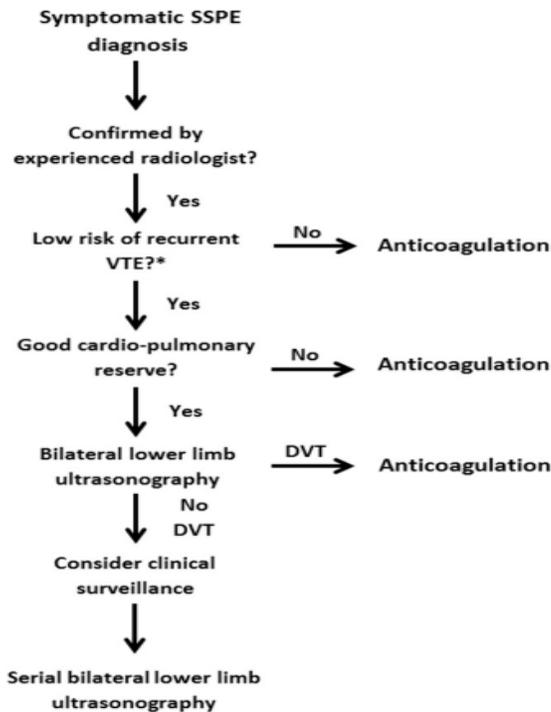
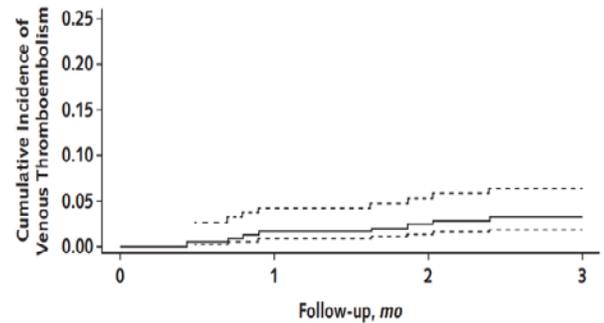


Uncertain Clinical Significance of Isolated Subsegmental PE (ISSPE)

Context: ISSPE have typically been lumped in with all other PE events and treated with anticoagulation.
Current: Newer-generation CT scanners are now able to detect filling defects down to approximately 3mm in size. Despite the rise in detection of PE, clinical outcomes have remained stable and inter-rater reliability among radiologists is often low.¹
Cutting Edge: Routine anticoagulation is probably not beneficial for all patients with ISSPE.

Recurrence Risk

Context: Anticoagulation is beneficial only if it reduces progression and/or recurrent events.
Current: Rate of recurrent VTE 90 days after ISSPE is approximately 3% without anticoagulation, but the recurrence rate was more than 2-fold higher among patients with multiple ISSPE lesions when compared to those with only a single lesion.²
Cutting Edge: Patients with single ISSPE managed without anticoagulation are less likely to have recurrent VTE at 90 days than patients receiving anticoagulation for proximal PE.



Optimal Pathways

Context: Although some variability exists between guidelines, some now recommend active surveillance rather than anticoagulation for ISSPE for low risk patients.³
Current: Variability also exists in defining low risk patients. Patients with cancer are considered elevated risk and generally anticoagulated.⁴ Typically patients with no hemodynamic instability, no proximal DVT, and no active cancer are considered candidates for active surveillance. Active surveillance has had poor community uptake even among patients with reasonable access to healthcare.⁵
Cutting Edge: For patients not started on anticoagulation, serial ultrasound to evaluate for proximal DVT are probably prudent.¹ Optimal timing and duration are uncertain but will hopefully be clarified soon with results from ongoing clinical trials.

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