Guidelines offer 28 recommendations for initial management, secondary prevention of DVT and PE

ACP Hospitalist Weekly Staff

New guidelines offer three strong and two conditional recommendations for the initial management of venous thromboembolism (VTE), as well as longer-term treatment and secondary prevention.

The evidence-based guidelines from the American Society of Hematology (ASH) included 28 recommendations and were published Oct. 2 in *Blood Advances*.

Among the recommendations are the following:

- For patients with uncomplicated deep venous thrombosis (DVT) or pulmonary embolism (PE) at low risk for complications, offering home treatment over hospital treatment is suggested. (This recommendation does not apply to patients who have other conditions that would require hospitalization, have limited or no support at home, cannot afford medications, or have a history of poor adherence. Patients with limb-threatening DVT, high risk for bleeding, or need for IV analgesics may benefit from initial treatment in the hospital, the authors noted.)
- For patients with DVT and/or PE, direct oral anticoagulants (DOACs) are suggested over vitamin K antagonists (VKAs), although certain patient subgroups (such as renal insufficiency or liver disease) are excepted from this recommendation. No specific DOAC is suggested over another.
- In most patients with proximal DVT, anticoagulation alone is suggested over adding thrombolytic therapy. For patients with PE and hemodynamic compromise, thrombolytic therapy followed by anticoagulation is recommended. For patients with submassive PE, anticoagulation alone is suggested, although thrombolysis is reasonable to consider for submassive PE and low bleeding risk in selected younger patients or for patients at high risk for decompensation due to concomitant cardiopulmonary disease
- For patients with extensive DVT in whom thrombolysis is considered appropriate, catheter-directed thrombolysis is suggested over systemic thrombolysis. For patients with PE, systemic thrombolysis is suggested.
- For patients with proximal DVT and significant pre-existing cardiopulmonary disease, as well as for patients with PE and hemodynamic compromise, anticoagulation alone is suggested over anticoagulation plus insertion of an inferior vena cava filter.

The guidelines also address longer-term anticoagulation, divided into the periods of primary treatment (three to six months) and prophylaxis to prevent recurrence (after six months). Among these recommendations, the guideline panel strongly recommended an international normalized ratio (INR) range of 2.0 to 3.0 over a lower INR range for patients with VTE who use a vitamin K antagonist (VKA) for secondary prevention, and indefinite anticoagulation for patients with recurrent

unprovoked VTE. Other recommendations address the options and doses for longer-term therapy.

“Treatment of VTE in day-to-day practice poses many challenges to clinicians. We acknowledge that not all of them are covered in this guideline. However, the guideline model implemented by ASH can be easily updated in the future, adding new recommendations to those already published,” the guidelines stated, later adding, “Finally, the recommendations are meant to inform the decisions of clinicians and patients. They do not, however, replace the careful consideration of the specific clinical circumstances and patients' values and preferences.”