Diagnosis treatment dvt new guidelines

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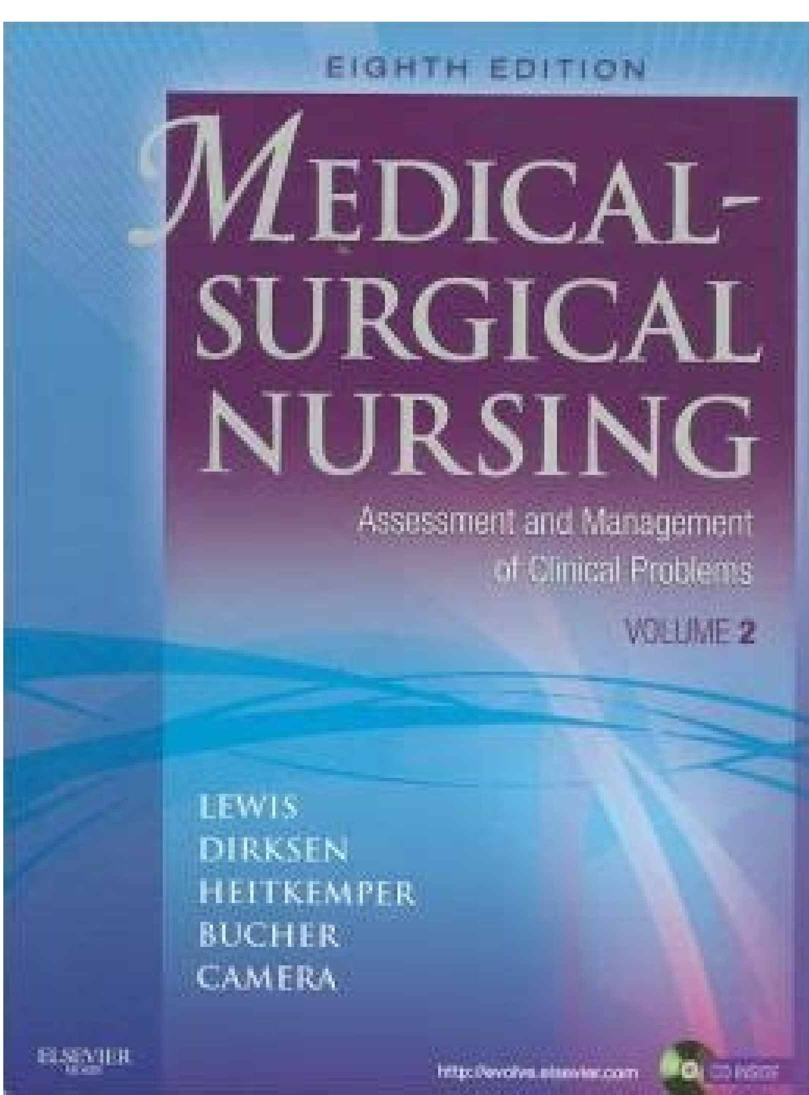


Diagnosing Leg Deep Vein Thrombosis (DVT): ACCP Evidence-Based Clinical Practice Guidelines

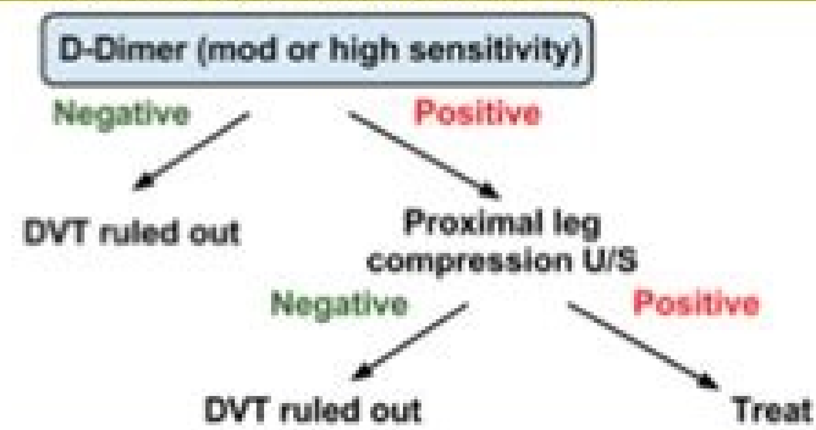
Bates et al. *Chest* 2012;141:e351S-e418S. PMID 22315267

(Courtesy of Dr. Jason West)

Determine first your pretest probability using Wells criteria:

Wells Clinical Prediction Criteria for DVT	
Active malignancy	+1
Major surgery within 4 weeks or bedridden > 3 days	+1
Asymmetric calf swelling >3 cm in affected leg	+1
Collateral, non-varicose superficial veins	+1
Entire leg swelling	+1
Localized tenderness along deep venous system	+1
Pitting edema greater in symptomatic leg	+1
Paralysis, paresis, or recent leg immobilization	+1
Previous DVT	+1
Alternative diagnosis equally or more likely	- 2

Wells score <1 (LOW pretest probability, Likelihood 5%)

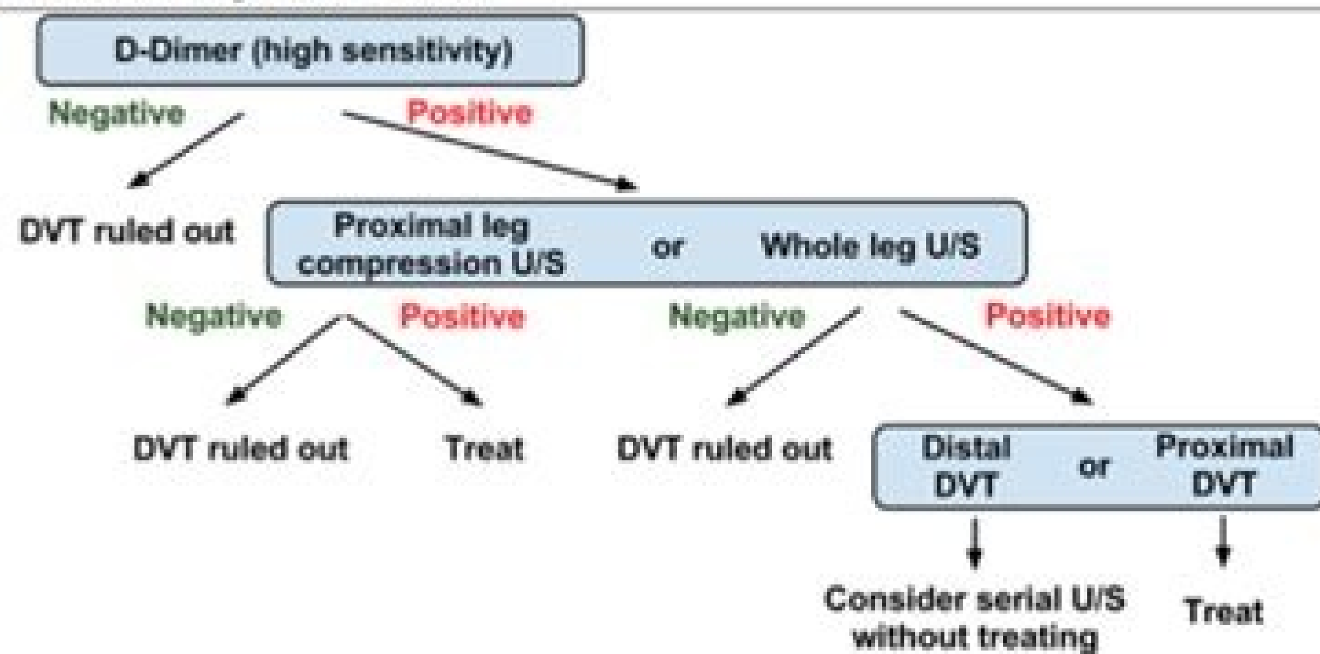


Wells score 1-2 (MODERATE pretest probability, Likelihood 17%)

Two options: Start with **D-dimer** or **ultrasound**.

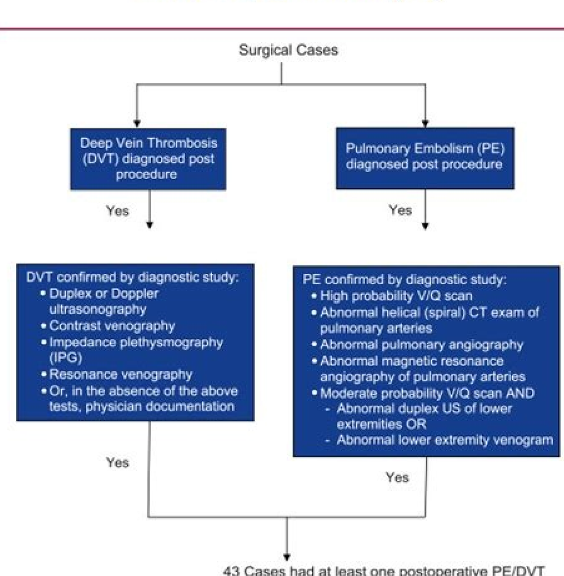
- If significant comorbidities exist that may cause D-Dimer elevation, start with ultrasound as initial test. If ultrasound is unfeasible (excessive tissue or leg casting), recommend venography as the imaging modality.

Option #1: Starting with D-Dimer



NICE Guidelines regarding DVT

- Base choice depending on DVT risk, risk of bleeding, clinical condition, patient choice and nature of surgical procedure
- Available prophylactic tools
  - TED anti-embolism stockings
  - LMWHeparin injections (! in kidney failure)
  - Foot impulse device
  - Intermittent limb compression
  - Me: treatment of avoidable risk factors (e.g. stop OCP 6w prior), active mobilisation
- Note: not from the guideline, if a patient has continuous PEs despite adequate anticoagulation, consider insertion of IVC filter.



Recommendations	Class[b]	Level[c]
It is recommended that anticoagulation with UFH, including a weight-adjusted bolus injection, be initiated without delay in patients with high-risk PE.	I	C
Systemic thrombolytic therapy is recommended for high-risk PE.[282]	I	B
Surgical pulmonary embolectomy is recommended for patients with high-risk PE, in whom thrombolysis is contraindicated or has failed.[d] [281]	I	C
Percutaneous catheter-directed treatment should be considered for patients with high-risk PE, in whom thrombolysis is contraindicated or has failed.[d]	IIa	C
Norepinephrine and/or dobutamine should be considered in patients with high-risk PE.	IIa	C
ECMO may be considered, in combination with surgical embolectomy or catheter-directed treatment, in patients with PE and refractory circulatory collapse or cardiac arrest.[d] [252]	IIb	C

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Dvt treatment nice guidelines. New treatments for dvt. Dvt treatment guidelines (2019). Diagnosis and treatment of dvt new guidelines.

PDF Split View Article contents Figures & tables Video Audio Supplementary Data Venous thromboembolism (VTE) incidence increases sharply with age (Figure1) and appears steady over the last 25 years, despite preventive strategies.1 Women are more often affected at younger ages; this ratio reverses in the elderly.2 Incidence is similar in Blacks but lower in Asians.3 Almost two-thirds of VTE cases are isolated deep vein thromboses (DVTs), and 80% are proximal.4 Recent European population studies reported DVT incidence of 70–140 cases/100,000 person-year.5Deep vein thrombosis are mostly secondary to predisposing factors common with pulmonary embolism (PE) (webtable 1).6 Distal (below knee) DVTs are more frequently related to transient situations while proximal ones to chronic conditions.7 In 25–50% of first DVT episodes, no predisposing factor is identified.In patients with DVT without PE, short-term mortality rates of 2–5% were reported, more frequent in proximal than distal DVT.7 Recurrence risk is high, especially within first 6 months.8Early- and mid-term complications include thrombosis extension, and PE and DVT recurrence (see Supplementary material online, only section).Long-term complications include post-thrombotic syndrome (PTS), defined as chronic venous symptoms and/or signs secondary to DVT. It represents the most frequent chronic DVT complication, occurring in 30–50% of patients within 2 years after proximal DVT.9 In 5–10% of cases, PTS is severe.9 Previous ipsilateral DVT, proximal location (ilio-femoral > popliteal), and residual veins obstruction are most significant PTS risk factors. Obesity and poor INR control during the first 3-months treatment are additional independent risk factors.10Villalta score is used for PTS diagnosis and treatment evaluation (Table1).11Symptoms and Clinical signs . None . Mild . Moderate . Severe . Symptoms Pain 0 points 1 points 2 points 3 points Cramps 0 points 1 points 2 points 3 points Haeviness 0 points 1 points 2 points 3 points Paresthesia 0 points 1 points 2 points 3 points Pruritus 0 points 1 points 2 points 3 points Clinical signs Pretibial edema 0 points 1 points 2 points 3 points Skin induration 0 points 1 points 2 points 3 points Hyperpigmentation 0 points 1 points 2 points 3 points Redness 0 points 1 points 2 points 3 points Venous ectasia 0 points 1 points 2 points 3 points Pain on calf compression 0 points 1 points 2 points 3 points Venous ulcer Absent Present Diagnosis Deep vein thrombosis without pulmonary embolism symptoms Clinical signs and symptoms are highly variable and unspecific but remain the cornerstone of diagnostic strategy. Symptoms include pain, swelling, increased skin veins visibility, erythema, and cyanosis accompanied by unexplained fever. Probability assessment and d-dimer testing Pre-test probability assessment is the first step in the diagnostic algorithm of DVT suspicion (Figure2). Sensitivity and specificity of clinical symptoms are low when considered individually; however, their combination, using prediction rules, allows pre-test clinical probability classification into two- (DVT unlikely or likely) or three-categories (low-, intermediate-, or high-clinical probability) corresponding to increasing disease prevalence.12,13 Wells score has been widely validated and can be applied both to out- and inpatients (Table2). The experts' panel favours the modified two-level pre-test probability as it is more straightforward.14Table 2 Clinical variable . Points . Active cancer (treatment ongoing or within previous 6 months or palliative) +1 Paralysis, paresis or recent plaster immobilization of the lower extremities +1 Recently bedridden for 3 days or more, or major surgery within the previous 12 weeks requiring general or regional anesthesia +1 Localized tenderness along the distribution of the deep venous system +1 Entire leg swelling +1 Calf swelling at least 3 cm larger than that on the asymptomatic leg (measured 10 cm below the tibial tuberosity) +1 Pitting edema confined to the symptomatic leg +1 Collateral superficial veins (non varicose) +1 Previously documented DVT +1 Alternative diagnosis at least as likely as DVT −2 Three-level Wells score Low 2 Two-level Wells score Unlikely ≤1 Likely ≥2 Open in new tabDownload slideProposed deep vein thrombosis diagnostic and management algorithm. AC, anticoagulation; DOAC, direct oral anticoagulant.Normal d-dimers render DVT unlikely,15 however, d-dimers have low specificity. Quantitative ELISA or ELISA-derived assays (>95% sensitivity) allow ruling out DVT in patients with DVT 'unlikely'. Negative ELISA d-dimer can exclude DVT without further testing in 30% of patients,16 with 3-month thromboembolic risk

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