Comment on “Do hospital doctors test for thrombophilia in patients with venous thromboembolism?”

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Dear Editor,

I read with great interest the recent article by Samim et al. dealing with the limited and inefficient predictive value of factor V Leiden and the G20210A prothrombin mutation regarding the recurrent venous thromboembolism (VTE) for the subsequent patient management [1]. The authors have clearly and diligently performed their study; on this basis, I agree with the authors and aimed to add some points.

Connors indicated in her recent review that ordering thrombophilia tests is easy, determining whom to test and how to use the results is not. Although inherited and acquired thrombophilias are acknowledged to increase the risk of VTE, the majority of patients with VTE should not be tested for thrombophilia, and similarly some investigators arguing that these tests should never be performed, and data also showing that the results do not affect clinical decisions about the treatment of VTE. Because most guidelines advocate for long term anticoagulation for patients with unprovoked VTE [2–6]. Importantly, data show no significant differences in rates of recurrent VTE between patients with and those without thrombophilia or between patients who undergo testing for inherited thrombophilia and those who do not. On the other hand, the significance of either positive or negative test results is often misinterpreted in clinical practice. Patients with positive results are frequently overtreated and kept on anticoagulant therapy indefinitely, even those with a provoked VTE and a low risk of recurrence, because of the perception that such patients have a significantly increased risk of recurrence [2, 7, 8].

As a supportive data shown by Samim et al. in their study that the thrombophilia status including FV Leiden and/or

prothrombin G20210A mutation did not impact to the initial management of VTE [1]. We hope that the above-mentioned items might add to the value of the article by Samim et al.

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