

GUEST EDITORIAL

Thrombotic disorders (part 2)

Thromboembolic disorders may be divided into those of arterial and venous origins, which encompass distinctive pathogenetic trajectories. Ischaemic heart disease and ischaemic stroke embody the majority of arterial thromboses, while deep-vein thrombosis and pulmonary embolism comprise the majority of venous thromboembolic events.

The subject of discussion is acquired thrombotic disorders, the second of a 2-part series in CME. Inherited thrombophilia is discussed in part 1 (previous issue).^[1]

The content elaborates on pathophysiological and diagnostic facets of thrombotic disorders likely to be encountered in clinical practice. As regards current management practice, readers are referred to the South African prophylactic and therapeutic guideline.^[2]

Causes of acquired thrombophilia are numerous and varied, precluding a comprehensive discussion of all listed thrombotic disorders. Common clinical scenarios, however, are covered in greater detail. Thrombosis may occur as a consequence or complication of a wide variety of disease states, such as diabetes, hypertension, thrombotic thrombocytopenic purpura and liver transplantation. These events are influenced by a multitude of factors with varied aetiologies that merit discussion on discipline-specific platforms, and are therefore not within the scope of this CME. The scope of discussion is limited to clinical entities associated with a marked increase in the risk of thrombosis. We conclude with a guide to diagnosis and further investigation of suspected thromboembolic disease.

Fig. 1, which also appeared in part 1,^[1] has been duplicated in the article in this issue for ease of reference.

The authors are indeed grateful for the opportunity to discuss this important and dynamic segment of coagulation disorders.



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