Superficial Venous Thrombophlebitis (SVT)

- Defined as a clot within a surface vein
- Traditionally thought to be benign and treated with supportive measures
  - Heat
  - NSAIDS
- More recent evidence has illustrated that SVT may be more ominous than previously suspected, requiring workup and directed treatment
- All venothrombotic events (VTE) are more common in pregnancy, and the issue of how to treat SVT in the pregnant woman is not clearly established

CALISTO

- 3002 patients with SVT at least 5 cm were randomized to fondaparinux 2.5 mg SQ QD vs placebo
- Primary outcomes were death, symptomatic PE, symptomatic DVT, extension to SFJ or recurrence
- Patients treated for 40 days, followed until day 77
- 83% wore stockings, 22% on asa

<table>
<thead>
<tr>
<th>Outcome</th>
<th>DVT*</th>
<th>PE*</th>
<th>Surgery*</th>
<th>SAE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondaparinux</td>
<td>0.9%</td>
<td>0.3</td>
<td>0</td>
<td>3.5%</td>
</tr>
<tr>
<td>Placebo</td>
<td>5.9%</td>
<td>1.3</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

* = P < 0.05

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Current SVT Treatment Guidelines

- Uncomplicated: < 5 cm, no suspicion of GSV, SSV or deep vein involvement, low risk patient
  - Symptomatic care with reassessment in 7-10 days
- Complicated:
  - Ultrasound
  - DVT Anticoagulation
  - Thrombus > 5 cm or within 5 cm SFJ antiocoagulation
  - Dose and type of anticoagulation for SVT is undetermined
  - Most guidelines suggest an intermediate dose regimen (e.g. enoxaparin 40 mg SQ QD) for lower risk patients, full dose anticoagulation for higher risk patients
  - Treatment duration variable, 45 days or until symptoms resolve is common

Pregnancy

- Pregnancy and postpartum state are risk factors for VTE
- 1/1600 will have DVT/VTE event
- 7th leading cause (9%) of maternal death
- Risk factors for antepartum VTE
  - Varicose veins
  - Multiple births
  - Inflammatory bowel disease
  - UTI
  - DM
  - BMI > 30
  - Maternal age > 35 years
- Postpartum VTE risk 2-5x that of antepartum
  - C-section and birth complications increase risk

Disclosures

- Speaker for Gore
- Grant support and speaker fees from Acelity
- President of IAC Vein Center Accreditation board

No disclosures related to this presentation
What about SVT During Pregnancy?

- SVT is increasingly being recognized as a marker for systemic risk for more serious VTE events
- Potentially more difficult diagnosis due to common complaints of limb swelling, limb pain, SOB
- Any patient with SVT in pregnancy should be treated as high risk

SVT Workup in Pregnancy

- D-Dimer levels unreliable
- MRV an alternative to compression US if US is unavailable or indeterminate

Conclusions

- SVT is generally a worse actor than has been traditionally thought
  - More DVT at time of presentation
  - More progression to DVT/PE immediately after diagnosis
- Pregnancy is a high risk condition for VTE with a high associated death rate
- Any pregnancy-related VTE is treated aggressively
- In consultation with obstetrician, treat SVT with;
  - Intermediate heparin-based anticoagulation in uncomplicated patients
  - Full anticoagulation in complicated/high risk women