

## Extended therapy for unprovoked venous thromboembolism: when is it indicated?

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### Abstract

Immediate initiation of anticoagulant therapy is imperative when acute venous thromboembolism (VTE) is diagnosed; 3 months is the minimum duration of treatment. Subsequently, the choice between anticoagulant agents and the continuation of treatment should be guided by the etiology of the VTE event. Etiology is best defined as provoked or unprovoked. Provoked is VTE associated with risk (provoking) factors that are transient or persistent, and major or minor. When risk factors are absent, VTE is classified as unprovoked. Unprovoked VTE has a high probability of recurrence once treatment is stopped, and studies suggest that this is unchanged by initial duration of therapy. The decision of whether to continue anticoagulant therapy in patients with unprovoked VTE is determined by the probability of recurrence, but this must be balanced by the risk of major bleeding and the case fatality rates associated with recurrence and bleeding. Patient preference must also be considered. The probability of recurrence can be further defined by single factors such as sex, whether the index event was deep vein thrombosis or pulmonary embolism, D-dimer, and residual venous obstruction but it is best determined by sex and by prediction rules. Men have a high probability of recurrence and should continue therapy, unless they have a high probability of bleeding and the initial event is a deep vein thrombosis. Women with low probability of recurrence by the HERDOO2 prediction rule (hyperpigmentation, edema, or redness in either leg; D-dimer level  $\geq 250$   $\mu\text{g/L}$ ; obesity with body mass index  $\geq 30$ ; and older age,  $\geq 65$  years) can discontinue anticoagulation. In women with higher probability of recurrence, indefinite treatment is indicated unless they are at high probability of bleeding.

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T.T.'s research was supported by a grant from the Swiss National Science Foundation (SNSF P2ZHP3\_177999).

Contribution: T.T. and P.S.W. wrote the manuscript.

Conflict-of-interest disclosure: T.T. has received travel and congress fees from Pfizer. P.S.W. has received honoraria for advisory board meetings from Bayer Healthcare, Sanofi, Bristol-Myers Squibb/Pfizer, and Daiichi Sankyo, and research funding from Bristol-Myers Squibb/Pfizer.

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