

# Improving DVT Patient Care

Michael R. Jaff, DO, discusses the state of deep vein thrombosis care and the obstacles that need to be overcome in order to enhance this area of treatment.



**What are the most significant barriers currently standing between patients with deep vein thrombosis (DVT) and efficient care?**

Actually, many patients with acute DVT receive very efficient care. In centers with algorithms for the rapid diagnosis and initiation of management, patients may have very efficient initial therapeutic plans implemented. However, many programs do not have such algorithms in place. So, when a patient is referred to an emergency department for evaluation of a swollen limb, diagnosis often depends on the day of the week and the time of day. For example, on a Tuesday at 9 AM, venous duplex ultrasonography is readily available. The technologist is on site, and the test may be performed rapidly. However, if the patient arrives on a Saturday at 2 AM, the technologist is at home, miles from the center, and is often unavailable to perform the examination. In this setting, the patient is left to either empiric anticoagulation, D-dimer assay, or waiting until the next day when the technologist is on site.

At a more basic level, lack of efficient care often occurs with the initial clinician. If the potential diagnosis of DVT is not considered, the patient will not be referred for testing, let alone made aware of all options for treatment.

**At which level does the disconnect between diagnosis and treatment occur?**

This is most often a multifactorial disconnect. The system must have a plan to rapidly diagnose DVT and then consider treatment options. They should consider whether the patient needs anticoagulant therapy alone

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to prevent pulmonary embolism or if interventional therapy is a viable option. For example, in a young woman with left iliac vein thrombosis, significant limb swelling, oral contraceptive use, and no overt hemorrhagic risk, is standard low-molecular-weight heparin enough? Should the patient be enrolled in the ATTRACT (Acute Venous Thrombosis: Thrombus Removal With Adjunctive Catheter-Directed Thrombolysis) trial?

**How can vascular interventionists improve this situation in their hospitals?**

The interventional community can improve this situation with peer and public education. It is not the responsibility of vascular interventionists alone, but also those physicians dedicated to the management of patients with venous thromboemboli. The data on thrombolytic therapy for acute iliofemoral DVT are inconclusive; therefore, we must inform our colleagues and our patients that a trial of pharmacomechanical thrombectomy and thrombolysis that is sponsored by the National Institutes of Health is being performed so that we actually can practice evidence-based medicine for patients with acute proximal DVT. Eligible patients should be considered for randomization in the ATTRACT trial so that we can answer this critical question.

### What impact do you think new medications will have on patient care during the next several years?

This is an area of great excitement—alternatives to warfarin as the oral agent used for long-term DVT treatment. With oral direct thrombin inhibitors, oral heparins, and other classes of agents, our patients finally have hope that their lives will be improved. These oral agents offer predictable dose-response curves, and thereby do not require repeated blood testing to assess anticoagulation intensity. This will result in marked improvements in the quality of life of our patients, and hopefully, the safety of anticoagulation.

### The American College of Chest Physicians Evidence-Based Clinical Practice guidelines are currently in the process of being updated. What do you hope will be included in the new publication?

I suspect this revision will include updates on the new antithrombotic and anticoagulant agents. It would be interesting to see more extensive recommendations on the appropriate use of permanent and retrievable vena cava filters. Unfortunately, there really is insufficient literature on antithrombotic therapy in peripheral artery disease (PAD) either for prevention of cardiovascular events or after endovascular intervention. We may see some doubt eroding recommendations for aspirin use in PAD due to recent data suggesting a lack of efficacy of aspirin in PAD patients. ■

*Michael R. Jaff, DO, is Associate Professor of Medicine, Harvard Medical School, and Medical Director, Vascular Center, Massachusetts General Hospital in Boston. He has disclosed that he is a member of the Steering Committee of the ATTRACT trial, for which he does not receive personal funds; board member, VIVA Physicians, a 501(c)(3) physician-directed, not-for-profit education and research organization; and a noncompensated advisor, Covidien. Dr. Jaff may be reached at (617) 726-3784; [mjaff@partners.org](mailto:mjaff@partners.org).*

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