DVT or PE: anticoagulation

PE with haemodynamic instability

Offer continuous UFH infusion and consider thrombolytic therapy

Body weight

If body weight <50 kg or >120 kg consider anticoagulant with monitoring of therapeutic levels.

Note cautions and requirements for dose adjustments and monitoring in SPCs. Follow local protocols, or specialist or MDT advice

INR monitoring

Do not routinely offer self-management or self-monitoring of INR

Prescribing in renal impairment and active cancer

Some LMWHs are off label in renal impairment, and most anticoagulants are off label in active cancer.

Follow GMC guidance on prescribing unlicensed medicines

Treatment failure

If anticoagulation treatment fails:

- check adherence
- address other sources of hypercoagulability
- increase the dose or change to an anticoagulant with a different mode of action

- Measure baseline full blood count, renal and hepatic function, PT and APTT but start anticoagulation before results available. Review and if necessary act on results within 24 hours
- Offer anticoagulation for at least 3 months. Take into account contraindications, comorbidities and the person's preferences
- After 3 months (3 to 6 months for active cancer) assess and discuss the benefits and risks of continuing, stopping or changing the anticoagulant with the person. See long-term anticoagulation for secondary prevention in the guideline

No renal impairment, active cancer, antiphospholipid syndrome or haemodynamic instability	**Renal impairment** (CrCl estimated using the Cockcroft and Gault formula; see the BNF)	**Active cancer** (receiving antimitotic treatment, diagnosed in past 6 months, recurrent, metastatic or inoperable)	**Antiphospholipid syndrome** (triple positive, established diagnosis)
Offer apixaban or rivaroxaban If neither suitable, offer one of: • LMWH for at least 5 days followed by dabigatran or edoxaban • LMWH and a VKA for at least 5 days, or until INR at least 2.0 on 2 consecutive readings, then a VKA alone	CrCl 15 to 50 ml/min, offer one of: • apixaban • rivaroxaban • LMWH for at least 5 days then – edoxaban **or** – dabigatran if CrCl ≥ 30 ml/min • LMWH or UFH and a VKA for at least 5 days, or until INR at least 2.0 on 2 consecutive readings, then a VKA alone CrCl < 15 ml/min, offer one of: • LMWH • UFH • LMWH or UFH and a VKA for at least 5 days, or until INR at least 2.0 on 2 consecutive readings, then a VKA alone Note cautions and requirements for dose adjustments and monitoring in SPCs. Follow local protocols, or specialist or MDT advice	Consider a DOAC If a DOAC is not suitable, consider one of: • LMWH • LMWH and a VKA for at least 5 days or until INR at least 2.0 on 2 consecutive readings, then a VKA alone Offer anticoagulation for 3 to 6 months Take into account tumour site, drug interactions including cancer drugs, and bleeding risk	Offer LMWH and a VKA for at least 5 days or until INR at least 2.0 on 2 consecutive readings, then a VKA alone