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Original article

# After deep vein thrombosis, which patients refer to vascular specialist for anticoagulant withdrawal? A Delphi study results between general practitioners and vascular specialists

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## Summary

*Aim >* Deep vein thrombosis (DVT) is a potential serious common disease. Its management is, except in particular cases, on an outpatient basis. General practitioner's (GP) role usually includes the treatment risk/benefit reassessment. The treatment duration can vary and is difficult to define. The national and international guidelines do not explain clearly when to refer, or not, to a vascular specialist in order to stop treatment. The study's objective was to identify, for DVT, when a GP has to refer or not to a vascular specialist, for anticoagulant withdrawal.

*Methods >* A modified Delphi consensus study had been conducted by a panel of general practitioners and vascular specialists to identify, in which situations all clinicians agree that GPs can stop anticoagulation on their own and other situations in which GP have to refer to vascular specialists. Clinical situations and their respective duration of anticoagulant therapy have been identified by a DVT management guideline literature research.

*Results >* After two rounds, a strong agreement had been reached for each clinical situation. For 7 clinical situations, GPs were able to stop anticoagulation on their own, for 13 clinical situations; it was necessary to refer to a vascular specialist. We obtained a consensus regarding 3 modulating factors.

*Discussion >* Consensual situations, in which the general practitioners may be able to stop anticoagulation themselves, are isolated distal DVT without cancer and proximal DVT caused by a major reversible risk factor. Situations justifying a vascular medical advice were unprovoked DVT, DVT in a context of pregnancy, postpartum, cancer and proximal DVT in a context of hormonal therapy.


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## Résumé

### Après une thrombose veineuse profonde, quels patients référer à un médecin vasculaire pour discuter de l'arrêt du traitement anticoagulant ? Enquête Delphi avec des médecins généralistes et vasculaires

*Objectif >* *La prise en charge de la thrombose veineuse profonde (TVP) est, sauf cas particuliers, ambulatoire. Le rôle du médecin généraliste est essentiel, notamment pour la réévaluation de la balance bénéfice/risque du traitement. Les recommandations ne préconisent pas clairement quand orienter ou non vers un médecin vasculaire pour l'arrêt du traitement. L'objectif de l'étude était d'identifier, pour les TVP, les situations dans lesquelles le médecin généraliste devait ou ne devait pas demander l'avis d'un médecin vasculaire pour l'arrêt de l'anticoagulation.*

*Méthodes >* *Une étude de consensus de type Delphi modifiée a été réalisée auprès d'un panel de médecins généralistes et de médecins vasculaires, afin d'identifier les situations cliniques dans lesquelles le médecin généraliste pouvait arrêter l'anticoagulation en autonomie et les situations dans lesquelles il était nécessaire d'obtenir l'avis d'un médecin vasculaire. Les situations cliniques et leurs durées d'anticoagulation respectives ont été identifiées par une revue de la littérature, puis soumises aux médecins généralistes et aux médecins vasculaires.*

*Résultats >* *Après 2 tours, un accord fort a été obtenu pour chaque situation clinique. Dans 7 situations cliniques le médecin généraliste pouvait arrêter l'anticoagulation en autonomie ; dans 13 situations cliniques, il était nécessaire d'avoir un avis spécialisé. Trois facteurs modulateurs de la prise en charge ont fait consensus.*

*Conclusion >* *Les situations consensuelles pour lesquelles le médecin généraliste pouvait arrêter de lui-même l'anticoagulation étaient les TVP distales isolées sans cancer associé et les TVP proximales avec facteur déclenchant majeur transitoire. Les situations pour lesquelles il était nécessaire d'avoir un avis spécialisé étaient les TVP idiopathiques, les TVP dans un contexte de grossesse, de post-partum ou de cancer et les TVP proximales dans un contexte de traitement hormonal.*

### What was known

- After a DVT, the anticoagulant therapy duration must be adapted to each patient.
- The treatment reassessment in general practice is essential to avoid a long and unnecessary anticoagulant therapy.
- To achieve this reassessment, the recommendations do not clearly explain when to refer, or not, to a vascular specialist to stop treatment.

### What this study adds

- Situations in which the general practitioner can stop anticoagulation on his own are isolated distal DVT without an associated cancer, and proximal DVT caused by a major reversible risk factor, surgical or not.
- Situations justifying a vascular medical advice to stop processing, are idiopathic DVT, DVT provoked by pregnancy, postpartum, cancer (active or in remission), and proximal DVT in a context of hormonal therapy.

Deep vein thrombosis (DVT) is common and serious. Its incidence is estimated to be 1.24 per 1000 people a year [1]. Without treatment, half of the DVT progresses into pulmonary embolism (PE) [2]. Patients with PE mortality are estimated to be at 17% in the first three months [3]. The medium and long-term prognosis are marked by the risk of recurrence and onset of post-thrombotic syndrome (PTS). The risk of recurrence is at 3% per year for DVT provoked by a major reversible risk factor and at least 10% per year for a persisting factor (eg: cancer) or unprovoked DVT [2]. The prevalence of PTS is 30–50% [4].

The initial DVT management involves the usage of anticoagulants, which have been the subject of national [5] and international [6] guidelines.

Except in specific cases, DVTs are treated at home. Outpatient management is as effective as hospital care [7]. Outpatient's care needs cooperation between general practitioners (GP), who have issued the diagnostic hypothesis, and vascular specialist who confirmed the diagnosis and initiated treatment. In a 2015 French survey, GPs declared referring to a vascular