VTE Prevention: Medical patients

If using pharmacological VTE prophylaxis for patients - aim to start it as soon as possible. Ideally within 14 hours of admission where possible, unless contraindicated or otherwise stated in population-specific recommendations

ALL Acutely ill patients:

If the likely benefit from reducing the risk of symptomatic VTE is greater than the risk of harm from major bleeding caused by anticoagulation:

- Add LMWH (prophylactic weight based dosing) for a minimum of 7 days if mobility not fully restored to baseline on discharge; or according to senior clinician discretion.

Patients with renal impairment: *If the likely benefit from reducing the risk of symptomatic VTE is greater than the risk of harm from major bleeding caused by anticoagulation:*

- If using pharmacological VTE prophylaxis for people with renal impairment, use LWMH or UFH
- If needed, reduce the dose of LMWH (see Appendix 3 for local protocol)

Ambulatory patients with cancer (Out-patients):

Unless patient at increased risk of VTE due to risk factors other than cancer, do not offer VTE prophylaxis to patients with cancer /receiving cancer-modifying treatments (radio-/ chemo-/ immunotherapy) **who are mobile, consider in:**

- **Pancreatic cancer receiving chemotherapy:** consider LMWH for duration of chemotherapy
- **Myeloma currently treated with thalidomide, pomalidomide or lenalidomide in combination with steroids:** LMWH (weight-based dosing), or aspirin (75mg or 150mg) or DOAC using locally agreed protocols

Acute stroke patients:

- Do not offer anti-embolism stockings (AES)
- Consider intermittent pneumatic compression (IPC) if immobile (start within first 3 days of stroke)
- Continue IPC for 30 days or until mobile or discharged
- Do not offer pharmacological thromboprophylaxis in acute stroke (ischaemic stroke within 2 weeks, reassess risk of VTE at 2 weeks; haemorrhagic stroke, consider after 1 month following discussion with senior clinician)

Acute coronary syndromes (ACS):

If receiving anticoagulation for ACS management, patients do not usually require VTE prophylaxis acutely, but should be risk assessed and prescribed LMWH once ACS resolved, if still an in-patient.

Patients receiving palliative care:

If the risk assessment of VTE outweighs the risk of bleeding:

- Use LMWH (weight-based dosing)
- If life expectancy short, consider views of patient and family/ carers (document clearly).
- Review thromboprophylaxis daily
- Do not offer VTE prophylaxis to patients in the last few days of life.

Patients admitted for psychiatric illness:

If the risk of VTE outweighs the risk of bleeding:

- LMWH (weight-based dosing)
- Continue VTE prophylaxis until patient no longer at risk for VTE.

Patients admitted to critical care:

If the risk assessment of VTE outweighs the risk of bleeding:

- LMWH (weight based dosing)
- Risk assess at least daily
- If pharmacological prophylaxis is contraindicated offer AES/ IPC until mobility returned to normal baseline
- Refer to BSUH Covid VTE guideline for specific guidance on this group of patients

Fondaparinux can be considered as an alternative to LMWH in certain circumstances – see Appendix 3

Taken from UHSussex East VTE Prevention Policy c031 Sept 2021 (Appendix 7)
Guidance intended for UHSussex East (Brighton RSCH and PRH)