Superficial thrombophlebitis

Mrs Philips is your 4th patient on a visit to the local nursing home. She has a sore leg and you find a tender swollen varicose vein extending from the mid thigh to the ankle. What do you do?

a) Try a non-steroidal gel.

b) Prescribe flucloxacillin and naproxen.

c) Refer for a scan and treat with LMWH.

d) Try elevation and compression with naproxen.

A BMJ Practice review considered this subject and has certainly challenged my usual practice (BMJ 2015;350:h2039).

This fairly common condition is probably not as benign as we once thought - it is being renamed superficial venous thrombosis, which should help us to remember it is associated with deep vein thrombosis and pulmonary embolism and has exactly the same risk factors.

Diagnosis

Superficial thrombophlebitis is a clinical diagnosis - we should suspect it in the following situations.

Sterile thrombophlebitis

This is the vast majority of cases - antibiotics are NOT indicated here:

- Presence of varicose veins.
- Pain and discoloration (red or later brown) over the affected vein.
- Tenderness and hardness on palpation of the vein.

Infective/traumatic thrombophlebitis

- May occur after prolonged cannulation or trauma to overlying skin.
- Need to assess if infection or irritant, e.g. from IV sclerosant most likely.
- Antibiotics may have a place.

Migratory thrombophlebitis

- Rarer - recurrent bouts at different sites should raise alarm bells for possible underlying malignancy, especially pancreatic.

Referral

Here are some slightly alarming statistics:

- DVT may co-exist with superficial thrombophlebitis in 5-53% of cases - it is more likely when the superficial vein affected is close to a junction with the deep venous system.
- Clinical assessment alone will underestimate the extent of venous involvement 77% of the time.

What should we do?

For these reasons, the authors of this review recommend that we refer all patients for duplex assessment (in practice in most areas this will be through the local DVT services).

D-dimer is of no value in differentiating superficial from deep venous thrombosis - it may be elevated in both.

Treatment

The review acknowledges that treatment remains controversial and there is not a strong evidence base to recommend one treatment over another.

Current recommended UK practice is:

Below knee + no evidence of DVT

- Offer compression hosiery and symptomatic relief with NSAIDs.

Extension of thrombus to saphenofemoral or saphenopopliteal junction

- Low molecular weight heparin (LMWH) may be indicated to prevent extension in addition to symptomatic management as
An RCT showed that unfractionated heparin, warfarin and LMWH were superior to compression alone in preventing extension and a more recent study suggests LMWH is superior to unfractionated heparin (not to mention a heck of a lot easier!). Fondaparinux, a newer sub-cut LMWH-like drug, has also been shown to reduce the symptoms and risk of extension compared with placebo, but has not been compared to standard LMWH therapy.

Antibiotics have no role unless there is a clear case of infection.

After the acute phase has passed, consider referring to the vascular team for varicose vein intervention (see NICE 2013, CG168). These guidelines can be found in the online handbook.

### Superficial thrombophlebitis
- Consider referring patients with clinical superficial thrombophlebitis for a duplex scan and assessment (usually via your local DVT service).
- Don’t use D-dimer to help you decide who to refer.
- Simple below knee thrombophlebitis with no DVT can be managed with compression +/- NSAIDs.
- If there is extension to saphenofemoral or saphenopopliteal junction LMWH and compression is beneficial.
- Consider referring patients with varicose veins and a history of superficial thrombophlebitis for a vascular surgery assessment.

Search your records for cases of superficial thrombophlebitis - to what extent does current care match these recommendations?
Share this learning with your practice team and repeat the search after 6 months.

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We make every effort to ensure the information in these pages is accurate and correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular check drug doses, side effects and interactions with the British National Formulary. Save insofar as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in these pages.

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February 2016
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Birmingham Sat 21 May
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Chelmsford Wed 25 May
London Thur 26 May
Belfast Wed 8 June
Oxford Fri 30 Sep
Southampton Sat 1 Oct
Cardiff Wed 5 Oct
Exeter Thur 6 Oct
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London Fri 1 Jul
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Leeds Thur 10 Nov
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2015 has seen the biggest shake up in cancer in the last 10 years with the publication of the updated NICE guidelines on suspected cancer. If, like many of us in England & Wales, you are still finding your way around them, then this course will definitely help!

London Thur 17 Mar
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The Medically Unexplained Symptoms Course
A significant proportion of patients who present to us will turn out to have symptoms that are medically inexplicable. We all know that there is no magic solution with these patients and sometimes they leave us feeling defeated and not sure what to do. However, there is evidence which can help address the issue.

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