TREATMENT OF ACUTE VENOUS THROMBOEMBOLISM
PULMONARY EMBOLISM & DEEP VEIN THROMBOSIS

**CRITERIA FOR sPESI** (Simplified Pulmonary Embolism Severity Index)

- Age > 80 years + 1
- Cancer (active or history) + 1
- Heart failure or chronic lung disease + 1
- Pulse > 110 bpm + 1
- Systolic BP < 100 mmHg + 1
- Arterial O2 sat < 90% + 1

*For patients with PE at very low risk of adverse outcomes, outpatient treatment may be reasonable. Clinical risk assessment models, e.g., sPESI, can be used to estimate the risk of mortality and other adverse outcomes.

**SELECT TREATMENT OPTION** based on patient characteristics, cost, convenience and patients preferences

1. **Rivaroxaban 15 mg bid x 3 weeks, then 20 mg once daily**
   - Avoid in patients with CrCl < 30 mL/min
   - Avoid in patients on potentially interacting medications
   - Limited data for BMI > 40 kg/m^2 or weight > 120 kg

2. **Apixaban 10 mg bid x 7 days, then 5 mg bid**
   - Use with caution in patients with CrCl < 25mL/min
   - Avoid in patients on potentially interacting medications
   - Limited data for BMI > 40 kg/m^2 or weight > 120 kg

3. **Enoxaparin 1 mg/kg SQ q12h x 5-10 days, then dabigatran 150 mg bid**
   - Adjust enoxaparin dose if CrCl < 60 mL/min
   - Avoid dabigatran if CrCl < 30 mL/min
   - Avoid dabigatran in patients on potentially interacting meds
   - Not recommended for BMI > 40 kg/m^2 or weight > 120 kg

4. **Enoxaparin 1 mg/kg SQ q12h + warfarin**
   - Stop enoxaparin when INR > 2.0 after a minimum of 5 days of overlap
   - Adjust enoxaparin dose if CrCl < 60 mL/min
   - Start warfarin on same day as heparin/LMWH

**Additional Considerations**

- **Arrange outpatient follow-up**

**FOR WARFARIN**: Check INR daily (inpatients) or q2-3 days (outpatients) until INR >2.0, then as appropriate

**FOR HEPARIN/ENOXAPARIN**: Check CBC (HCT and plt) daily (inpatients) or q2-3 days (outpatients) for the first 2 weeks of heparin/enoxaparin therapy

**FOR CANCER-ASSOCIATED THROMBOSIS**: Use oral factor Xa inhibitor or enoxaparin

**FOR PATIENTS WITH HIT**: See UW Medicine Guidelines for Management of HIT†

**FOR DURATION OF THERAPY**: See UW Medicine Recommendations for Duration of Anticoagulant Therapy Following VTE†

†https://sites.uw.edu/anticoag/