If using pharmacological VTE prophylaxis for patients - aim to start it as soon as possible unless contraindicated or otherwise stated in population-specific recommendations.

<table>
<tr><th>Spinal injury:</th><th>Cranial surgery:</th><th>Elective spinal surgery:</th></tr>
<tr><td colspan="3">• Start either anti-embolism stockings (AES) or intermittent pneumatic compression (IPC) from admission.
• Continue for 30 days or until the patient is fully mobile or discharged, whichever is sooner.</td></tr>
<tr><td>Reassess risk of bleeding at 24 hours AFTER admission.

If the risk of VTE outweighs the risk of bleeding:

• Add LMWH for patients not having surgery in the next 24–48 hours.

• Continue VTE prophylaxis for 30 days or until the person is fully mobile or discharged, whichever is sooner.</td><td>If the risk of VTE outweighs the risk of bleeding:

• add LMWH starting 24– 48 hours after surgery
• Continue LMWH (prophylactic weight based dosing) for a minimum of 7 days

• If high risk of VTE consider LMWH < 24 hours post-op according to senior/ MDT opinion.

Contraindications to pharmacological VTE prophylaxis:
• Ruptured cranial vascular malformations (eg: brain aneurysms)
• Intracranial haemorrhage (spontaneous or traumatic) until lesion secured/condition stable.</td><td>Consider individual patient & surgical factors (major or complex surgery), and senior clinical judgement.

If the risk of VTE outweighs the risk of bleeding:

• Add LMWH starting 24–48 hours after surgery.

• Continue LMWH for 30 days or until the patient is fully mobile or discharged, whichever is sooner.

• If patient high risk for VTE consider LMWH < 24 hours post-op according to senior/ MDT opinion.</td></tr>
<tr><td colspan="3">• If pharmacological VTE prophylaxis is contraindicated, consider intermittent pneumatic compression (IPC).
• Continue until mobility restored to baseline or discharged, whichever is sooner.</td></tr>
</table>

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