Upper extremity deep vein thrombosis management in a district general hospital

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Introduction

Recent UK guidance on venous thromboembolic disease is notably silent on upper extremity deep vein thrombosis (UEDVT) management, despite its high incidence (10% of all cases of DVT). Available guidance recommends catheter-directed thrombolysis (CDT) for patients with acute extensive UEDVT, good functional status, and low bleeding risk, followed by anticoagulation for 3 months. First rib resection is currently not routinely recommended. With increasing use of CDT in UEDVT, we reviewed the demographics and management of patients diagnosed with UEDVT at our hospital over the past 5 years.

Method

Cases of UEDVT were retrospectively identified over a 5-year period from archived radiological imaging, as well as from admission records from our Ambulatory Day Unit and Vascular Imaging Laboratory.

Results

54 cases were identified, of which records for 4 were unavailable. 30 cases (60%) were men. The majority of cases (70%) were provoked by central venous catheter (CVC)/pacemaker insertion or malignancy. The rest were either unprovoked or effort-related (Paget-Schröter disease). 8 cases (16%) were referred to vascular surgery for consideration of CDT, which was performed successfully in 5 patients. 1 patient had first rib resection, and 1 patient had cervical band excision. Anticoagulation treatment was only documented in 6 cases, and duration varied from 3 months to lifelong.

Conclusions

Treatment of UEDVT locally is currently haphazard and has no clear protocol for either referral for CDT or for anticoagulation duration. We propose a streamlined multidisciplinary pathway (Figure 2) which can be instigated in our Ambulatory Day Unit, and which will hopefully optimise care of patients with UEDVT. This will need subsequent audit to ascertain uptake and compliance.

References