

CONTINUING MEDICAL EDUCATION ΣΥΝΕΧΙΖΟΜΕΝΗ ΙΑΤΡΙΚΗ ΕΚΠΑΙΔΕΥΣΗ

Vascular Diseases Quiz – Case 57

A 35-year-old man presented to the emergency department with warm erythema on medial surface of the left thigh, acute onset of pain in the area and edema. His medical history was unremarkable. The Doppler ultrasound showed great saphenous vein thrombosis (SVT) ≥ 5 cm in length located >3 cm from the sapheno-femoral junction (SFJ) (fig. 1). His oxygen saturation was 99% and had no sign of dyspnea. The general practitioner prescribed oral non-steroidal anti-inflammatory drugs (NSAIDs) and compression stockings up to the thigh. Is this the best treatment?

Comment

For a long period of time, the idea that SVT (or superficial thrombophlebitis) is a benign pathology and administering NSAIDs was a common therapeutic strategy. Nowadays, recent epidemiological studies of large patient cohorts have shown the potential severity of SVTs and have clearly defined SVT place within the VTE disease. A synchronous deep vein thrombosis (DVT) and pulmonary embolism (PE) was identified at presentation in 25–30% and 4–75% of SVT

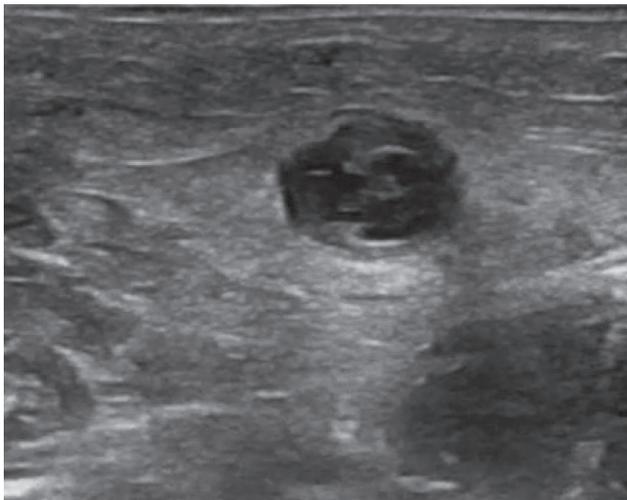


Figure 1. Thrombosed great saphenous vein.

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patients, respectively. Patients with SVT should have bilateral duplex scanning to confirm the diagnosis of SVT, to determine the precise location and extent of the thrombosis, as well as to diagnose or rule out the presence of a DVT. Today, SVT management has changed. Anticoagulant therapy is widely used instead of NSAIDs. Isolated SVT ≥ 5 cm in length located >3 cm from the SFJ should receive prophylactic doses of fondaparinux (2.5 mg subcutaneously per day), rivaroxaban 10 mg po daily or prophylactic/intermediate doses of low molecular weight heparin (LMWH) for 45 days. Patients can also receive NSAIDs and or compression therapy for symptomatic relief in conjunction with anticoagulation.

References

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Diagnosis: Anticoagulation along NSAIDs is necessary