

KISS: Superficial Venous Thrombosis

References: [DTB2017;6;66](#); [BMJ2015;350;h2039](#); [SIGN 2014 CG122](#)

Superficial venous thrombosis and thrombophlebitis are common presentations in GP and can provide real conundrums throwing up lots of questions about management: should we scan, should we anticoagulate and how should we manage it symptomatically?

Assessment

- Superficial venous thrombosis or thrombophlebitis?
 - The primary pathology results from thrombosis rather than inflammation, so the term superficial venous thrombosis (SVT) is increasingly preferred (SVT is clearly not ideal as an acronym given that it has already been 'taken' but hopefully context will make it clear we are not talking about supraventricular tachycardia!). SVT occurs in varicose veins 80% - 90% of the time and shares its other risk factors with DVT and PE e.g. age, obesity, cancer, oral contraceptive use, recent surgery etc.
- SVT remains a clinical diagnosis of pain, erythema and on palpation the vein is tender and hard ('cord like'). Although it usually affects the legs it can affect any superficial vein in the body.
- Assess carefully for any sign of a current co-existent DVT or PE (between 6% and 44% of patients will have a co-existent DVT)
- Refer for immediate scanning and consideration of full anticoagulation if there is any indication of co-existing DVT or PE, or if the patient is at high risk with:
 - SVT close to the sapheno-femoral or sapheno-popliteal junctions
 - More extensive (e.g. $\geq 5\text{cm}$) or progressive SVT, especially if above knee

Treatment

- Patients with limited SVT elsewhere can be safely managed in primary care
 - Oral NSAIDs and compression stockings may help alleviate symptoms
 - If oral NSAIDs are contraindicated, there is some evidence from one small study that topical diclofenac gel improves symptoms compared to placebo
 - Patients should be carefully followed up to ensure they are not progressing or developing signs of DVT in which case refer for immediate scanning and consideration of full anticoagulation
- Patients who do not need full anticoagulation but who are at higher risk should be considered for prophylaxis (with specialist advice) with LMWH or fondaparinux s/c usually for 45 days. New research suggests that oral rivaroxaban 10mg is an effective option, non-inferior to fondaparinux, but is currently unlicensed (SURPRISE Study [Lancet Haematol 2017](#)).