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DVT Treatment Guideline Summary

This is a very condensed summary of the 2012 ACCP Evidence-Based Clinical Practice Guidelines Regarding DVT and PE (9th Edition), specifically focussing on the "everyday" types of DVT which GP's see routinely. The original document is very much more comprehensive, and should be consulted for further information. The summary given below is a guide only, and directly taken from these guidelines (except for statements in square parentheses, which I have added], and does not constitute individual advice for every patient.
*These guidelines are from: **Chest** - vol 141, Issue 2 Suppl (Feb 2012). *Antithrombotic therapy and prevention of thrombosis, 9th ed*

For the purposes of this summary, a "Proximal" DVT is one where the proximal extent of the thrombus is in the popliteal vein or above, whereas a "Distal" DVT is entirely in the anterior tibial, posterior tibial, and/or peroneal veins.

Please note that if the patient presents with moderate to severe symptoms and an iliofemoral DVT (i.e. extends proximally to include the common femoral and iliac veins), urgent vascular surgical referral is required, as the long-term outcome can be greatly changed by urgent thrombus removal in the correctly selected patient.

Guideline Summary (focussed on treatment of DVT only):

Initiation of anticoagulation: Start parenteral anticoagulation (Low molecular weight heparin, LMWH), AND warfarin on the same day. Continue both for at least 5 days AND until INR >2. The best initial parenteral anticoagulant is clexane (1.5mg/kg daily or 1mg/kd bd). [Reasoning - the first few days of warfarin actually cause a PROcoagulant effect, with inhibition of Protein C and S, which are anti-clotting factors. Hence if the patient is not covered with clexane at the commencement of warfarin treatment, the risk of thrombus extension is *increased*].

Choice of long-term anticoagulation: In patients with DVT and no malignancy - use warfarin. If the patient has a malignancy, use LMWH. NB warfarin is contraindicated in pregnancy - use LMWH.

Aim for INR between 2.0 and 3.0

Duration of anticoagulation for Proximal DVT:

Proximal DVT from surgery or non-surgical transient risk factor - 3 months. If non-transient risk factor (especially an active malignancy) - continue indefinitely.

Unprovoked DVT - at least 3 months.

1st Venous Thromboembolism (VTE) from unprovoked proximal DVT with low to moderate bleeding risk - continue anticoagulation indefinitely. If patient has a high bleeding risk - 3 months.

2nd unprovoked VTE - indefinite anticoagulation in patients with low-moderate bleeding risk; 3 months for high bleeding risk.

Supplementary treatment for DVT:

Early *ambulation* is of benefit (rather than bed rest).

Compression stockings for all patients with acute symptomatic DVT for 2 years, and beyond that if the patient develops post thrombotic syndrome.

Management of Distal DVT:

Patients with isolated distal DVT without severe symptoms or risk factors

- serial imaging over 2/52. Anticoagulate if thrombus extends.

If symptoms severe - anticoagulate.

1st VTE from unprovoked distal DVT - 3 months

If anticoagulating for a distal DVT, treat for the same duration as a proximal DVT.

IVC Filters:

Indication = proximal DVT + contraindication to anticoagulation, or extension/PE despite therapeutic anticoagulation. If the contraindication to anticoagulation resolves - commence anticoagulation.

[Note: IVC filters should be removed if possible once the transient risk factor has abated]

Superficial Venous Thrombosis (SVT):

If the SVT is >5cm in length - treat with a prophylactic dose of LMWH (eg 40mg clexane/day) for 45 days.

[NB It is abnormal to develop unprovoked SVT unless the patient has varicose veins. If the patient does have varicose veins, SVT is an indication for vein treatment. If there are no varicose veins, then other pro-thrombotic conditions such as occult malignancy and thrombophilia must be considered]

Upper limb DVT:

If the thrombus involves the axillary or subclavian vein - anticoagulate.
If from venous catheter - do not remove the catheter if the catheter is functional & necessary.
Anticoagulate for 3 months whether catheter is the cause, or not.
Continue at least as long as catheter is in.

If you need further advice about your patient, please call the rooms on 07 5539 6306 during business hours.

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