NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Thrombophlebitis, Superficial, Secondary Care, Adults (excluding pregnancy)

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

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Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

MANAGEMENT OF SUPERFICIAL THROMBOPHLEBITIS IN SECONDARY CARE IN ADULTS (EXCLUDING PREGNANCY)

Scope of guideline

This guideline focuses on the diagnosis and treatment of superficial thrombophlebitis in non-pregnant adult patients (16 years and over) in the acute setting.

Background

Superficial vein thrombosis also known as superficial thrombophlebitis (STP) is a common condition[1]. STP can occur alone or in association with deep vein thrombosis (DVT). STP within the great saphenous vein appear to have the strongest association with venous thromboembolism [2-3,5,7,9,11,13-14].

The aims of management include;

- Detection and treatment of DVT
- Symptomatic relief of STP
- Prevention of both extension of STP and development of DVT+/- PE

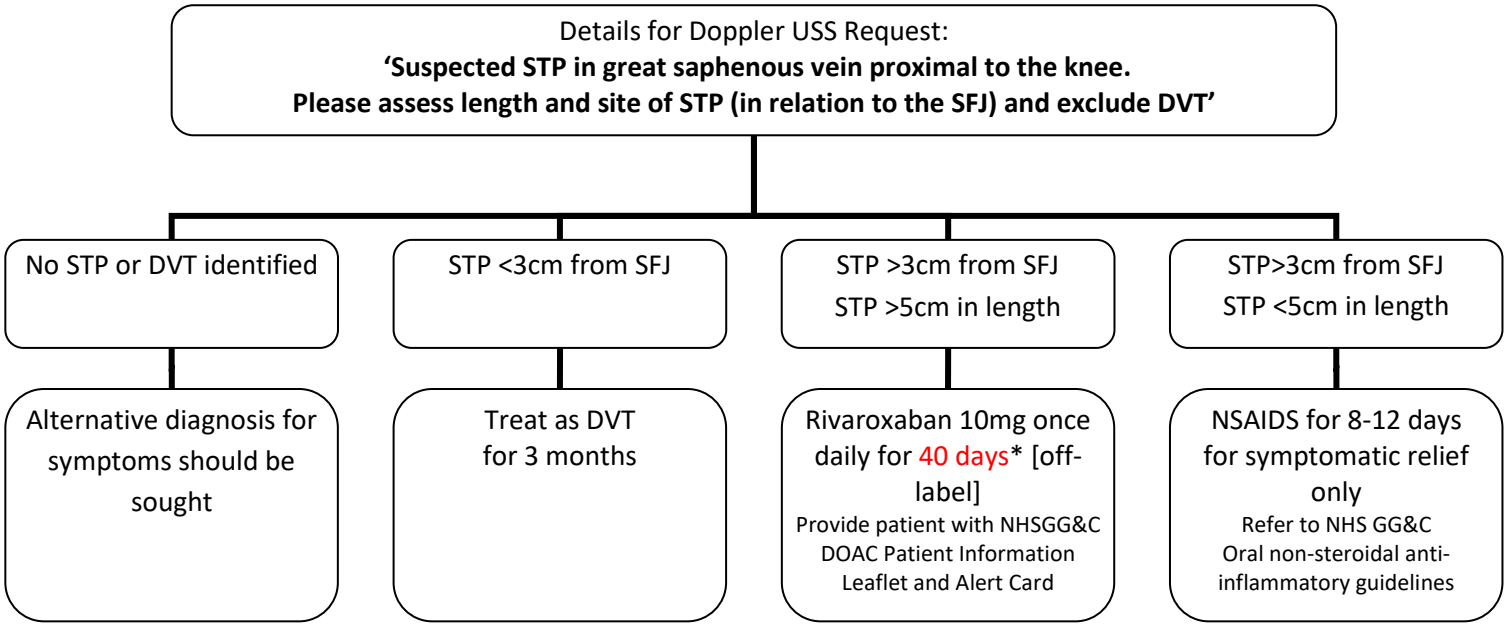
Most patients presenting to hospital with a history and symptoms suggestive of proximal STP should have a compression Doppler USS to assess the length and position of the superficial thrombus and exclude a concurrent DVT.

Patients with clinical evidence of STP in a varicose vein recently treated with either radiofrequency ablation or foam sclerotherapy **should not** be investigated further as these treatments should result in an inflammatory phlebitis. Such patients should be discussed with the vascular StR on call (via Ex 82758) who will give advice and organise vascular follow up if required.

Those presenting with proximal STP in the community should be referred to their local DVT service for a Doppler Ultrasound scan (USS) **ONLY** if there is either clinical evidence of concurrent DVT, or the STP has features indicative of a high risk of STP extension, recurrence or progression to DVT. These include;

- STP involving the main trunk of the great saphenous vein (rather than its branches)
- history of VTE
- cancer
- absence of varicose veins
- severe chronic venous insufficiency

Recommendations



Treatment

Any STP <3cm from the saphenofemoral junction (SFJ) should be treated as a DVT as the rate of extension to DVT in these patients is very high [3, 5, 7, 9,11,13-14].

-Patients with a STP of >5cm in length, who do not meet the criteria for therapeutic anticoagulation, should receive rivaroxaban 10mg once daily for 40 days, as long as there are no contraindications to its use.*

-If rivaroxaban is not suitable or contraindicated, enoxaparin should be used as this is the prophylactic low molecular weight heparin (LMWH) of choice in GG&C. The use of enoxaparin for this indication is off-label.

- ***Patients unsuitable for rivaroxaban (*see below*¶) should receive enoxaparin 40mg once daily (reduced to 20mg once daily if eGFR <30ml/min/1.73m^2 or weight <50kg [see GG&C policies on 'Heparin Dose Adjustment, Adult Patients with Very High or Low Body Weight' and 'Heparin Dose Adjustment Renal Impairment']).

- Patients unsuitable for enoxaparin should be considered for NSAIDS (for symptomatic relief only [see GG&C policy 'Oral non-steroidal anti-inflammatory guidelines']) or surgical options. Avoid using NSAIDS in patients prescribed an anticoagulant.

- Compression stockings are recommended for all patients, if tolerated.

- All patients receiving rivaroxaban or enoxaparin should have a baseline FBC and coagulation screen.

- Anti-Xa levels are not required unless high prophylactic LMWH doses are being used for >10 days in obese patients, or patients with renal impairment.

- If a scan reports on a superficial vein thrombosis distal to the knee >5cm in length, prophylactic dose rivaroxaban or enoxaparin can also be considered. There is no evidence on the use of therapeutic anticoagulation if the STP is <3cm from the saphenopopliteal junction. Therapeutic anticoagulation (treating as a DVT) for 3 months can be given based on clinical judgment.

¶Unsuitability for rivaroxaban would include;

- Pregnancy, breast feeding
- eGFR <15ml/min/1.73m^2 ,
- Liver disease with cirrhosis and/or coagulopathy (LMWH should also be avoided in patients with coagulopathy)
- Concurrent use of
  - Triazoles and imidazole antifungals (except fluconazole)
  - Protease inhibitors
  - Strong CYP3A4 inducers e.g. rifampicin

  Refer to BNF for interactions and contraindications.

Additional background information

STP It is a painful condition affecting the superficial veins, usually of the lower limbs. It should not be confused with superficial femoral vein thrombosis, as this is thrombosis in a deep vein and requires full anticoagulation therapy.

STP is usually a clinical diagnosis based on symptoms of localised swelling, erythema and pain with tenderness over the affected vein. Patients should be assessed for risk factors for DVT and an assessment using the Wells score should be carried out to encourage consideration of this complication. Any chest symptoms should also be taken seriously and PE considered in the differential.

The recommendations within this guideline are based on the fact that studies of the epidemiology and natural history of STP have focused on cases referred to secondary care for assessment and therefore are likely biased towards the more clinically severe forms of the condition. Furthermore, the evidence for aggressive treatment of STP, as outlined above, is limited to those presenting to secondary care.

Various treatments have been used for STP, including compression stockings, NSAIDs, fondaparinux, rivaroxaban, surgical intervention and topical agents.

Two recent studies have demonstrated both fondaparinux and rivaroxaban to be effective in the management of STP, resulting in a reduction in the incidence of DVT and PE. In one study, fondaparinux was demonstrated to be superior to placebo [15]. Due to non-submission, fondaparinux is not recommended by SMC. A more recent study has demonstrated that rivaroxaban is non-inferior to fondaparinux with no increased risk of bleeding [16]. It should be noted that the use for rivaroxaban for this indication is off-label.

Rivaroxaban should be used in preference to fondaparinux for the following reasons;

- Oral medication is likely to be more acceptable to patients than parenteral treatment
- Rivaroxaban has a lower acquisition cost than fondaparinux

References

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