Preventing VTE in hospitalized patients

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- How do we determine risk of venous thromboembolism (VTE) in patients scheduled for surgery?
- Do all surgical patients require VTE prevention?
- Is aspirin adequate to prevent VTE in low-risk hospitalized patients?
- Which anticoagulant is appropriate for a patient scheduled for total knee replacement?

The committee categorized recommendations by type of surgical procedure and risk status. In this summary, the recommendations are reorganized by strength of recommendation.

Three outcomes were regarded:
1. Efficacy of various prophylactic strategies
2. Rates and relative risk of venous thromboembolism outcomes—ie, fatal pulmonary embolism, symptomatic deep vein thrombosis, pulmonary embolism, or asymptomatic proximal deep vein thrombosis

The committee used a rating scheme that accounted for both the risk/benefit ratio (clear or unclear) and the strength of the supporting recommendation (A, B, C). The grades of evidence were altered to correspond to the grades of recommendation of the Oxford Centre for Evidence-Based Medicine. (For an explanation of these grades, see page 32.)

RELEVANT RECOMMENDATIONS

This guideline is clinically relevant because of the high mortality associated with pulmonary embolus complicating VTE.

It offers a practical, tabulated guide, listed by surgical procedure performed. It is pertinent to hospitalized patients under the care of family physicians. The rationale for each
### PRACTICE RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Surgery +</th>
<th>Patient age (yr) +</th>
<th>Risk factors</th>
<th>Level of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>&lt; 40</td>
<td>No</td>
<td>Low</td>
</tr>
<tr>
<td>Minor</td>
<td>Any, 40–60</td>
<td>Yes*</td>
<td>Moderate</td>
</tr>
<tr>
<td>Major</td>
<td>&lt; 40</td>
<td>No</td>
<td>Low</td>
</tr>
<tr>
<td>Minor</td>
<td>&gt; 60</td>
<td>No</td>
<td>High</td>
</tr>
<tr>
<td>Major</td>
<td>&gt; 40</td>
<td>Yes*</td>
<td>High</td>
</tr>
<tr>
<td>Major</td>
<td>&gt; 40, Prior VTE, cancer, hypercoagulable states, hip/knee arthroplasty, hip fracture, major trauma, spinal injury</td>
<td></td>
<td>Very high</td>
</tr>
</tbody>
</table>

*Additional risk factors: immobility, stroke, paralysis, trauma, obesity, varicose veins, cardiac dysfunction, indwelling central venous catheter, inflammatory bowel disease, nephrotic syndrome, pregnancy, estrogen use, congenital thrombophilic abnormalities
- For all risk groups of patients, aspirin is not recommended for prophylaxis (strength of recommendation [SOR: A])
- Every hospital should have an appropriate thromboembolic event prevention strategy, determined by proper risk assessment (SOR: D)
- Antithrombotics should be used with caution before invasive spinal or epidural procedures (SOR: C)

#### Grade B Recommendations
- LDUH, GCF, IPC, or LMWH for open urologic procedures
- IPC for total knee replacement
- LMWH or warfarin for hip fracture; an alternative is IPC
- LMWH for acute spinal cord injury. Alternative GCS or IPC in combination with LMWH or LDUH, if LMWH is contraindicated

#### Grade C Recommendations
- Early ambulation (with no antithrombotic agents) for low-risk surgery patients or uncomplicated gynecologic procedures
- LDUH, LMWH, or IPC for higher-risk surgery patients
- For very-high-risk surgery patients, LDUH or LMWH combined with GCS or IPC. Some patients may benefit from post-hospital LMWH or warfarin
- Daily LDUH or IPC for major gynecologic procedures for benign disease
- LDUH plus GCS or LMWH for gynecologic surgery for malignancy
- Early ambulation for low risk urologic and gynecologic procedures
- High-risk urologic procedures GCS plus with LDUH or LMWH
- GCS or IPC added to antithrombotic drugs for total hip or total knee replacement surgery; continue for longer periods in higher-risk patients. Adjusted-dose intravenous heparin is an acceptable alternative, but more difficult to manage
- Aspirin alone is not acceptable for hip fracture patients
- IPC with GCS for intracranial surgery; LDUH or postoperative LMWH are acceptable alternatives
- LMWH or intravenous heparin for the acute myocardial infarction patient (for the VTE prevention indication)
- LDUH or LMWH for immobilized stroke patient. GCS if anticoagulation is contraindicated
- LDUH or LMWH for medical patients with cancer, bedrest, congestive heart failure, or severe lung disease
The rationale for each recommendation is clear and well supported by the referenced literature. The objectives of the guideline were met and the outcome measures were appropriate.

The guideline is weakened by the lack of cost-effectiveness considerations.

### GUIDELINE DEVELOPMENT AND EVIDENCE REVIEW

Literature searches were performed for each patient group. Criteria for inclusion included relevant patient group, sample size of at least 10 patients per group, verified deep vein thrombosis, and patients with adequate outcome assessments.

In considering baseline risk of thrombosis, only either prospective cohort studies or control groups of randomized trials were considered. For prophylaxis efficacy recommendations, only randomized trials were considered. The consensus group analyzed data from 630 sources before making these recommendations.

### OTHER GUIDELINES ON PREVENTION OF VTE


### SOURCES FOR THIS GUIDELINE

**Sixth ACCP Consensus Conference on Antithrombotic Therapy**

The Consensus Conference guidelines can be found at:


Tables illustrating these guideline, organized by type of surgical procedure can be accessed at: chestnet.safeserver.com/guidelines/antithrombotic/p8.php

In the same issue of this journal, there were reports on the mechanism of action for oral anticoagulants, managing oral anticoagulant therapy, platelet active drugs, mechanisms of action of heparin and low molecular weight heparin, hemorrhagic complications of anticoagulation, use of antithrombotic medications during pregnancy, antithrombotic therapy for heart disease and peripheral vascular disease, use of these for stroke, and their role in treating children.