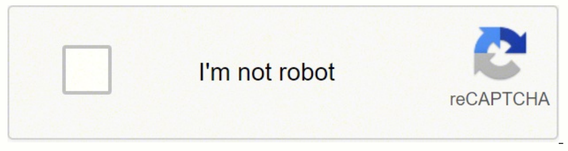

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Chest guidelines anticoagulation for dvt

Standard Agents: Clinical Studies

Knowledge Check
In clinical studies, compared to heparins, fondaparinux shows ____(fill in the blank) in major bleeding events.
Choose the correct answer

- an increase
- no difference
- a decrease

Patient and disease type	Recommendations for duration of anticoagulant treatment	
	ACCP 2012[2]	ESC 2014[1]
Patient with proximal DVT or hemodynamically stable PE associated with transient risk factors	VKA preferred over LMWH or NOAC Treat for 3 months	Anticoagulant treatment for 3 months
Patient with unprovoked proximal DVT or hemodynamically stable PE	VKA preferred over LMWH or NOAC First or subsequent unprovoked VTE with low/moderate bleeding risk: >3 months' treatment	First or subsequent unprovoked PE with a low bleeding risk: >3 months to indefinite anticoagulant treatment
Patient with isolated distal DVT	Consider serial imaging rather than anticoagulation to monitor for any clot extension if symptoms are not severe or clot extension is considered unlikely. Provide anticoagulant treatment if symptoms are severe or clot extends (recommended therapy and durations as above)	Recommendations not provided
VTE in a patient with active cancer	LMWH preferred over VKA: >3 months	LMWH for 3–6 months, then consider indefinite anticoagulation or until cancer is in remission
VTE in a pregnant woman	LMWH preferred over UFH: continue for a minimum of 3 months and for at least 6 weeks postpartum	LMWH preferred over UFH Anticoagulation (VKA permitted after birth) to continue for at least 6 weeks postpartum for a minimum overall treatment duration of 3 months
VTE in a patient with severe renal impairment (CrCl <30 mL/min)	UFH preferred over LMWH, rivaroxaban, or dabigatran owing to lack of renal clearance	UFH preferred to LMWH owing to short half-life and rapid reversal by protamine
Patient with PTS secondary to DVT	Use of mechanical compression (stockings, venous foot pump)	Recommendations not provided
Patient with CTEPH secondary to PE	Extended anticoagulation; pulmonary thromboendarterectomy if expertise available	Pulmonary thromboendarterectomy if operable, or targeted medical therapy (riociguat) if not All patients should receive lifelong anticoagulation
Patient with inherited thrombophilia	Recommendations not provided	Consider indefinite anticoagulant treatment after a first unprovoked VTE

DVT Recommendations

Level of Risk	DVT, %		PE, %		Successful Prevention Strategies
	Calf	Proximal	Clinical	Fatal	
Low risk	2	0.4	0.2	<0.01	
Minor surgery in patients < 40 yr with no additional risk factors					No specific prophylaxis; early and "aggressive" mobilization
Moderate risk	10–20	2–4	1–2	0.1–0.4	
Minor surgery in patients with risk factors					LDUH (q12h), LMWH (≤ 3,400 U daily), GCS, or IPC
High risk	20–40	4–8	2–4	0.4–1.0	
Surgery in patients > 60 yr					LDUH (q8h), LMWH (> 3,400 U daily), or IPC
Highest risk	40–80	10–20	4–10	0.2–5	
Surgery in patients with multiple risk factors, Trauma, Ortho					LMWH (> 3,400 U daily), fondaparinux, oral VKAs (INR, 2–3), or IPC/GCS + LDUH/LMWH

Geerts et al. Chest, 2004; 126:338S

Central Catheter Related Venous Thrombosis (CCRVT): Treatment Guideline Recommendations

Government of Western Australia North Metropolitan Health Service

Clinical suspicion of CCRVT? Notify IV Access team dect 7917

Is there evidence of superior vena cava occlusion (SVCO)? or limb threat?

NO / YES

- Discuss with Interventional Radiology

Request
- chest x-ray (state: confirm line placement)[1,2]
- ultrasound (state: query CCRVT) [1-3]

-ve CCRVT
- Continue to use catheter and exclude other causes

-ve CCRVT
- with high level of suspicion (evidence of SVC obstruction)

Ultrasound Report → -ve

+ve

+ve CCRVT
- Commence therapeutic Anticoagulation:[4 (Grade 1 B)] Clexane [4 (Grade 2 B)]
- See contraindications

Is the Central Vascular Device
- Infected[1]
- Malpositioned [1] (Chest x-ray to confirm tip location)
- Malfunctioning[1] (IV team unable to restore)
- Is intended IV treatment completed?

NO / YES

Note if after hours action is non urgent discuss with IV access at earliest convenience

IF NO to all of these: KEEP Central Vascular Access Device (CVAD)[4 (Grade 2 C)]
- Continue Therapeutic Anticoagulation
- Discuss with Anticoagulation Nurse Practitioner
- Vit K antagonist whilst whilst catheter insitu and ≥ 3 months post removal [5 (Grade 1 C)]
- Alternate anticoagulant if clinically indicated
- Monitor patient's symptoms including neurovascular observation, pain & swelling
- Re ultrasound at 3 months
- ADVISE IV Access Team if symptoms progress

If YES to any of these: Remove Central Vascular Access Device (CVAD)[4 (Grade 2 C)]
- In a controlled environment during office hours
- In supine position
- Discuss with Anticoagulation Nurse Practitioner
- Vit K antagonist ≥ 3 months post removal [5 (Grade 1 C)]
- Alternate anticoagulant if clinically indicated
- Re ultrasound at 3 months

Contraindications or If Unsure At Any Stage
Advise: Multidisciplinary approach
Contact: IV Access Team dect 7917
and send E Referral

AVPU SCGH 0847-13

Anticoagulation in Deep Vein Thrombosis

(According to American College of Chest Physician guidelines)

Jibran Mohsin
Resident, Surgical Unit I
SIMS/Services Hospital, Lahore

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We have not changed the recommendations for those who have to stop anticoagulation 3 months or receive prolonged therapy. Thrombolytic therapy for pulmonary embolism hypotension (Grade 2B) and systemic therapy for catheter-directed thrombolysis (Grade 2C) is suggested. For TEVs treated with anticoagulants, it is recommended to use a lower hollow vein filter (Grade 1B). The updated CHEST guideline also strongly recommends the administration of anticoagulants for the first 3 months (treatment phase) rather than anticoagulant therapy in patients with cerebral venous thrombosis or cerebral sinus. Treatment phase Ã strongly recommended use apixaban, dabigatran, edoxaban or rivaroxaban in addition to a vitamin K antagonist (AVK) as anticoagulant therapy during treatment in patients with leg DVT or EP. Conversely, in patients with severe symptoms or risk factors for extension, anticoagulation is suggested compared to serial imaging. Prolonged treatment LÂ" use of reduced dose apixaban or rivaroxaban Ã¨ recommended in addition to full doses of apixaban or rivaroxaban for patients offered prolonged anticoagulant therapy. According to the guideline, outpatient treatment of EP acute Ã¨ is indicated for patients who meet all of the following criteria: clinically stable with good cardiopulmonary reserve; absence of contraindications (e.g. recent bleeding, severe kidney or liver disease or severe thrombocytopenia); compliant with therapy; and subjective reports of feeling good enough to receive treatment at home. In most patients with acute EP not associated with hypotension, the guidance committee strongly recommended systemic thrombolytic therapy. In the attached guide based the CHEST panel suggests use serial deep vein imaging for 2 weeks vs anticoagulants in patients with isolated acute distal leg DVT who do not have symptoms or serious risks. serious. by extension. To prevent recurrent DVT, the guidelines suggest use aspirin on no aspirin in patients with unprovoked proximal DVT or PE who are discontinuing anticoagulant therapy and who do not have a contraindication to aspirin. For patients with subosemic pulmonary embolism (PE) and absent proximal DVT in the legs, as well as low recurrent DVT risk, the guideline suggests that doctors use clinical surveillance vs anticoagulation. With regard to extended phase therapy, the guideline strongly recommends that extended phase anticoagulant therapy should not be used in patients with VTE who are diagnosed under a higher transient risk factor. Direct oral anticoagulants (DOACs) An oral inhibitor of Xa Ã ④ ÂÂ such as apixaban, edoxaban or rivaroxaban ÃÂ Ã is strongly recommended on low molecular weight heparin for initiation and treatment steps in patients with acute VTE in the context of cancer. The authors of the guidelines noted that while graduated compression socks may reduce acute DVT-related symptoms or chronic symptoms in patients with PTS, there is no evidence that these socks reduce the risk of development of PTS. For recurrent IFP on a non-LMWH anticoagulant, LMWH (Grade 2C) is suggested; for recurrent DVT on LMWH, it is suggested to increase the dose of LMWH (Grade 2C).Of 54 recommendations included in the 30 statements, 20 were strong and none was based on high quality evidence, highlighting the need for of further research.AT99th edition of the antithrombotic guidelineAT1010th edition of the antithrombotic guidelineCHESTAamerican College of Chest PhysiciansCDTthrombolysis-cateterCTEPHchronic pulmonary pertensionCTPAGOCG Oversight CommitteeINRIinternational Normalized RatioLMWHeparin low weight oral non-vitaminic KPTSRCTrandomized controlled trialsUEDVTupper extremity deep vein thrombosisView Abstract Updates to to The College of Chest Physicians (CHEST) clinical practice guidelines on antithrombotic therapy in venous thromboembolism (VTE) include recommendations on several Population, Intervention, Comparator, Outcome (PICO) questions covering a broad spectrum of antithrombotic management scenarios related to VTE. According to the authors of the guidelines, the recommendation applies to patients with or without CVT-related intracranial haemorrhage. For patients with unprovoked VTE or VTE caused by a persistent risk factor, the guidance recommends the use of extended phase anticoagulation with a DOAC. In addition, the guideline suggests thrombolytic therapy given systematically in some patients with acute PE who show signs of deterioration after initiation of anticoagulant therapy but who have not developed hypotension and who continue to have an acceptable risk of bleeding. Initial anticoagulation In terms of anticoagulation setting In the initial setting, the updated TORACE guideline recommends outpatient treatment as opposed to inpatient treatment in low-risk PE patients, but only if there is adequate access to medication, an ability to access outpatient care, and adequate home conditions. The guidelines also suggest offering extended phase anticoagulation with VKA to patients with VTE who are diagnosed in the absence of transient risk factors and who cannot receive a DOAC. The updated policy recommendations, summarised here, have been published in a recent edition of Chest. 2021;160 (6):2247-2259. For DVT and cancer, we suggest LMWH on VKA (Grade 2B), dabigatran (Grade 2C), rivaroxaban (Grade 2C), apixaban (Grade 2C), or edoxaban (Grade 2C). If to Treat Recommendations The first PICO question presented in the updated guide was whether anticoagulant therapy should be used patients with isolated distal deep vein thrombosis (DVT). The guideline also suggests not to provide for a with VTE diagnosed with a lower transient risk factor. The guideline recommends avoiding anticoagulant therapy in patients with isolated acute distal leg DVT treated with serial imaging if the thrombus does not extend. Abstract: antithrombotic therapy for VTE: second update of the CHEST Guideline and expert group report. Interventional and adjuvant treatments In patients with acute leg DVT, anticoagulant monotherapy is suggested compared to interventional thrombolytic, mechanical or pharmacomechanical therapy. The reduced dose of DOAC Ã¨ strongly recommended compared to aspirin or no therapy in patients offered prolonged anticoagulant therapy. Complications For routine prevention of post-thrombotic syndrome (PTS) in patients with acute leg DVT, the guideline suggests that compression socks should not be used. Reference Stevens SM, Woller SC, Baumann Kreuziger L, et al. For DVT, it is recommended not to routinely use compression socks to prevent PTS (Grade 2B). In addition, in patients with confirmed antiphospholipid syndrome who are receiving anticoagulant therapy, a dose adjustment of AVK is suggested in addition to DOAC therapy during the treatment phase.

2021-8-3 · The American College of Chest Physicians (CHEST) recently released new clinical guidelines for venous thromboembolism (VTE) management, “Antithrombotic Therapy for VTE Disease: Second Update of the CHEST Guideline and Expert Panel” that provides 29 recommendations on 17 Patients, Interventions, Comparators, Outcomes (PICO) questions, … 2003-6-1 · In 1997 the British Thoracic Society (BTS) published advice entitled “Suspected acute pulmonary embolism: a practical approach”.1 It was recognised that it would need updating within a few years. Subsequent publications in several areas (CT pulmonary angiography, d-dimer, clinical probability, low molecular weight heparin) now provide sufficient evidence to allow this … 2022-2-10 · Venous thrombosis is blockage of a vein caused by a thrombus (blood clot). A common form of venous thrombosis is deep vein thrombosis (DVT), when a blood clot forms in the deep veins. If a thrombus breaks off and flows to the lungs to lodge there, it becomes a pulmonary embolism (PE), a blood clot in the lungs.The conditions of DVT only, DVT with PE, and PE … 2019-8-29 · Guidelines summarize and evaluate available evidence with the aim of assisting health professionals in proposing the best management strategies for an individual patient with a given condition. Guidelines and their recommendations should facilitate decision making of health professionals in their daily practice. However, the final decisions concerning an individual … Antithrombotic Therapy and Prevention of Thrombosis (9 th Edition), Published: February 2012. This CHEST guideline series presents recommendations for the prevention, diagnosis, and treatment of thrombosis, addressing a comprehensive list of clinical conditions, including medical, surgery, orthopedic surgery, atrial fibrillation, stroke, cardiovascular disease, pregnancy, and … This page contains Clinical Practice Guidelines for the administration of Standard Heparin infusions, systemic lytic therapy and the management of a blocked central venous access device. In addition, the Clinical Haematology department has developed guidelines to support clinician’s management of warfarin and low molecular weight heparin (Clexane). 2022-2-4 · However, anticoagulation is recommended over surveillance in similar patients with a high risk of recurrent VTE. The updated CHEST guideline also strongly recommends the provision of anticoagulation for the first 3 months (treatment phase) over no anticoagulant therapy in patients with cerebral vein or cerebral venous sinus thrombosis. 2021-2-5 · The American College of Chest Physicians has guidelines that give direction as to what medications might best be used in different situations. For example, a patient with a DVT, and no active cancer, treatment with a NOAC would be recommended. If active cancer exists, the treatment of DVT would be with enoxaparin as the drug of first choice. 2018-11-27 · At 2 years (the minimum duration of follow-up), patient satisfaction with anticoagulation, as measured by the Duke Anticoagulation Satisfaction Scale (in which scores range from 25 to 225, with lower scores indicating better satisfaction), was greater in the PST group than in the control group (difference, −2.4 points [95% CI, −3.9 to −1 … 2022-2-12 · Deep vein thrombosis (DVT) is a type of venous thrombosis involving the formation of a blood clot in a deep vein, most commonly in the legs or pelvis. A minority of DVTs occur in the arms. Symptoms can include pain, swelling, redness, and enlarged veins in the affected area, but some DVTs have no symptoms. The most common life-threatening concern with DVT is the … Anticoagulant-associated traumatic intracranial hemorrhage (tICrH) is a devastating injury with high morbidity and mortality. For survivors, treating clinicians face the dilemma of restarting oral anticoagulation with scarce evidence to guide them. Thromboembolic risk is high from the bleeding event, patients’ high baseline risks, that is, the pre-existing indication for … 2021-2-8 · These include the 2020 CHEST COVID-19 Guidelines, the Anticoagulation (AC) Forum interim clinical guidance, the International Society on Thrombosis and Haemostasis (ISTH) Scientific and Standardization Committee (SSC) COVID-19 clinical guidance, and the American College of Cardiology (ACC) clinical guidance. 85-88 Major differences between the ... 2022-1-21 · However, anticoagulation is recommended over surveillance in similar patients with a high risk of recurrent VTE. The updated CHEST guideline also strongly recommends the provision of anticoagulation for the first 3 months (treatment phase) over no anticoagulant therapy in patients with cerebral vein or cerebral venous sinus thrombosis. 2017-3-1 · Deep venous thrombosis (DVT) and pulmonary embolism (PE) are the two most important manifestations of venous thromboembolism (VTE), which is the third most common life-threatening cardiovascular …

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