NHS Greater Glasgow and Clyde

CLINICAL GUIDELINE

Outpatient Management of Person Who Injects Drugs (PWID) with suspected Deep Venous Thrombosis (DVT)

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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Does this version include changes to clinical advice:	Yes
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Lead Author:	Tadhg Kelliher
Approval Group:	Medicines Utilisation Subcommittee of ADTC

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.

DVT management in PWIDs *(past or present).*

- Check Blood Borne Virus (BBV) status. Consider BBV test (9ml EDTA/Purple tube) if last check > 3 months and ongoing risk taking behaviour)
- If PWID is pregnant, refer to on-call obstetrics team – to be managed as per DVT in pregnancy protocol[1]

Initial Attendance

Assess suitability for outpatient management

- Cellulitis or injection site abscess → Admit for IV Antibiotics ± Incision & Drainage[2]
- Dyspnoea / Chest pain → Consider Pulmonary Thrombo Embolus (PTE) algorithm
- High chance of default for scan → Consider inpatient DVT Management

Continuing Intravenous (IV) drug use before ultrasound scan / review

- Yes → Do not administer anticoagulation
- No → Administer anticoagulation (Apixaban)[3,4] and reinforce avoidance of IV drug use

- Arrange outpatient ultrasound slot & next day clinic review appointment
- Discharge with oral antibiotics[2] if required and relevant patient information[5]
- Consider Outpatient Parenteral Antibiotic Therapy (OPAT) for more significant cellulitis

DVT Clinic Review

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

Reassess suitability for any outpatient anticoagulant therapy

Exclude patients if:

- Significant coagulopathy and/or platelets <75 x10^9/L
- Likely to continue to inject and/or chaotic lifestyle and/or not on a substitution programme
- Not registered with a primary care provider (GP, Community Homeless / Community Addiction Team (CAT))[6]

Suitable	Not suitable
Continue anticoagulation [*see options 1, 2 & 3 below*] Review any cellulitis/abscess	Stop anticoagulant therapy before discharge & suggest self-referral to CAT

Ascertain if on a substitution programme

- **No**: refer to hospital addiction liaison nurse for assessment if an inpatient or if for discharge refer to ADRS (Alcohol and Drug Recovery Service). Trakcare referral for ADRS Crisis Outreach and Addictions Liaison Inreach available. Hospital specific contacts listed.[7]
- **Yes**: identify prescriber/pharmacist to obtain current substitution/dose regimen and refer to addiction liaison nurse

Anticoagulation

Apixaban

- Supply Apixaban 10 mg twice daily for 7 days, then maintenance 5 mg twice daily

Determine duration of anticoagulant therapy

Option 1	Option 2
6 weeks Apixaban[3] • off-label duration, but safer if drug use unstable.	**Standard 3 months Apixaban[3]** • No IV drug use >12 months • Non-chaotic lifestyle (usually on, or having completed a substitution programme), and compliance with treatment likely

Option 3

Where Apixaban is contraindicated use 3 month Dalteparin [4]

- Agree plan with patient's primary care (substitution) prescriber
- Issue immediate discharge letter[8]
- These patients do not require referral to an anticoagulant clinic

Authors: Dr T.Kelliher (EM Cons), Dr C.Bagot (Cons Haematologist) ¦
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Notes:

1. [CG] Thromboembolic disease in pregnancy and the puerperium: acute management | Right Decisions (scot.nhs.uk)
   Thromboembolic Disease during Pregnancy and the Puerperium (605) | Right Decisions (scot.nhs.uk)
2. If moderate to severe cellulitis/sepsis (e.g. severe systemic upset, NEWS ≥2 and/or VBG lactate >4) then consider admission for antibiotics. Liaise with microbiology regarding local infection patterns and antibiotic requirements. Ideal is 2 sets of blood cultures prior to antibiotic administration. Only consider for discharge if limited cellulitis without systemic upset.
   Antibiotic therapy should be prescribed as per NHS GGC Infection Management Guidelines and/or microbiology or infectious diseases advice.

   Infection Management, Empirical Antibiotic Therapy in Adults (165) | Right Decisions (scot.nhs.uk)

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

   The OPAT (Outpatient Parental Antibiotic Therapy Service) is an alternative to admission for some cellulitis and can utilise a once weekly IV antibiotic. Refer via Trakcare (*New request > OPAT*) and phone 83107 (83105 on weekends).
3. Apixaban not recommended if CrCl is <15ml/min. Use with caution if CrCl is 15–29ml/min.
   Other exclusions for Apixaban treatment include:
   Liver disease associated with cirrhosis or coagulopathy
   Pregnancy or breast feeding
   Concurrent therapy with azoles (except Fluconazole), protease inhibitors or strong CYP3A4 inducers (e.g. Rifampicin, Phenytoin, Carbamazepine, Phenobarbitol or St John's Wort)
   Patients perceived to be at high bleeding risk who would not be suitable for any therapeutic anticoagulant therapy.
4. Where Apixaban is contraindicated consider the use of Dalteparin at 200mgs/kg/day.
   For dose adjustment at extremes of weight see:
   156-heparin-dose-adjustment.pdf (scot.nhs.uk) Page 2
   For dose adjustments for abnormal renal function see:
   heparin-dose-adjustment-157.pdf (scot.nhs.uk) Page 3
5. Patient should be given routine DVT/anticoagulation patient advice sheet and warned to avoid any further IV drug use. Patients being discharged on Apixaban should be issued with an Apixaban Patient Alert card and offered counselling about this anticoagulant medication.
6. If PWID 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 to allow liaison with the Addiction Nurse who can provide assistance to register with the appropriate service. Any decision not to offer anticoagulant therapy should be discussed with senior medical staff.
7. **GRI & QEUH Acute Addiction Liaison:**

Inpatient:	Tel 0141 211 0231, 211 0238. Email: AALNSED@ggc.scot.nhs.uk
Outpatient:	Tel 0141 211 3102. Email: Ggc.Prog@ggc.scot.nhs.uk
IRH Addictions:	Tel 0141 314 4472. Email: Addiction.liaison@inverclyde.gov.uk
RAH Addictions:	Tel 0141 314 4472. Email: addictions.sw@renfrewshire.gov.uk
8. An Immediate discharge letter should be given to the patient (with copies sent to primary care prescriber +/- GP, if different). This should include the diagnosis, date of first dose of Apixaban or Dalteparin, the intended duration of anticoagulant use, the date of dose reduction and the date treatment should cease. The number of doses of Apixaban/Enoxaparin issued to patient at discharge and any additional medicines prescribed (e.g. antibiotics) should also be noted.