EDITORIAL

The new Dutch antithrombotic management guideline
Treating venous thrombosis with direct oral anticoagulants for a lifetime?

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A new guideline for antithrombotic management has recently been published.[1] This Dutch guideline advises doctors about the prevention and treatment of venous thromboembolism (VTE). Furthermore, the guideline outlines the indication when bridging of anticoagulation is needed, and implicated the HESTIA criteria, a clinical score for outpatient treatment of patients with a newly diagnosed pulmonary embolism (PE).[2] We would like to recommend our readers to read this new guideline, which is easily accessible online[1] as well as a practical Dutch summary published recently.[3]

A main question remains unanswered: what is the length of treatment of a first episode VTE? As compared with the previous guideline,[4] a change of practice has been proposed; namely, to treat a patient with an idiopathic VTE for three months, after which the physician is recommended to evaluate his treatment yearly. The continuation of the antithrombotic treatment should be considered if the risk of a recurrent venous thrombotic event outweighs the bleeding risk.[1]

The recurrent rate after a first idiopathic thrombotic event is 30% in five years.[5-7] Additional treatment of anticoagulant treatment in unprovoked pulmonary embolism did not prevent the recurrence of VTE after antithrombotic treatment was discontinued.[5] The type of VTE is of importance in the recurrence rate as well. Patients presenting with PE are three times more likely to suffer a recurrence PE than patients presenting with a deep venous thrombosis.[6]

It would be a challenge for the physician to annually re-evaluate the continuation of antithrombotic treatment for each individual patient. It is unknown to what extent this patient group will burden the outpatient clinics. Or should the primary physician be left with this yearly consult? The main goal should be the communication with the patient, leading to a shared decision to continue his antithrombotic treatment or not. In addition, we could gain more experience with the usage of direct oral anticoagulants (DOACs) and therefore a yearly consult might be just what is needed to get a better overview of the side effects of DOACs.

The guideline[1] does not elucidate whether patients who are currently using a vitamin K antagonist (VKA) should switch to a DOAC. DOACs have less bleeding complications and are more patient friendly, as no regular laboratory control is needed. In this issue of the Netherlands Journal of Medicine, Brekelmans et al.[8] performed a questionnaire in patients using a VKA, proposing a choice: VKA or DOAC. A majority of the patients were willing to switch to a DOAC. In addition, for VKA and DOACs the 'to switch or not to switch' decision should be based on clinical parameters as well.[9]

Finally, the outcome of antithrombotic treatment versus no-treatment is of great interest, as most probably not many patients will choose to take pills for a lifetime. What would the doctor choose if he were the patient?

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