mainly on factors to do with infrastructure rather than medical reasons. In our study, only 3% of patients were admitted for medical reasons, and in 9% admission was because medication and international normalised ratio could not be monitored. Even these patients could have been treated as outpatients if adequate professional care had been available at home. No serious complications were noted in patients treated in an outpatient setting. Another 9% of our patients presented in the emergency room and were already being treated for deep vein thrombosis suspected on clinical grounds alone. They were admitted until ultrasound examination could be performed.

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Contributors: TS and SMS had the original idea for the study, recruited a large number of patients, created the trial database, analysed the data, and wrote the paper. BS conducted statistical analysis and recruited patients. UH advised on data collection and analysed the data. JB recruited patients for the study. HES revised the final version of the manuscript and is the guarantor of the paper. All authors approved the final version of the paper.

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How many patients are candidates for home treatment of DVT?

EDITOR—Schwarz et al demonstrate the feasibility of home treatment (HT) for most patients with acute deep vein thrombosis (DVT). These data, along with those reported previously,[1] mainly regard patients investigated at vascular units where uncomplicated DVT is usually seen. This population may be different from that evaluated in the emergency department (ED), where most of the patients clinically suspected of having acute venous thromboembolism (VTE) are firstly investigated.[2] In this respect, the ED can be an appropriate setting not only for detecting acute DVT but also for fully investigating and identifying patients who may be suitable for HT.

In the past 23 months, we applied a HT program for acute VTE in 121 consecutive patients with objectively confirmed acute VTE: 84 with DVT (69.4%) and 37 with pulmonary embolism (PE) (30.5%).[3] During a short hospitalization (mean 2 hours, SD 1 hour) in the ED, patients were screened as potentially eligible for HT (absence of concomitant disorders) or for standard in-hospital care.[4] Low-risk patients (n=46, 38%) and those at high risk who refused hospitalization (n=15, 12%) were treated at home (enoxaparine 100 IU antiFXa/Kg/12h plus warfarin according to the international normalized ratio (INR)); the remaining high-risk patients (n=68, 56.1%) received standard in-hospital care. In a table published on the Internet (http://bmj.com/cgi/eletters/322/7296/1212), we report the results concerning the initial period of anticoagulation (heparin plus warfarin) (mean 10 days, SD 3 days) between the two groups of patients. There was no difference between hospitalized and HT patients in terms of major outcomes. This lack of difference is even more evident if one takes into account that a subgroup of high-risk patients was treated at home. At three months follow-up, two patients in standard in-hospital care died for causes other than VTE, and one HT patient developed a non-fatal intra-cranial hemorrhage (his INR was in the therapeutic range).

Although we also considered for HT patients with symptomatic, hemodynamically stable PE and massive DVT, the proportion of patients treated at home was lower (50.4%, 95% confidence interval (CI) 41.5-58.3) than that reported by Schwarz et al (78.6%, 95% CI 70.1-85.7). As reported above, our data are derived from a population with a rate of concomitant medical disorders (62.8%, 95% CI 54.2-71.4) higher than that seen in the study by Schwarz et al (2.6%, 95% CI 0.9-7.1); such patients are representative of the population usually referred to an ED.

Our preliminary results suggest that a careful HT program for high-risk patients performed in an appropriate setting is as feasible and safe as standard in-hospital management or HT for uncomplicated DVT. In addition, these data show that the proportion of patients potentially eligible for HT varies according to the clinical setting where they are first evaluated.

Sergio Siragusa *hematologist*
Francesco Falaschi
Paola Tatoni

Servizio Pronto Soccorso Accettazione
Emergency Department IRCCS Policlinico
San Matteo, Pavia, Italy
sergiosiragusa@yahoo.com

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