SEPTIC PELVIC THROMBOPHLEBITIS CLINICAL GUIDELINES

Evaluation:

Candidates for evaluation:
- Postpartum patients who remain febrile >38.3 degrees centigrade despite ≥5 days of broad spectrum antibiotic therapy for pelvic infection
- Other etiologies for persistent fever are unlikely (e.g. appendicitis, nephrolithiasis, hematoma, pyelonephritis, pelvic abscess, sepsis)
- Typical presentation
  1. high, spiking fevers
  2. non-toxic appearance
  3. often complain of noncolicky, constant flank and lower abdominal pain, there may be tenderness to palpation in the lower abdomen

Imagining:

- Perform abdominopelvic CT or MRI (both acceptable) to rule out other etiologies for persistent fever and possibly to make diagnosis
- Lack of confirmation of pelvic thrombophlebitis by CT or MRI does not exclude the diagnosis

Management:

An evidence-based treatment protocol for patients with septic pelvic thrombophlebitis is not available at the present time, nor any randomized control trials comparing LMWH and unfractionated heparin. These recommendations are made based on interpretation of the available literature,1,2 expert recommendations,3,4 and consensus of the division of Maternal-Fetal Medicine.

1. SPT diagnosed by clinical suspicion, but no evidence of pelvic vessel thrombosis by CT or MRI, OR small pelvic vessel thrombosis noted by Ct or MRI
   → Unfractionated heparin added to broad spectrum antibiotic regimen
   1. Bolus of 5000 U IV followed by 1000 U/hr
   2. Monitor PTT while on heparin with goal of 1.5 to 2.0 times the baseline
   3. Continue heparin and antibiotics until afebrile 48 hrs
   OR:
   1. Low dose molecular weight heparin added to antibiotic regimen
      1. I.e. Enoxaparin 1 mg/kg SQ bid
      2. Continue LMWH and antibiotics until afebrile 48 hrs.
   ALTERNATIVE:
   2. Antibiotics may be given without anticoagulation until afebrile for 48 hrs.1

2. Ovarian vein thrombus detected:
   a. Administration of antibiotics and heparin as above until afebrile for 48 hours.

3. Ovarian vein thrombus detected with extension into renal veins or inferior vena cava:
   a. Administration of antibiotics and heparin as above until afebrile for 48 hours
   b. Oral anticoagulation may be started once heparin is therapeutic and may be continued for up to 3 months in the outpatient setting

*If fevers persist despite ≥2 weeks of therapy with broad spectrum antibiotics and anticoagulation, the alternative etiology of drug fever should be taken into consideration.
References