

that has been in use for several years in our institution for patients with PVT.

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Response:

Anticoagulation in splanchnic vein thrombosis

In response to Spahr et al,^{1,2} we would like to point out that the “How I treat” *Blood* articles are meant to feature therapeutic aspects for which evidence from randomized trials is lacking. These articles are based on opinions of experts who have a large clinical experience in the specific fields.³⁻⁵ With this as preamble, we believe that the main disagreement between Spahr et al¹ and us² is on whether or not indefinite anticoagulation should be always prescribed to patients with previous splanchnic vein thrombosis (SVT), because there is no disagreement—although data stem from studies with various limits—on the indication for anticoagulants in the acute phase of SVT.⁶⁻⁸ In the acute phase, anticoagulants are meant to avoid the extension of thrombosis and thereby decrease the risk of portal hypertension and its related complications, mainly gastrointestinal bleeding from ruptured esophagogastric varices.

What about the use of these drugs beyond the acute phase, particularly when portal hypertension has developed despite anticoagulation? In this instance the risk of thrombosis recurrence must be carefully weighted against the risk of bleeding. Thrombosis recurrence, the prevention of which is the true goal of anticoagulation, is not frequent in SVT,² being the main reason for our “shyness” to recommend this therapy in these patients at high risk of bleeding. Barring a slightly higher cutoff in platelet count, the difference between our algorithm² and that promoted by Spahr et al¹ is that we do envisage the possibility that beta blockers and endoscopic therapies fail to prevent variceal bleeding. Because the latter is life-threatening, we find it important to avoid the additional risk that anticoagulants entail. Thrombocytopenia, so frequent in these patients, is a strong risk factor for bleeding, superimposed on that carried by anticoagulants themselves.

In conclusion, we are reluctant to recommend indefinite anticoagulation in the majority of patients with SVT. But of course, as in

all clinical conditions where therapeutic evidence is lacking, each SVT case must be considered in itself, with an accurate balance of the pros for anticoagulation (thrombophilia abnormalities and inflammatory conditions) against the cons (severe thrombocytopenia and large gastroesophageal varices).

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To the editor:

Scientific profiling

We regret to read that the editors at *Blood* would outright reject a review manuscript, regardless of its scientific merit, if someone employed by a pharmaceutical company had any role in the

development of that manuscript.¹ This stance implies that all scientists employed by a pharmaceutical company do not have the ability to be unbiased while writing or contributing to a manuscript.