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MEDIA RELEASE

NEW GUIDELINES FOR VENOUS THROMBOEMBOLISM

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THE first Australasian guidelines for the diagnosis and management of venous thromboembolism (VTE) have been produced, with a summary published online today by the *Medical Journal of Australia*.

Led by Associate Professor Huyen Tran, Head of the Haemostasis and Thrombosis Unit at Alfred Health and Monash University in Melbourne, a working group from the Thrombosis and Haemostasis Society of Australia and New Zealand developed the guidelines, which are available in full at https://www.thanz.org.au/resources/thanz-guidelines.

VTE, which includes deep vein thrombosis (DVT) and pulmonary embolism (PE), is the third most common cardiovascular disease globally, with an annual incidence of over 10 million people.

“In Australia, at least 17 000 people develop VTE each year (annual incidence, 0.83 per 1000 population),” Tran and colleagues wrote. “The lifetime risk of VTE is 8%, with 1% of people aged over 80 years experiencing their first VTE.

“This disease is a major cause of health-related economic loss for the patient and the community (estimated to be $1.7 billion for Australia in 2008). It is a chronic and frequently recurrent disease.”

Coauthor Associate Professor Harry Gibbs, Deputy Director of General Medicine at Alfred Health, said three important new recommendations were for oral factor Xa inhibitors (rivaroxaban or apixaban) “upfront” rather than injections of low molecular weight heparin; every VTE patient receives 3 months (6 weeks for those with distal DVT) of anticoagulation with a decision then to be made about whether to continue long-term; and, that “low-intensity anticoagulation over the long term is both safe and effective and is suitable for many patients”.

The major change to guidelines was a recommendation to use a factor Xa inhibitor, such as rivaroxaban or apixaban, rather than warfarin for the treatment of acute VTE.

Other recommendations from the guidelines:

- the diagnosis of VTE should be established with imaging; it may be excluded by the use of clinical prediction rules combined with D-dimer testing;
- proximal DVT or PE caused by a major surgery or trauma that is no longer present should be treated with anticoagulant therapy for 3 months;
- proximal DVT or PE that is unprovoked or associated with a transient risk factor (non-surgical) should be treated with anticoagulant therapy for 3–6 months;
- proximal DVT or PE that is recurrent (two or more) and provoked by active cancer or antiphospholipid syndrome should receive extended anticoagulation;
- distal DVT caused by a major provoking factor that is no longer present should be treated with anticoagulant therapy for 6 weeks;
- for patients continuing with extended anticoagulant therapy, either therapeutic or low dose direct oral anticoagulants can be prescribed and is preferred over warfarin in the absence of contraindications;
- routine thrombophilia testing is not indicated; and,
- thrombolysis or a suitable alternative is indicated for massive (haemodynamically unstable) PE.

Please remember to credit *The MJA*.

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