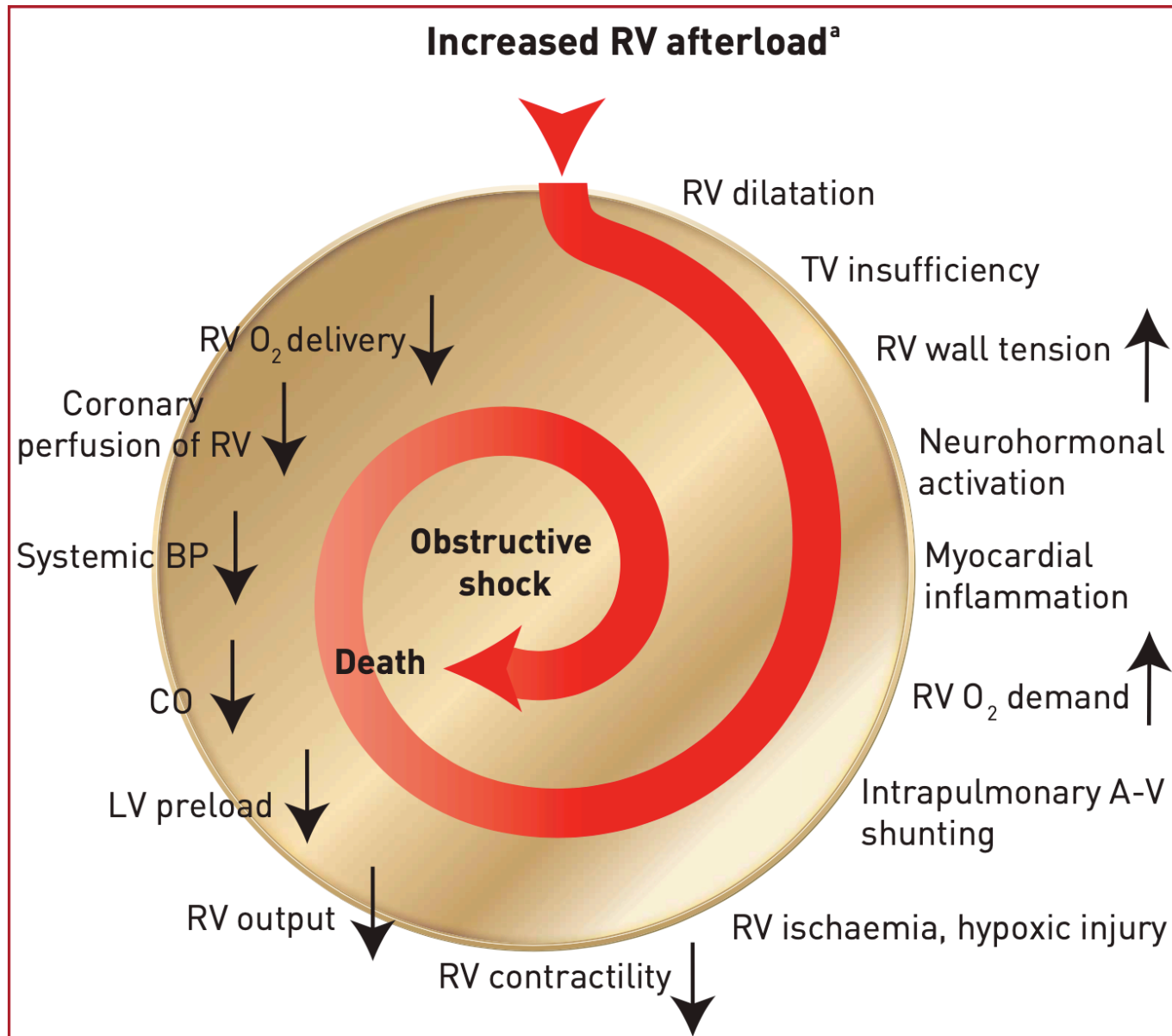
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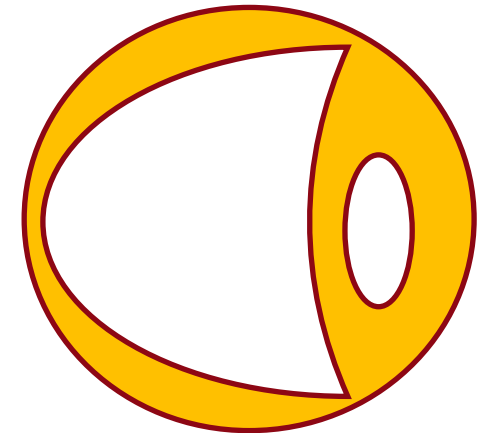
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How do patients die from PE?

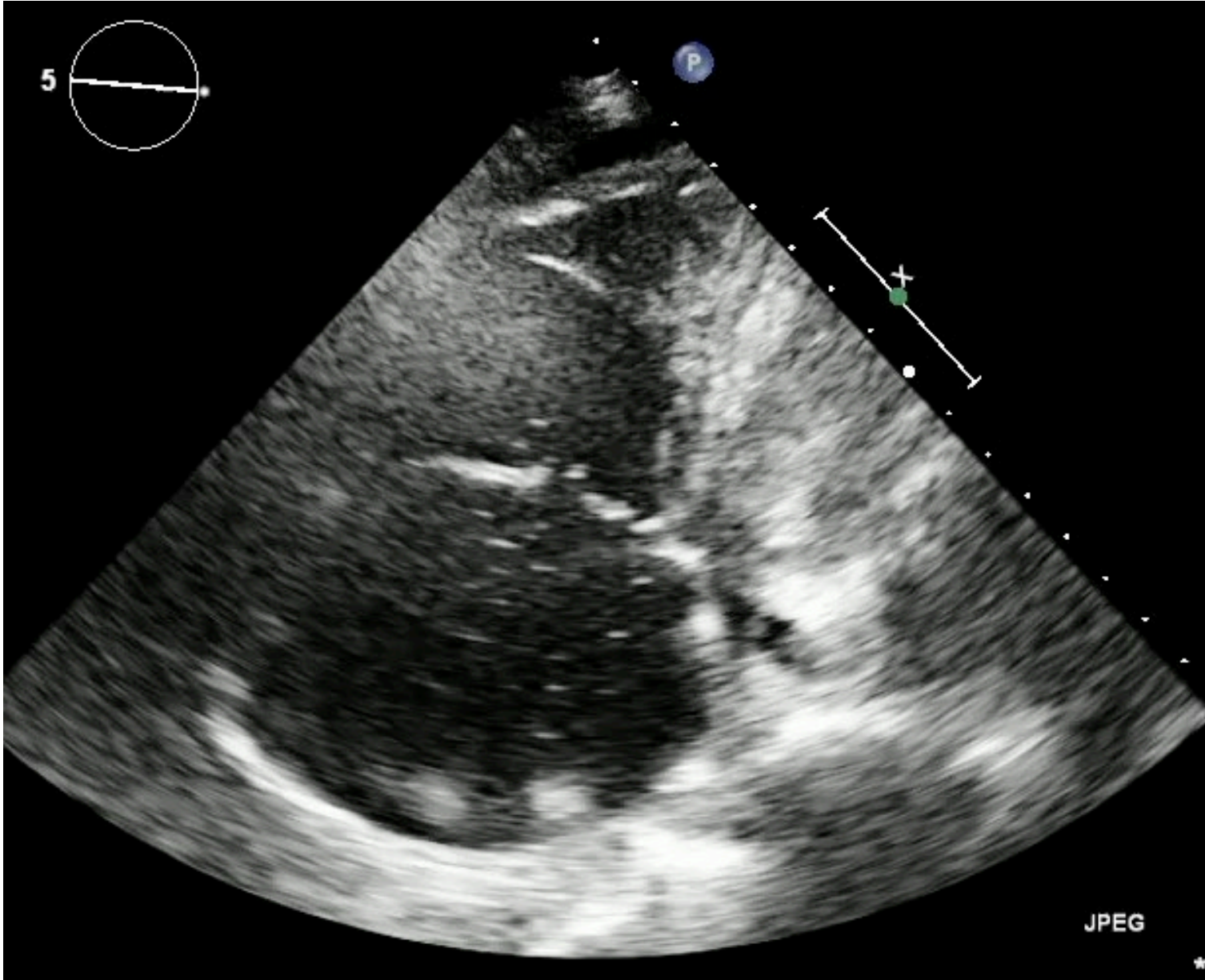


**Progressive
RV Dilatation**

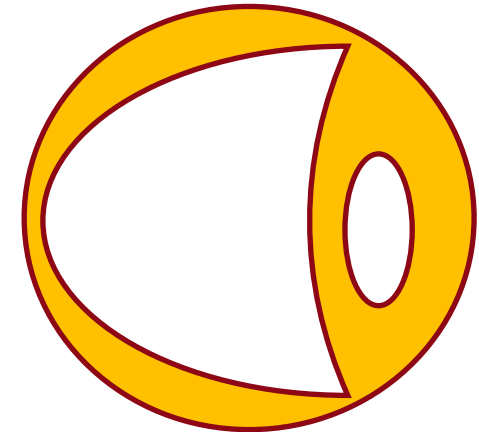


Death!

How do patients die from PE?



Progressive
RV Dilatation



Death!



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Target: Pulmonary Embolism



Srinivas Yallapragada, MD, FACC, RPVI

Interventional Cardiologist

Coronary, Endovascular & Structural Heart Specialist

Medical City Heart Hospital (HCA) – Dallas, TX

Section Chief, Cardiology – Medical City Heart Hospital

Chair, PERT Council – HCA Division

Co-Director, Cardiac Cath Lab – Medical City Heart Hospital

Medical Director, Cardiology – Medical City Las Colinas

Target: Pulmonary Embolism – Definitions, Diagnosis and Evidence Based Strategies in PE Management



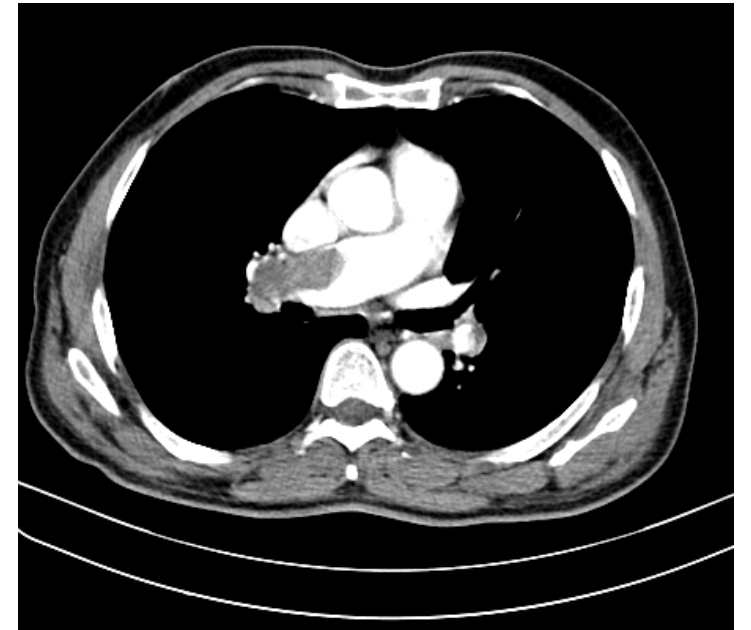
Srinivas Yallapragada MD
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Medical City Heart and Spine Hospital
Medical City Las Colinas Hospital

Objectives

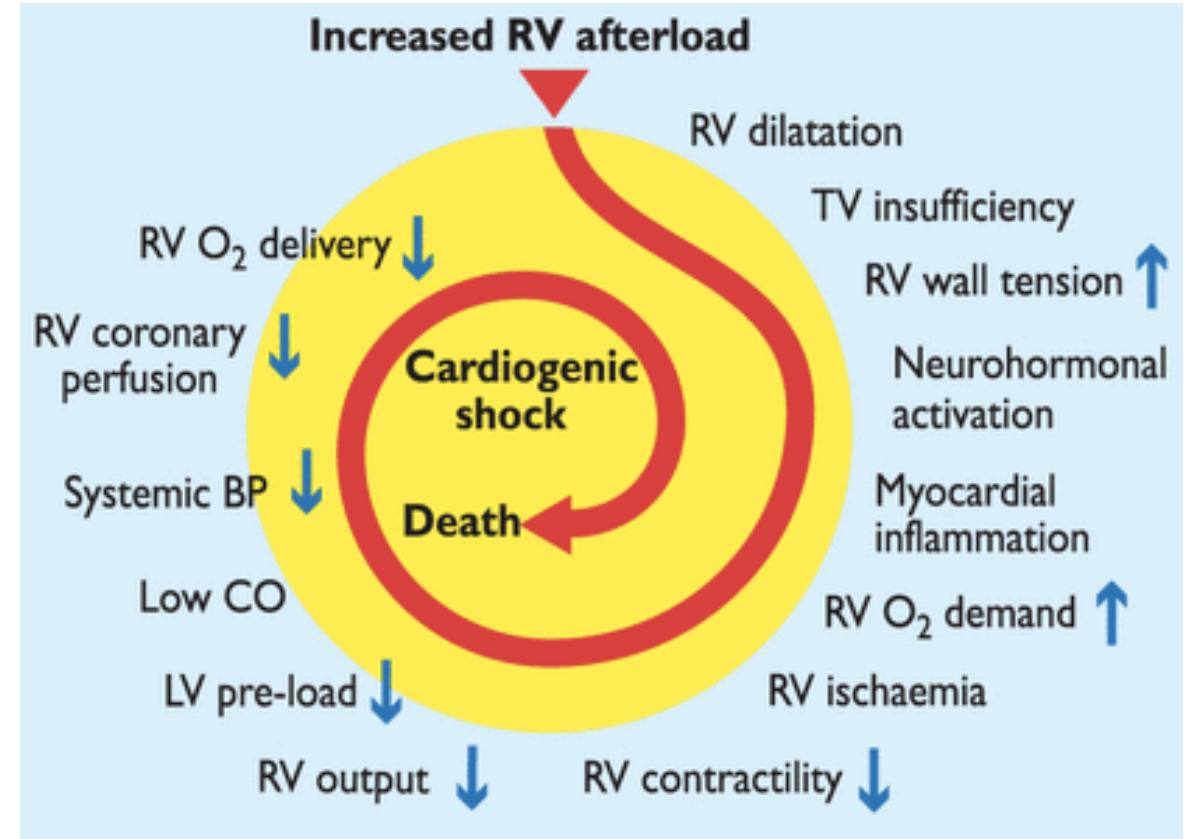
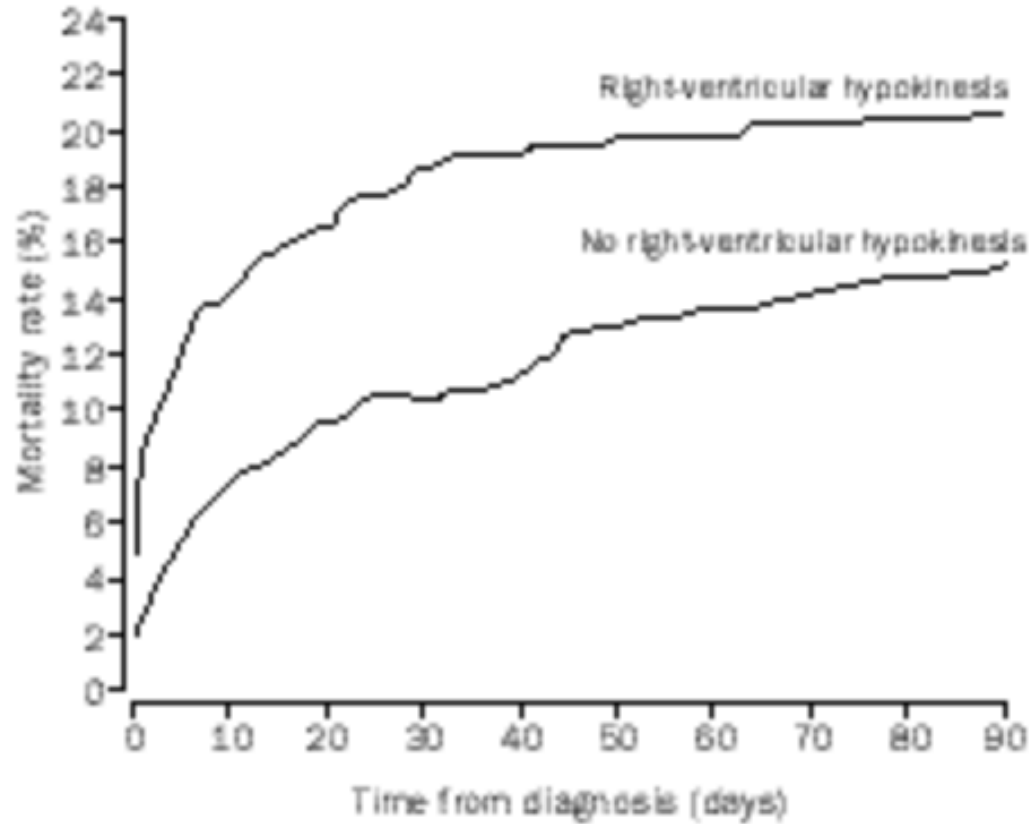
- Defining Pulmonary Embolism
- Understanding Diagnostic Approach
- Review Risk Stratification
- Application of Evidence Based Treatment Strategies

Pulmonary Embolism - Pathophysiology

- Occurs when there is an obstruction of a pulmonary artery due to thrombus
- Usually form a Deep Venous Thrombosis (DVT)
- Incidental (asymptomatic) → Massive (Highest Risk)
- Higher Risk PEs linked to RV dysfunction/ low BP

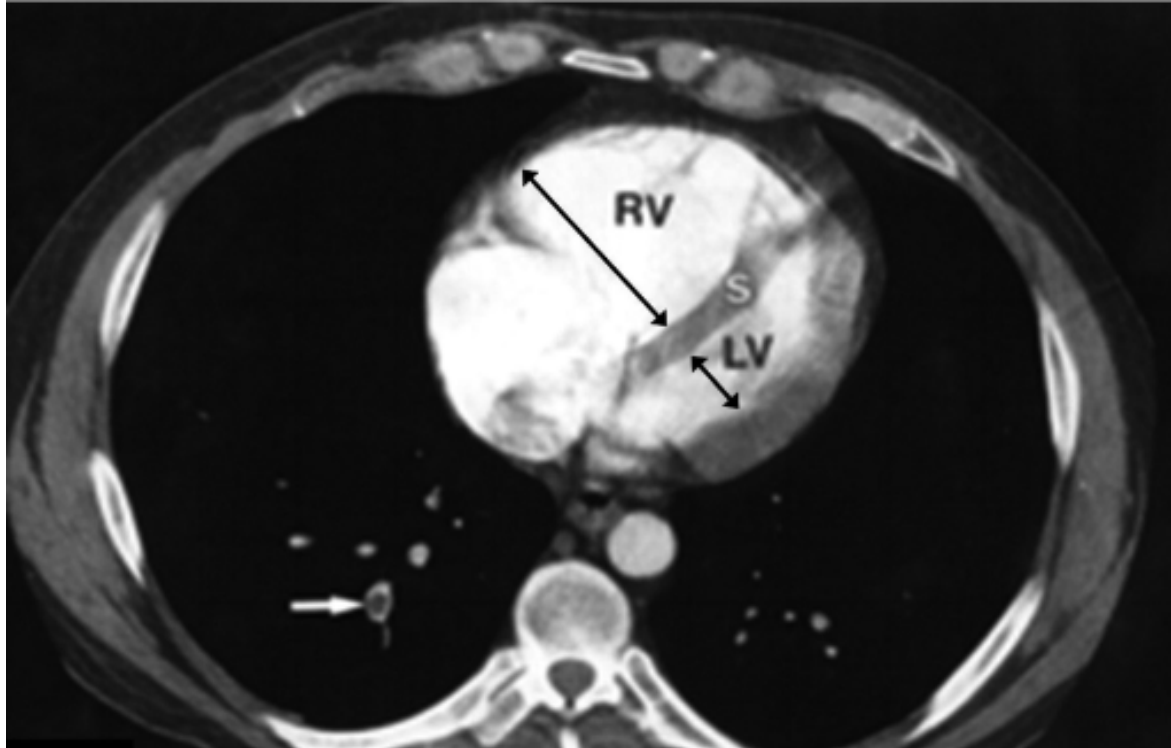


Pulmonary Embolism - Pathophysiology



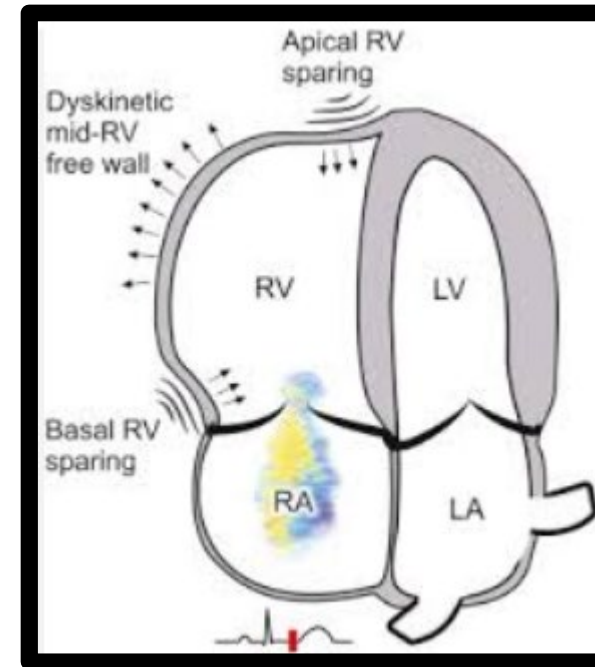
Goldhaber et al. The Lancet. April 24, 1999 – ICOPER

Risk Strain and Prognosis



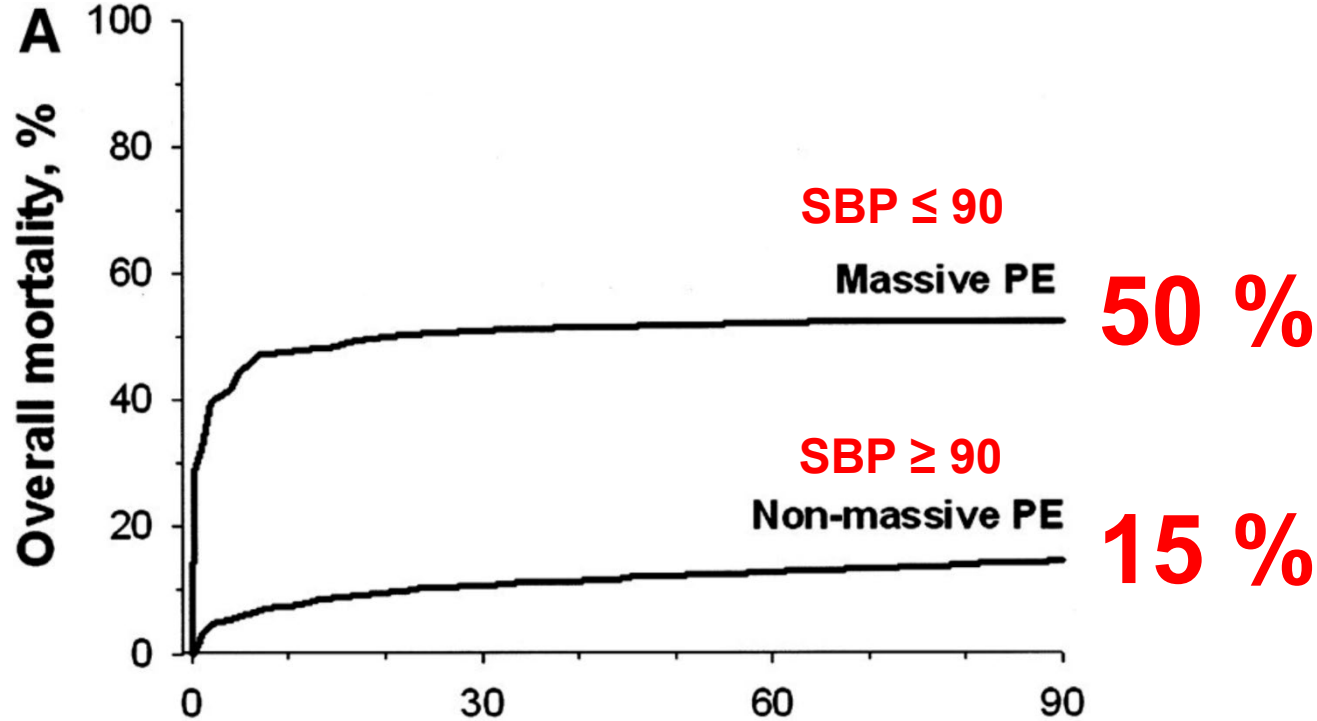
Tapson, NEJM 2008:358-1037-52

RV/LV Ratio
0.9-1.0 < Normal
1.0 > 2x higher 30-day mortality
1.2 – 1.5 > moderate to severe RV strain
1.7 > severe RV strain



McConnell's Sign

Hypotension and Mortality



- Longterm mortality for massive/high risk PE and non-massive/intermediate : 71.4%, 44.5% respectively
- Third most common cause of death in hospitalized patients

Kucher et al. Circulation 2006;113:577-582

Gupta et al. Vasc Med. 2020 Apr

PE – Clinical Factors and Diagnosis

- Virchows Triad – Stasis (immobility, surgery), Hypercoagulability (cancer, pregnancy), Endothelial Injury.
- Clinical Symptoms – Dyspnea, Pleuritic chest pain, Tachycardia, Hypoxia, Hemoptysis, **Syncope**
- Diagnostic Testing:
 - CT Pulmonary Angiography
 - VQ scan (alternative)
 - Echo



Beyond Medical Therapy – The Evidence

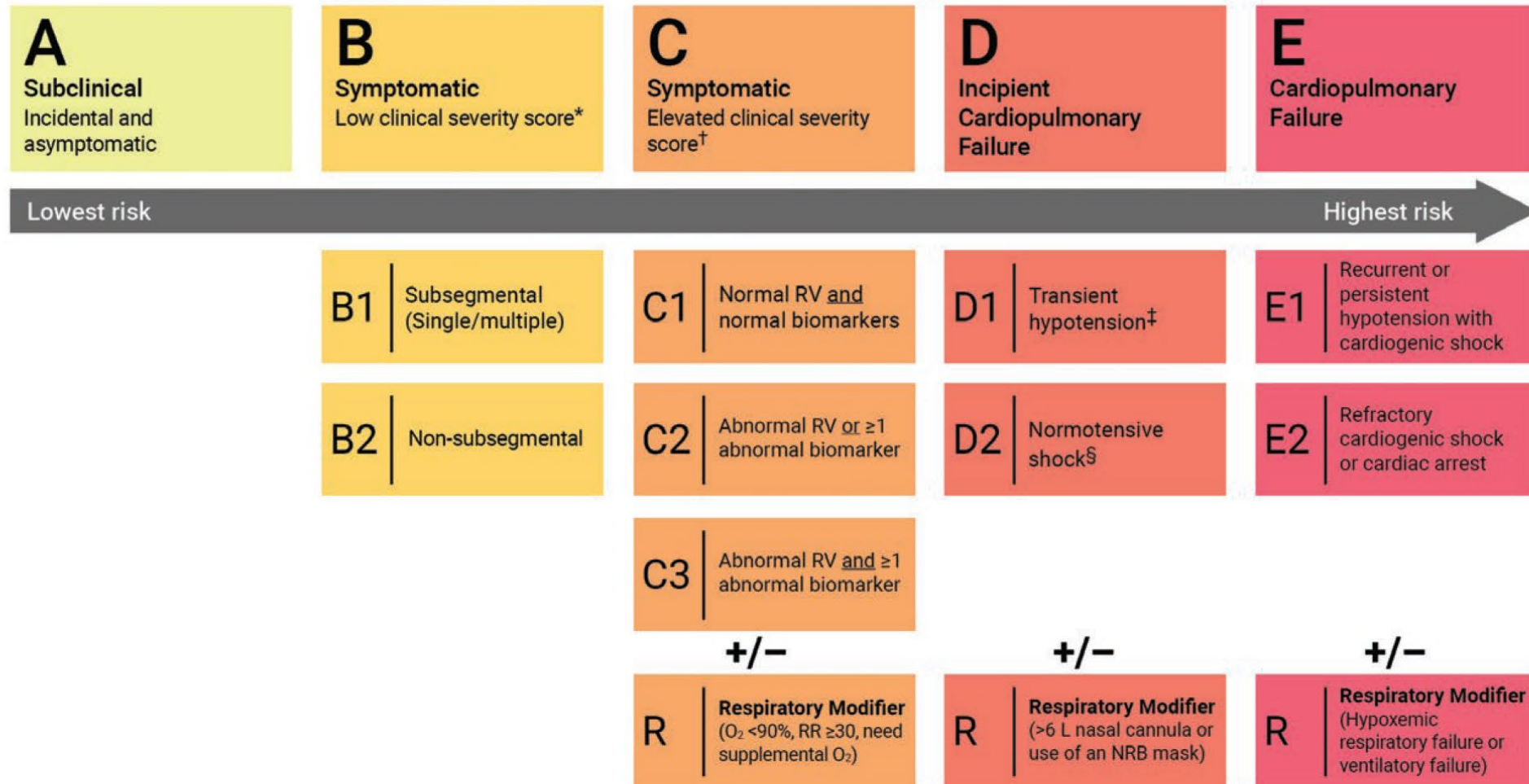
Pulmonary embolism severity index scores: Full and simplified

Pulmonary embolism severity index (PESI) - Full		
Clinical feature		Points
Age		x (eg, 65)
Male gender		10
History of cancer		30
Heart failure		10
Chronic lung disease		10
Pulse ≥110/min		20
Systolic blood pressure <100 mmHg		30
Respiratory rate ≥30/min		20
Temperature <36° Celcius		20
Altered mental status		60
Arterial oxygen saturation <90 percent		20
Class I	Low risk	<66
Class II		66 to 85
Class III	High risk	86 to 105
Class IV		106 to 125
Class V		>125
Simplified pulmonary embolism severity index (sPESI)		
Clinical feature		Points
Age >80 years		1
History of cancer		1
Chronic cardiopulmonary disease		1
Pulse ≥110/min		1
Systolic blood pressure <100 mmHg		1
Arterial oxygen saturation <90 percent		1
Low risk		0
High risk		≥1

The full PESI score is rarely calculated in clinical practice since it is generally considered cumbersome. In contrast, sPESI is brief, contains a limited number of easily accessible parameters, and is therefore, much more practical.

Obrosky et al.. *Am J Respir Crit Care Med* 2005; 172:1041.
Aujesky et al. *Arch Intern Med* 2010; 170:1383.

AHA/ACC Acute PE Clinical Categories



Medical Treatment – The Evidence

PEITHO Trial

- 1005 patients randomized with submassive PE
- Lytic & heparin vs Placebo & heparin in stable patients

Table 4. Safety Outcomes.*		Table 3. Efficacy Outcomes.*			
Outcome		Tenecteplase (N = 506)	Placebo (N = 499)	Odds Ratio (95% CI)	P Value
Primary outcome — no. (%)		13 (2.6)	28 (5.6)	0.44 (0.23–0.87)	0.02
Death from any cause		6 (1.2)	9 (1.8)	0.65 (0.23–1.85)	0.42
Hemodynamic decompensation		8 (1.6)	25 (5.0)	0.30 (0.14–0.68)	0.002
Time between randomization and primary efficacy outcome — days		1.54±1.71	1.79±1.60		
Bleeding between randomization and day 7 — no. (%)		1 (0.2)	5 (1.0)	0.20 (0.02–1.68)	0.12
Major extracranial bleeding		0	3 (0.6)		
Minor bleeding		1 (0.2)	2 (0.4)		
Major bleeding†					
Stroke between randomization and day 30 — no. (%)					
Ischemic stroke					
Hemorrhagic stroke					
Serious adverse events between randomization and day 30 — no. (%)					
Recurrent pulmonary embolism between randomization and day 7 — no. (%)		1 (0.2)	5 (1.0)	0.20 (0.02–1.68)	0.12
Fatal		0	3 (0.6)		
Nonfatal		1 (0.2)	2 (0.4)		
Other in-hospital complications and procedures — no. (%)					
Mechanical ventilation		8 (1.6)	15 (3.0)		
Surgical embolectomy		1 (0.2)	2 (0.4)		
Catheter thrombus fragmentation		1 (0.2)	0 (0.0)		
Vena cava interruption		5 (1.0)	1 (0.2)		
Thrombolytic treatment other than study medication		4 (0.8)	23 (4.6)		
Death from any cause between randomization and day 30 — no. (%)		12 (2.4)	16 (3.2)	0.73 (0.34–1.57)	0.42
Patient still hospitalized at day 30 — no. (%)		59 (11.7)	50 (10.0)		
Rehospitalization between randomization and day 30 — no. (%)		22 (4.4)	15 (3.0)		

Meyer et al. NEJM 2014;370:1402-11

Rationale for Catheter Based Treatment Options → for more rapid reduce RV strain, safely and to avoid bleeding

- To reduce thrombus burden beyond standard anticoagulation
- Allows for more immediate improvement in pulmonary gas exchange, hypoxia
- Decreasing the risk of CTEPH, recurrent PE, future VTE events
- *With Catheter based treatment pathways, we are seeing sicker and sicker patients being treated...*

Beyond Medical Therapy – The Evidence

ULTIMA 2014

Design: Randomized trial; US/CDT + heparin vs heparin alone in 59 patients with intermediate to high risk PE

Signal: RV/LV fell by 0.3 vs 0.03 in 24 hrs, no bleeding events - safe

Main caveat: Small trial; not powered for mortality or recurrent PE

SEATTLE II 2015

Design: Prospective single-arm; 150 massive/submassive PE patients

Signal: RV/LV fell from 1.55 to 1.13 (-.042); PA pressure and clot burden also improved

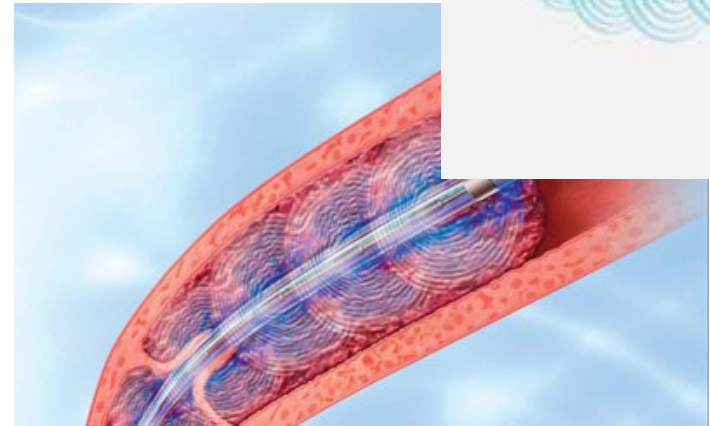
Main caveat: No control. *Moderate and severe bleeding 10%*

OPTALYSE-PE + SUNSET sPE 2018 / 2021

Design: TPA dose finding trial plus device comparison (US use or not) RCT patients

Signal: Lower doses, shorter duration infusion still improved RV strain, use of US was not superior to standard multi-side-hole CDT *Moderate and severe bleeding 4%*

Main caveat: Small trials; CDT choice and regimen dose and time remains unsettled

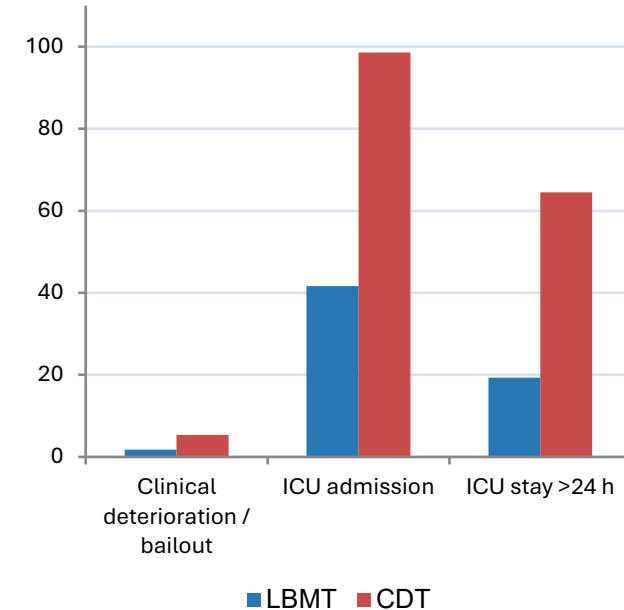


What about Mechanical Thrombectomy?

PEERLESS TRIAL (Intermediate Risk PE)

- RCT mechanical thrombectomy vs CDT
- Win Ratio 5.01 in favor of MT over CDT
- No difference in mortality
- No difference in RV strain improvement
- Hospital course was shorter with MT
- Less clinical bailouts

Operational advantages seen in PEERLESS

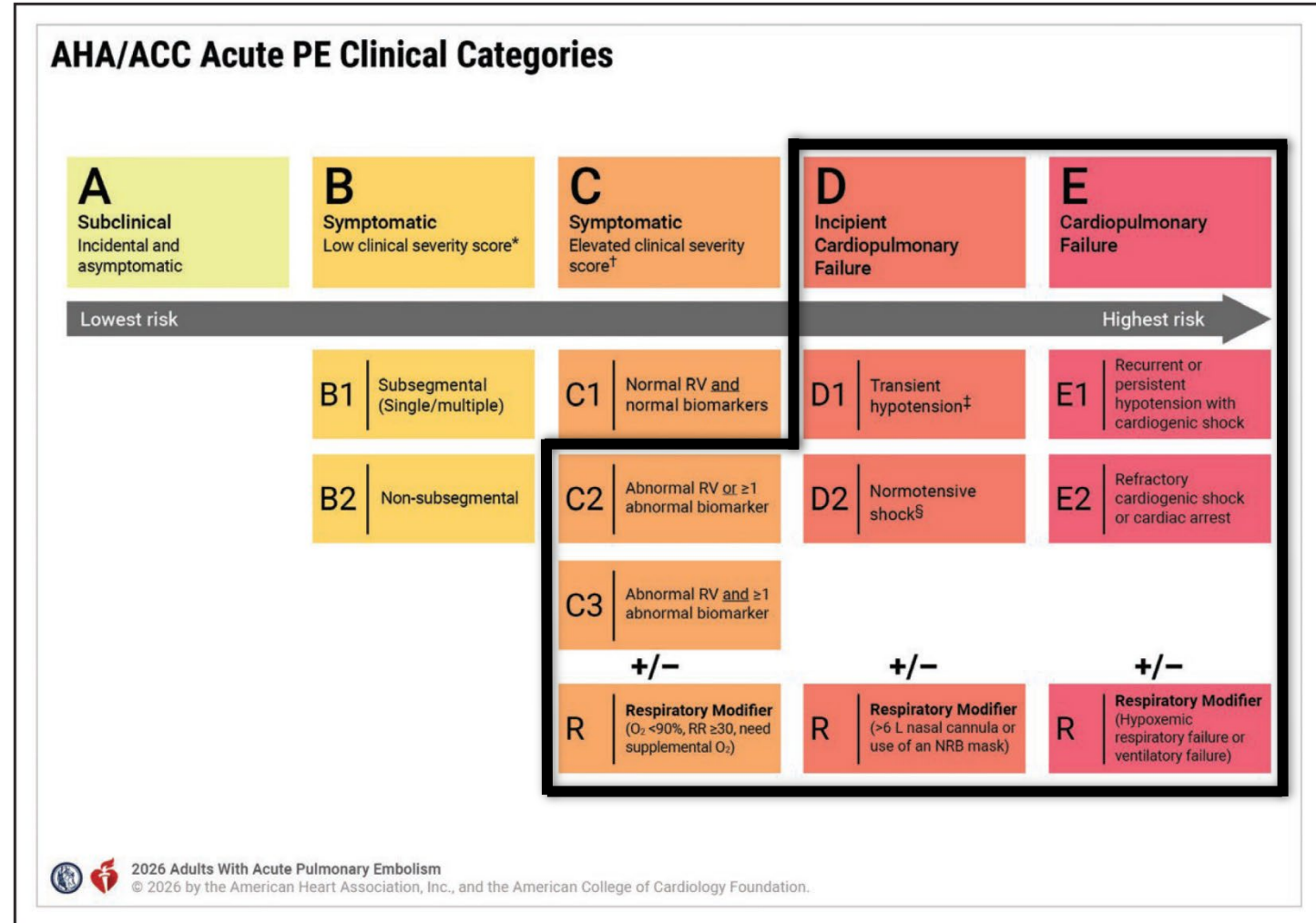


Jaber et al. Circulation, Oct 2024

Beyond Medical Therapy – The Evidence

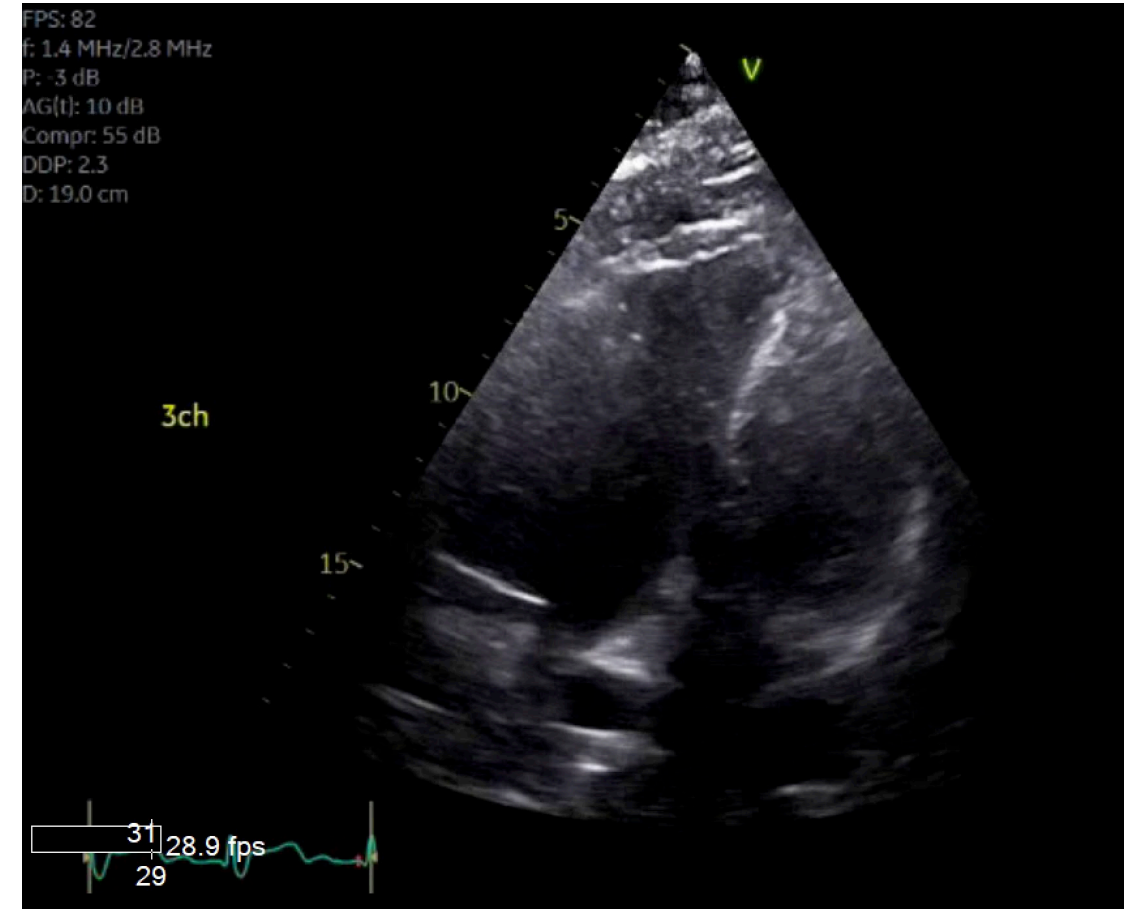
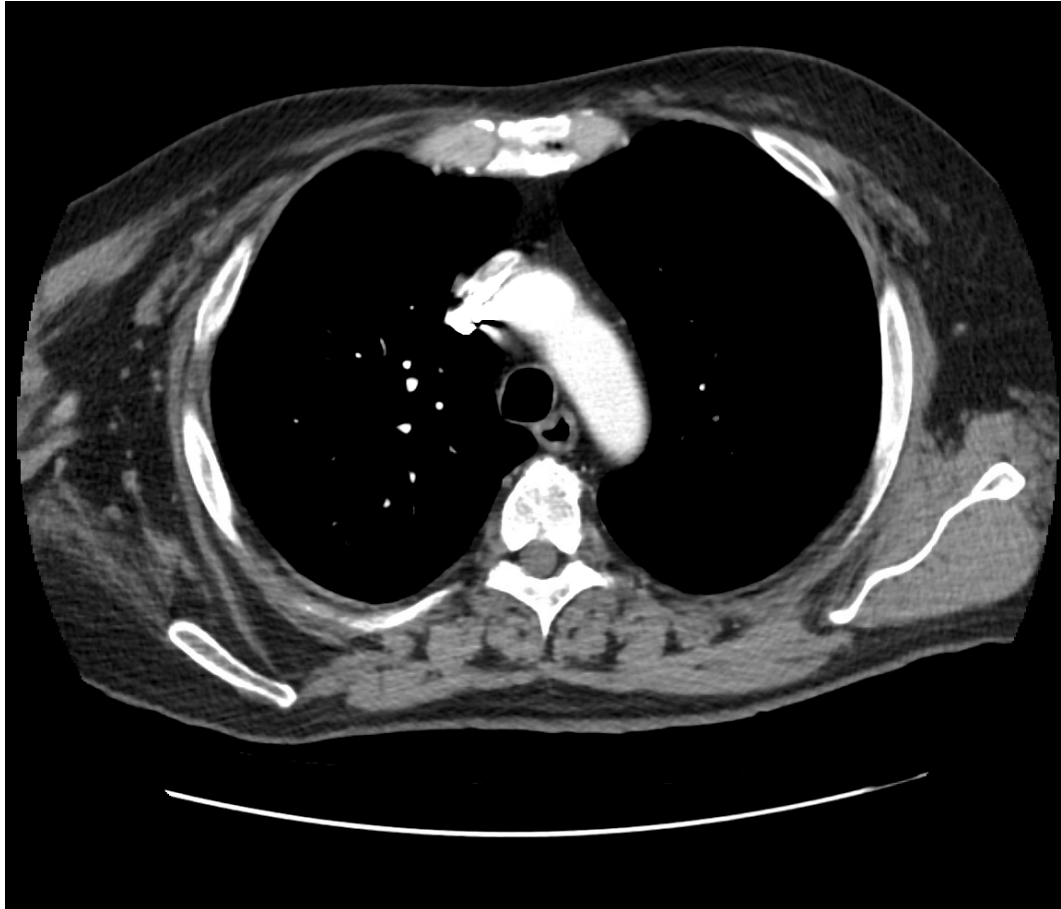
2026 AHA/ACC

Reasonable in E1; may be considered in selected D1–D2; not recommended in low-risk A–C1 PE.



Case Presentation - PE

58 yo M HTN, HL, hx of tobacco abuse, sudden SOB/CP 3AM, came by EMS on 9L NC, on RA O2 sat initially was < 90%. Normotensive.





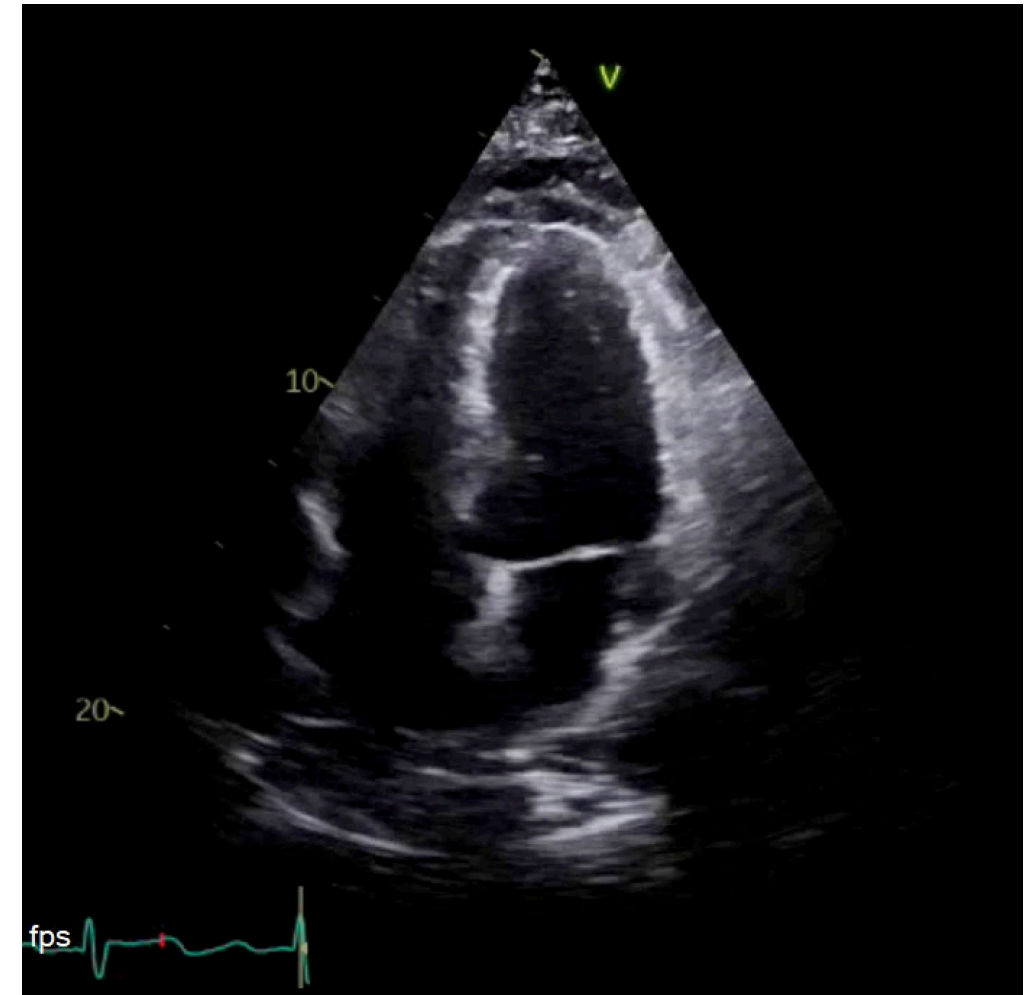
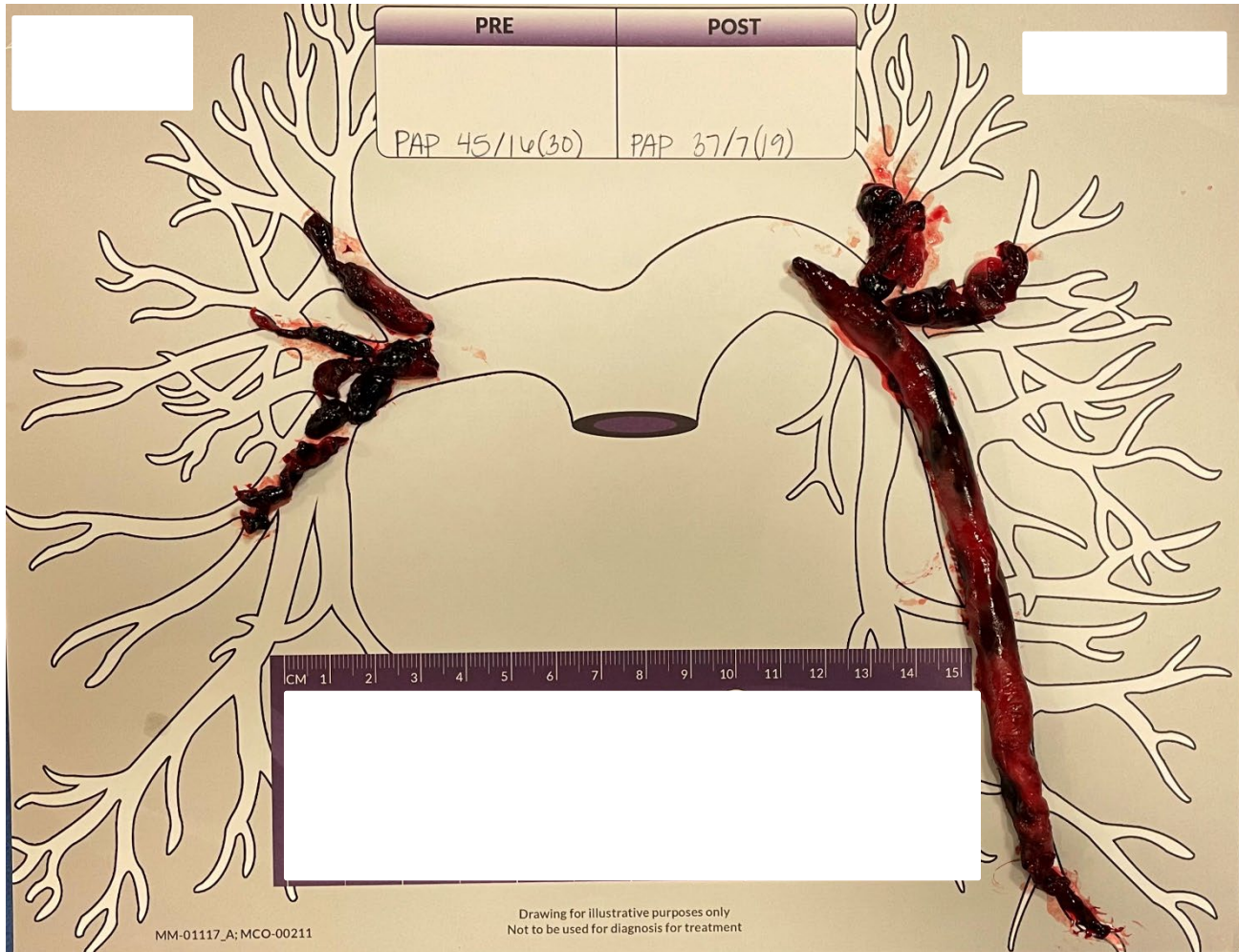






Case Presentation - PE

2 Days Post-MT



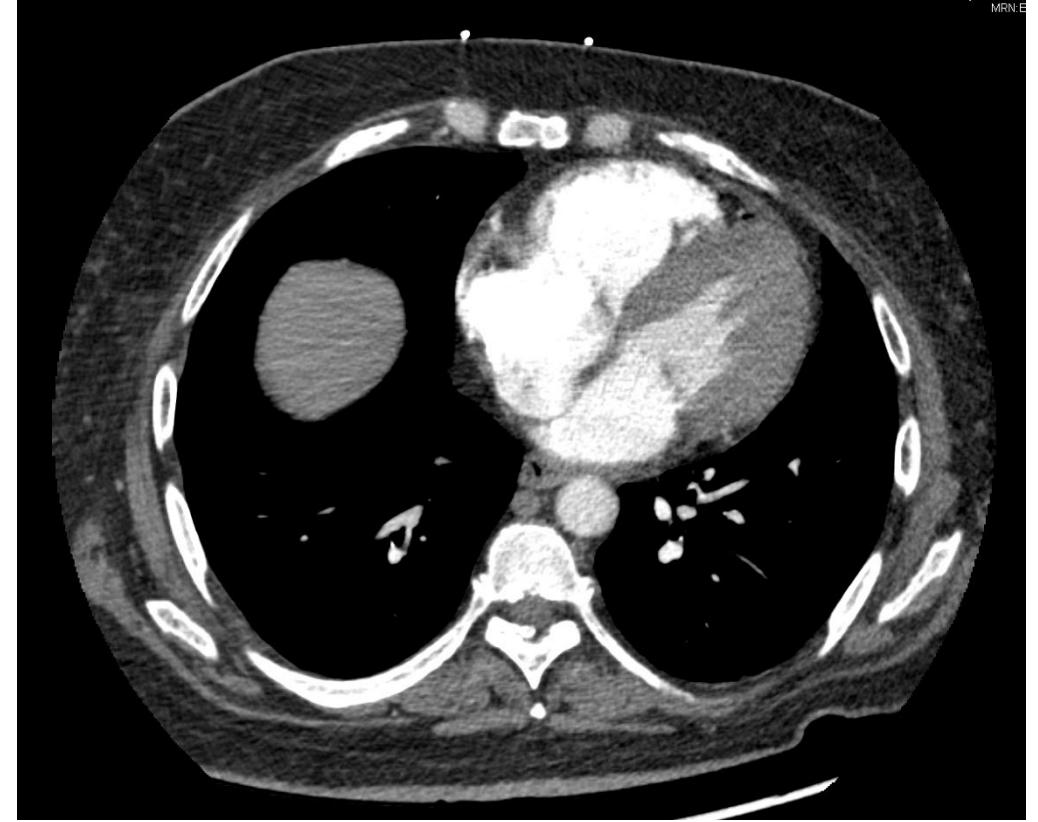
Case Presentation - PE

56-year-old female with a past medical history of HTN, HL, end-stage renal disease previous history of HD with left arm AV fistula, cadaveric kidney transplant 1 mo ago, presents with sudden Syncope, transferred to MCHH after CTPE showed large PE burden bilaterally.

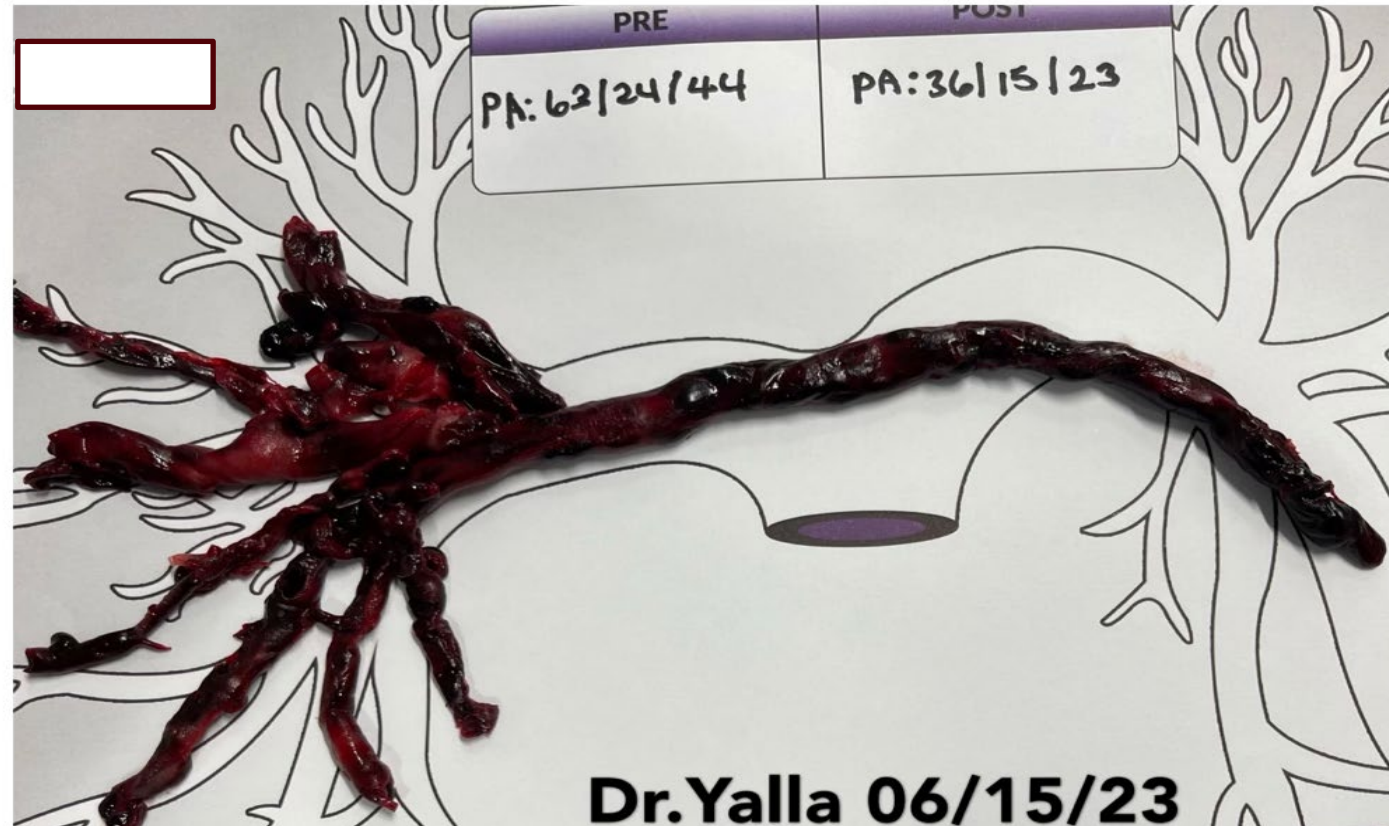


Trop 324
BNP 947
LA 2.3

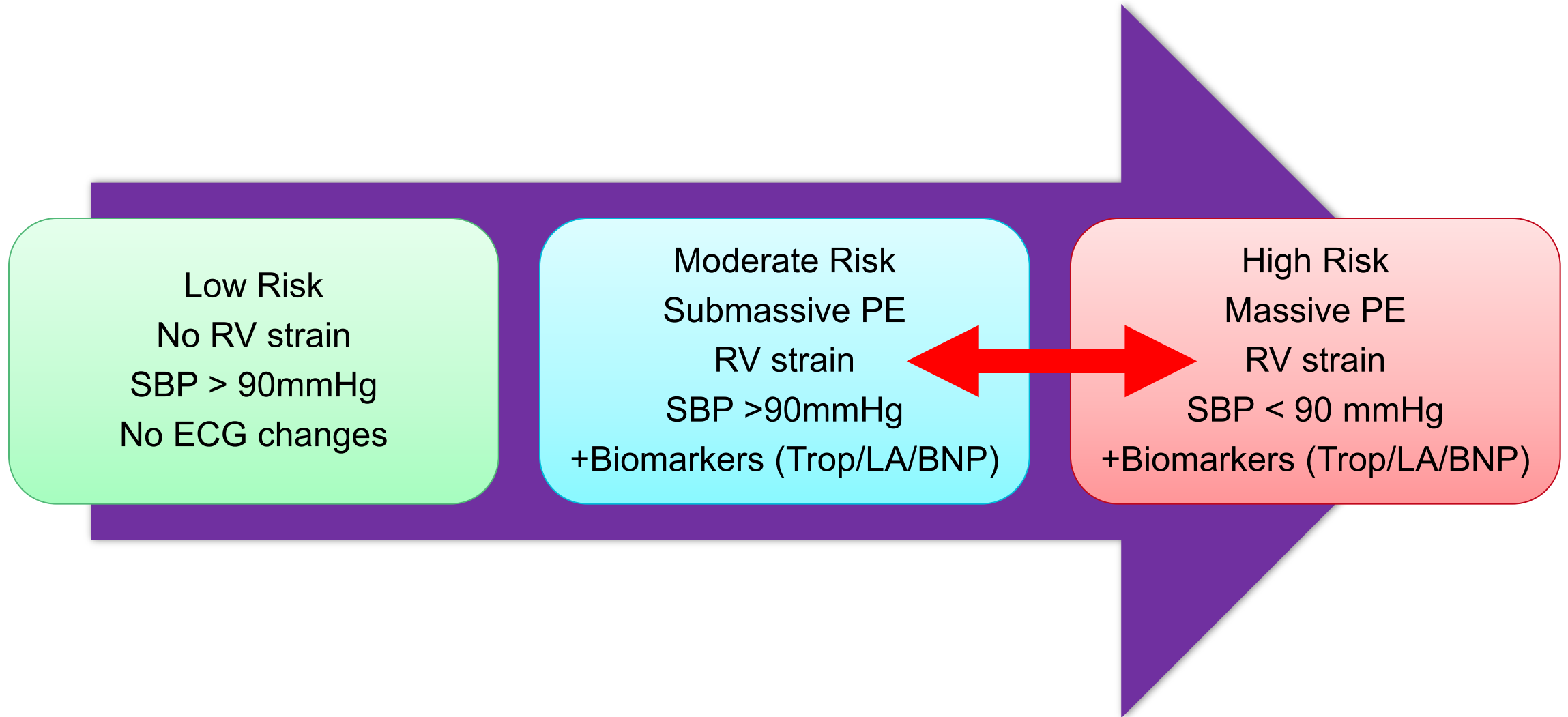
Normotensive



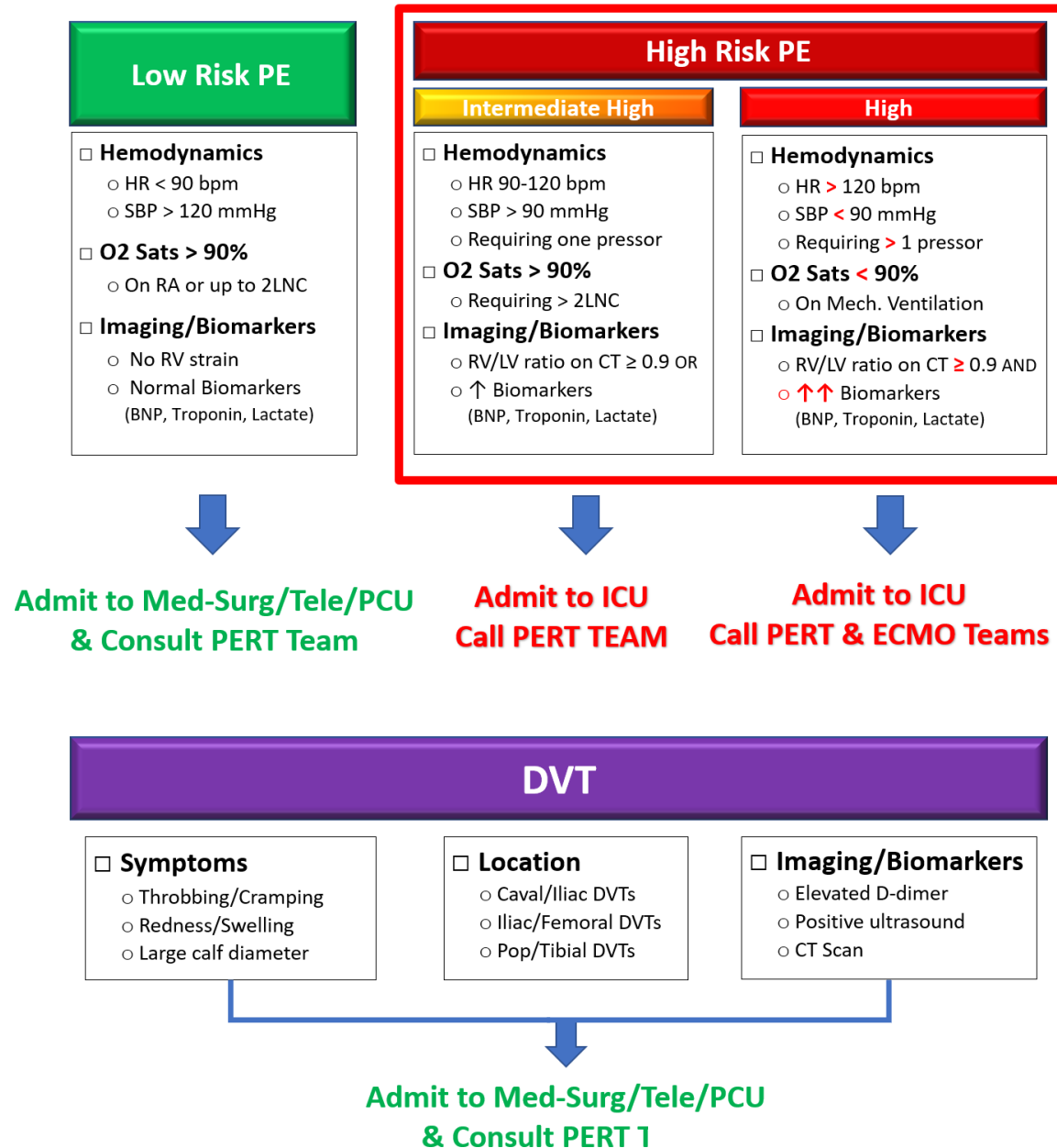
Case Presentation - PE



PE Risk Stratification

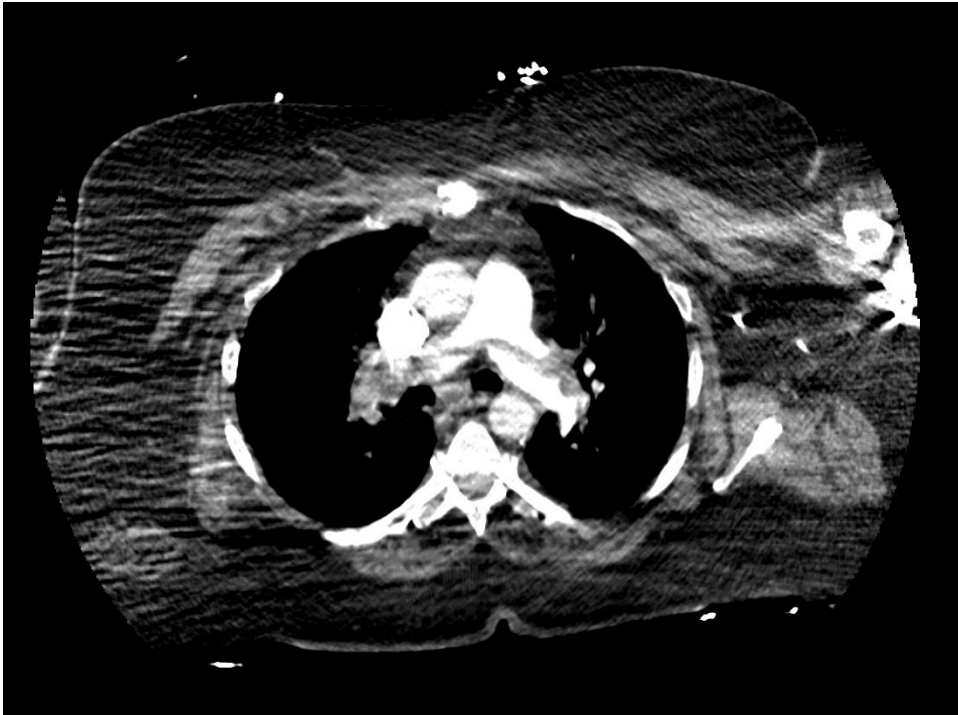


Emergency Department VTE Algorithm



Case Presentation – PE & ECMO

52 yo F with a PMH of HTN, Morbid Obesity (400 lb +), DM2, Fibromyalgia, Bipolar D/o, presents with SOB and challenges with walking, found to have Saddle PE with RV strain on CT scan imaging. Transferred from MCLC to MCHH.



Peak Trop 382
BNP 3824
LA 5.7

On BiPAP

SBP low 100s

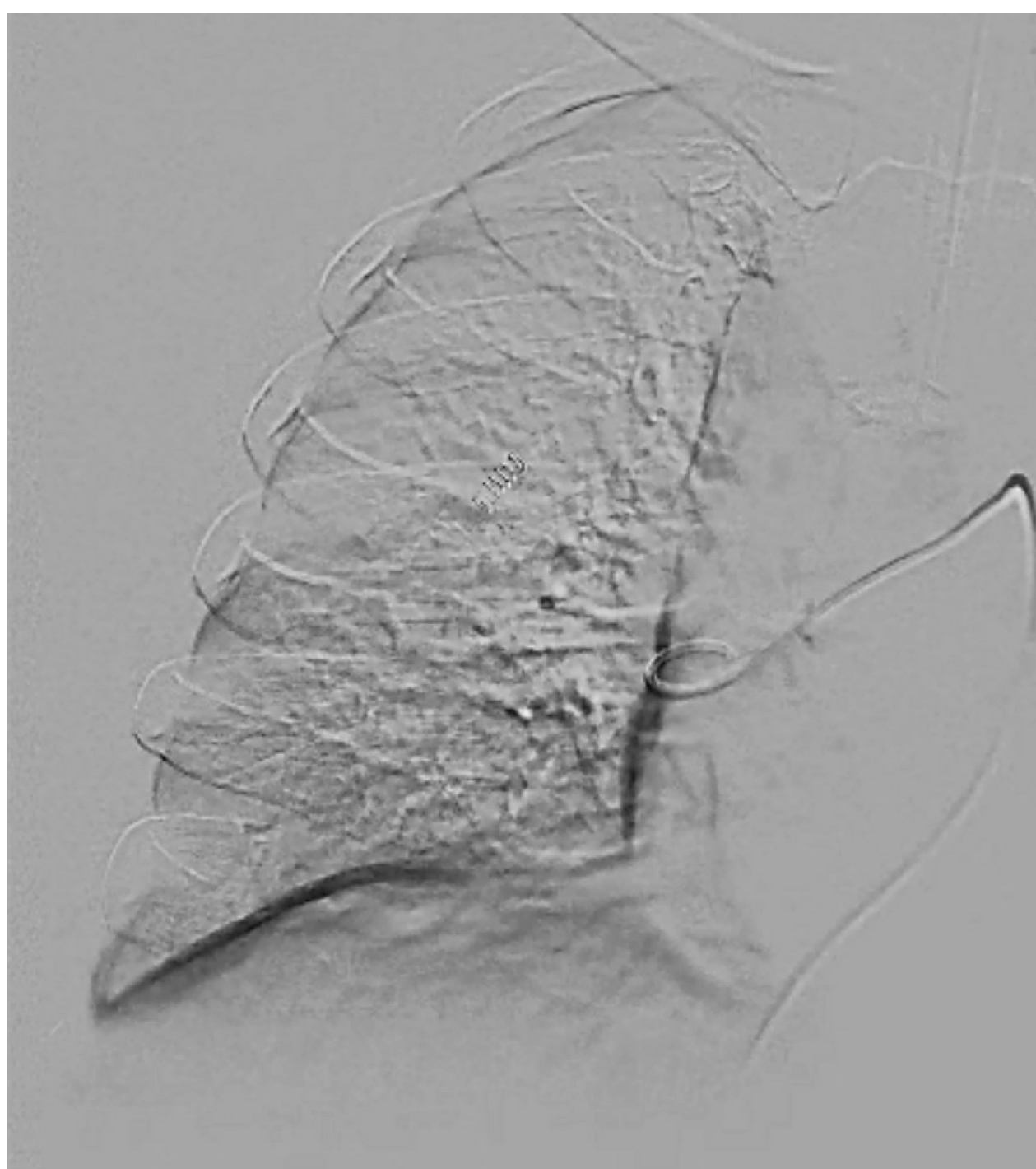


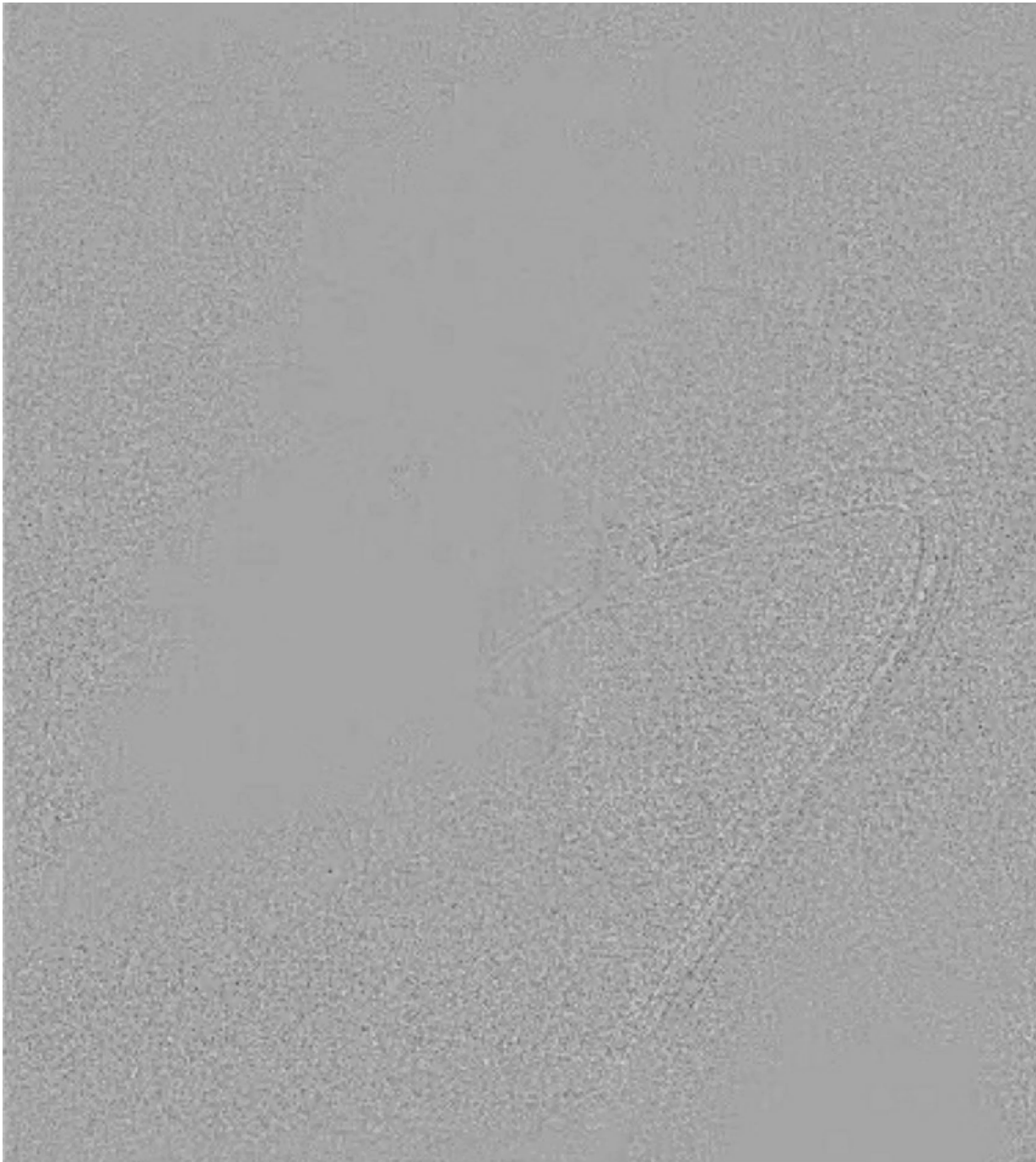
Discussed w/ ICU, developed a Plan...

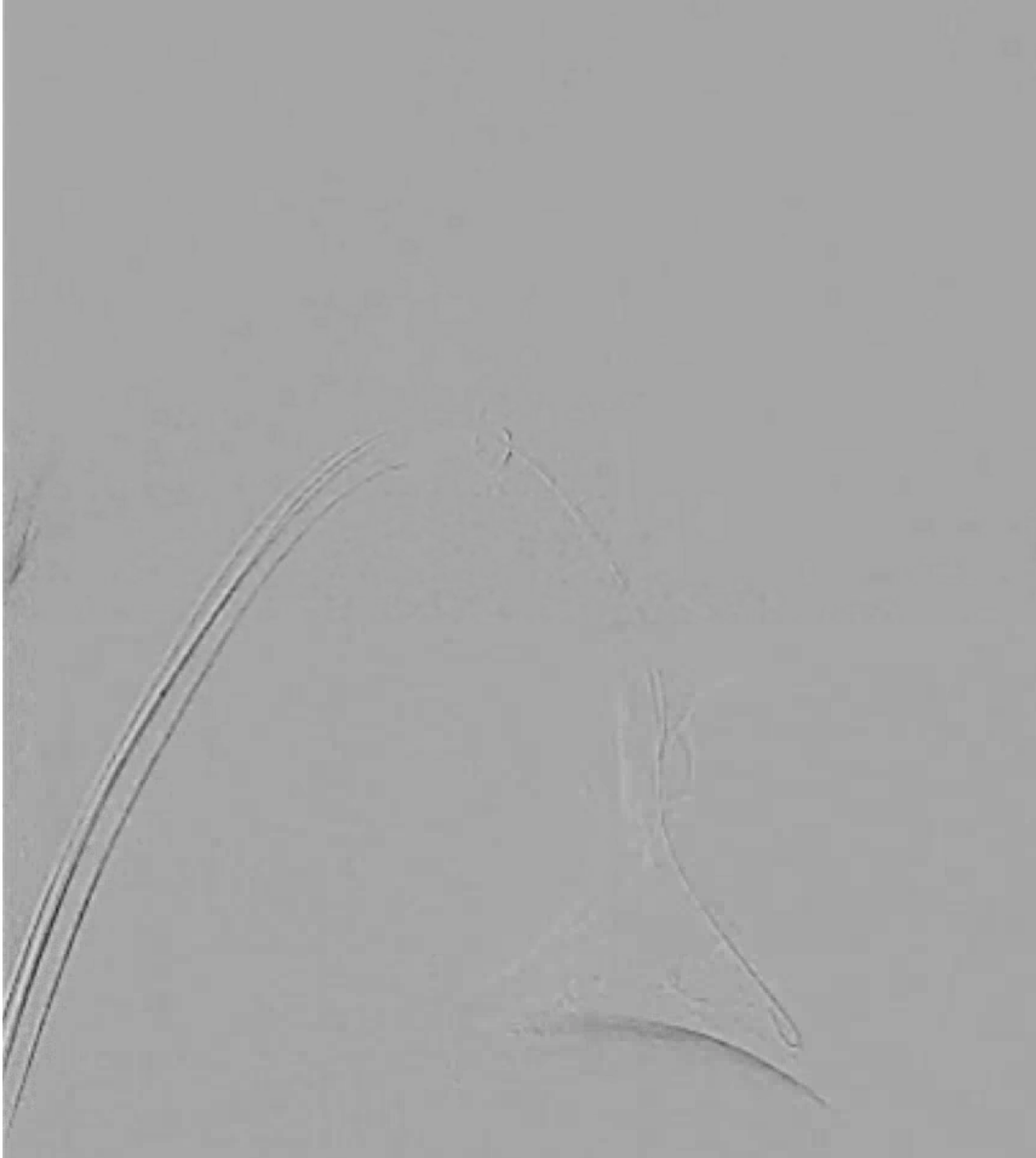
Intubated patient, to protect airway

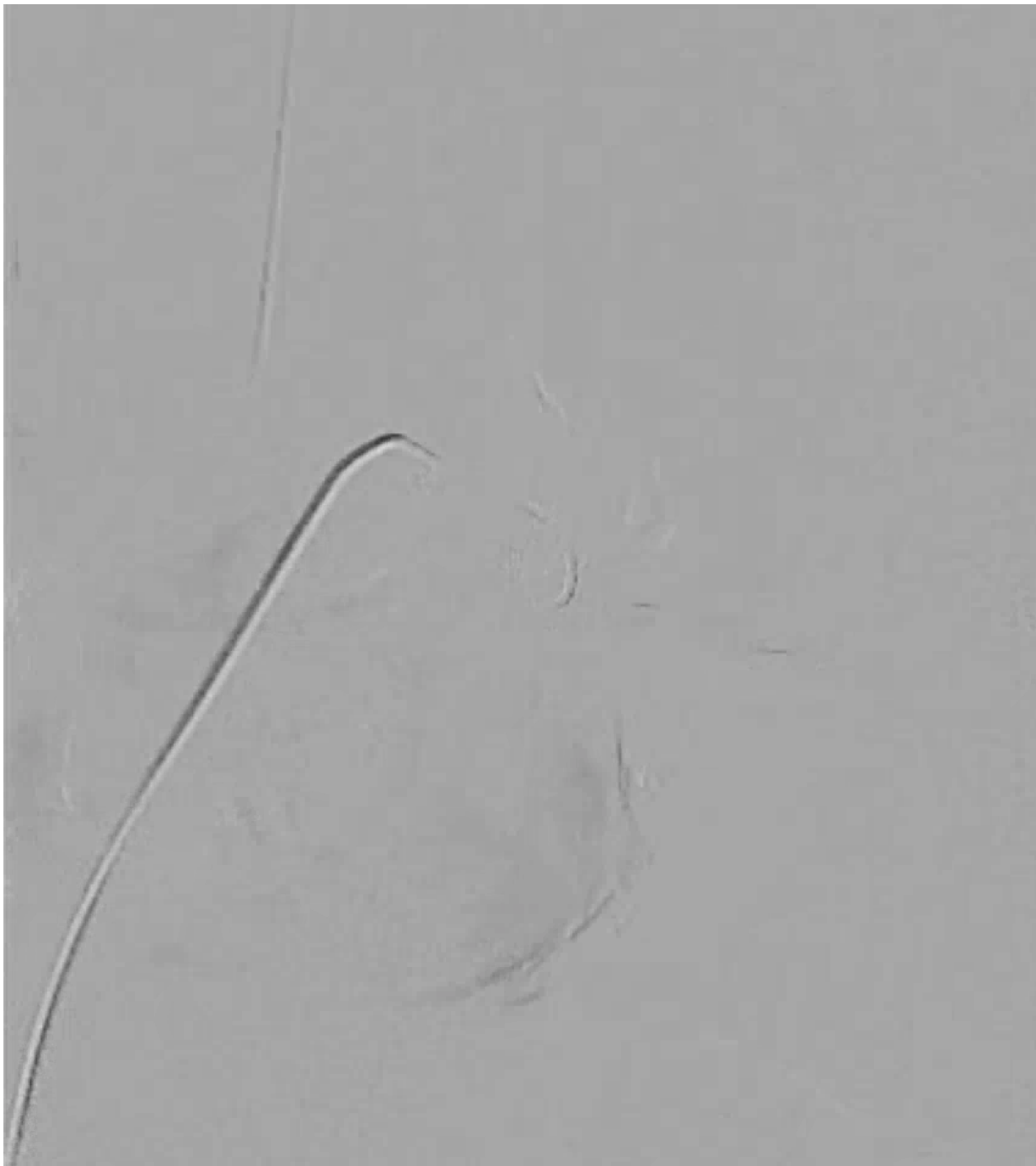
Given RV strain / hemodynamics, we cannulated patient upfront, placed on VA ECMO...

Then proceeded with Thrombectomy









Case Presentation – PE & ECMO

- Patient thrived
- We eventually had patient decannulated, this was done percutaneously in the cath lab 2 days after MCS/Mechanical Thrombectomy

- I. Pulmonary Embolism is a high mortality disease state, RV strain/dysfunction is a predictor of worse outcomes
- II. Risk stratification is key in treatment plan and decision making, especially in higher risk PE cases
- III. Catheter Directed therapies have been shown to be safe and effective
- IV. The current evidence for interventional procedures to address PE is sound and will continue to expand in the future

Thank You!



Srinivas Yallapragada MD
Interventional Cardiology
Chair of Medical City Healthcare NTX
Division PERT Council
Section Chief of Cardiology
Medical City Heart and Spine Hospital
Medical City Las Colinas Hospital

Q & A

Questions from the Audience
for Dr. Pugliese or Dr. Yallapragada?



Upcoming National Events

1st National
Connection
Forum (Virtual)
Jun 4, 2026

PERT 2026
Sep 30-Oct 3, 2026

VIVA VEINS 2026
Oct 3-7, 2026

AHA Scientific
Sessions
Nov 5-8, 2026

Join us for the first **Target: Pulmonary Embolism National Connection Forum**
on **June 4, 2026** from **11am-2pm CST / 12pm-3pm EST**.

Learn about pressing topics in PE care!

Registration link will be sent in follow-up!



American Heart Association®

Target: Pulmonary Embolism

Thank You!

For any questions, please reach out to
Alexa Cohen (alexa.cohen@heart.org)

Visit our website to keep up to date
with Target: PE!

Heart.org/TargetPE



American Heart Association.

Target: Pulmonary Embolism

Resources

Target: PE Initiative

- [Initiative Landing Page](#)
- [News Release](#)
- [Press Release](#)
- [Patient Education Website](#)

National Education

- [Year-1 National Model-Sharing Toolkit](#)
- [Webinar #1 \(March 2026\)](#)
- [Webinar #2 \(August 2026\)](#)
- [Virtual Connection Forum \(June 2026\)](#)

2026 AHA/ACC Acute PE Guidelines

- [2026 AHA/ACC Acute PE Guidelines](#)
- [Guideline Hub Website](#)
- News Release: [First AHA/ACC Acute Pulmonary Embolism Guideline Prompt Diagnosis and Treatment are Key](#)
- [JACC Editorial — 2026 Acute PE Guideline-at-a-Glance](#)
- [Top Things to Know: 2026 Guideline for the Evaluation and Management of Acute Pulmonary Embolism in Adults](#)
- [Acute Pulmonary Embolism Guideline Slide Set \(PPTX\)](#)
- [Acute Pulmonary Embolism Pocket Guide](#)
- [Top Take-Home Messages for the Emergency Physician \(PDF\)](#)
- [Key Patient Messages for Acute Pulmonary Embolism \(PDF\)](#)
- [Patient Resource: What is a Pulmonary Embolism Infographic \(PDF\)](#)
- [Patient Resource: Que es una Embolia Pulmonar Infographic Spanish \(PDF\)](#)



American Heart Association.

Target: Pulmonary Embolism

Check out the press release!

Improving care for life-threatening blood clots

New American Heart Association effort will bring together diverse hospitals to create scalable models for timely, effective pulmonary embolism treatment



DALLAS, October 31, 2025 — Pulmonary embolism (PE), a type of blood clot in the lungs, sends more than half a million people to U.S. hospitals each year — and kills about one in five high-risk patients, according to the American Heart Association [2025 statistical update](#). PE is the third leading cause of cardiovascular death in the U.S.^[1] While progress has been made in PE care, pulmonary embolism remains underdiagnosed, undertreated and inconsistently managed.

To address these gaps in care, the American Heart Association, devoted to changing the future to a world of healthier lives for all, is launching a three-year quality improvement initiative, supported by Inari, now part of Stryker, to better understand barriers and advance best practices for pulmonary embolism diagnosis, treatment and follow-up care.

The [Pulmonary Embolism Quality Improvement Initiative](#) will convene a 20-site national learning collaborative representing urban, rural and under-resourced communities. These diverse care teams will share data, insights and experiences through an “all teach, all learn”

Related Images



Heart and lungs illustration

Human Chest Cavity illustration: Right lung, left lung, heart

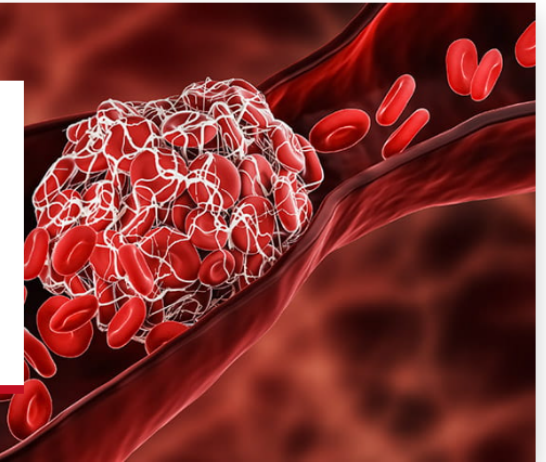
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Target: Pulmonary Embolism

Addressing persistent gaps in PE care and strengthening systems of care nationwide



Pulmonary embolism (PE) is a type of venous thromboembolism (VTE), or blood clots in the veins. PE occurs when a blood clot breaks free, usually from a deep vein in the legs, and becomes lodged in the lungs. VTE is a potentially life-threatening condition that contributes to up to 100,000 deaths each year in the United States.¹

Recent data show that PE-related mortality increased between 2008 and 2018, underscoring its persistent and growing impact as a leading cause of cardiovascular morbidity and mortality.²

Despite its high clinical burden, PE continues to be underdiagnosed, undertreated and inconsistently managed across health systems.^{3,4} Significant variability exists in how hospitals identify, risk-stratify, treat and monitor patients with PE, which results in preventable complications, poor outcomes and persistent disparities in care.

These ongoing gaps in practice underscore the urgent need to implement robust, evidence-based systems that ensure timely diagnosis, effective treatment and comprehensive follow-up for all people affected by PE.



American Heart Association.
Target: Pulmonary Embolism

Check out our website to stay up to date with the latest PE information!

Heart.org/TargetPE