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Right from the Onset: DVT Diagnosis, Management

### Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

### Dr. Davidson:

This is Dr. Bruce Davidson. We're going to blitz through acute DVT diagnosis and management.

First, my medical approach. Provide multiple layers of safety between the patient and a bad outcome. This is not a passion at all, this is training. The second thing I was trained about was the very best way to care for patients is also the simplest: treat them all the same, the way you'd want to be treated. All right, let's begin.

DVT diagnosis. Usually there will be an acute history of lower extremity, but be aware that upper extremity risk exists also, particularly in women taking oral contraceptives or fertility-enabling treatments upper extremities more common. Look at sites of recent interventions, knee replacement, Achilles tendon repair, or Achilles tendon break. Increased risk situations – lengthy relative immobility, individuals with nephrotic syndrome or significant proteinuria; that's diabetics and others. It doesn't require 3 g a day. Smaller amounts make people lose antithrombin in their urine and that increased risk. People with brain primaries or brain metastases are also at excess high risk of DVT, even with none of the above problems.

Now exam, ideal it's in person, but sometimes these days we do it over the phone with talking. Have the person take photos or a video. Send them to you by e-mail or, if you're willing, to your phone. Is there asymmetry and pitting edema against the anterior tibia? Have them push their finger one-third of the way up from the ankle. Is there redness? Is there pain? Is the temperature elevated?

Diagnostic test. Well, if you can, get a D-dimer. If it's greater than 500 or greater than 10 times their age if they're over 50, that's positive test. And if it's borderline, that counts as positive as well. The diagnostic test, really, is duplex ultrasound. Duplex ultrasound involves both B-mode and Doppler, and that's ideal.

All right, immediate management. Obtain a prompt D-dimer. If it's elevated or borderline obtain a duplex ultrasound. If you can't get a D-dimer, obtain the duplex or at least B-mode ultrasound. Can't get either, start oral treatment while arranging for them.

Drug treatment. Oral treatment is rivaroxaban 15 mg every 12 hours with food for 3 weeks, then 20 mg once daily. And with food is important, otherwise you have only roughly half the absorption. Apixaban 10 mg every 12 hours for 7 days, then 5 mg every 12 hours. If the GI tract is not for sure reliable, start with low-molecular-weight heparin sub-Q 1 mg/kg every 12 hours. Insist upon a 12-hour, not once-daily, regimen. If the diagnosis is unproven, give them 2 to 4 days of drugs until you can get those diagnostic studies completed.

Other management. Rest the body part. Elevate the swollen arm or the leg. Knee-high elastic compression stockings may help prevent post-phlebotic syndrome, but you have to wait until the edema is gone, then you have them wear them during the time they're on treatment. Duration 3, 6, or 12 months, or indefinite. That's a separate talk. It depends on the underlying risk factors, but there's good evidence for considering a one-half-dose reduction after 6 to 12 months. And if the patient's already taking aspirin, like half of them were

in this big study, then in that case, they get extra benefit. If you want, you can start baby aspirin 81 to 100 mg.

Well, I thank you for your attention to this, and if you have questions or comments, please feel free to contact me.

**Announcer:**

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