

INVITED COMMENTARY

INSIGHTS into Superficial Vein Thrombosis Management — Some New Light and Room for Improvement

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Isolated superficial vein thrombosis (SVT) has clearly been underestimated in the past and is now increasingly recognised in view of the potential association with thromboembolic complications. Bauersachs *et al.*¹ conducted a large, prospective observational study (INSIGHTS-SVT) that gives a real world perspective of the current management of acute isolated SVT in Germany. With a very similar design to previous observational studies on the subject, the INSIGHTS-SVT study presents an updated, contemporary view on risk profile and treatment patterns.

The three month results of a composite primary endpoint of symptomatic venous thromboembolism (VTE) that occurred in 5.8%, confirmed the potential risk of SVT. However, this is especially due to extension and recurrence of SVT (4.7%, vs. 1.5% deep vein thrombosis [DVT], and 0.8% pulmonary embolism), which means that only a fraction of patients meeting the endpoint will suffer from extensive or life threatening VTE. This composite endpoint is common to other studies, but compiles two levels of severity that should also be looked at separately.

In multivariable analysis, previous SVT history (hazard ratio [HR] 2.3) and SVT extension/thrombus length (HR 1.04) were identified as risk factors associated with VTE recurrence. Age (HR 0.98) and duration of drug treatment (HR 0.98) were identified as “protective”. Cancer was not a significant factor. These findings can be helpful when deciding which patients to select for more aggressive primary treatment (i.e., full/intermediate instead of prophylactic dose) or extension of anticoagulation over the 45 days recommended by the European Society for Vascular Surgery (ESVS) venous thrombosis guidelines.²

Although the study reflects practice in Germany, which may differ significantly from other countries, it shows high adherence to anticoagulation at baseline (93,6%). However, this diminishes over time, to only half at day 25, one quarter at day 45 and less than 10% at three months. Additionally, great heterogeneity of drug choice and dosage suggests low compliance to current recommendations —

supporting the need for standardisation of treatment (and follow up) for SVT.

Concerning the choice of anticoagulant, fondaparinux was dominant (65.7%), which is in line with the randomised CALISTO trial³ and the ESVS guidelines.² This seems justified since the authors report that a 5.2% absolute risk reduction was observed compared with low molecular weight heparin (the treatment of choice in 22.8% of patients). Of note, there was a very low 4.3% rate of direct oral anticoagulant (DOAC) use for SVT treatment. In 2017, the SURPRISE trial,⁴ a randomised, open label trial comparing rivaroxaban 10 mg with fondaparinux and including nearly 500 subjects, had shown non-inferiority for prevention of thromboembolic complications without major bleeding excess. The insufficient time between INSIGHTS-SVT enrolment and the publication of SURPRISE combined with the fact that the scientific community still has not been able to replicate these results in a sufficiently powered randomised controlled trial could justify the very low rate of DOAC use. Despite being a well established therapy for DVT with the advantage of oral administration, DOACs remain off label in Europe for SVT. Extension of its use for this indication is expected in the future.

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