

Le RÔLE de la COMPRESSION dans la PRÉVENTION du SYNDROME POST-THROMBOTIQUE après THROMBOSE VEINEUSE AIGÛE : REVUE de la LITTÉRATURE

The ROLE of COMPRESSION THERAPY in the PREVENTION of the POSTTHROMBOTIC SYNDROME after ACUTE DVT: an UPDATE

H. PARTSCH, M.D.

RÉSUMÉ

Contexte : La compression dans la prévention et le traitement du syndrome post-thrombotique (SPT) est encore sous-utilisée et sous-estimée.

But : Faire une revue de la littérature concernant l'utilisation de la compression au stade aigu de la thrombose veineuse profonde (TVP) et durant les années suivantes comme un élément majeur du traitement.

Matériel et méthodes : Récapitulation des essais randomisés et contrôlés et des méta-analyses concernant la définition, l'incidence, les facteurs de risques et les méthodes de prévention et de traitement du SPT.

Résultats : Les bas de compression portés durant deux ans après une TVP permettent de réduire l'incidence d'un SPT de 50 %. Une recommandation pratique essentielle est de débiter les mesures anti-stase (compression et exercices de marche) dès que possible, chez les patients mobiles présentant une TVP, même à la phase aiguë. Une anticoagulation appropriée permet de réduire les récurrences de TVP mais ne remplace pas la compression. Chez les patients présentant des signes évidents et les symptômes d'un SPT, la compression représente le geste thérapeutique de base. Cette attitude est largement basée sur l'expérience et sur les données de la littérature.

Conclusion : Dans le contexte de la triade de Virchow, la stase associée à une hypercoagulabilité et à des lésions vasculaires sont des éléments essentiels dans le déclenchement d'une thrombose. En plus d'une anticoagulation adéquate, des mesures anti-stase efficaces associant compression et marche active ne doivent pas être oubliées. Ces procédures peuvent diminuer la douleur et l'œdème à la phase aiguë d'une TVP et réduire le développement d'une TVP.

Mots-clefs : *compression, thrombose veineuse profonde, syndrome post-thrombotique, bas de contention.*

DEFINITION OF PTS

According to the recent definition proposed by an international study group post-thrombotic syndrome (PTS) may be defined by "chronic venous symptoms and/or signs secondary to previous deep vein thrombosis" [1]. The diagnosis of PTS is based on clinical grounds only if patients report a history of documented DVT; otherwise, objective testing is required [2].

SUMMARY

Background: Compression therapy for the prevention and the management of the postthrombotic syndrome (PTS) is still underused and underestimated.

Aim: To review available data from the literature concerning the use of compression in the acute stage of deep vein thrombosis and in the following years as an important part of treatment.

Material and Methods: A review concentrating on published randomized controlled trials and meta-analyses is given on definition, incidence, risk factors and methods for prevention and therapy of the PTS.

Results: Compression stockings worn for two years after deep vein thrombosis (DVT) are able to reduce the incidence of a PTS to about one half. A deciding practical recommendation is to start anti-stasis measures (compression and walking exercises) as early as possible, in mobile DVT patients already in the acute phase. Exact anticoagulation is able to reduce recurrent DVT but can not replace compression. In patients with manifest signs and symptoms of PTS compression is the basic treatment option. Up to now this proposal is mainly based on experience and should be endorsed by evidence based data.

Conclusion: Considering the triade of Virchow stasis together with hyper-coagulation and vessel-damage is one deciding triggering factor for (recurrent) thrombosis. Besides an adequate anti-coagulation effective anti-stasis measures using compression and exercise should not be forgotten. These procedures are able to reduce pain and edema in the acute phase of DVT and to reduce the development of a PTS.

Keywords : compression therapy, deep vein thrombosis, post-thrombotic syndrome, medical compression stockings.

CLINICAL SIGNS AND SYMPTOMS

A very valuable scoring system for assessing the severity of a PTS considering both, subjective symptoms and objective signs has been proposed by Villalta and Prandoni [3]. Table 1 summarizes the deciding criteria.

This scoring system describes the clinical picture in a patient who suffered from a documented DVT and is

1. Professor of Dermatology Baumeistergasse 85 A 1160 VIENNA Austria.

Scores cliniques du SPT (0 = absent, 1 = léger, 2 = modéré, 3 = sévère)	
5 symptômes <ul style="list-style-type: none"> • Douleurs • Crampes • Lourdeurs • Prurit • Paresthésies 	6 signes <ul style="list-style-type: none"> • Œdème • Induration • Pigmentation • Ectasie veineuse • Rougeur • Tension des mollets
Léger = 5-14, sévère ≥ 15	
Villalta S. et al. Haemostasis 1994; 24 (suppl. 1): 158a	

Table 1. – Clinical scores for the evaluation of a PTS.

very useful for studies following the fate of patients after DVT. However, there are a large proportion of patients suffering from PTS in whom episodes of DVT may have stayed unrecognized. Some decades ago most venous ulcers have been attributed to a post-thrombotic syndrome. Based on Duplex investigations in different series of patients with venous leg ulcers we know now that nearly half of them show isolated superficial reflux, the other half present superficial and deep reflux. The proportion of purely deep refluxes is about 10% (Fig. 1) [4]. Among 71 legs with extended deep axial reflux and the clinical manifestation of C3-C6 Gillet et al. identified a primary etiology in 11 (15,5%) and a postthrombotic etiology in 60 limbs (84,5%). In the latter group, all but four patients were aware that they had had a previous deep venous thrombosis [5].

Different studies show that venous reflux namely in the popliteal vein, the lower leg veins and in superficial veins are more important for the development of skin changes and ulceration than proximal venous obstruction which may play a "permissive role" in promoting distal reflux [6].

INCIDENCE

About one third to half of DVT patients will develop PTS, in most cases within 1-2 years of acute DVT. The prevalence of severe post-thrombotic syndrome after

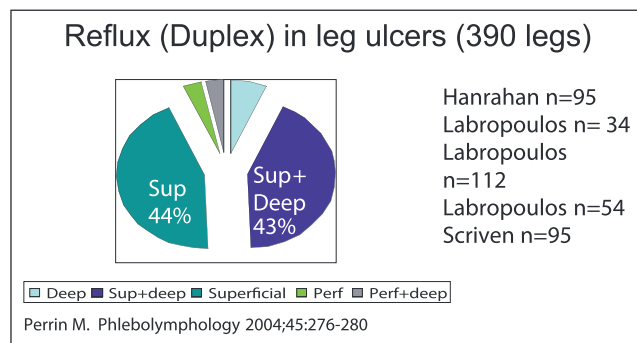


Fig. 1. – Distribution of venous reflux in leg ulcers reported in 5 studies [4].

that time is 4% [7]. In a 12-year follow-up study Franzeck and co-workers found among 58 patients with DVT mild skin changes in 28%, marked trophic changes in 5%, and only one venous ulcer [8].

Asymptomatic DVT seems to be associated with a lower incidence of PTS. Patients who develop postoperative proximal or distal DVT and who receive 6 to 12 weeks of anticoagulant therapy are not predisposed to PTS [9]. However, it was shown that the overall relative risk of developing PTS was 1.58 (95% confidence intervals: 1.24-2.02) in patients suffering from asymptomatic DVT as compared to patients without DVT ($p < 0.0005$) [10].

RISK FACTORS

Important risk factors for PTS are older age, ipsilateral recurrence of DVT, and increased body mass index [11, 12]. Proximal DVT, male gender, and high D-dimer levels are independently associated with the development of PTS in patients with a first DVT. Patients with PTS have an increased risk of recurrent venous thromboembolism [13].

Poor quality of initial anticoagulation for the treatment of DVT as a risk factor for PTS is still under dispute. While intensity and duration of anticoagulation have been shown not to influence the risk of developing a post-thrombotic syndrome [14, 15], van Dongen and co-workers have demonstrated that patients who spend more than 50% of their time beneath an INR level of 2.0 are at higher risk for PTS [odds ratio (OR): 2.71, 95% CI: 1.44-5.10] [16].

Whether the extent and location of the initial thrombosis are associated with the development of PTS is controversial. The lack of vein recanalization within the first 6 months appears to be an important predictor of PTS, whereas the development of transpopliteal venous reflux seems to be of minor importance [12]. These findings are endorsed by the experiences of Meissner showing that early recanalization is important in preserving valve integrity [17]. Immediate mobilization with compression in the acute stage of DVT may prevent thrombus growth and promote recanalization [18, 19, 20].

A multiple regression analysis based on follow-up investigations by Duplex and plethysmography found that the most important risk factor for early clinical signs of PTS was superficial reflux in months 3, 6, and 12 [21].

PREVENTION

Two randomized controlled trials have clearly shown that the long term use of compression stockings after an acute deep vein thrombosis (DVT) is able to reduce the incidence of PTS to about one half (Table II). While custom-made garments were used in the study from Brandjes and co-workers [22], similar beneficial results could be obtained by Prandoni et

Auteur	N	Années après TVP	SPT total	SPT sévère	ulcère
Brandjes 97 chaussettes	96	6	20%	11%	1%
Pas de chaussettes	98	6	47%	23%	3%
Prandoni 04 Chaussettes*	90	2-5	25,6%	3,3%	
Pas de chaussettes	90	2-5	48,9%	11,1%	

* Chaussettes sous le genou.
Compression initiée à 1-2 semaines après TVP.

Table II. – Incidence of PTS after proximal DVT reported by two randomized controlled trials [22, 23].

al using ready-made stockings [23]. The indicated pressure range for the knee length stockings used in both trials was 30-40 mm Hg. No serious adverse effects were mentioned in both studies.

Recent systematic reviews and meta-analyses have endorsed the routine use of compression stockings during the following years after DVT [24, 25]. The review from Kakkos and co-workers has clearly shown that wearing compression stockings is able to reduce the incidence of PTS but not of new episodes of recurrent DVT [24].

Following these evidence medicine based facts it would be unethical to withhold medical compression stockings to patients after DVT. Prandoni et al recommend that stockings must be applied quickly after the thrombotic episode since venous hypertension and valve damage occur soon [23]. In fact compression

was started only before hospital discharge, in average one week after the acute event. It may be hypothesized that immediate compression and walking could even further improve the positive outcome.

Starting compression in the acute stage of DVT

The timing of compression and walking in the acute stage of DVT seems to have a considerable impact on the development of a PTS. In a questionnaire sent to 38 Canadian thrombosis physicians who had prescribed elastic compression stockings in their practices 26% recommended compression as soon as DVT was diagnosed, 3% 1-2 days after DVT treatment was initiated, 26% within the month after DVT was diagnosed, 3% three months after DVT, 24% when acute symptoms of DVT improved or resolved and 18% when symptoms developed or became chronic [26]. With the kind allowance of the Canadian authors we have sent out the same questionnaire to a group of international phlebologists in different countries using a fax-service edited by the Sigvaris-company (Compression Bulletin). One of the interesting results of this review is presented in Fig. 2.

As can be seen the majority of the colleagues who corresponded to our questionnaire usually recommend compression stockings already in the acute stage of DVT. In Austria showing some slight aberration from the international trend compression bandages are mostly used in the acute phase of DVT replaced by compression garment only later [27]. Even considering that the selection criteria of the interviewed doctors in our review were certainly biased, the difference compared with the Canadian routine is remarkable.

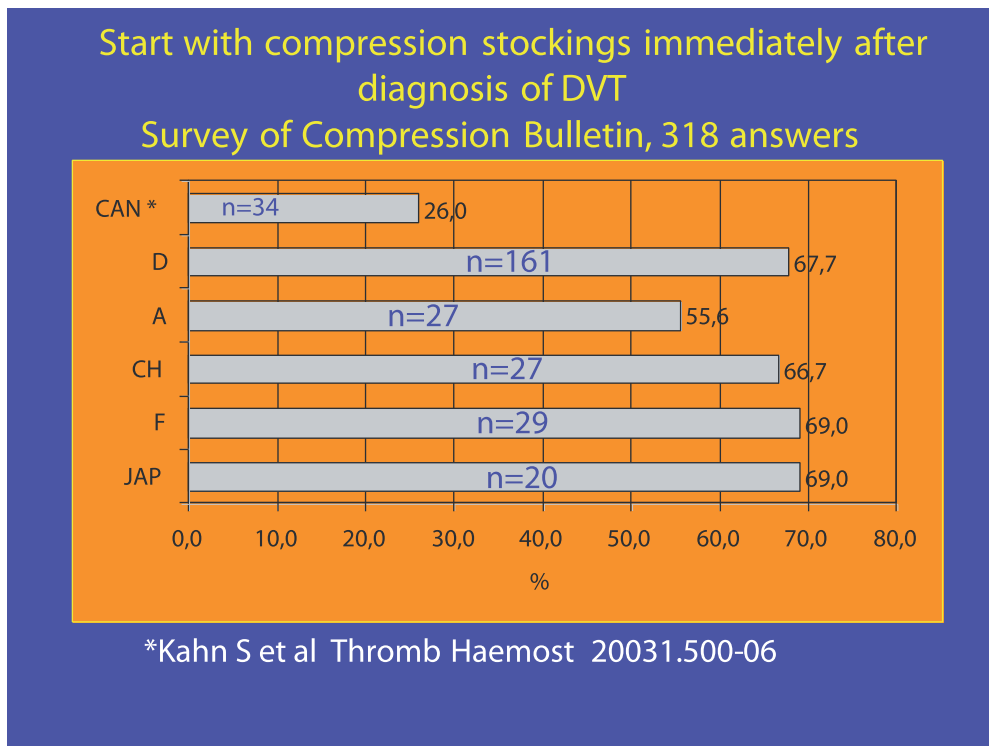


Fig. 2. – The columns represent the percentage of colleagues who declared to start with compression stockings in the acute phase of DVT. (318 answers returned).

longer than one year the calf circumference was even smaller compared to the contra lateral leg (*Fig. 5*). In contrast all patients treated initially by bed-rest had considerable leg swelling, also if they had continued to wear the stockings for longer than one year.

THERAPY OF PTS

To abate the prevalence of PTS, the best policy is to prevent recurrent thrombosis and to use stockings.

It is an amazing fact that only very few evidence based medicine data are available concerning the treatment of a manifest postthrombotic syndrome. Kolbach et al have shown in a Cochrane review that there are only two trials, both from the same group of investigators that addressed physical treatment of post-thrombotic syndrome. One crossover study lasting two months compared low and high pressure with intermittent compression units for severe post-thrombotic syndrome showing a beneficial effect of higher pressures. The second study, in patients with mild to moderate post-thrombotic symptoms, showed no effect of elastic compression stockings (30-40 mm Hg at the ankle region) when compared to so-called 'placebo' stockings that actually were one to two sizes too large. [31]. The conclusion of the authors that "the use of elastic compression stockings to treat post-thrombotic syndrome cannot be supported on the basis of the currently available data" clearly demonstrates that future research will be needed to endorse the usual everyday practice to prescribe compression stockings in such instances. The example of *Fig. 6* nicely illustrates that a lot of educational work has still to be done in order to convince our colleagues about the effectiveness of good compression in PTS.

Walking exercises seem to be beneficial in combination with compression stockings. A 6-month exercise-



Photo. – Postthrombotic syndrome of the right leg.

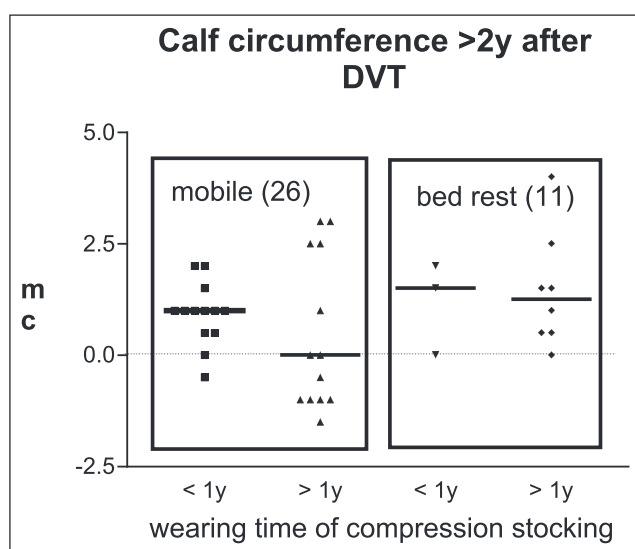


Fig. 5. – Differences of the largest calf-diameter between the thrombosed and the contralateral leg more than 2 years after DVT. Wearing the compression stockings more than 1 year leads to less swelling in the group which was kept mobile in the acute phase of DVT.

training program improved calf muscle strength and pump function, and high levels of physical activity at one month tended to be associated with reduced severity of postthrombotic symptoms during the subsequent 3 months [32].

Despite several surgical options, conservative treatment is preferable because half of the patients improve or remain stable during follow-up, provided they wear elastic stockings [2]. Based on the findings that patients with superficial reflux have an increased risk of development of the first clinical signs of PTS as early as after the third month [21] abolishment of reflux could theoretically be considered. Practically the main concern in the first 3 months after DVT will concentrate on the anticoagulation treatment, not to forget well-fitted compression stockings and walking exercises. However, the point of superficial reflux correction in order to prevent severe PTS could be taken as one of the positive arguments for active treatment before (recurrent) DVT or after the cessation of anticoagulation.

A relatively new field for abolishment of superficial reflux by surgery, sclerotherapy or endovenous procedures was opened by reports demonstrating accelerated healing of venous leg ulcers, even in the presence of deep reflux due to a PTS [33-35]. A reduction of ulcer-recurrence by such interventions has been clearly demonstrated [36].

PTS surgery for deep reflux has a relatively high failure rate, especially in patients with PTS, and should only be performed in highly specialized and well-trained centers. When significant obstruction above the inguinal ligament is associated with reflux; most authors agree that obstruction should be treated first. Secondary deep venous reflux, mainly post-thrombotic syndrome may be treated only after failure of conservative treatment [37].

Adjunctive prescription of so-called venotropic drugs may be of value especially in patients with subjective symptoms [38].

REFERENCES

1. Perrin M., Eklöf B., et al. Venous Terminology. An International Initiative for a Venous Glossary. In preparation.
2. Bernardi E., Bagatella P., Frulla M., Simioni P., Prandoni P. Postthrombotic syndrome: incidence, prevention, and management. *Semin Vasc Med* 2001; 1(1): 71-80.
3. Villalta S., Bagatella P., Piccioli A., Lensing A.W., Prins M.H., Prandoni P. Assesment of validity and reproducibility of a clinical scale for the post-thrombotic syndrome. *Haemostasis* 1994; 24: 158a.
4. Perrin M. Rationale for surgery in the treatment of venous ulcer of the leg. *Phlebolympology* 2004; 45: 276-80.
5. Gillet J.L., Perrin M.R., Allaert F.A. Clinical presentation and venous severity scoring of patients with extended deep axial venous reflux. *J Vasc Surg* 2006; 44: 588-94.
6. Neglén P., Hollis K.C., Olivier J., Raju S. Stenting of the venous outflow in chronic venous disease: long-term stent-related outcome, clinical, and hemodynamic result. *J Vasc Surg* 2007; 46: 979-90.
7. Kahn S.R., Ginsberg J.S. Relationship between deep venous thrombosis and the postthrombotic syndrome. *Arch Intern Med* 2004; 164: 17-26.
8. Franzeck U.K., Schalch I., Jäger K.A., Schneider E., Grimm J., Bollinger A. Prospective 12-year follow-up study of clinical and hemodynamic sequelae after deep vein thrombosis in low-risk patients (Zürich study). *Circulation* 1996; 93: 74-9.
9. Ginsberg J.S., Hirsh J., Julian J., Vander LaandeVries M., Magier D., MacKinnon B., Gent M. Prevention and treatment of postphlebotic syndrome: results of a 3-part study. *Arch Intern Med* 2001; 161: 2105-9.
10. Wille-Jørgensen P., Jørgensen L.N., Crawford M. Asymptomatic postoperative deep vein thrombosis and the development of postthrombotic syndrome. A systematic review and meta-analysis. *Thromb Haemost.* 2005; 93: 236-41.
11. Kahn S.R. Frequency and determinants of the postthrombotic syndrome after venous thromboembolism. *Curr Opin Pulm Med* 2006; 12: 299-303.
12. Pesavento R., Bernardi E., Concolato A., Dalla Valle F., Pagnan A., Prandoni P. Postthrombotic syndrome. *Semin Thromb Hemost* 2006; 32: 744-51.
13. Stain M., Schönauer V., Minar E., Bialonczyk C., Hirschl M., Weltermann A., Kyrle P.A., Eichinger S. The post-thrombotic syndrome: risk factors and impact on the course of thrombotic disease. *Thromb Haemost* 2005; 3: 2671-6.
14. Kahn S.R., Kearon C., Julian J.A., Mackinnon B., Kovacs M.J., Wells P., Crowther M.A., Anderson D.R., Van Nguyen P., Demers C., Solymoss S., Kassis J., Geerts W., Rodger M., Hambleton J., Ginsberg J.S. Extended Low-intensity Anticoagulation for Thrombo-embolism (ELATE) Investigators Predictors of the post-thrombotic syndrome during long-term treatment of proximal deep vein thrombosis. *J Thromb Haemost* 2005; 3: 718-23.
15. Schulman S., Lindmarker P., Holmström M., Lärfares G., Carlsson A., Nicol P., Svensson E., Ljungberg B., Viering S., Nordlander S., Leijd B., Jahed K., Hjorth M., Linder O., Beckman M. Post-thrombotic syndrome, recurrence, and death 10 years after the first episode of venous thromboembolism treated with warfarin for 6 weeks or 6 months. *J Thromb Haemost* 2006; 4: 734-42.
16. van Dongen C.J., Prandoni P., Frulla M., Marchiori A., Prins M.H., Hutten B.A. Relation between quality of anticoagulant treatment and the development of the postthrombotic syndrome. *J Thromb Haemost* 2005; 3: 939-42.
17. Meissner M.H., Manzo R.A., Bergelin R.O., Markel A., Strandness D.E. Jr. Deep venous insufficiency: the relationship between lysis and subsequent reflux. *J Vasc Surg* 1993; 18: 96-605
18. Partsch H., Blättler W. Compression and walking versus bed rest in the treatment of proximal deep venous thrombosis with low molecular weight heparin. *J Vasc Surg* 2000; 32: 861-9.
19. Blättler W., Partsch H. Leg compression and ambulation is better than bed rest for treatment of acute deep venous thrombosis. *Int Angiol* 2003; 22: 393-400.
20. Arpaia G., Cimminiello C., Mastrogiacomo O., de Gaudenzi E. Efficacy of elastic compression stockings used early or after resolution of the edema on recanalization after deep venous thrombosis: the COM.PRE Trial. *Blood Coagul Fibrinolysis* 2007; 18: 131-7.
21. Haenen J.H., Janssen M.C., Wollersheim H., Van't Hof M.A., de Rooij M.J., van Langen H., Skotnicki S.H., Thien T. The development of postthrombotic syndrome in relationship to venous reflux and calf muscle pump dysfunction at 2 years after the onset of deep venous thrombosis. *J Vasc Surg* 2002; 35: 1297-8.
22. Brandjes D.P.M., Büller H., Hejboer H., Huisman M.V., de Rijk M., Jagt H., ten Cate J.W. Incidence of the postthrombotic syndrome and the effects of compression stockings in patients with proximal venous thrombosis. *Lancet* 1997; 349: 759-62.
23. Prandoni P., Lensing A.W.A., Prins M.H., Frulla M., Marchiori A., Bernardi E., Tormene D., Mosena L., Pagnan A., Girolami A. Below-knee elastic compression stockings to prevent the post-thrombotic syndrome. *Ann Intern Med* 2004; 141: 249-56.
24. Kakkos S.K., Daskalopoulos S.S., Daskalopoulos M.E., Nicolaides A.N., Geroulakos G. Review on the value of graduated elastic compression stockings after deep vein thrombosis. *Thromb Haemost* 2006; 96: 441-5.
25. Giannoukas A.D., Labropoulos N., Michaels A. Compression with or without early ambulation in the prevention of postthrombotic syndrome: A systematic review. *Eur J Vasc Endovasc Surg* 2006; 32: 217-21.
26. Kahn S.R., Elman E., Rodger M.A., Wells P.S. Use of elastic compression stockings after deep venous thrombosis: a comparison of practices and perceptions of thrombosis physicians and patients. *Journal of Thrombosis and Haemostasis* 2003; 1: 500-06.
27. Partsch B., Pannier F., Rabe E., Partsch H. Use of Compression Stockings after Deep Vein Thrombosis. An International Survey. *Vasomed* 2005; 17: 82-7.

28. Schulman S. Studies on the medical treatment of deep vein thrombosis. *Acta Med Scand* 1988; suppl 704.
29. Büller H.R., Agnelli G., Hull R.D., Hyers Th M., Prins M.H., Raskob G.E. Antithrombotic Therapy for Venous Thromboembolic Disease Chest 2004; 126, (suppl) 401S-428 S.
30. Partsch H., Kaulich M., Mayer W. Immediate mobilisation in acute vein thrombosis reduces post-thrombotic syndrome. *Int Angiol* 2004; 23: 206-12.
31. Kolbach D.N., Sandbrink M.W.C., Neumann H.A.M., Prins M.H. Compression therapy for treating stage I and II (Widmer) post-thrombotic syndrome (Cochrane Review). In: The Cochrane Library, Issue 3, 2004.
32. Kahn S.R., Shrier I., Kearon C. Physical activity in patients with deep venous thrombosis: A systematic review. *Thromb Res.* 2007 Dec 11 [Epub ahead of print].
33. Danielsson G., Arfvidsson B., Eklof B., Kistner R.L., Masuda E.M., Satoc D.T. Reflux from thigh to calf, the major pathology in chronic venous ulcer disease: surgery indicated in the majority of patients. *Vasc Endovascular Surg* 2004; 38: 209-19.
34. Obermayer A., Göstl K., Walli G., Benesch T. Chronic venous leg ulcers benefit from surgery: long-term results from 173 legs. *J Vasc Surg* 2006; 44: 572-9.
35. Cabrera J., Redondo P., Becerra A., Garrido C., Cabrera J. Jr, García-Olmedo M.A., Sierra A., Lloret P., Martínez-González M.A. Ultrasound-guided injection of polidocanol microfoam in the management of venous leg ulcers. *Arch Dermatol.* 2004; 140: 667-73.
36. Barwell J.R., Davies C.E., Deacon J., Harvey K., Minor J., Sassano A., et al. Comparison of surgery and compression with compression alone in chronic venous ulceration (ESCHAR study): randomised controlled trial. *Lancet* 2004; 363(9424): 1854-9.
37. Perrin M. Surgery for deep venous reflux in the lower limb. *J Mal Vasc* 2004; 29: 73-87.
38. Coleridge-Smith P., Lok C., Ramelet A.A. Venous leg ulcer: a meta-analysis of adjunctive therapy with micronized purified flavonoid fraction. *Eur J Vasc Endovasc Surg* 2005; 30: 198-208.