

APPENDIX 1: ORTHOPAEDICS & TRAUMA VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS GUIDELINE FOR ADULTS (≥16 YEARS) (for use in conjunction with full guideline)



For **EVERY** Patient (see overleaf):
CONSIDER MECHANICAL PROPHYLAXIS – please tick
 Anti-Embolic Stockings / Flowtron (Intermittent PC) / Foot Impulse Device

Establish if VTE prophylaxis required using flow chart below
 Give patient VTE information
 Review VTE Prophylaxis every 48 hours

Write or attach label
 CHI No:
 Surname:
 Forename: Sex:
 Address:
 Date of Birth:

1. THROMBOSIS RISK FACTORS (tick all that apply)

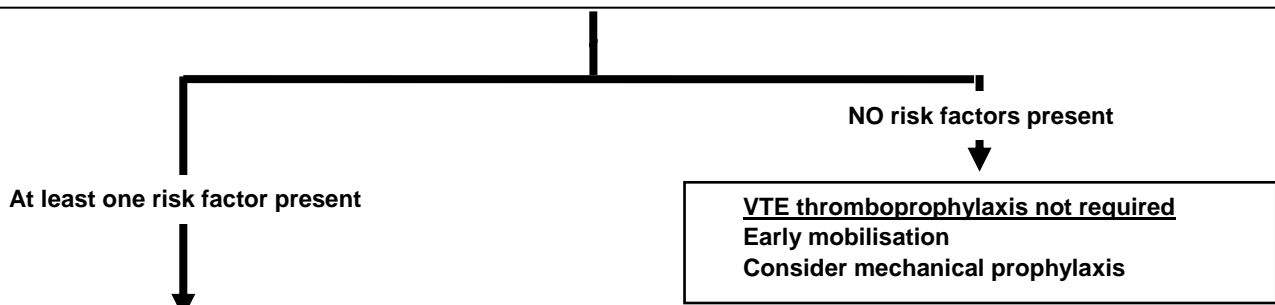
Patient Related

- Age >60 years of age
- Dehydration
- Obesity (BMI >30kg/m²)
- Any significant medical illness (e.g. heart, metabolic, endocrine, or respiratory disease; acute infection; inflammatory condition)
- Use of hormone replacement therapy
- Use of oestrogen-containing contraceptive
- Active cancer or cancer treatment
- Known thrombophilias
- Pregnancy or <6 weeks post-partum
- Varicose veins with phlebitis
- Personal history or first degree relative with a history of VTE

Admission Related

- Significantly reduced mobility for 3 days or more
- Surgery with significant reduction in mobility
- Critical care admission e.g. HDU/ITU
- Hip or knee replacement
- Hip fracture
- Total anaesthetic + surgical time > 90 minutes
- Surgery involving pelvis or lower limb with a total anaesthetic + surgical time > 60 minutes
- Acute surgical admission with inflammatory or intra-abdominal condition
- Achilles tendon rupture
- Ankle fracture with splint/cast + non weight-bearing
- Lower limb injury with splint/cast + non weight-bearing

Any admissions or illnesses YES / NO / N.A.



2. CONTRAINDICATIONS (tick all that apply)

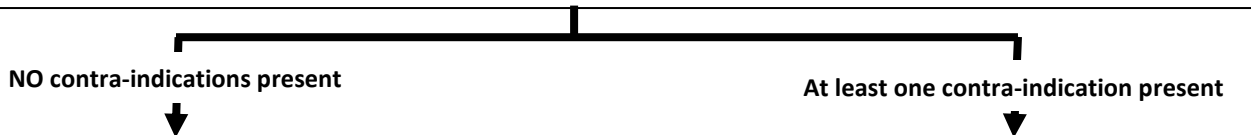
Patient Related

- Active bleeding
- Recent stroke
- Acute gastro-duodenal ulcer
- Acute bacterial endocarditis
- Known hypersensitivity (including HIT)
- Thrombocytopenia (Platelets <75x10⁹/L)
- Concurrent use of oral anticoagulants – see main guideline
- Concurrent use of oral dual antiplatelets–see main guideline
- Concurrent use of therapeutic heparin
- Untreated inherited bleeding disorders e.g. haemophilia, von Willebrand disease
- Acquired bleeding disorders e.g. acute liver failure
- Uncontrolled hypertension ≥230/120 mmHg

Admission Related

- Epidural/Spinal Anaesthesia/Lumbar Puncture in previous 4 hours or expected within next 12 hours
- Any other procedure with high bleeding risk
- Neurosurgery, spinal or eye surgery
- Acute Coronary Syndrome or Suspected DVT/PE should receive fondaparinux or dalteparin as appropriate^{3,4}
- Any other concern - describe here (e.g. type of surgery/procedure)**

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Prescribe VTE prophylaxis

- No risk factors: **VTE prophylaxis not required**
- Risk factor(s): **subcutaneous dalteparin/ Oral aspirin 150mg/ rivaroxaban 10mg (see over for treatment pathways)**
- Patient declined prophylaxis**

Do not prescribe VTE thromboprophylaxis

- Consider mechanical prophylaxis**
- Document in notes if not prescribed for any other reason**

Assessed by:
 Print Name _____ Signature _____
 Date _____ Grade _____ GMC / NMC No. _____

ORTHOPAEDICS / TRAUMA THROMBOPROPHYLAXIS FOR ADULTS (≥16 YEARS)

Disclaimer if declining VTE Prophylaxis

I confirm that the risk of deep venous thrombosis and pulmonary embolus has been discussed with me. I wish to decline the recommended prophylaxis.

Print Name _____ Signature _____ Date _____

Mechanical Prophylaxis:

- Apply on admission and continue until there is a return to the pre-morbid level of mobility
 - **Contraindications:** Pulmonary oedema, Peripheral vascular disease, Peripheral arterial disease, Cellulitis, Leg oedema, Leg/foot ulceration, Pressure sore, Peripheral neuropathy, Local leg conditions i.e. dermatitis, extreme deformity; acute stroke
- Advice on how to apply correctly and recommended wear should be given to the patient
- Intermittent Pneumatic Compression (IPC) devices (Flowtron®) or foot impulse devices should be applied peri-operatively

VTE prophylaxis with LMWH (Dalteparin[#] - LMWH of choice in NHS Ayrshire & Arran)

Emergency Admission/Trauma	Pelvic fracture - Dalteparin 5000 units [#] subcutaneously 6-12 hours post-operatively then once daily subcutaneously for 28 days. Withhold 12 hours prior to surgery. Hip Fracture - Dalteparin 5000 units [#] subcutaneously 6-12 hours post-operatively then once daily subcutaneously for 35 days. Withhold 12 hours prior to surgery. Spinal Injury Patients are treated as per Local Spinal Injuries Policy
Elective Total Hip replacement	First line: Dalteparin 5000 units [#] subcutaneously 6-8 hours post-operatively then once daily subcutaneously for 35 days. Second Line: Dalteparin 5000 units [#] subcutaneously 6-8 hours post-operatively then once daily for 10 days and then Aspirin 150mg once daily for a further 28 days
Elective Total Knee replacement	First Line: Dalteparin 5000 units [#] subcutaneously 6-8 hours post-operatively then once daily subcutaneously for 14 days Second line: Aspirin 150mg once daily for 14 days.
Other elective/trauma admissions Consider additional predisposing risk factors – see risk assessment tool	Dalteparin 5000 units [#] subcutaneously 6-8 hours post-operatively then once daily until discharge/mobile. Extended prophylaxis should be considered for patients with additional predisposing risk factors.
Outpatients and Day Surgery patients treated for lower limb injuries that require them to be non-weight bearing	First Line: Rivaroxaban 10mg orally, once daily for period of immobility (maximum 35 days) Second Line: Dalteparin (see section 8.1 in main guideline for dosing information) subcutaneously, once daily for period of immobility (maximum 35 days)

DO NOT GIVE LMWH if Epidural/Spinal Anaesthesia/Lumbar Puncture in previous 4 hours or expected within next 12 hours

Dalteparin dose: If patient weight <50kg consider reducing dose to 2500 units. If patient weight 100-150kg consider increasing dose to 5000units twice daily. If patient weight > 150kg consider increasing dose to 7500 units twice daily. In patients with eGFR < 30ml/min refer to main guideline for dosing information

General measures:

- Facilitate early mobilisation as soon as possible
- Ensure adequate hydration
- Reassess VTE risk and bleeding risk regularly, review treatment plan where appropriate and document any changes in notes
- Do not offer VTE prophylaxis to patients on full anticoagulant therapy
- Patients on established anti-platelet therapy
 - Assess risks and benefits of stopping
 - Do not regard ant-platelet therapy as adequate VTE thromboprophylaxis