

THE LEG DETECTIVE / CASE FILE 001

Medical review dossier

DRAFT — NOT MEDICALLY APPROVED. Version 1.2, 28 October 2026. The current Portuguese SmPC has not been verified. This document is a review package, not authorisation for external dissemination or a patient-specific prescription.

English medical-review dossier for an interactive educational case intended for cardiology, vascular medicine/angiology and vascular surgery specialists. The game contains five single-best-answer decisions, option-specific feedback and a final diagnostic, treatment/prescribing and prognostic assessment.

Fictional case record

Presentation

Jane FatalSmith, 62, is a retired shop assistant. She reports months of bilateral leg heaviness/pain, nocturnal cramps and ankle swelling, worse later in the day. The case describes bilateral truncal varicose veins and ankle oedema.

Background

Hypertension, type 2 diabetes and BMI 32 kg/m². Previous prolonged standing at work; now largely sedentary.

Medication record

Metformin, empagliflozin, valsartan/hydrochlorothiazide, amlodipine 5 mg and atorvastatin. Other doses and the chronology of medication changes are not supplied.

Not yet established

No duplex findings, renal function, blood pressure, arterial pressures, neuropathy assessment, cardiac status, albumin, allergies or thrombotic history are supplied. Pigmentation, eczema and ulcers are not documented; this is not equivalent to a negative examination. Illustrations are not diagnostic images.

Scope of the case

Working C3s phenotype; the cause of oedema remains to be assessed. No proven reflux, obstruction, complete E/A/P classification or undocumented test result is assigned. The supplied images illustrate the story and are not diagnostic evidence.

References: [1], [2], [10]

Learning objectives

- Describe a provisional CEAP clinical phenotype without inventing aetiology, reflux or obstruction.
- Recognise possible medication-related and systemic contributors to bilateral oedema.
- Select the appropriate first-line venous imaging investigation.
- Interpret symptom-treatment evidence within its limitations and local prescribing requirements.
- Build a practical non-pharmacological plan and identify escalation triggers.

QUESTION 1 / 5

Which CEAP clinical class best fits this presentation?

Truncal varicose veins, bilateral ankle oedema and symptoms. Choose the best working clinical class; the cause of the oedema still needs assessment.

Best answer: C**A. C1s**

C1 describes telangiectasias or reticular veins. It does not capture the described varicose veins with oedema. [1]

B. C2s

C2 describes varicose veins. If the oedema is attributable to venous disease, the higher clinical class is C3s. [1]

C. C3s — BEST ANSWER

C3 denotes oedema and “s” denotes symptoms. Here it is a working clinical phenotype: assess the cause of the swelling before completing the venous diagnosis. [1], [10]

D. C4as

C4a requires pigmentation or eczema. Neither is described. Oedema alone does not establish C4a. [1]

CEAP describes the clinical phenotype. The case does not supply the aetiological, anatomical or pathophysiological findings needed for a complete classification.

References: [1], [2]

QUESTION 2 / 5

How should amlodipine be interpreted in this case?

Jane takes amlodipine 5 mg alongside valsartan/hydrochlorothiazide. Her bilateral ankle swelling may have more than one contributor.

Best answer: B**A. It explains the entire presentation on its own**

Amlodipine can cause ankle oedema, but this does not establish the cause of every symptom or explain all the venous findings. [3]

B. It may contribute and coexist with chronic venous disease — BEST ANSWER

Review the timing of oedema against treatment and dose changes, while assessing venous and systemic contributors. Multiple causes may coexist. [3], [10]

C. It excludes a venous cause

A medication-related contribution does not exclude coexisting venous disease. Both mechanisms need consideration. [3], [10]

D. It confirms venous thrombosis

Taking amlodipine does not diagnose thrombosis. Suspected acute DVT requires clinical probability assessment and the appropriate diagnostic pathway. [8]

Review antihypertensive treatment with the treating clinician. Jane already takes an ARB: do not add an ACE inhibitor for hypertension or empirically escalate diuretics to treat presumed CCB-related oedema.

References: [3], [11]

QUESTION 3 / 5

Which investigation best characterises suspected chronic venous disease?

Select the first-line venous imaging investigation for this chronic presentation. No duplex result has been provided.

Best answer: D**A. Arterial CT angiography**

Arterial imaging addresses a different clinical indication. The current question is venous anatomy, patency, reflux and obstruction. [1], [2]

B. D-dimer alone

D-dimer does not map chronic venous reflux. Its role in suspected acute VTE depends on the diagnostic probability pathway. [8]

C. Plain radiographs of the legs

Plain radiographs cannot provide the venous flow information needed to characterise this presentation. [1], [2]

D. Full lower-limb venous duplex ultrasound — BEST ANSWER

Duplex is the first-line venous imaging investigation, assessing anatomy, patency, reflux and obstruction to guide management. No result has yet been supplied. [1], [2]

This answer concerns chronic venous assessment. New acute symptoms or suspected thrombosis require the appropriate urgent VTE pathway.

References: [8]

QUESTION 4 / 5

Which benefit has been studied with sulodexide in chronic venous disease?

Distinguish a studied symptom benefit from a claim of cure or an automatic prescribing decision.

Best answer: A**A. Improvement in symptoms and oedema — BEST ANSWER**

Studies reported improvement in symptoms and oedema. Designs and populations vary: this does not guarantee benefit for Jane or establish an automatic prescription. [4], [5]

B. Definitive cure of varicose veins

The cited symptom evidence does not establish elimination of varicose veins or definitive correction of reflux. [4]

C. Normalisation of blood glucose

The CVD findings concern symptoms and signs, not normalisation of glycaemia. Diabetes requires its own management plan. [4]

D. No further need for vascular assessment

Symptom treatment does not replace diagnostic evaluation or assessment for an appropriate venous intervention. [5], [7]

The 2023 SVS/AVF/AVLS suggestion including sulodexide is weak, with low-to-very-low certainty evidence, for selected symptomatic patients who are not intervention candidates, are awaiting intervention, or have residual symptoms. Portuguese prescribing must follow the current local SmPC; that document remains a medical-review requirement.

References: [5], [6]

QUESTION 5 / 5

Which habit supports venous return?

Choose a practical non-pharmacological measure, adapted to Jane's mobility and comorbidities.

Best answer: B**A. Remaining still for hours**

Prolonged immobility limits the contribution of the calf-muscle pump. Encourage regular movement when clinically appropriate. [2]

B. Walking and moving the ankles — BEST ANSWER

Walking and ankle movement activate the calf-muscle pump and support venous return. Adapt activity to mobility and comorbidity. [2]

C. Avoiding all physical activity

Routine inactivity is not a CVD treatment strategy. An individualised, feasible exercise plan is more appropriate. [2]

D. Keeping the legs dependent while resting

Dependency does not assist venous drainage. Appropriate leg elevation can be considered for symptom relief. [2]

Agree on achievable activity and breaks from prolonged sitting or standing. Review function, symptoms and adherence at follow-up.

References: [2]

Diagnostic assessment

Working hypothesis

Symptomatic chronic venous disease with varicose veins and a working C3s clinical phenotype. Venous causation of oedema and the anatomical/pathophysiological classification remain unconfirmed.

Next diagnostic step

Obtain full lower-limb venous duplex before assigning reflux, obstruction or a procedural target. Reassess symptom chronology, symmetry, skin findings, previous thrombosis and medication changes; examine for cardiac, renal, hepatic and lymphatic contributors.

Targeted additional assessment

Select renal function, urinalysis/protein assessment, albumin/liver tests, thyroid or cardiac investigations according to findings. These are proposed investigations, not existing results.

References: [1], [2], [10]

FINAL CLINICAL REPORT / CONTINUED

Treatment & prescribing

Conservative plan

Agree on feasible walking and ankle movement, breaks from prolonged immobility, weight management and appropriate elevation. Consider below-knee compression at 20–40 mmHg for C3 oedema only after assessing arterial perfusion, neuropathy, skin, cardiac status, fit and tolerance. In diabetes, ABI may be unreliable; assess toe pressures where indicated. Severe arterial disease or other contraindications require modification or avoidance.

Antihypertensive review

Review amlodipine with the treating clinician; do not stop it automatically. Any reduction or alternative depends on blood pressure and the overall regimen. Jane already receives valsartan/HCTZ: do not add an ACE inhibitor for hypertension or empirically escalate diuretics for presumed CCB-related oedema.

Venous intervention

If duplex demonstrates clinically relevant truncal reflux and she is suitable, discuss intervention, alternatives and preferences. Compression for symptom control does not replace evaluation for treatable reflux; it is not presented as definitive treatment when an appropriate intervention is available.

Pharmacotherapy decision

Sulodexide has symptom/oedema evidence, with important uncertainty. The guideline suggestion is weak and applies to selected symptomatic patients. A decision requires current Portuguese SmPC confirmation, a defined indication and an individual benefit–risk assessment. This game issues no sulodexide dose or treatment order.

Safety information to verify

The historical Portuguese leaflet (March 2022) lists hypersensitivity to sulodexide/heparin-related substances and haemorrhagic conditions among contraindications, and warns about bleeding and concomitant anticoagulants. It does not verify the current SmPC. Review the complete current label and concomitant antithrombotics before prescribing.

References: [2], [3], [4], [5], [6], [7], [11]

Prescribing boundary

No product dose or treatment order is generated. Medical review must confirm current Portuguese approved information, the local indication, the complete safety text and the company-required prescribing-information presentation before external release.

Prognosis & follow-up

Expected course

Symptoms and oedema may improve with an individualised plan, but the case cannot support a promise of cure or a personal ulcer-risk percentage. Chronic venous disease can progress or recur; Jane's trajectory needs duplex assessment and follow-up.

Reassessment

Agree on follow-up after the investigations and any treatment adjustment, with timing determined by findings and the local pathway. Review symptoms, swelling, skin condition, function, adherence, treatment tolerance and response. Record changes rather than inferring benefit from the score.

References: [2], [7], [9]

When to escalate

Acute changes require a different pathway

New acute painful swelling requires urgent assessment for DVT. Sudden breathlessness, chest pain or haemoptysis requires urgent assessment for PE. Bleeding varicose veins requires immediate vascular referral.

References: [7], [8]

Game logic & content controls

Sequence

The centred logo opens four case files. Jane opens Part I; its end starts the five-decision landscape quiz. Finishing the last feedback opens Part II; its end returns to the case files. The completed clinical report remains accessible. The two supplied films are embedded using Vimeo. End-of-video events advance the sequence; playback errors expose retry and manual continuation controls.

Scoring

One point for each best first confirmed answer; maximum five points. Key: C, B, D, A, B. Confirmed choices cannot be changed within a run. A fresh case resets the score.

Clinical independence

The final clinical assessment is identical for all participants. The score changes only the educational recap and answer review. An incorrect answer does not produce an unsafe fictional prescription.

Evidence boundaries

No investigation result is generated, no personal probability of ulceration is estimated, and no dose or treatment order is issued. The clinical summary is deterministic, not AI-generated at runtime.

Data and access

The game asks for no patient or clinician identifying data. Answers are stored in localStorage in the current browser; restarting replaces them. No analytics scripts are added by the game. Vimeo is embedded with dnt=1; technical requests to Vimeo and provider/hosting logs are outside this browser-local answer storage.

Audience and release

The visible review banner and private review deployment are not professional credential verification. Medical/legal reviewers must decide the appropriate HCP access controls and publication setting before wider distribution.

Evidence register

Sources reviewed 28 October 2026. This targeted register supports the case; it is not an exhaustive systematic review. Current local SmPC confirmation is outstanding.

[1] SVS/AVF/AVLS guideline, Part I; CEAP 2020 consensus

Gloviczki P et al. The 2022 clinical practice guidelines for management of varicose veins of the lower extremities, Part I. J Vasc Surg Venous Lymphat Disord. 2023;11:231–261.e6. CEAP consensus: Lurie F et al., 2020.

Table II (CEAP); duplex recommendations. Consensus defines the revised classification.

Limitations: CEAP describes phenotype; it does not prove that every instance of swelling is venous.

[Open primary source / record](#) · [Supporting text](#)

[2] ESVS 2022 Clinical Practice Guidelines

De Maeseneer MG et al. Management of Chronic Venous Disease of the Lower Limbs. Eur J Vasc Endovasc Surg. 2022;63:184–267.

Recommendations 3 (duplex), 8 (exercise), 10 (C3 compression); section 3.2 and Table 8 (arterial assessment and contraindications).

Limitations: Guideline recommendations require individual assessment. Exercise evidence is limited. The official society PDF redirected to login during checking; an accessible reproduction of the guideline was consulted.

[Open primary source / record](#) · [Supporting text](#)

[3] NHS Specialist Pharmacy Service: CCB-related oedema

Managing peripheral oedema caused by calcium channel blockers. Updated 26 May 2026.

Onset; optimisation of CCB therapy; non-pharmacological options; diuretics not recommended for this mechanism.

Limitations: Medication changes depend on blood pressure, comorbidity and the treating clinician's assessment.

[Open primary source / record](#)

[4] Sulodexide: systematic review and meta-analysis

Bignamini AA, Matuška J. Sulodexide for the Symptoms and Signs of Chronic Venous Disease. Adv Ther. 2020;37:1013–1033.

Methods, symptom/oedema results and limitations; 13 studies supplied quantitative data for 1,901 participants.

Limitations: Heterogeneous designs, including observational evidence, limit causal certainty. Do not extrapolate ulcer-healing findings to Jane. Disclosure: Bignamini reported consultancy fees from Alfasigma and Bayer.

[Open primary source / record](#) · [Supporting text](#)

[5] SVS/AVF/AVLS 2023 guideline, Part II

Gloviczki P et al. The 2023 clinical practice guidelines for management of varicose veins of the lower extremities, Part II. J Vasc Surg Venous Lymphat Disord. 2024;12:101670.

Recommendation 3.2; Table XXX and sulodexide evidence discussion. Grade 2 (weak), evidence C (low to very low).

Limitations: Selected symptomatic patients who are ineligible for, awaiting, or symptomatic after intervention. This is not a Portuguese regulatory approval or a claim of superiority to intervention.

[Open primary source / record](#)

[6] Historical Portuguese sulodexide patient leaflet

Alfasigma Portugal. Vessel 250 LSU soft capsules, patient leaflet revised March 2022.

Sections 1–2: indication, contraindications, warnings and anticoagulant interaction.

Limitations: Not a verified current Portuguese SmPC. Local approved indication, availability, route, regimen, duration and complete safety wording must be checked against the current INFARMED/INFOMED record before approval. No dose is issued by this game.

[Open primary source / record](#)

Evidence register / continued

[7] NICE CG168: Varicose veins

Varicose veins: diagnosis and management. Clinical guideline CG168.

1.1 (information and recurrence), 1.2.1–1.2.2 (referral), 1.3.1–1.3.4 (duplex, intervention and compression).

Limitations: NICE restricts compression as definitive treatment for varicose veins when intervention is suitable. Distinguish this from ESVS symptom/oedema control guidance.

[Open primary source / record](#) · [Supporting text](#)

[8] NICE NG158: Venous thromboembolic diseases

Venous thromboembolic diseases: diagnosis, management and thrombophilia testing. Guideline NG158.

1.1.1–1.1.10 (DVT probability, D-dimer and ultrasound); 1.1.15–1.1.21 (PE).

Limitations: Use the applicable local acute VTE pathway. D-dimer alone does not characterise chronic venous reflux.

[Open primary source / record](#)

[9] Edinburgh Vein Study: progression

Lee AJ et al. Progression of varicose veins and chronic venous insufficiency in the general population. J Vasc Surg Venous Lymphat Disord. 2015;3:18–26.

Cohort results and conclusions on progression and associated risk factors.

Limitations: Population-level observations cannot be converted into Jane's personal risk percentage.

[Open primary source / record](#) · [Supporting text](#)

[10] Diagnostic approach to lower-limb oedema

Gasparis AP et al. Diagnostic approach to lower limb edema. Phlebology. 2020;35:650–655.

History, physical examination, diagnostic testing, Table 1 and Figure 1.

Limitations: Expert diagnostic algorithm, not a randomised trial; supports assessment for multiple causes of swelling.

[Open primary source / record](#) · [Supporting text](#)

[11] NICE NG136: Hypertension in adults

Hypertension in adults: diagnosis and management. Guideline NG136.

Recommendation 1.4.34: do not combine an ACE inhibitor with an ARB for hypertension.

Limitations: Prevents inappropriate addition of an ACE inhibitor in a patient already taking valsartan.

[Open primary source / record](#)

Claim-to-source map

Location	Claim boundary	Refs
Q1 / diagnosis	Working C3s; CEAP does not establish the cause of oedema.	1, 2, 10
Q2 / medication	CCB-related oedema may coexist; review the regimen without automatic withdrawal or unsafe combinations.	3, 10, 11
Q3 / investigation	Duplex for chronic venous anatomy, reflux and obstruction; acute VTE has a different pathway.	1, 2, 8
Q4 / evidence	Studied symptom/oedema improvement; weak guideline suggestion and current local label check.	4, 5, 6, 7
Q5 / conservative plan	Walking/ankle movement and individualised activity; compression requires assessment.	2
Final report / prognosis	Possible improvement, progression/recurrence and reassessment; no individual risk promise.	7, 9

Medical approval checklist

Every item requires review. No approval has been inferred or recorded. The commissioning team must identify the sponsor/company and reviewers.

1. Confirm the fictional case record, symptom chronology and examination findings. Missing information must not be presented as a negative test.
2. Validate the provisional C3s wording and ensure no duplex result or complete E/A/P classification is invented.
3. Review all five questions, all 20 option-specific feedback messages and the C / B / D / A / B answer key. Keep Question 5 product-free.
4. Obtain and archive the current Portuguese SmPC/INFOMED record. Confirm indication, availability, full safety wording and any required prescribing information before releasing the product discussion.
5. Approve the Q4 evidence balance, uncertainty and relevant company/author relationships. Do not imply cure, automatic prescription, high-certainty benefit or prevention of progression.
6. Validate the compression wording and local vascular pathway, including arterial disease, diabetes/neuropathy and cardiac contraindications.
7. Confirm the antihypertensive advice: no automatic amlodipine withdrawal, no ACE inhibitor added to valsartan, and no empirical diuretic escalation for CCB oedema.
8. Validate the differential diagnosis, proposed investigations, follow-up and acute escalation advice against the intended country's clinical pathways.
9. Confirm that final clinical advice is independent of game score, and that the score assesses five learning decisions rather than professional competence.
10. Approve English copy, fictional images and their rights, intended audience, publication setting, references, version/date, pharmacovigilance requirements and any company-mandated notices.

Review record

Company / commissioning team: _____

Medical reviewer / speciality: _____

Current SmPC identifier and revision date: _____

Medical decision and release conditions: _____

Legal / regulatory / pharmacovigilance review: _____

Approved version, signature and date: _____

Changes to case facts, scoring, feedback, prescribing language, evidence or artwork require version control and reassessment.
Approval of this dossier does not automatically approve later edits.

FUTURE EPISODE 02 / CONCEPT FOR REVIEW

The Swollen Alibi

Vinnie “The Vein” Scarponi · 61



Acute unilateral swelling · VTE differential

Vinnie “The Vein” Scarponi, 61, is the imposing gangster glimpsed at the end of Jane’s case. He arrives in a dark overcoat after an overnight journey, reporting a newly painful, swollen left calf. Warmth and tenderness complicate his account of a minor injury. He wants a quick explanation; the detective needs a careful history. Deep vein thrombosis, superficial venous thrombosis, cellulitis and a ruptured popliteal cyst remain possibilities. No D-dimer or ultrasound result is available. The episode centres on clinical probability, timely investigation and recognition of symptoms that would trigger urgent assessment for pulmonary embolism.

Proposed episode. Film and interactive decisions are not yet available.

Specialist learning objectives

- Build a focused differential for acute unilateral swelling and establish DVT pre-test probability using a validated pathway rather than a single symptom.
- Select and interpret D-dimer and venous ultrasound in the correct sequence, including age-adjusted thresholds and repeat imaging when indicated.
- Recognise PE warning symptoms and apply time-sensitive investigation and interim-management pathways when imaging is delayed, with individual safety assessment.

The initial narrative does not supply every Wells item. Do not display a computed score or a confirmed DVT diagnosis until those facts and test results are explicitly authored.

Clinical foundations

[NICE NG158 — Venous thromboembolic diseases: diagnosis, management and thrombophilia testing](#)

1.1.1–1.1.10: DVT probability, D-dimer, ultrasound and repeat testing; 1.1.13–1.1.14: quantitative and age-adjusted D-dimer; 1.1.15–1.1.21: PE assessment; 1.3.3–1.3.4: interim anticoagulation safety investigations.

[Gasparis AP et al. Diagnostic approach to lower limb edema. Phlebology. 2020;35:650–655.](#)

Table 1: acute/chronic and unilateral/bilateral differential; history and examination; Figure 1: diagnostic algorithm.

The fictional portrait is narrative artwork, not evidence of a diagnosis. Full episode content and jurisdiction-specific prescribing information require separate medical review.

FUTURE EPISODE 03 / CONCEPT FOR REVIEW

The Vanishing Footsteps

Eleanor Legsworth · 68



Exertional leg pain · Arterial and non-arterial causes

Eleanor Legsworth, 68, a retired schoolteacher with tortoiseshell glasses and a tweed jacket, can no longer complete her favourite evening route. Calf discomfort appears after a similar walking distance and settles when she stops, but intermittent back pain and foot tingling complicate the picture. Her history includes diabetes, dyslipidaemia and previous smoking. She reports no rest pain or current foot wound; no vascular examination or physiological testing has yet been supplied. Peripheral artery disease is one hypothesis alongside neurological and musculoskeletal causes. The detective must connect the symptom pattern to objective testing before discussing cardiovascular risk reduction or a treatment pathway.

Proposed episode. Film and interactive decisions are not yet available.

Specialist learning objectives

- Differentiate vascular claudication from neurogenic and musculoskeletal symptoms using exercise, recovery, posture, examination and risk-factor clues.
- Choose resting ABI with waveforms, exercise ABI for appropriate normal/borderline results, and toe pressure/TBI when arteries are noncompressible.
- If PAD is confirmed, distinguish cardiovascular prevention and structured exercise from indications for anatomical imaging and revascularisation; identify limb-threatening symptoms.

Do not treat diabetes, a walking-distance pattern or a portrait as diagnostic proof. No ABI, TBI, duplex finding, arterial lesion or intervention target has been supplied.

Clinical foundations

[2024 ACC/AHA multisociety Guideline for the Management of Lower Extremity Peripheral Artery Disease](#)

Table 7: non-PAD causes of leg pain; §3.1 recommendations 1, 2, 5 and 6: resting ABI, noncompressibility, TBI and exercise ABI; §3.2: imaging and revascularisation planning; §§5–6: medical care and exercise; §11: acute limb ischaemia.

The fictional portrait is narrative artwork, not evidence of a diagnosis. Full episode content and jurisdiction-specific prescribing information require separate medical review.

FUTURE EPISODE 04 / CONCEPT FOR REVIEW

The Case That Wouldn't Close

Marcus Swellington · 57



Persistent swelling after DVT · Chronic venous sequelae

Marcus Swellington, 57, a former photojournalist in an olive cardigan and tweed jacket, brings a photograph from before his left-leg DVT three years ago. The clot was treated, but heaviness and ankle swelling now interfere with long days on his feet. He describes gradual worsening and intermittent skin discolouration, without a new acute onset. Previous records are incomplete and no current duplex study is available. Post-thrombotic disease is a working possibility, not a settled diagnosis. The episode explores residual obstruction, reflux, recurrent thrombosis and non-venous contributors, linking symptom burden and anatomy to a proportionate follow-up and management discussion.

Proposed episode. Film and interactive decisions are not yet available.

Specialist learning objectives

- Distinguish possible post-thrombotic disease from recurrent DVT and alternative causes; use validated severity measures without treating a score as proof of mechanism.
- Plan full-leg venous duplex and, when proximal obstruction is suspected, appropriate abdominal/pelvic assessment and additional imaging before intervention.
- Relate symptoms, function and documented anatomy to conservative care or specialist intervention assessment; avoid automatic stenting or anticoagulation for chronic swelling alone.

Do not imply that previous anticoagulation should be restarted, that a residual abnormality represents acute thrombosis, or that an iliac stent is indicated without a complete assessment.

Clinical foundations

[ESVS 2022 Clinical Practice Guidelines on the Management of Chronic Venous Disease of the Lower Limbs](#)

Table 6 and recommendation 2: Villalta/r-VCSS and specificity caveat; recommendations 3–5: leg duplex, abdominal/pelvic ultrasound and cross-sectional imaging; recommendation 58: selected severe symptomatic iliac outflow obstruction; recommendation 61: no invasive treatment without severe symptoms; §5.3.6: multidisciplinary care.

[NICE NG158 — Venous thromboembolic diseases: diagnosis, management and thrombophilia testing](#)

1.1.1–1.1.10: DVT probability, D-dimer, ultrasound and repeat testing; 1.1.13–1.1.14: quantitative and age-adjusted D-dimer; 1.1.15–1.1.21: PE assessment; 1.3.3–1.3.4: interim anticoagulation safety investigations.

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Table 1: acute/chronic and unilateral/bilateral differential; history and examination; Figure 1: diagnostic algorithm.

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