Sulodexide for the Prevention of Recurrent Venous Thromboembolism

The Sulodexide in Secondary Prevention of Recurrent Deep Vein Thrombosis (SURVET) Study: A Multicenter, Randomized, Double-Blind, Placebo-Controlled Trial

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Background—Patients with a first episode of unprovoked venous thromboembolism have a high risk of recurrence after discontinuation of anticoagulant therapy. Extending anticoagulation reduces the risk of recurrence but is associated with increased bleeding. Sulodexide, a glycosaminoglycan, exerts antithrombotic and profibrinolytic actions with a low bleeding risk when administered orally, but its benefit for preventing recurrent venous thromboembolism is not well known.

Methods and Results—In this multicenter, double-blind study, 615 patients with first-ever unprovoked venous thromboembolism who had completed 3 to 12 months of oral anticoagulant treatment were randomly assigned to sulodexide 500 lipasemic units twice daily or placebo for 2 years, in addition to elastic stockings. The primary efficacy outcome was recurrence of venous thromboembolism. Major or clinically relevant bleeding was the primary safety outcome. Venous thromboembolism recurred in 15 of the 307 patients who received sulodexide and in 30 of the 308 patients who received placebo (hazard ratio, 0.49; 95% confidence interval [CI], 0.27–0.92; P=0.02). The analysis in which lost to follow-up was assigned to failure yielded a risk ratio among treated versus control subjects of 0.54 (95% confidence interval, 0.35–0.85; P=0.009). No major bleeding episodes occurred; 2 patients in each treatment group had a clinically relevant bleeding episode. Adverse events were similar in the 2 groups.

Conclusion—Sulodexide given after discontinuation of anticoagulant treatment reduced the risk of recurrence in patients with unprovoked venous thromboembolism, with no apparent increase of bleeding risk.

Clinical Trial Registration—URL: https://www.clinicaltrialsregister.eu/. Identifier: EudraCT number 2009-016923-77.

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Key Words: glycosaminoglycans ■ randomized controlled trial ■ recurrence ■ venous thromboembolism

The risk of recurrence of venous thromboembolism (VTE) persists for many years after anticoagulant treatment is withdrawn1 and is particularly high among patients with unprovoked VTE.2 About 20% of patients have a recurrence within 2 years after discontinuation of treatment with a vitamin K antagonist (VKA).3–6 Extending the treatment with VKA reduces the risk of recurrence but increases the risk of
bleeding, as well as the inconvenience and costs of labora-
tory monitoring and dose adjustments.7,8 The effects of the
newer non-VKA oral anticoagulants for therapy of acute VTE
events9–12 and for extended treatment to avoid recurrences13,14
have recently been investigated by a number of clinical trials
that, as a whole, showed an efficacy noninferior to VKA and
rates of bleeding in general inferior to VKA, especially for
extended treatment.

Sulodexide is a natural glycosaminoglycan with anti-
thrombotic and profibrinolytic activities15 that can be adminis-
tered orally or parenterally and affects the normal hemostasis
to a lower extent than heparin with a very low risk of bleeding.
Several clinical studies proved that prolonged sulodex-
ide administration was associated with no or negligible risk
of bleeding,16–18 as also highlighted in a recent review.19
Sulodexide exerts its actions through complexation with anti-
thrombin and heparin cofactor II and the attending inhibition
of some factors of the coagulation cascade.20–22 It also exerts
favorable effects on endothelial dysfunction, release of cyto-
kines and chemokines, and metalloproteinase-9 secretion from
white blood cells.23,24

The pharmacological and clinical profiles suggest that oral
sulodexide may have a role in the prevention of recurrent VTE
when classic anticoagulation is discontinued. Indeed, recent
clinical studies proved a positive effect of oral sulodexide
administration in reducing the risk of recurrence compared
with either anticoagulation with acenocoumarol23 or stan-
dard of care after withdrawal of VKA treatment.18 The aim
of this randomized, double-blind, controlled trial (Sulodexide
in Secondary Prevention of Recurrent Deep Vein Thrombosis
[SURVET]) was to verify the efficacy and safety of sulodex-
ide in the prevention of recurrent VTE after the end of the
VKA treatment in patients with a first-ever unprovoked VTE.

Methods

Patients

We recruited patients of 218 years of age with a documented first-ever
unprovoked proximal deep vein thrombosis or pulmonary embolism
treated with VKA for 3 to 12 months. VTE was considered unpro-
voked when it occurred in the absence of any known risk factor for this
event. We excluded patients with persistent pulmonary hypertension
after pulmonary embolism, those with solid neoplasm or blood dis-
ease, those with anti-phospholipid antibody syndrome or antithrombin
congenital deficit, patients with New York Heart Association class III
to IV cardiorespiratory failure, and patients with known hypersensitiv-
ity to glycosaminoglycans. Fertile women were enrolled if not lactat-
ing if their pregnancy test at screening was negative and they were
willing to use contraception (except oral contraceptives) throughout
the study period. Each subject was enrolled only after having issued
the written informed consent to participate in the study.

Study Design and Intervention

SURVET was a multicenter, multinational, randomized, double-
blind, parallel-group, placebo-controlled clinical trial. Eligible
patients were allocated to treatment for 2 years with oral sulodexide
(2×250–lipasemic unit capsules twice daily) or matching placebo in
a 1:1 ratio based on a computer-generated randomization list in blocks
of 4 produced by an independent operating unit. This same unit also
packaged drug and matching placebo in identical-looking treatment
units, 1 for each randomized patient, identified exclusively by the
randomization number. Patients, recruiting physicians, physicians or
 pharmacists delivering the treatments units, physicians or technicians
assessing the outcome, and Steering Committee members were
blinded to the intervention and to the block size until the end of the
statistical analysis. Each sequentially numbered treatment unit was
accompanied by an opaque, sealed envelope that allowed unblinding
of the individual patient treatment in case of need. Randomization
occurred within 1 to 12 weeks after VKAs had been withdrawn, with
the patient assigned to the treatment unit with the lowest number
available at the relevant study center.

Outcome Measures

The central adjudication committee members who were unaware of
the group assignments and who reviewed all the patients’ raw data
assessed all suspected study outcome events. The primary efficacy
outcome was symptomatic, objectively confirmed recurrence of VTE,
declared as the composite of deep vein thrombosis objectively con-
firmed by compression ultrasonography26 and nonfatal or fatal pul-
monary embolism objectively confirmed by computed tomography
or lung scanning. Secondary efficacy outcomes included distal or
superficial vein thrombosis and nonfatal or fatal myocardial infarc-
tion, stroke, or acute ischemia of the lower limbs.

The principal safety outcome was major or clinically relevant
nonmajor bleeding. An overt bleeding event was defined as major if
fatal, if it occurred in a critical location, or if it required a transfu-
sion of ≥2 U whole blood or red cells. Clinically relevant nonmajor
bleeding was defined as overt bleeding that did not meet the criteria
for major bleeding but was associated with the need for medical inter-
vention, contact with a physician, interruption of the study drug, or
discomfort or impairment of activities of daily life.27

Surveillance and Follow-Up

The investigators, according to the study protocol, recommended to
each participant the use of a class II elastic stocking after the diagno-
sis of proximal deep vein thrombosis. Their use was to be continued
for 2 years. The investigators renewed this recommendation at each
periodic visit. Patients were re-examined at the relevant clinical cen-
ter every 3 months for 24 months after randomization. Patients were
instructed to report to the study center if they had symptoms suggestive
of VTE, other circulatory events, or bleeding complications for
objective evaluation. Each patient was contacted by telephone every
month between examinations. In case of symptoms suggesting that an
end point occurred, the patient was invited to the center of reference
for an unplanned interview. Symptoms and signs suggestive of adverse
events (AEs) were also recorded. At month 24, we contacted by tele-
phone all patients who prematurely interrupted or left the study with-
out formally withdrawing consent so that we could monitor whether
symptoms or signs suggestive of a vascular event had occurred.

Study Oversight

The members of the Steering Committee designed the study, regis-
tered in the EU Clinical Trials Register with the EudraCT number
2009-016923-77 (https://www.clinicaltrialsregister.eu/ctr-search/
search?query=SURVET). Independent contract research organiza-
tions monitored the study and collected and maintained the data. The
Department of Pharmaceutical Sciences of the University of Milan
(Milan, Italy) analyzed the data. Each study center initiated the trial
only after the local Ethics Committee or Institutional Review Board
had approved the protocol. The study was performed in accordance
with the protocol, with the Declaration of Helsinki, with Good
Clinical Practice, and with local regulations.

The Steering Committee had final responsibility for verification and
analyses of the data, wrote the manuscript, and vouches for the
accuracy and completeness of the reported data. All authors contrib-
uted to the interpretation of the results, approved the final version of
the manuscript, and made the decision to submit the manuscript for
publication. The study was supported by Alfa Wassermann SpA (Via
Ragazzi del 99, 5-Bologna, Italy), which supplied its commercially
available capsules of sulodexide and manufactured the matching pla-
censo.
study but played no role in the design of the study, in data collection or analysis, or in manuscript preparation.

Statistical Analysis
Assuming an incidence of recurrent VTE with standard care of \( \approx 17.5\% \) in 2 years \( ^{2,3} \) and hypothesizing a 50% relative reduction by adding sulodexide, \(^{18} \) we determined that a total of 620 patients (\( \approx 310 \) per group) had 90% power to show superiority of sulodexide over placebo at a 2-sided level of \( \alpha=0.05 \).

The primary efficacy analysis, which considered all outcome events occurring from randomization to the end of treatment, was performed according to the intention-to-treat (ITT) principle and included all patients who had been randomized (except 2 blinded administrative exclusions). Hazard ratios, 95% confidence intervals (CIs), and \( P \) values were calculated with the Cox proportional hazards models and SPSS statistical software, version 17.0, with treatment as the only covariate. A Cox proportional hazards model analysis was also performed with adjustment for age (in decades), sex, type of index event (pulmonary embolism or deep vein thrombosis), country, dichotomized (<6 months) exposure to VKA, and dichotomized (<1/21 month) delay between the end of VKA treatment and randomization. An “all failures” efficacy analysis was performed in which all patients for whom no information on health status at 24 months was available were considered as having had an event (failure), the proportion of failures was compared with the Fisher exact probability test, and the incidence risk ratio and 95% CI were estimated with “epiR,” \(^{28} \) available were considered as having had an event (failure), the proportion of failures was compared with the Fisher exact probability test, and the incidence risk ratio and 95% CI were estimated with “epiR.” \(^{28} \) The outcome for patients lost to follow-up was also estimated by assigning the outcome of the nearest neighbor estimated by propensity score, computed from the same predictors as for the Cox regression except treatment. An additional sensitivity analysis was performed on the per-protocol population that included all patients of the ITT population who had the 24-month evaluation, had taken at least 75% of the planned study medication, and were exempt of major protocol violations as indicated by the study Steering Committee in a blind review. The safety analysis included all randomized patients.

Results
Patients and Study Treatment
Between September 2010 and May 2012, 629 patients were screened in 43 centers in 7 European countries. The follow-up was closed on May 2014. Twelve patients were screening failures; 617 were included in the safety population. Two patients were excluded from efficacy analysis because of administrative reasons: 1 was the sole individual recruited in 1 of the planned countries, and 1 entered twice in the trial at 2 different sites, and the first entry was excluded from efficacy analysis. A total of 308 patients received placebo and 307 received sulodexide for a median duration of 23.9 months. The blinded review by the study Steering Committee included 521 patients in the per-protocol analysis (Figure 1). The study drug was discontinued prematurely in 28 patients given sulodexide (9.1%) and in 29 patients given placebo (9.4%; Figure 1). There were no significant differences between groups in baseline characteristics of the patients (Table 1), except for exposure to VKA (slightly more sulodexide patients in the <6-month category; \( P=0.044 \)).

Recurrent VTE
Recurrent of VTE occurred in 45 patients as a result of proximal deep vein thrombosis in 36 patients and pulmonary embolism in 9 patients (fatal in 1 patient).

The primary outcome, recurrence of VTE, occurred in 15 of the 307 patients who received sulodexide (4.9%; 95% CI, 2.9–8.1) compared with 30 of the 308 patients who received placebo (9.7%; 95% CI, 6.8–13.7; hazard ratio, 0.49; 95% CI, 0.27–0.92; \( P=0.02 \); Figure 2A).

The analysis adjusted for age, sex, index event (pulmonary embolism or deep vein thrombosis), country, duration of exposure to VKA, and delay between the end of VKA treatment and randomization confirmed that sulodexide treatment reduced the risk of recurrence (adjusted hazard ratio, 0.45; 95% CI, 0.24–0.84; \( P=0.01 \); Figure 2B). Independent risk factors for recurrent VTE included age (hazard ratio, 1.33 per decade; 95% CI, 1.06–1.65; \( P=0.01 \)) and male sex (hazard ratio, 2.45; 95% CI, 1.25–4.78; \( P=0.01 \)). No association was found between recurrent VTE and length of exposure to VKA (hazard ratio, 0.79; 95% CI, 0.41–1.53; \( P=0.48 \)), delay between the end of VKA treatment and randomization (hazard ratio, 0.71; 95% CI, 0.37–1.36; \( P=0.71 \)), country (\( P=0.09 \)), or index event (hazard ratio, 1.67; 95% CI, 0.63–4.44; \( P=0.30 \)).

Under the “all failures” assumption, the proportion of failures among control subjects was 48 of 308 or 15.6% (95% CI, 11.7–20.1) and that among treated patients was 26 of 307 or 8.5% (95% CI, 5.6–12.2; \( P=0.009 \), Fisher test). The incidence risk ratio of failure among treated patients was 0.54 (95% CI, 0.35–0.85) versus control subjects. The results of the logistic analysis adjusted for the same confounders indicated for the Cox analysis are reported in the text and in Table I in the online-only Data Supplement.

Applying the nearest-neighbor outcome to the 29 patients lost to follow-up using the propensity score yielded a proportion of events of 30 of 308 (9.7%) among control subjects and 16 of 307 (5.2%) among treated subjects (\( P=0.045 \), Fisher test; incidence risk ratio, 0.54; 95% CI, 0.30–0.96).

In the per-protocol population, VTE occurred in 14 of the 263 patients who received sulodexide compared with 30 of the 258 patients who received placebo (hazard ratio, 0.45; 95% CI, 0.24–0.85; \( P=0.014 \)). In addition, the results of the adjusted Cox analysis in the per-protocol population did not differ appreciably from those in the ITT population (data reported in the online-only Data Supplement). The different procedures used to estimate the outcome in the ITT population resulted in a number needed to treat ranging 15 to 24, with variable width of the CI. The number needed to treat estimated from the adjusted Cox regression was 24 (95% CI, 16–98; details given in the online-only Data Supplement).

We also performed an unplanned subgroup analysis of recurrence rates by major potentially prognostic subgroups that failed to indicate subgroups more or less likely to respond to treatment (details in the text and Figure I in the online-only Data Supplement).

Hemorrhagic Complications
There were no episodes of major bleeding. Clinically relevant, nonmajor bleeding occurred in 2 patients who received sulodexide (occasional nose bleeding in 1 patient, and 2 episodes of bleeding after evacuation in the other) and in 2 patients who received placebo (occasional events of rectal bleeding in 1 patient, and a dysfunctional uterine bleeding in the other). The hazard ratio for clinically relevant bleeding was 0.97 (95% CI, 0.14–6.88; \( P=0.98 \)).
Secondary End Points

Individually, none of the protocol-defined secondary end points was frequent enough to warrant a separate analysis (details in the online-only Data Supplement). The total incidence of primary plus secondary vascular events was 43 of 308 (14.0%; 95% CI, 10.3–18.3) among control subjects and 22 of 307 (7.2%; 95% CI, 4.5–10.6) among treated subjects (P=0.008, Fisher test; Table 2). Death occurred in 1 patient in the sulodexide group (as a result of stroke) and 3 patients in the placebo group (1 as a result of lower-limb ischemia, and 2 resulting from acute coronary syndrome).

Safety End Points

We analyzed the AEs in the safety data set. The 309 control and 308 treated patients reported 397 and 368 treatment-emergent AEs, respectively. There was no significant difference in the number of patients with at least 1 AE (52.4% of control versus 48.7% of treated subjects), at least 1 serious AE (11.0% versus 8.1%), at least 1 AE causing discontinuation (13.6% versus 9.1%), at least 1 AE resulting in death (1.3% versus 0.3%), and at least 1 not definitely unrelated AE (12.9% versus 16.6%). The most frequent (>1% of patients) AEs, regardless of the potential correlation with treatment, are reported in Table II in the online-only Data Supplement.

Discussion

This study aimed at assessing whether a standard oral treatment with sulodexide after an anticoagulant regimen could, in addition to compression therapy, decrease the risk of recurrent deep vein thrombosis or pulmonary embolism over a period of 2 years.

The hazard ratio of qualifying events with sulodexide was 0.45 (95% CI, 0.24–0.84; P=0.01) after adjustment for age, sex, type of index event, country, exposure to VKA, and delay between the end of VKA treatment and randomization. Similar results were seen in the per-protocol population, in the “all failures” approach to the ITT population, and in the sensitivity analysis by propensity score in the ITT population.

The generalizability of these results appears sufficiently supported. The study included patients from different European countries with different healthcare systems without showing statistically significant heterogeneity.

The results of the SURVET study were similar to those of the trials performed with aspirin, the Warfarin and Aspirin (WARFASA) trial30 and the Aspirin to Prevent Recurrent Venous Thromboembolism (ASPIRE) trial,31 which were published while the SURVET study was underway. The pooled ASPIRE-WARFASA hazard ratio for VTE was 0.68 (95% CI, 0.51–0.90); the unadjusted hazard ratio in SURVET was 0.49 (95% CI, 0.27–0.92). The pooled ASPIRE-WARFASA hazard ratio for major vascular events was 0.66 (95% CI, 0.51–0.86) and that in SURVET was 0.50 (95% CI, 0.30–0.83). Finally, the ASPIRE-WARFASA pooled hazard ratio for clinically relevant bleeding was 1.47 (95% CI, 0.70–3.08) and that in SURVET was 0.97 (95% CI: 0.14–6.88). The studies performed with the newer direct anticoagulants, similarly published while the SURVET study was in progress, reported high efficacy compared with placebo for preventing
recurrence (1.7% versus 8.8% with apixaban, 0.4% versus 5.6% with dabigatran, and 1.3% versus 7.1% with rivaroxaban) at the expense of increased major or clinically relevant nonmajor bleeding (3.2% versus 2.3%, 5.3% versus 1.8%, and 6.0% versus 1.2%, respectively).10,13,14

Our study, however, has some limitations. The total incidence of qualifying events was less than expected but similar to that of other trials.32,33 A better preventive approach during the period immediately after the index events and perhaps more frequent application of compressive therapy in the studied population could have contributed to decrease this incidence that, however, under the “all failures” assumption was close to the one anticipated in the sample size calculation. The smaller incidence of primary end point therefore appears unlikely to have biased the estimate of the effect size.

The proportion of patients entered in the study with major protocol violations was larger than expected. These violations included cases at lesser (longer anticoagulant treatment or short interval from anticoagulant withdrawal to randomization) and at higher (shorter or no anticoagulant treatment or long untreated interval before randomization) risk. None of these factors significantly affected the risk of recurrence in the multivariable analysis. Furthermore, the results in the per-protocol population were similar to those in the ITT population. There is therefore no evidence that the potential bias associated with protocol violations may have affected the estimate of the effect to an appreciable extent.

The proportion of patients prematurely interrupting the study without having reached the end point was also higher than expected yet limited for a 2-year study (5% total; 18 of 308 among control subjects and 11 of 307 among treated subjects). We performed a number of sensitivity analyses to monitor whether, and in which direction, this could have affected the assessment of the effect size. Applying constant risks ranging from 0 (“all successes” case) to 1 (“all failures” case) to the patients lost to follow-up yielded risk ratios from 0.50 (95% CI, 0.28–0.91; \(P=0.029\)) to 0.54 (95% CI, 0.35–0.85; \(P=0.009\)). Assigning instead the outcomes at random resulted in 228 possible combinations, with a median value of \(P=0.016\). Not statistically significant results could occur only if the risk ratio of having the event among those randomized to treatment and lost to follow-up versus those randomized to control and lost to follow-up was \(\geq 1.5\). It was considered clinically improbable that patients extracted from a group who, when monitored, had a risk ratio of 0.49 (15 of 296 versus 30 of 290) could exhibit a risk ratio of \(\geq 1.5\) when not monitored. Finally, we performed a number of sensitivity analyses applying the nearest-neighbor outcome to the patients lost to follow-up using the propensity score, which was considered essentially independent from any assumption and more clinically reliable (more details are given in the online-only Data Supplement). These analyses yielded risk ratios between 0.44 (95% CI, 0.22–0.86; \(P=0.014\)) and 0.54 (95% CI, 0.30–0.96; \(P=0.045\)). The combination of the results of the survival analysis, those under the “all failures” assumption, those estimated by sensitivity analyses (in particular by propensity score), and those estimated per protocol, all comparable to each other, suggests that the subjects who left the study prematurely were a random subset of the total population and that the estimates

![Figure 2. Risk of recurrence of venous thromboembolism in patients randomly assigned to sulodexide or placebo. A. Cumulative risk of recurrent venous thromboembolism. B. Results of an analysis of risk after adjustment for age, sex, index event (pulmonary embolism, or deep vein thrombosis), duration of anticoagulant therapy, and time from completion of anticoagulation therapy to randomization.](http://circ.ahajournals.org/)}
Adjudication Committee to define the occurrence of events and the committee, having full blinded access to all the data, acted also as Committee of 3 experts: Drs Andreozzi, Davì, and Palareti. The same Committee: The SURVET study was monitored by a Steering Supplement) that contributed to recruiting the patients. Study this study and to all clinical centers (listed in the online-only Data

<table>
<thead>
<tr>
<th>Event</th>
<th>Sulodexide ((n = 307))</th>
<th>Placebo ((n = 308))</th>
<th>Hazard Ratio ((95% CI))</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total episodes</td>
<td>15</td>
<td>30</td>
<td>0.49 ((0.27–0.92))</td>
<td>0.025</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>3</td>
<td>6</td>
<td>0.49 ((0.12–1.97))</td>
<td>0.32</td>
</tr>
<tr>
<td>Deep vein thrombosis</td>
<td>12</td>
<td>24</td>
<td>0.49 ((0.25–0.99))</td>
<td>0.045</td>
</tr>
<tr>
<td>Bleeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinically relevant nonmajor bleeding</td>
<td>2</td>
<td>2</td>
<td>0.97 ((0.14–6.88))</td>
<td>0.98</td>
</tr>
<tr>
<td>Secondary events</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distal venous thrombosis</td>
<td>1</td>
<td>4</td>
<td>0.25 ((0.03–2.20))</td>
<td>0.21</td>
</tr>
<tr>
<td>Superficial venous thrombosis</td>
<td>4</td>
<td>6</td>
<td>0.62 ((0.18–2.21))</td>
<td>0.47</td>
</tr>
<tr>
<td>Lethal and nonlethal arterial event</td>
<td>2*</td>
<td>3†</td>
<td>0.63 ((0.11–3.79))</td>
<td>0.62</td>
</tr>
<tr>
<td>Total of recurrent VTE and secondary events</td>
<td>22</td>
<td>43</td>
<td>0.50 ((0.30–0.83))</td>
<td>0.008</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; and VTE, venous thromboembolism.

*These events included 1 nonlethal acute myocardial infarction and 1 lethal ischemic stroke.
†These events included 1 episode of acute lower-limb ischemia and 2 episodes of acute coronary failure, all lethal.

of the effect size were sufficiently accurate for all practical purposes.

The proportion of patients with pulmonary embolism as the index event was low (7.6%). The results of this study should therefore be considered poorly applicable to this specific subpopulation.

Safety was favorable without unexpected AEs, likely in correlation with the treatment and clinically irrelevant risks of bleeding despite the 2-year continued treatment. It should be noted, however, that the absence of serious bleeding could be a chance finding because this study was underpowered to detect events occurring with very small frequency.

Conclusions

Treatment with oral sulodexide at 500 lipasemic units twice daily for 2 years along with compression therapy decreased the incidence of recurrences of thromboembolic events without detectable risks for the patient safety. Future investigations should examine whether a similar effect can be obtained after treatment of the index event with non-VKA oral anticoagulants; whether there is a summation of effects with aspirin; whether prevention of recurrence could equally be performed with sulodexide, antiplatelets, or extended anticoagulation; and whether specific subgroups are more or less likely to benefit from sulodexide or other treatments.

Acknowledgments

We are indebted to all the patients who agreed to participate in this study and to all clinical centers (listed in the online-only Data Supplement) that contributed to recruiting the patients. Study Committee: The SURVET study was monitored by a Steering Committee of 3 experts: Drs Andreozzi, Davì, and Palareti. The same committee, having full blinded access to all the data, acted also as Adjudication Committee to define the occurrence of events and the attribution of individual subjects to the analysis populations, after which the database was frozen. The same committee monitored the statistical analysis, which was performed blinded by the study statistician (Dr Bignamini) on the frozen database.

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Disclosures

Dr Andreozzi received consultancy fees or lecture grants from Mediolanum Farmaceutici, Alfa Wassermann, and Laboratoriors Elmor. Drs Bignamini and Davì received consultancy fees from Bayer Healthcare and Alfa Wassermann. Dr Palareti received consultancy fees from Alfa Wassermann and Daiichi-Sankyo, as well as lecture fees from Werfen Group and Stago. Dr Sokurenko received lecture grants from Alfa Wassermann and Sanofi. The other authors report no conflicts.

References

risk. In clinical practice, VKAs are generally discontinued when the perceived risk of bleeding outweighs the risk of recurrence. Extending treatment with VKAs reduces the recurrence risk but increases the bleeding risk. In the 2 years of treatment in the Sulodexide in Secondary Prevention of Recurrent Deep Vein Thrombosis (ASPIRE) trials showed a significant risk reduction of venous thromboembolism recurrence, although the reduction was at a lower extent than with the new non-VKAs, but still a worse result than placebo in terms of the occurrence of clinically relevant bleeding. The pooled data of the Warfarin and Aspirin (WARFASA) and Aspirin to Prevent Recurrent Venous Thromboembolism (DARECUS Investigators Group). The diagnostic value of compression ultrasonography in patients with suspected recurrent deep vein thrombosis. Thromb Haemost. 2002;88:402–406. doi: 10.1267/THRO088030402.


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SUPPLEMENTAL MATERIAL

Sulodexide for the Prevention of Recurrent Venous Thromboembolism: The SURVET Study: A Multicenter, Randomized, Double-Blind, Placebo Controlled Trial
SUPPLEMENTAL RESULTS

Results of the logistic analysis assigning all lost to follow-up to failure

All patients without confirmed information as to the health status at 24 months after randomization were classified as failures, as if they had had reached the endpoint (recurrence of thromboembolism). All patients with confirmed recurrent thromboembolism were also classified as failure. Only patients with definite information that in the 24-month period after randomization had not had the event were classified as success.

The logistic regression analysis adjusted the results observed by treatment, for sex, age, length of exposure to VKA (<6 months/≥6 months), delay from the end of VKA treatment and randomization (<1 month/≥1 month), country, and type of index event (deep vein thrombosis/pulmonary embolism).

The model resulted to fit well (Hosmer and Lemeshow test: P=0.620) and to improve by almost 10% the accuracy of prediction over the null model (Nagelkerke R square=0.098).

The results confirmed that also in terms of failure under the worst-case assumption, the significant predictors were the same as those indicated by the Cox analysis (Table S-1).
**Proportion of events assigning the outcome to patients lost to follow-up by propensity score**

A sensitivity analysis of the outcome was also performed by assigning the outcome to the patients lost to follow-up by propensity score.

If we assume that the risk of recurrence among those who abandoned the study is determined by the factors considered putative predictors of the event - with the exclusion of treatment – we can estimate the propensity score for recurrence from the monitored patients. From the relevant equation, we can estimate the score for those lost to follow-up; subsequently the patients lost to follow-up are assigned the status (event/no-event) of the nearest neighbor.

We estimated the propensity score for having the primary event using the data from the 586 patients who either had the event or reached the 24 months without event. As predictors, the same used for the Cox survival analysis were employed, once considering treatment and once not considering treatment.

The equations estimating the propensity score were then applied to the 29 patients lost to follow-up.

**CASE: CONSIDERING TREATMENT IN THE EQUATION**

The 29 patients lost to follow-up were assigned the outcome exhibited by the subject of the same treatment group, having the nearest propensity score. This assigned 1 case among placebo and none among treated to the category FAILURE. The resulting estimate of the proportion of events was 31/308 (10.1%) among controls, and 15/307 (4.9%) among treated (P=0.021, Fisher’s test; incidence risk ratio: 0.49 [0.27-0.88]).

We repeated the same procedure, assigning to the 29 cases the outcome exhibited by the subject with the nearest propensity score, regardless of the treatment group. This assigned 2 cases among placebo and none among treated to the category FAILURE. The resulting
estimate of the proportion of events was 32/308 (10.4%) among controls, and 15/307 (4.9%) among treated (P=0.014, Fisher’s test; incidence risk ratio: 0.44 [0.22-0.86]).

CASE: NOT CONSIDERING TREATMENT IN THE EQUATION

The 29 cases were assigned the outcome exhibited by the subject with the nearest propensity score, regardless of the treatment group. This assigned 0 cases among placebo and 1 among treated to the category FAILURE.

The resulting estimate of the proportion of events was 30/308 (9.7%) among controls, and 16/307 (5.2%) among treated (P=0.045, Fisher’s test; incidence risk ratio: 0.54 [0.30-0.96]).

Regardless of the approach taken, the results consistently confirmed that the probability of having a recurrence of DVT/PE was significantly greater among controls than among treated patients.

The variations that could be seen with the different procedures to assign outcomes to the patients lost to follow-up affected the size, but not the direction, of the effect.
NNT estimates for the primary clinical endpoint (recurrence of DVT)

We estimated the NNT to avoid one event more of recurrent DVT/PE in two years with the indicated dosage scheme of sulodexide added to the standard of care, vs. the standard of care alone. Since the probability of recurrence was estimated under different assumptions and with different techniques, several different estimates of NNT were computed.

ESTIMATES FROM THE ABSOLUTE RISK REDUCTION

The most common estimate of NNT is from the absolute risk reduction that, however, in this study should be estimated under the different assumptions made about the cases lost to follow-up.

1. The estimate from the absolute risk reduction (considering all lost to follow-up as non-events) yielded NNT=21 [95% CI: 10-232].

2. The estimate from the absolute risk reduction (considering all lost to follow-up as events) yielded NNT=15 [95% CI: 7-60].

3. The estimate from the absolute risk reduction (excluding all lost to follow-up) yielded NNT=19 [95% CI: 10-159].

However, these estimates do not take into account neither the actual exposure to treatment, nor the effect of potential confounders that, even in a randomised study, is definitely evident (as shown by the significant effects of predictors at the Cox analysis). We therefore estimated the NNT from the Kaplan-Meyer procedure, the unadjusted NNT from the Cox regression analysis and the NNT from the adjusted Cox regression analysis (using the covariates indicated in the text). (Altman DG, Andersen PK. Calculating the number needed to treat for trials where the outcome is time to an event. BMJ. 1999;319:1492-1495)
ESTIMATES FROM SURVIVAL ANALYSES

4. The estimate from the Kaplan-Meyer was NNT = 19 [95% CI: 10-102].

5. The estimate from the unadjusted Cox regression was NNT = 20 [95% CI: 13 - 121].

6. The estimate from the adjusted Cox regression was NNT = 24 [95% CI: 16-98].

Overall, while the NNT is approximately 20, the width of the confidence interval is largely determined by the application of adjustments for exposure to treatment (that, being longer for the treated group, reduces the point estimate of the NNT) and for the potential confounders (which results in substantially smaller width of the confidence interval). Under actual clinical conditions, the NNT estimated from the adjusted Cox regression of 24 [16-98] can be considered to reflect the true treatment effect.

Further studies, which will allow estimating the NNT from the summary measure of effect, would allow to better estimate the point NNT and to reduce the width of the confidence interval.
**Results in the per-protocol population**

The per-protocol population was composed of 521 patients, of whom 263 received sulodexide and 258 received placebo (Figure 1). Venous thromboembolism recurred in 44 patients (one patient with a primary event was excluded from this population because of a major protocol violation) and was due to deep-vein thrombosis in 36 patients and to pulmonary embolism in 8 patients (fatal in 1 patient).

The primary outcome, recurrence of venous thromboembolism, occurred in 14 of the 263 patients who received sulodexide, as compared with 30 of the 258 patients who received placebo (hazard ratio, 0.45; 95% CI, 0.24 to 0.85; P = 0.014).

The analysis adjusted for age, sex, index event (pulmonary embolism or deep-vein thrombosis), country, duration of exposure to VKA, and delay from end of VKA treatment and randomization, confirmed that sulodexide treatment reduced the risk of recurrence (adjusted hazard ratio, 0.43; 95% CI, 0.23 to 0.81; P = 0.01). Independent risk factors for recurrent venous thromboembolism included age (hazard ratio, 1.03; 95% CI, 1.01 to 1.05; P = 0.02), male sex (hazard ratio, 2.40; 95% CI, 1.23 to 4.70; P = 0.01), and marginally the country (P=0.042 without any country differing significantly from the overall trend). No association was found between recurrent venous thromboembolism and length of exposure to VKA (hazard ratio, 0.84; 95% CI, 0.43 to 1.68; P = 0.63), delay from end of VKA treatment and randomization (hazard ratio, 0.71; 95% CI, 0.37 to 1.38; P = 0.31), or index event (hazard ratio, 1.74; 95% CI, 0.65 to 4.64; P = 0.27).
Unplanned subgroup analysis of the incidence of primary events

We estimated the risk ratio of recurrence in different subgroups of potential prognostic relevance, after exclusion of the cases lost to follow-up. The analysis was performed with epiR in R. No formal comparison was performed across subgroups, since the 95% confidence intervals are already sufficient to estimate the extent of superposition across levels of subgroups, and the displacement of the individual estimate from the overall estimate of the effect.

This unplanned subgroup analysis was performed with the exclusive aim of detecting whether there was any major discrepancy across potentially important subgroups, that could suggest major modifications to protocol in future randomized controlled trials. Indeed, being the analysis unplanned, any possible difference seen by subgroups levels, could only be considered a hypothesis-generating finding.

The results are summarized in Figure S-1.
Secondary vascular events

Five patients had distal leg DVT (4 randomized to placebo vs. 1 randomized to sulodexide), 10 had superficial vein thrombosis (6 vs. 4), and 5 had arterial events considered secondary endpoints (3 vs. 2). The incidence of these events did not differ between groups, although each of these events occurred more frequently among controls. The number of patients who had any one of these secondary events was 13/308 among the patients randomized to placebo, and 7/307 among those randomized to sulodexide (4.2% vs. 2.3%), without evidence of a significant difference (P=0.26).

Some arterial events were considered secondary study endpoint (AMI, stroke, peripheral ischemia); others were not (identification of carotid stenosis or peripheral artery thrombosis). Overall, 9/308 patients among controls exhibited arterial events (2.9%; 95% CI: 1.3-5.5%) vs. 4/307 among treated patients (1.3%; 95% CI: 0.4-3.3%; P=0.262, Fisher test). The IRR with sulodexide was comparable with that observed for the occurrence of venous events: 0.45 [0.14-1.43].
### SUPPLEMENTAL TABLES

Table S-1. Odds ratio (OR) for the putative predictors in the multivariable logistic analysis of failures under the worst-case scenario.

<table>
<thead>
<tr>
<th>Predictor</th>
<th>OR [95% confidence interval]</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment: sulodexide</td>
<td>0.467 [0.277-0.787]</td>
<td>0.004</td>
</tr>
<tr>
<td>Male sex</td>
<td>1.837 [1.083-3.116]</td>
<td>0.024</td>
</tr>
<tr>
<td>Age</td>
<td>0.979 [0.961-0.997]</td>
<td>0.024</td>
</tr>
<tr>
<td>Exposure to VKA ≥6months</td>
<td>0.855 [0.495-1.478]</td>
<td>0.574</td>
</tr>
<tr>
<td>Randomization ≥1 month after the end of VKA treatment</td>
<td>0.830 [0.479-1.439]</td>
<td>0.507</td>
</tr>
<tr>
<td>Country*</td>
<td></td>
<td>0.127</td>
</tr>
<tr>
<td>Index_event: pulmonary embolism</td>
<td>1.251 [0.512-3.057]</td>
<td>0.624</td>
</tr>
</tbody>
</table>

* none of the countries deviated significantly from the overall trend
Table S-2. Number of Patients with Adverse Events and Number of Adverse Events by Study Groups.*

<table>
<thead>
<tr>
<th></th>
<th>Sulodexide (N=308)</th>
<th>Placebo (N=309)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>regardless of correlation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>any</td>
<td>150 (48.7) [368]</td>
<td>162 (52.4) [397]</td>
</tr>
<tr>
<td>severe</td>
<td>22 (7.1) [35]</td>
<td>25 (8.1) [36]</td>
</tr>
<tr>
<td>causing treatment interruption</td>
<td>28 (9.1) [31]</td>
<td>42 (13.6) [48]</td>
</tr>
<tr>
<td>serious</td>
<td>25 (8.1) [30]</td>
<td>34 (11.0) [45]</td>
</tr>
<tr>
<td>causing death</td>
<td>1 (0.3) [1]</td>
<td>4 (1.3) [5]</td>
</tr>
<tr>
<td><strong>potentially correlated</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>any</td>
<td>51 (16.6) [94]</td>
<td>40 (12.9) [77]</td>
</tr>
<tr>
<td>severe</td>
<td>7 (2.3) [10]</td>
<td>6 (1.9) [9]</td>
</tr>
<tr>
<td>causing treatment interruption</td>
<td>13 (4.2) [14]</td>
<td>12 (3.9) [13]</td>
</tr>
<tr>
<td>serious</td>
<td>9 (2.9) [11]</td>
<td>5 (1.6) [7]</td>
</tr>
<tr>
<td>causing death</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td><strong>most frequent (&gt;1%), regardless of correlation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain in extremity</td>
<td>15 (4.9) [23]</td>
<td>16 (5.2) [19]</td>
</tr>
<tr>
<td>Condition</td>
<td>Occurrence</td>
<td>Reference</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Deep vein thrombosis</td>
<td>12 (3.9) [13]</td>
<td>24 (7.8) [24]</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>13 (4.2) [20]</td>
<td>8 (2.6) [10]</td>
</tr>
<tr>
<td>Hypertension</td>
<td>10 (3.2) [11]</td>
<td>13 (4.2) [13]</td>
</tr>
<tr>
<td>Oedema peripheral</td>
<td>13 (4.2) [13]</td>
<td>6 (1.9) [8]</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>11 (3.6) [11]</td>
<td>8 (2.6) [10]</td>
</tr>
<tr>
<td>Respiratory tract infection viral</td>
<td>9 (2.9) [9]</td>
<td>7 (2.3) [8]</td>
</tr>
<tr>
<td>Headache</td>
<td>2 (0.6) [2]</td>
<td>11 (3.6) [15]</td>
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<tr>
<td>Pulmonary embolism</td>
<td>5 (1.6) [5]</td>
<td>8 (2.6) [8]</td>
</tr>
<tr>
<td>Vertigo</td>
<td>5 (1.6) [6]</td>
<td>5 (1.6) [7]</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>5 (1.6) [5]</td>
<td>7 (2.3) [7]</td>
</tr>
<tr>
<td>Abdominal pain upper</td>
<td>6 (1.9) [6]</td>
<td>5 (1.6) [5]</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>1 (0.3) [1]</td>
<td>9 (2.9) [9]</td>
</tr>
<tr>
<td>Hypercholesterolaemia</td>
<td>6 (1.9) [8]</td>
<td>2 (0.6) [2]</td>
</tr>
<tr>
<td>Blood pressure increased</td>
<td>1 (0.3) [2]</td>
<td>7 (2.3) [7]</td>
</tr>
<tr>
<td>Back pain</td>
<td>2 (0.6) [2]</td>
<td>5 (1.6) [7]</td>
</tr>
<tr>
<td>Blood glucose increased</td>
<td>5 (1.6) [5]</td>
<td>3 (1.0) [3]</td>
</tr>
<tr>
<td>Gout</td>
<td>4 (1.3) [5]</td>
<td>3 (1.0) [3]</td>
</tr>
<tr>
<td>Pain</td>
<td>4 (1.3) [4]</td>
<td>2 (0.6) [3]</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td>4 (1.3) [4]</td>
<td>2 (0.6) [3]</td>
</tr>
<tr>
<td>Condition</td>
<td>Number of Patients</td>
<td>Percentage of Patients</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>3 (1.0) [3]</td>
<td>4 (1.3) [4]</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>3 (1.0) [3]</td>
<td>4 (1.3) [4]</td>
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<tr>
<td>Sciatica</td>
<td>2 (0.6) [2]</td>
<td>4 (1.3) [4]</td>
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<tr>
<td>Pruritus</td>
<td>4 (1.3) [5]</td>
<td>1 (0.3) [1]</td>
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<tr>
<td>Nausea</td>
<td>0 (0.0) [0]</td>
<td>4 (1.3) [6]</td>
</tr>
<tr>
<td>Carotid arteriosclerosis</td>
<td>1 (0.3) [2]</td>
<td>4 (1.3) [4]</td>
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<tr>
<td>Vomiting</td>
<td>0 (0.0) [0]</td>
<td>5 (1.6) [6]</td>
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<tr>
<td>Condition aggravated</td>
<td>5 (1.6) [5]</td>
<td>0 (0.0) [0]</td>
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</table>

* Number of patients with the events (%). Square brackets denote the number of nonconsecutive events.
### SUPPLEMENTAL FIGURES

<table>
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<tr>
<th>Subgroup</th>
<th>Treated events</th>
<th>Controls events</th>
<th>Risk ratio</th>
<th>RR</th>
<th>95% CI</th>
</tr>
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<td><strong>Sex</strong></td>
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<tr>
<td>Females</td>
<td>4/128</td>
<td>8/144</td>
<td>0.562</td>
<td>[0.173; 1.824]</td>
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<td>Males</td>
<td>11/168</td>
<td>22/146</td>
<td>0.435</td>
<td>[0.218; 0.865]</td>
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<tr>
<td><strong>Age</strong></td>
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<td></td>
<td></td>
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<tr>
<td>&lt;50</td>
<td>5/96</td>
<td>5/91</td>
<td>0.948</td>
<td>[0.284; 3.166]</td>
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<tr>
<td>50–64</td>
<td>3/117</td>
<td>12/117</td>
<td>0.250</td>
<td>[0.072; 0.863]</td>
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<td>65+</td>
<td>7/83</td>
<td>13/82</td>
<td>0.532</td>
<td>[0.224; 1.266]</td>
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<td><strong>Country</strong></td>
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<td>Czech Republic</td>
<td>3/39</td>
<td>4/40</td>
<td>0.769</td>
<td>[0.184; 3.216]</td>
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<td>Italy</td>
<td>4/32</td>
<td>9/32</td>
<td>0.444</td>
<td>[0.152; 1.297]</td>
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<td>Poland</td>
<td>3/81</td>
<td>6/78</td>
<td>0.481</td>
<td>[0.125; 1.858]</td>
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<td>Romania</td>
<td>0/25</td>
<td>0/24</td>
<td>0.961</td>
<td>[0.020; 46.549]</td>
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<td>Russia</td>
<td>4/98</td>
<td>10/94</td>
<td>0.364</td>
<td>[0.123; 1.181]</td>
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<td>Slovakia</td>
<td>1/21</td>
<td>1/22</td>
<td>1.048</td>
<td>[0.070; 15.691]</td>
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<td><strong>Index Event</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Deep vein thrombosis</td>
<td>13/273</td>
<td>27/268</td>
<td>0.473</td>
<td>[0.249; 0.896]</td>
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<td>Pulmonary embolism</td>
<td>2/23</td>
<td>3/22</td>
<td>0.638</td>
<td>[0.118; 3.459]</td>
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<tr>
<td><strong>Exposure to VKA</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;6 months</td>
<td>7/130</td>
<td>10/102</td>
<td>0.549</td>
<td>[0.217; 1.393]</td>
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</tr>
<tr>
<td>≥6 months</td>
<td>8/166</td>
<td>20/188</td>
<td>0.453</td>
<td>[0.205; 1.001]</td>
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</tr>
<tr>
<td><strong>Delay from stopping VKA to randomization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 month</td>
<td>11/174</td>
<td>20/161</td>
<td>0.509</td>
<td>[0.252; 1.029]</td>
<td></td>
</tr>
<tr>
<td>≥1 month</td>
<td>4/122</td>
<td>10/129</td>
<td>0.423</td>
<td>[0.136; 1.313]</td>
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<td><strong>Use of ASA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>ASA no</td>
<td>11/220</td>
<td>20/217</td>
<td>0.542</td>
<td>[0.266; 1.105]</td>
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<tr>
<td>ASA yes</td>
<td>4/76</td>
<td>10/73</td>
<td>0.384</td>
<td>[0.126; 1.171]</td>
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<tr>
<td><strong>Post-thrombotic syndrome (PTS) at baseline</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTS yes</td>
<td>7/172</td>
<td>14/176</td>
<td>0.512</td>
<td>[0.212; 1.237]</td>
<td></td>
</tr>
<tr>
<td>PTS no</td>
<td>8/124</td>
<td>16/114</td>
<td>0.460</td>
<td>[0.205; 1.033]</td>
<td></td>
</tr>
<tr>
<td><strong>History of CHD/stroke</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>13/269</td>
<td>29/270</td>
<td>0.450</td>
<td>[0.239; 0.847]</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2/27</td>
<td>1/20</td>
<td>1.481</td>
<td>[0.144; 15.223]</td>
<td></td>
</tr>
</tbody>
</table>

**Overall incidence risk ratio**

0.490 [0.269; 0.891]

**Supplemental Figure S-1.** Unplanned analysis of the risk ratio for recurrent VTE (with 95% confidence interval) in the SURVET Study patients (after exclusion of the cases lost to follow-up), stratified by clinically relevant subgroups.
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Sulodexide는 정맥 혈전색전증 환자의 재발을 줄일 수 있다: SURVET 연구

초록

배경
정맥 혈전색전증이 처음 발생한 환자는 항혈전제의 투여가 중단되면 혈전의 재발 위험이 높다. 항혈전제 투여기간을 연장하면 재발의 위험은 감소될 수 있으나, 투여의 위험을 높이는 문제로 발생한다. Sulodexide는 glycosaminoglycan으로 경구 투여하였을 경우, 출혈 위험이 적고, 항혈전(antithrombotic) 및 전구 혈전용해(profibrinolytic) 작용을 가지고 있다고 알려져 있으나, 정맥 혈전색전증 환자의 재발을 줄이는 데 유익한지에 대해서는 잘 알려져 있지 않다.

방법 및 결과
본 다기관, 이중맹검 연구는 첫 정맥 혈전색전증이 나타난 이후 3-12개월간의 경구 항혈전제 치료를 마친 615명의 환자들을 대상으로 하였으며, 대상 환자들은 암박 스터킹을 착용하고 하루 2회 sulodexide 500 lipasemic unit 또는 위약을 2년간 투여 받았다. 일자 효능 관련 종료점은 정맥 혈전색전증의 재발이었고, 안전성 관련 종료점은 주요 또는 임상적으로 관련된 출혈의 발생 여부였다. 정맥 혈전색전증의 재발은 sulodexide를 처방 받은 307명 중 15명, 위약군 308명 중 30명에서 발생하였다(HR, 0.49; 95% CI, 0.27-0.92; P=0.02). 그리고 추적관찰에 실패한 사람들을 고려한 치료군과 위약군의 발생비도 위험비는 0.54(95% CI, 0.35-0.85; P=0.009)였다. 주요 출혈은 발생하지 않았으나, 약제 관련 출혈은 2명의 환자에서 발생하였고, 두 군 간에 약제 관련 부작 용의 발생비도는 유사하였다.

결론
첫 발생한 정맥 혈전색전증에 대해 항혈전제 치료 중단 후 sulodexide를 투여하면, 출혈 합병증은 증가하지 않으면서 혈전의 재발 위험이 줄어든다.