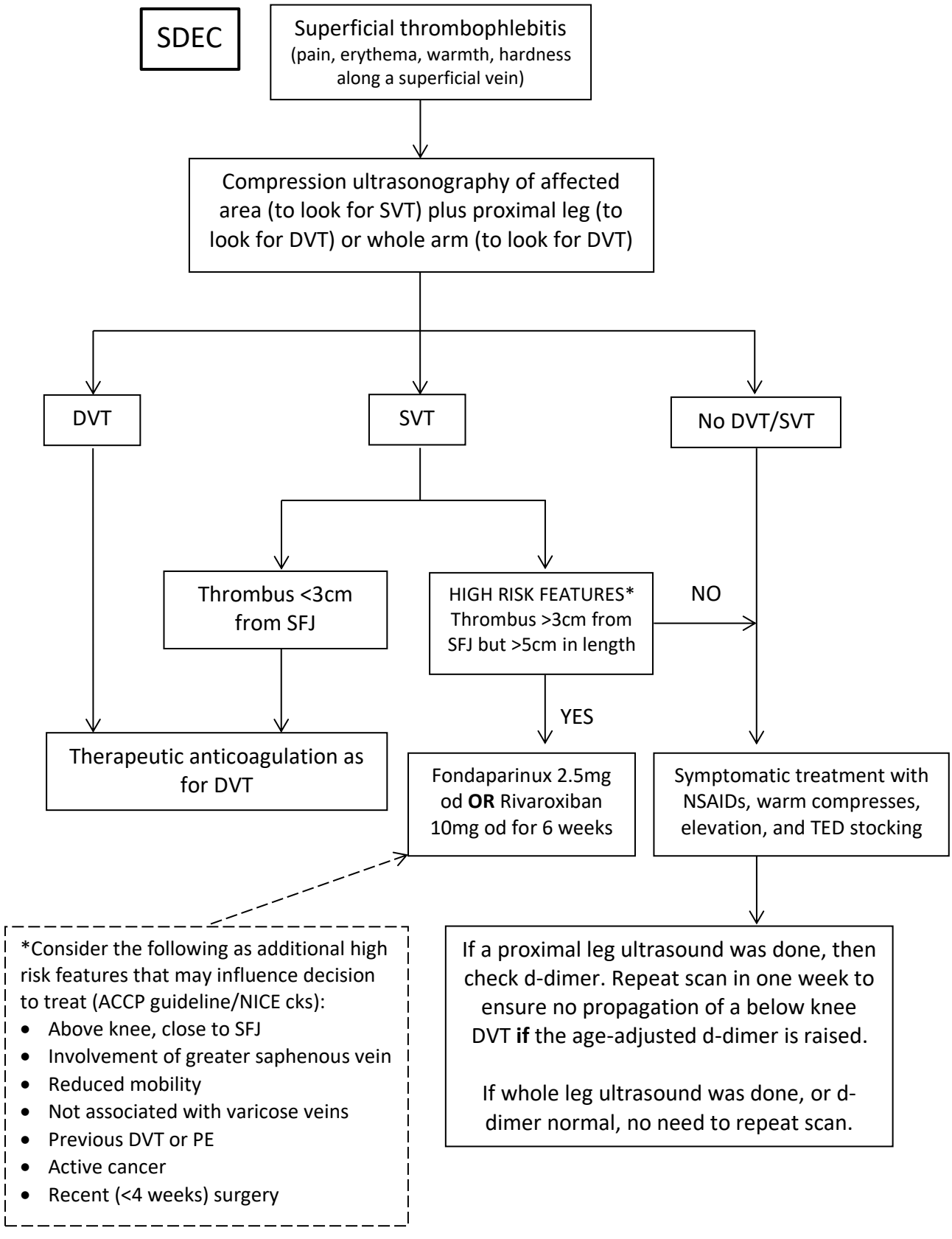
51. VTE: superficial vein thrombosis

This quick reference guideline is based on Scott G et al. Superficial vein thrombosis (SVT): a current approach to management. (2015). British Journal of Haematology; 168: 639-645. https://doi.org/10.1111/bjh.13255 and the NICE clinical knowledge summary https://cks.nice.org.uk/topics/superficial-vein-thrombosis-superficial-thrombophlebitis/ (2020).



VTE: superficial vein thrombosis - notes

1. Superficial venous thrombosis (a clot in a superficial vein) usually presents as **thrombophlebitis** – pain, erythema, warmth, and hardness along the course of a vein. Sometimes this is just inflammation (phlebitis) but sometimes there is a superficial clot present (thrombosis).

2. Up to 25% of patients with superficial thrombophlebitis have a deep vein thrombosis (DVT), which may or may not be in close proximity to the symptomatic area. For this reason, all patients with superficial thrombophlebitis should have compression ultrasonography of the affected limb to look for DVT, as well as a scan of the affected area to see whether there is a clot in the superficial vein.

3. There is no role for d-dimer in the investigation of superficial venous thrombosis. D-dimer is not sensitive enough in this condition. The Wells' Score is also not relevant and should not be used.

4. Superficial thrombophlebitis most commonly occurs in the leg. Studies of this condition involved whole leg compression ultrasonography. This poses a dilemma, because current practice for the investigation of DVT is to perform proximal leg compression ultrasonography and to repeat the scan in a week if the d-dimer is raised. Therefore, in this guideline, we have included d-dimer at the relevant point to decide whether a person should have a repeat proximal leg scan. If the upper limb is affected, see guideline no 50: upper limb DVT.

5. A superficial vein thrombosis (SVT) within 3cm of the saphenofemoral junction (SFJ) in the groin is considered high risk for propagation to DVT so is treated the same as DVT.

6. SVT with risk factors for extension, recurrence, or progression should be offered treatment with fondaparinux 2.5mg daily for 6 weeks. (Studies used prophylactic doses of LMWH or fondaparinux, but fondaparinux is preferred based on available data). Rivaroxaban 10mg od has been demonstrated to be non-inferior. Risk factors for extension, recurrence, or progression is usually when the superficial thrombus is greater than 5cm in length. However, other risk factors may influence the decision whether to treat for 6 weeks (see dotted line box in the flowchart).

7. There are no robust studies investigating the incidence of undiagnosed cancer and SVT. Current best evidence suggests that clinicians should **consider** an underlying undiagnosed cancer and screen for this with a careful history. There is no evidence that routine screening with tests is warranted. Exceptions to this are:

    a. Migratory thrombophlebitis (recurrent superficial thrombophlebitis at different sites) which is a well-documented paraneoplastic phenomenon, particularly associated with pancreatic cancer
    b. Mondor disease, which is superficial thrombophlebitis affecting the superficial veins of the breasts (~12% breast cancer incidence) – a mammogram is warranted in these cases.

8. Patients diagnosed with DVT after presenting with superficial thrombophlebitis should be screened for an underlying cancer and be followed up in a DVT clinic – see guideline 49: VTE lower limb.