NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Suspected Deep Vein Thrombosis, Intravenous Drug Users Integrated Care Pathway

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Patient Name (or addressograph label): _____ **CHI:** _____

DVT management in IV Drug Users *(past or present)*

Consider HIV test (9ml EDTA/Purple tube) – 3 monthly (or opportunistic if < 3 months but ongoing risk taking)
If IVDU patient is pregnant, refer to on-call obstetrics team – to be managed as per DVT in pregnancy protocol

Initial attendance

Assess suitability for Outpatient management

- Cellulitis or injection site abscess → Admit for IV Antibiotics ± I&D[1]
- SOB / Chest pain → Consider PTE algorithm
- Chaotic lifestyle-High chance DNA for scan → Consider IP DVT Management

Continuing IV drug use before Ultra-Sound Scan / review?
Yes → Do not administer LMWH
No → Administer LMWH and reinforce avoidance of IV drug use

Arrange Outpatient Ultrasound slot & next day review appointment
Discharge with oral antibiotics[1] if required and relevant patient information[2].

Review

Acute DVT confirmed on ultrasound
(not just old chronic thrombus or fibrosis)

Reassess suitability for any out-patient anticoagulant therapy?
Exclusion criteria include:
Significant coagulopathy or platelets <75 x10^9/L
Likely to continue to inject or chaotic life style and not on a substitution programme
Not registered with primary care provider (GP, Community Homeless / Addiction Teams)[3]

Suitable

Continue anticoagulation [*see options below*]
Review any cellulitis/abscess

Not suitable

Stop anticoagulant therapy before discharge
& suggest self-referral to CAT

Ascertain if on a substitution programme

- **No**: refer to hospital addiction liaison nurse [ext 52835] for assessment [in-patients]. If out-patient encourage self referral to Community Addiction Team [CAT] (GGC [exc RAH]: 0141 201 0204/0205, Clyde: Renfrewshire Drug Services: 0141 618 2585)
- **Yes**: if concerns regarding lifestyle and safety of anticoagulation use, liaise with addiction services

Anticoagulation

Determine type and duration of anticoagulant therapy

- No IV drug use for >12 months
- Stable, non-chaotic life style (usually on, or completed, a substitution programme)
- Deemed likely to comply with medication & monitoring [if warfarin]
- Lifestyle and habits conducive to stable INR control (consider alcohol intake, other medicines etc.), if warfarin

NO

6 weeks rivaroxaban
[off-label duration, but safer if drug use unstable]

- If rivaroxaban contra-indicated[4] offer *sc* LMWH[5]
- Supply 21 days Rivaroxaban 15mg twice daily and issue rivaroxaban discharge letter to GP[6]
- Agree plan with primary care / substitution prescriber

YES

Standard 3 month rivaroxaban[4,6] or warfarin

- Supply 21 days Rivaroxaban 15mg twice daily and issue rivaroxaban discharge letter to GP[6]
- Agree plan with patient's primary care/ (substitution) prescriber

Establish on anticoagulant & refer to GCAS
[if warfarin]

Issue immediate discharge letter[7]

[1] If moderate to severe cellulitis/sepsis (e.g. ≥2 SIRS criteria and/or VBG lactate >4) then admit for antibiotics. Liaise with microbiology regarding local infection patterns/antibiotic requirements. Ideal is 2x blood cultures pre antibiotics. Only consider for discharge if limited cellulitis without systemic upset.

Antibiotic therapy should be prescribed as per NHS GGC Infection Management Guidelines (see StaffNet) and/or microbiology or infectious diseases advice. Microbiology samples, when obtained, usually require 48hrs for full result including sensitivities.

Consider if any abscess requiring incision & drainage (I&D) – liaise with appropriate specialty (e.g. general surgeons, orthopaedics, plastics). Remember *necrotising fasciitis* (guideline on StaffNet), *anthrax*, *myositis*, *tetanus* and *pseudoaneurysms* can all occur in IVDUs.

[2] Patient should be given routine DVT/anticoagulation patient advice & literature and warned to avoid any further IV drug use.

[3] If IVDU patient with proven DVT is not registered with any primary care service [GP, Community Addiction Team or Homeless Addiction Team] then best option may be short admission and liaison with Addiction Nurse and assistance to register with appropriate service. Any decision not to offer anticoagulant therapy should be discussed with senior medical staff.

[4] For details of rivaroxaban prescribing and contra-indications refer to BNF and SPC. In particular, given the patient population, be aware of significant interactions between rivaroxaban and some anti-retrovirals e.g. protease inhibitors.

[5] If prescribing therapeutic dose sc LMWH, a maximum of 7-14 doses [+sharps bin] should be issued from secondary care. Patients should be taught *sc* self injection technique. There is no need for platelet count monitoring for HIT.

[6] Primary care prescriber should start prescribing rivaroxaban from day 22, when the dose should be reduced to 20mg **once daily**. The discharge letter should state the date once daily dosing should start and the date it should cease. Rivaroxaban should be taken with food. In renal impairment (CrCl 15-49ml/min) reduce rivaroxaban dose to 15mg once daily in patients perceived to be at high risk of bleeding. In patients with CrCl of 15-29ml/min, rivaroxaban plasma concentrations are significantly increased, therefore, it should be used with caution.

[7] Immediate discharge letter, and rivaroxaban discharge letter if appropriate, given to patient (with copies sent by post or electronically to primary care prescriber +/- GP, if different). Also supply Direct Oral Anticoagulant [DOAC] Patient Information Booklet and Alert Card or Warfarin Patient Information Booklet and Alert card.

Immediate discharge letter should include

- Diagnosis
- Date of first dose of anticoagulant
- Intended duration of anticoagulant, its dose and proposed stop date
- Number of doses of rivaroxaban or LMWH issued to patient at discharge
- Any additional medicines prescribed (e.g. antibiotics)

Advice for Primary Care Prescriber [normally the same individual prescribing the patient's substitution therapy]

- Rivaroxaban and warfarin management as per immediate discharge letter, and rivaroxaban discharge letter if appropriate
- IVDU patients should already have been instructed in sub-cut self injection technique [if prescribed LMWH] while attending hospital OP-DVT programme.
- LMWH should be prescribed for dispensing on a daily basis (e.g. when attends pharmacy for substitution therapy) or at most 7 doses weekly for 4 weeks – the hospital already having dispensed the first 7-14 days supply.