MANAGEMENT OF RECURRENT VENOUS THROMBOEMBOLISM

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INTRODUCTION

Despite gains in our abilities to identify patients at high risk of venous thromboembolism and provide them with rather safe and effective forms of primary prophylaxis (1-5), venous thromboembolism (V T-E) continues to occur at a substantial rate. Part of the problem is a failure to recognize the high risk patient; part, limited application of the available prophylactic options. Clearly, educative and logistic initiatives are still needed in many health care facilities, the key ingredient being a physician catalyst who can carry forward a primary prophylaxis program.

However, the current reality is that acute venous thromboembolism continues to be a common event. Even in facilities which neglect primary prophylaxis, the occurrence of acute V T-E attracts substantial attention. A positive venogram or positive angiogram in a patient with signs and symptoms of acute embolism (Fig. One) generate major interest. Much discussion usually surrounds initial management decisions. Some controversies regarding initial treatment of V T-E still exist (6), and ongoing studies of newer thrombolytic agents will fuel others. Nonetheless, the acute therapeutic approach is now reasonably uniform and successful. Quite different, however, is the situation with respect to the long-term management of V T-E; that is, therapy designed to prevent recurrent V T-E.

One key difference between the acute and chronic management of V T-E is that substantially less physician interest and concern attach to therapy once the initial diagnostic-management decisions have been made. My observations suggest that, beyond the acute event, the decision-making process becomes anti-climactic and, unfortunately, substantially less careful and uniform. Furthermore, in these days of heavy emphasis on cost containment and reducing hospital stays, there is a tendency to rush toward discharge. Considerations regarding prevention of recurrence often are neglected in this harried environment.
Figure One. Angiogram in patient with acute embolism who was admitted to the intensive care unit in shock. Extensive occlusion is present.

The effects of these practical considerations are compounded by the relative dearth of hard information upon which long-term prophylactic decisions can be made. There are several reasons that we lack such data. These studies are logistically complex. They require long-term follow-up of a significant number of patients, a mandate which, at least in the current U.S. health care system, is difficult to follow. Furthermore, such studies may lack the allure (and funding) of more fundamental investigations regarding thrombogenesis and its consequences.

These considerations have led to a paradox in the logic applied to the management of V T-E. The primary goal of initial therapy, including some aspects of thrombolytic therapy, is to