Intervention for Acute Deep Vein Thrombosis (DVT): How to build your practice? A multidisciplinary approach

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1. Honoraria for lectures: yes	BD, Medtronic, Guerbet
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4. Research funding: yes	Balt

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Introduction

- 300,000 to 600,000 DVT patients/year in the US[1]
- What have restricted endovascular referrals over the last decade ?
  - Conservatism
    - Anticoagulants & compression stocking
  - Catheter-directed thrombolysis
    - Long ICU stay
    - High bleeding risk
  - ATTRACT study

1: Venous Thromboembolism A Public Health Concern: Michele G. Beckman, MPH, W. Craig Hooper, PhD, Sara E. Critchley, MS, Thomas L. Ortel, MD, PhD

Strategy for initiating a DVT practice

- Educate your practice
- Identify the referral base
- Outreach and educate the referring physicians
- Keep patients informed
- Patient selection
- Using the right equipment

Educate your practice

- Be familiar with the literature that supports early intervention
- Be prepared to provide clinicians with copies of articles
- Educate your partners in reading DVT US
- Be engaged in DVT clinical studies
- Lessons learned from ATTRACT trial

Identify the referral base

- Potential referring physician specialties
  - Emergency department +++
  - Hospitalists
  - Hematology/Oncology
  - Obstetrics/Gynecology
  - Primary care
- Build an angiology unit (vascular lab) in your IR department +++
  - Own recruitment
  - Good relationships
  - Direct proposal of treatment options

Outreach & educate the referring physicians

- Be resourceful to get the patients
- Talk to the referring physicians
- Develop a lecture to give at grand rounds in your hospital to the specialists
- Show the physicians the new device
- Present any cases you have
- Call up the referring physician after treating a patient to let him know the procedure
- Convince them that their patients will have immediate symptomatic relief and will be less likely to have venous incompetence

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Keep patients informed

- Website +++
  - https://www.radiologie-interventionnelle-chu-dijon.fr

Patient selection

- Selecting patients with proximal symptomatic DVT
  - Best outcomes
- Treating upper-extremity DVT
  - More frequent
- Focus on younger patients
  - Better QoL on the long-term
- Starking with nonacute DVT patients
  - Easier-to-treat patients
- Do not discount the importance of symptom relief
  - Heavy, swollen

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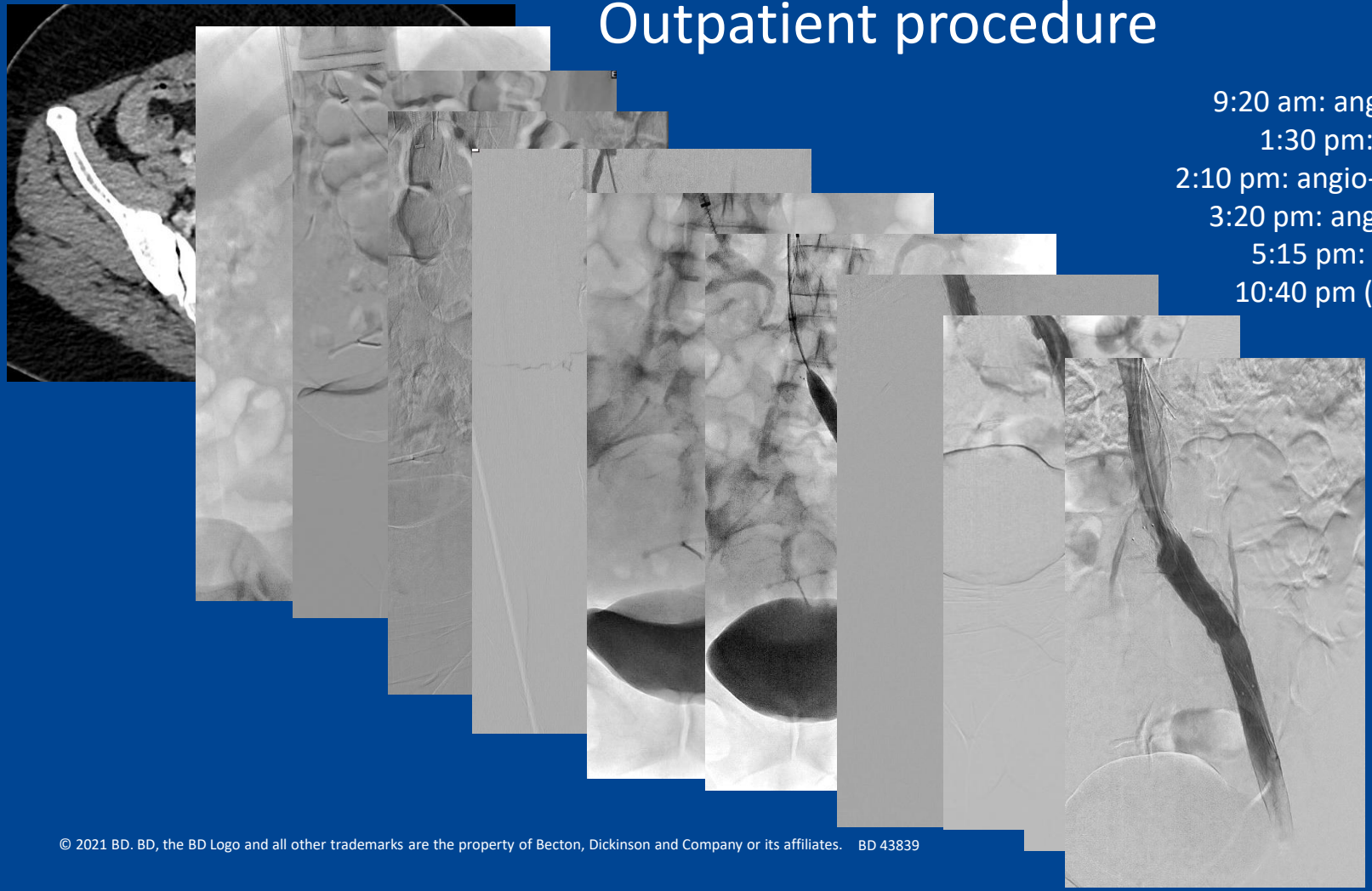
Using the right equipment

- Mechanical thrombectomy device allowing single-setting treatment +++
  - More acceptable to the referring physicians
    - No ICU stay
    - No lytics
  - Patient satisfaction
    - Fast clot debulking & relief of acute symptoms
    - Restoring vein patency & preserving valve function
    - Outpatient procedure
  - Economics are favorable
    - Prevention of PTS (Post Thrombotic Syndrome)

Outpatient procedure



9:20 am: angiologist call
1:30 pm: CT scan
2:10 pm: angio-suite entrance
3:20 pm: angio-suite exit
5:15 pm: go home
10:40 pm (day 1): US

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Conclusions - from my experience:

- Identify your referral base and effectively educate them regarding the benefits of early intervention
- You will provide DVT patients with a greater service in a short period of time
- That will benefit the patient, the referring physician, and the hospital
- It will ensure the continued growth of your DVT practice

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