TREATMENT OF ACUTE VENOUS THROMBOEMBOLISM

SELECT TREATMENT OPTION based on patient characteristics, cost, convenience and patients preferences

1. Rivaroxaban 15mg bid x 3 weeks, then 20mg once daily
   - Avoid in patients with CrCl < 30ml/min
   - Avoid in patients on potentially interacting medications
   - Limited data in morbid obesity

2. Apixaban 10mg bid x 7 days, then 5mg bid
   - Avoid in patients with CrCl < 30 ml/min
   - Avoid in patients on potentially interacting meds
   - Limited date in morbid obesity

3. Enoxaparin 1mg/kg SQ q12h x 5-10 days, then dabigatran 150mg bid
   - Adjust enoxaparin dose if CrCl < 60ml/min
   - Avoid dabigatran if CrCl < 50 ml/min
   - Avoid dabigatran in patients on potentially interacting meds
   - Limited data in morbid obesity

4. Enoxaparin 1mg/kg SQ q12h + warfarin
   Stop enoxaparin when INR > 2.0 after a minimum of 5 days of overlap
   - Adjust enoxaparin dose if CrCl < 60 ml/min
   - Start warfarin on same day as heparin/LMWH

Additional Considerations

Arrange outpatient follow-up

For Warfarin/Enoxaparin
Refer to Anticoagulation Clinic or local PCP

FOR WARFARIN: Check INR daily (inpatients) or q2-3 days (outpatients) until INR>2

FOR HEPARIN/ENOXAPARIN: check CBC (HCT and plt) daily (inpatients) or q2-3 days (outpatients) for the first 2 weeks of heparin/enoxaparin therapy

FOR CANCER-ASSOCIATED THROMBOSIS: continue enoxaparin alone for 3-6 months

FOR PTS WITH HIT: see UWMedicine Guidelines for Management of HIT*

FOR DURATION OF THERAPY: seeUWMedicine Recommendations for Duration of Anticoagulant Therapy Following VTE*

* https://depts.washington.edu/anticoag

CRITERIA FOR sPESI

Age > 80 years +1
Cancer (active or history) +1
Heart failure or chronic lung disease + 1
Pulse > 110 bpm + 1
Systolic BP < 100 mmHg + 1
Arterial O2 sat < 90% + 1

Medical or social reasons for acute hospitalization
Creatinine Clearance < 30ml/min
Severe liver disease
Severe thrombocytopenia
If PE is present, sPESI > 0
[Simplified Pulmonary Embolism Severity Index]