Form 1

Record ID	_____
What is your specialty?	◯ Surgeon ◯ Gastroenterologist ◯ Radiologist ◯ Other
What is your specialty?	_____
In what kind of institution do you work?	◯ Academic hospital ◯ Non-academic, teaching hospital ◯ Non-academic, non-teaching hospital
How many years of experience do you have in treating patients with acute pancreatitis?	◯ 0-5 years ◯ 5-10 years ◯ 10-15 years ◯ 15-20 years ◯ >20 years
Do you prescribe therapeutic anticoagulation in case of detected thrombosis in one (or more) of the splanchnic veins in patients with acute pancreatitis?	◯ Always ◯ Usually ◯ Sometimes ◯ Never
Do you prescribe therapeutic anticoagulation in case of detected compression of one (or more) of the splanchnic veins in patients with acute pancreatitis?	◯ Always ◯ Usually ◯ Sometimes ◯ Never
What would be your main reason(s) to start therapeutic anticoagulation? (check all that apply)	☐ To achieve vessel recanalization ☐ To avoid complications (i.e. portal hypertension, bowel ischemia, hepatic failure) ☐ To prevent formation of altered venous anatomy (i.e. cavernoma/collaterals/varices) ☐ To prevent recurrence of splanchnic vein thrombosis ☐ To prevent other venous thromboembolism ☐ Other reason
What are other reasons to start therapeutic anticoagulation?	_____
In my decision on anticoagulant therapy for splanchnic vein thrombosis, I consider ..... of the thrombosis as an important factor (check all that apply):	☐ Age ☐ Anatomical location ☐ Extent ☐ Progression ☐ Other factor
What are other important factors in your decision on anticoagulant therapy?	_____
When do you prescribe therapeutic anticoagulation? In case of...:	◯ (Sub)acute thrombosis ◯ Chronic thrombosis ◯ Both

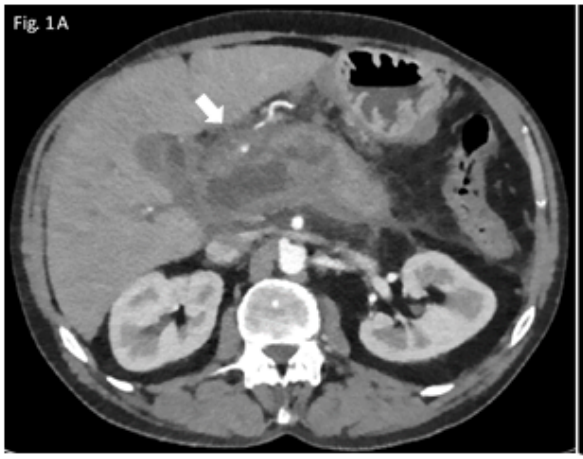
Rank the anatomical location of the thrombosis from most likely to less likely to start anticoagulant therapy	◯ Portal vein - splenic vein - superior mesenteric vein ◯ Portal vein - superior mesenteric vein - splenic vein ◯ Splenic vein - portal vein - superior mesenteric vein ◯ Splenic vein - superior mesenteric vein - portal vein ◯ Superior mesenteric vein - portal vein - splenic vein ◯ Superior mesenteric vein - splenic vein - portal vein
When do you prescribe therapeutic anticoagulation? In case of...:	◯ Total thrombotic occlusion ◯ Partial thrombosis ◯ Both
Does the involvement of multiple vessels influence your decision regarding anticoagulant therapy?	◯ Yes ◯ No
In my decision on anticoagulant therapy for splanchnic vein thrombosis, I consider the risk of ..... as a major barrier (check all that apply):	☐ Bleeding in general ☐ Bleeding related to portal hypertension ☐ Bleeding related to pseudoaneurysm ☐ Other risk
What would be an other barrier to prescribe therapeutic anticoagulation?	_____
Does the need for invasive interventions for local complications of acute pancreatitis influence your decision regarding anticoagulant therapy for splanchnic vein thrombosis?	◯ Yes ◯ No
Which initial type of therapeutic anticoagulation do you prefer?	◯ (Low molecular weight) heparin s.c. ◯ Unfractionated heparin i.v. ◯ Direct oral anticoagulation (DOAC) ◯ Vitamin K antagonist ◯ Platelet aggregation inhibitor ◯ Urokinase / recombinant tissue plasminogen activator
And which follow-up type of therapeutic anticoagulation do you prefer?	◯ (Low molecular weight) heparin s.c. ◯ Unfractionated heparin i.v. ◯ Direct oral anticoagulation (DOAC) ◯ Vitamin K antagonist ◯ Platelet aggregation inhibitor ◯ Urokinase / recombinant tissue plasminogen activator
After how long do you usually stop the therapeutic anticoagulation?	◯ In case of achieved radiological recanalization ◯ 3 months ◯ 6 months ◯ 12 months ◯ Never
Do you generally follow-up splanchnic vein thrombosis after index admission?	◯ Yes, clinically only ◯ Yes, with imaging ◯ No

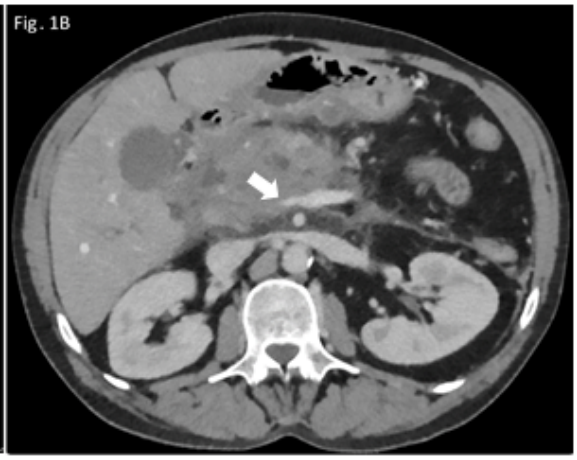
Do you screen for an underlying prothrombotic disorder in patients diagnosed with splanchnic vein thrombosis?	◯ Always ◯ Usually ◯ Only in patients with a history of one (or more) thrombotic events ◯ Never
Is, in your opinion, splanchnic vein thrombosis associated with worse clinical outcomes (e.g. mortality, organ failure, bleeding and other complications) in patients with acute pancreatitis?	◯ Yes ◯ No
17. Do you think that therapeutic anticoagulation for splanchnic vein thrombosis improves clinical outcomes in patients with acute pancreatitis?	◯ Yes ◯ No
Please explain	_____

Patient A

The patient is a 50 year old, previously healthy man, presented to the emergency department with acute alcoholic pancreatitis

- 5 days after onset of abdominal pain
- Contrast-enhanced CT (CECT) shows necrotizing pancreatitis with acute necrotic collection in the head of the pancreas (figure 1A) and luminal narrowing of the portal vein without the presence of collateral circulation (figure 1B)

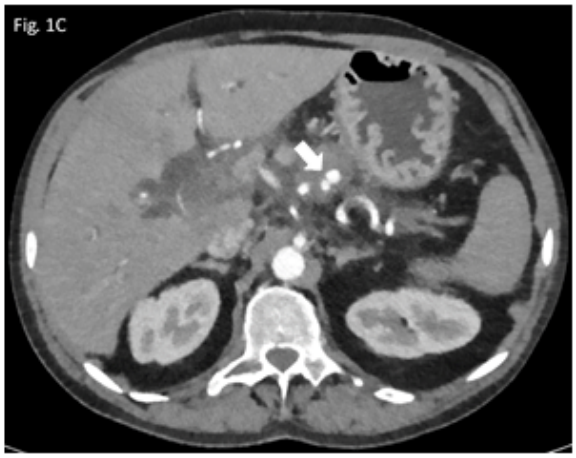




Would you treat this patient with anticoagulation?	◯ Yes, with therapeutic dose anticoagulation ◯ Only with prophylactic dose anticoagulation ◯ No
Would your treatment strategy be different when an actual filling defect is visualized in the portal vein?	◯ Yes ◯ No
Please explain	_____

Patient A

An experienced radiologist reassessed the CECT and found a luminal filling defect in the portal vein. The radiologist also detected a pseudoaneurysm in the proximal splenic artery (figure 1C).

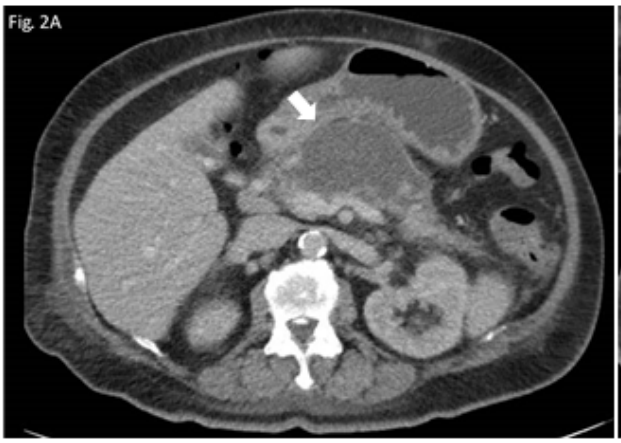


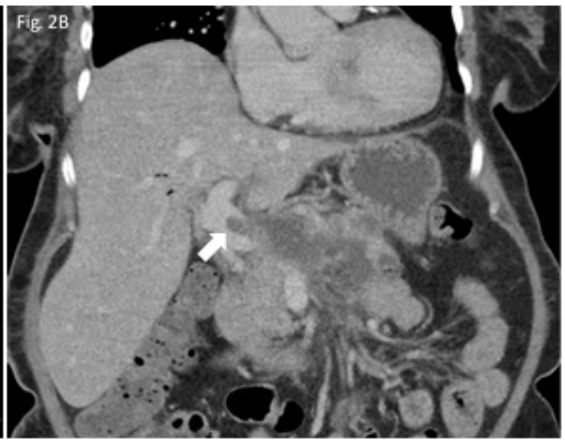
Would you treat this patient with anticoagulation?

- ◯ Yes, with therapeutic dose anticoagulation
- ◯ Only with prophylactic dose anticoagulation
- ◯ No

Patient B

The patient is a 50 year old, previously healthy man, admitted to the ward with acute necrotizing pancreatitis
- 14 days after onset of acute pancreatitis
- Clinical deterioration with fever and rising inflammatory parameters
- CECT (compared to a CECT from 10 days ago) shows almost fully encapsulated pancreatic necrosis without gas configurations (figure 2A) and a new luminal filling defect in the portal vein without the presence of collateral circulation (figure 2B)
- The diagnosis of suspected infected pancreatic necrosis (as no other infection focus is found) and portal vein thrombosis are made
- You decide to treat with broad spectrum antibiotics and postpone drainage





Would you treat this patient with anticoagulation?

- ◯ Yes, with therapeutic dose anticoagulation
- ◯ Only with prophylactic dose anticoagulation
- ◯ No

Does the presence of (suspected) infected pancreatic necrosis influence your choice of anticoagulant agent?

- ◯ Yes
- ◯ No

Please explain

_____

Patient C

The patient is a 50 year old, homeless man, now presenting to the emergency department with acute alcoholic pancreatitis
- 30 days after onset of vague abdominal pain
- CECT shows necrotizing pancreatitis, a luminal filling defect in the portal vein and formation of hilar collaterals. There are no prior CECTs available.
- The diagnosis of portal vein thrombosis is made

Would you treat this patient with anticoagulation?

- ◯ Yes, with therapeutic dose anticoagulation
- ◯ Only with prophylactic dose anticoagulation
- ◯ No

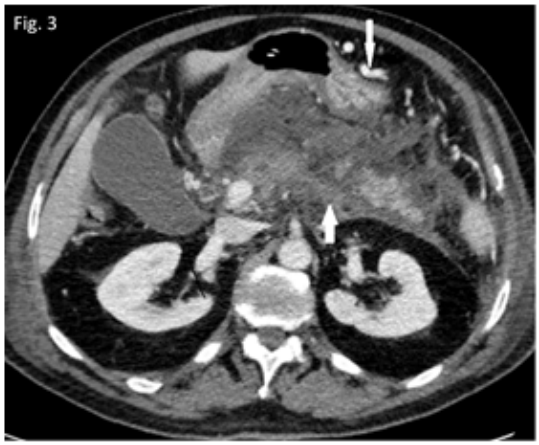
Patient C

Would you perform upper endoscopy to screen for and eventually treat esophageal varices before starting anticoagulant therapy?

- ◯ Yes
- ◯ No

Patient C

Repeat CECT was done after 5 days (figure 3) and shows extension of the thrombus to the splenic vein (arrow pointing upwards) and expansion of the collateral pathway in the gastroepiploic veins along the great curvature of the stomach (arrow pointing downwards).



How would you treat this patient?

- ◯ Stay conservative (no therapeutic dose of anticoagulation)
- ◯ Start therapeutic dose of anticoagulation
- ◯ Continue therapeutic dose of anticoagulation
- ◯ Proceed to intervention

Please explain which intervention

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