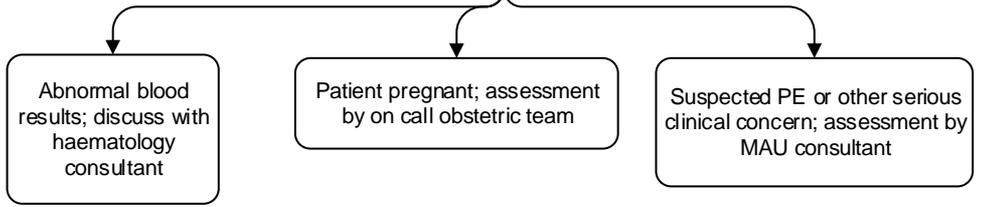


Body weight kg	Dalteparin dose (units)
Under 46	7500 once daily
46 – 56	10000 once daily
57 – 68	12500 once daily
69 – 82	15000 once daily
83 and over	18000 once daily
>110kg	You may wish to give a higher dose although this is unlicensed, discuss with haematology consultant



Treatment of confirmed DVT

Dalteparin
(dependent on eGFR see unfractionated heparin)*

- Active cancer patients should ideally be treated with Dalteparin for duration of therapy. Reduce dose to 150u/kg/day after 1 month.
- Pregnant women should only be treated with Dalteparin

Warfarin
As per policy after initial heparin treatment

Duration of treatment is generally 1/12 for extensive thrombophlebitis, 3-6/12 for DVT

Unfractionated heparin*
If eGFR < 30 do not use dalteparin
Admit and treat with UFH as per heparin policy

Rivaroxaban
15mg twice daily for 21 days then 20mg once daily.
Reduce maintenance dose to 15mg od if CrCl = 15-49ml/min, do not use if CrCl $< 15\text{ml/min}$

To calculate CrCl:
Male: $((140 - \text{age}) \times (\text{wt in kg}) \times 1.23 \text{ divided by } (\text{Cr } \mu\text{mols/L}))$
Female: the above $\times 0.85$

Catheter-directed thrombolysis
Consider catheter-directed thrombolytic therapy for patients with symptomatic iliofemoral DVT who have:

- symptoms of less than 14 days' duration **and**
- good functional status **and**
- a life expectancy of 1 year or more **and**
- a low risk of bleeding.

- Follow-up**
- Contact anticoagulant team who can advise on ongoing treatment and initiate or direct to GP if the practice concerned self-manages warfarin.
 - FBC must be checked Day 4 & Day 7-10 in all patients on unfractionated heparin and in patients with cancer continuing on Dalteparin to look for a fall in platelet count which might herald Heparin induced thrombocytopenia with thrombosis (HITT) – a $>50\%$ fall from baseline must be discussed with consultant haematologist.
 - Underlying cause for DVT must be considered with investigations normally done by GP (e.g. further investigations for cancer in all patients aged over 40 years with a first unprovoked DVT who do not have signs or symptoms of cancer such as CXR, USS, abdomino-pelvic CT scan (and a mammogram for women))
 - Thrombophilia clinic review for patients with unprovoked or recurrent DVT (if appropriate). Do NOT send blood tests for heritable thrombophilia screening whilst the patient has active thrombosis. You may send bloods for investigation of antiphospholipid syndrome screening if warfarin has not been started (anticardiolipin antibodies & lupus anticoagulant).
 - GP to offer below-knee graduated compression stockings with an ankle pressure $> 23 \text{ mmHg}$ to patients with proximal DVT a week after diagnosis or when swelling is reduced sufficiently and if there are no contraindications, advise patients to continue wearing the stockings for at least 2 years ensure that the stockings are replaced 2 or 3 times a year and advise patients that the stockings need to be worn only on the affected leg or legs.

Two-level Wells Score for deep vein thrombosis (DVT)

Clinical feature	Points
Active cancer (treatment ongoing, within 6 months or palliative)	1
Paralysis, paresis or recent plaster immobilisation of the lower extremities	1
Recently bedridden for 3 days or more or major surgery within 12 weeks requiring general or regional anaesthesia	1
Localised tenderness along the distribution of the deep venous system	1
Entire leg swollen	1
Calf swelling at least 3cm than the asymptomatic side	1
Pitting oedema confined to the symptomatic leg	1
Collateral superficial veins (non-varicose)	1
Previously documented DVT	1
An alternative diagnosis is at least as likely as DVT	- 2
Clinical probability simplified score	
	DVT likely 2 points or more
	DVT unlikely 1 point or less

Alternative diagnoses

Alternative diagnoses Include

- Cellulitis
- Superficial thrombophlebitis
- Ruptured Baker's cyst
- Haematoma in muscle
- Muscle tear or strain
- Dependent (stasis) oedema
- Post-thrombotic syndrome
- Lymphatic obstruction
- Arthritis
- Heart failure, Cirrhosis or nephrotic syndrome
- External compression of major veins (e.g. by foetus or cancer)
- Arteriovenous fistula.

Superficial thrombophlebitis

Patients with **extensive superficial thrombophlebitis** where the risk of deep vein thromboembolism is high should be considered for full anticoagulation. If this is necessary, and there is no contra-indication, full anticoagulation should be given for 30 days with therapeutic dalteparin or warfarin.

High risk of DVT:

- Superficial thrombophlebitis extending to the junction of the long saphenous vein with the femoral vein.
- Superficial thrombophlebitis extending to the junction of the short saphenous vein with the deep veins at the crease behind the knee.
- Past history of VTE.

Patients with **limited superficial thrombophlebitis** can be treated with:

- Nonsteroidal anti-inflammatory drugs (NSAIDs) topical or oral
- Painkillers

Treatment should continue until pain and redness have settled (usually within 2–6 weeks, although the thrombosed vein may be palpable and tender for months).

There is only weak evidence that oral/topical NSAIDs reduce the risk of extension and/or recurrence of superficial thrombophlebitis.