Michigan Quality Improvement Consortium
Clinical Practice Guideline Update Alert

Guideline: Outpatient Management of Acute Uncomplicated Deep Venous Thrombosis

Released: August 2019

This alert provides a summary of only the recommendations which were updated. Refer to the complete guideline for all recommendations and level of evidence.

Updated recommendations include:

Definitions

Acute DVT: new thrombosis in lower extremity deep veins (iliac, common femoral, femoral, deep femoral, popliteal, anterior/posterior tibial or peroneal).

Initial Assessment

- Assess for absolute contraindications to outpatient management: fresh surgical wound, active GI bleeding, history of intracranial hemorrhage, multiple/major trauma, recent neurosurgery/spine surgery, medication compliance concerns, concurrent symptomatic pulmonary embolism, renal failure, non-ambulatory due to DVT, platelet count <50,000. Low molecular weight heparin (LMWH) is contraindicated if history of heparin-induced thrombocytopenia (HIT).

Initiating Therapy

Begin anticoagulation therapy as soon as possible with one of these 3 options (proper dosing is required[1]). *See guideline for all options*

- Direct oral anticoagulants (DOACs) – preferred therapy, but avoid in patients taking antiplatelet agents, azole antifungals,[2] several protease inhibitors,[3] and some anticonvulsants.[4] NSAIDS increase risk of bleeding.
  - Rivaroxaban, apixaban (direct Factor Xa inhibitors): does not require LMWH bridging or lab test for monitoring; reversal agent (andexanet alfa) available. Do not use if eGFR < 30 ml/min.
- Warfarin with LMWH bridging for 5 days; requires initial and periodic INR monitoring to maintain therapeutic range of 2.0-3.0. Anti-clotting action can be reversed with oral or IV vitamin K and plasma clotting factors (prothrombin complex concentrate [PCC] is preferred over fresh frozen plasma).
- LMWH as monotherapy (recommended in active cancer or pregnancy). In low-risk patients with HIT, use fondaparinux instead.

Duration of therapy is 3 months for acute uncomplicated DVT with a clear precipitating cause ("provoked DVT"). Recurrent, unprovoked or other types of DVT may require long-term anticoagulation.

Testing/Monitoring

- For patients on warfarin: order and check INR on 3rd day after drug initiation and frequently thereafter (usually 2 checks/week in first 3 weeks of therapy).
  - Monitor INR results through an anticoagulation clinic, or use standardized protocols (such as established anticoagulation toolkit[1]).

[1] Michigan Anticoagulation Quality Improvement Initiative Anticoagulation Toolkit Version 1.7
[2] e.g., ketoconazole
[3] e.g., ritonavir
[4] e.g., phenytoin, carbamazepine