

***Venous Disease Coalition Annual Meeting
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New ACCP Guidelines for VTE Prevention

**William Geerts, MD
Thromboembolism Specialist
Professor of Medicine, U. of Toronto
Chair, ACCP Guidelines on Prevention of VTE
VDC Steering Committee**



Rationale for Thromboprophylaxis

- I. **High prevalence of VTE** in most hospitalized patient groups
- II. **Adverse consequences** of unprevented VTE
- III. **Effectiveness** and **cost-effectiveness** of thromboprophylaxis

VTE is a Very Important Complication of Hospital Stay

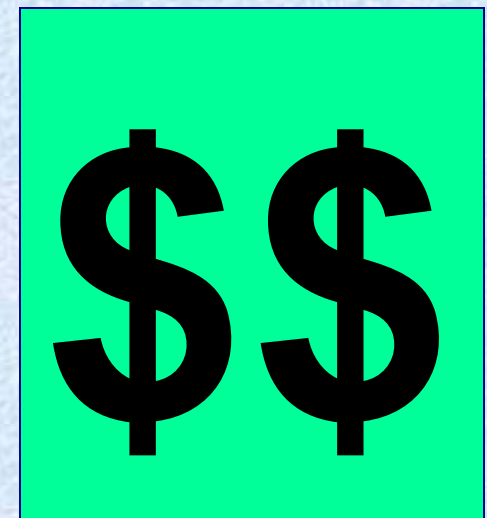
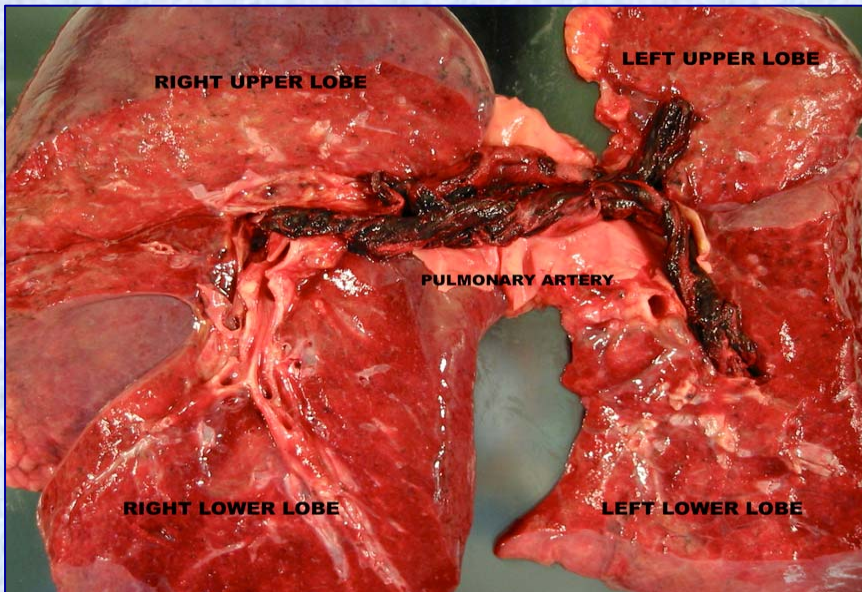
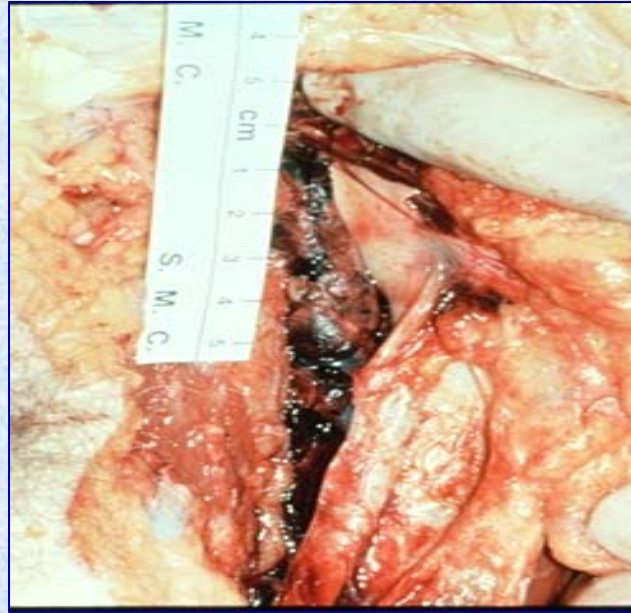
- ~70% of all VTE is **hospital-acquired**
- One of the most **common** complications
- Commonest preventable cause of hospital **death**
- Doubles **length of stay** and **costs**

Risk of DVT in Hospitalized Patients

- if no prophylaxis given + routine screening for DVT

Patient group	DVT prevalence, %	
Medical patients	10 - 20) Moderate risk
General surgery	15 - 40	
Major gynecologic surgery	15 - 40	
Major urologic surgery	15 - 40	
Neurosurgery	15 - 40	
Stroke	20 - 40	
Hip, knee arthroplasty, hip fracture	40 - 60) High risk
Major trauma	40 - 80	
Spinal cord injury	60 - 80	

Consequences of Unprevented VTE

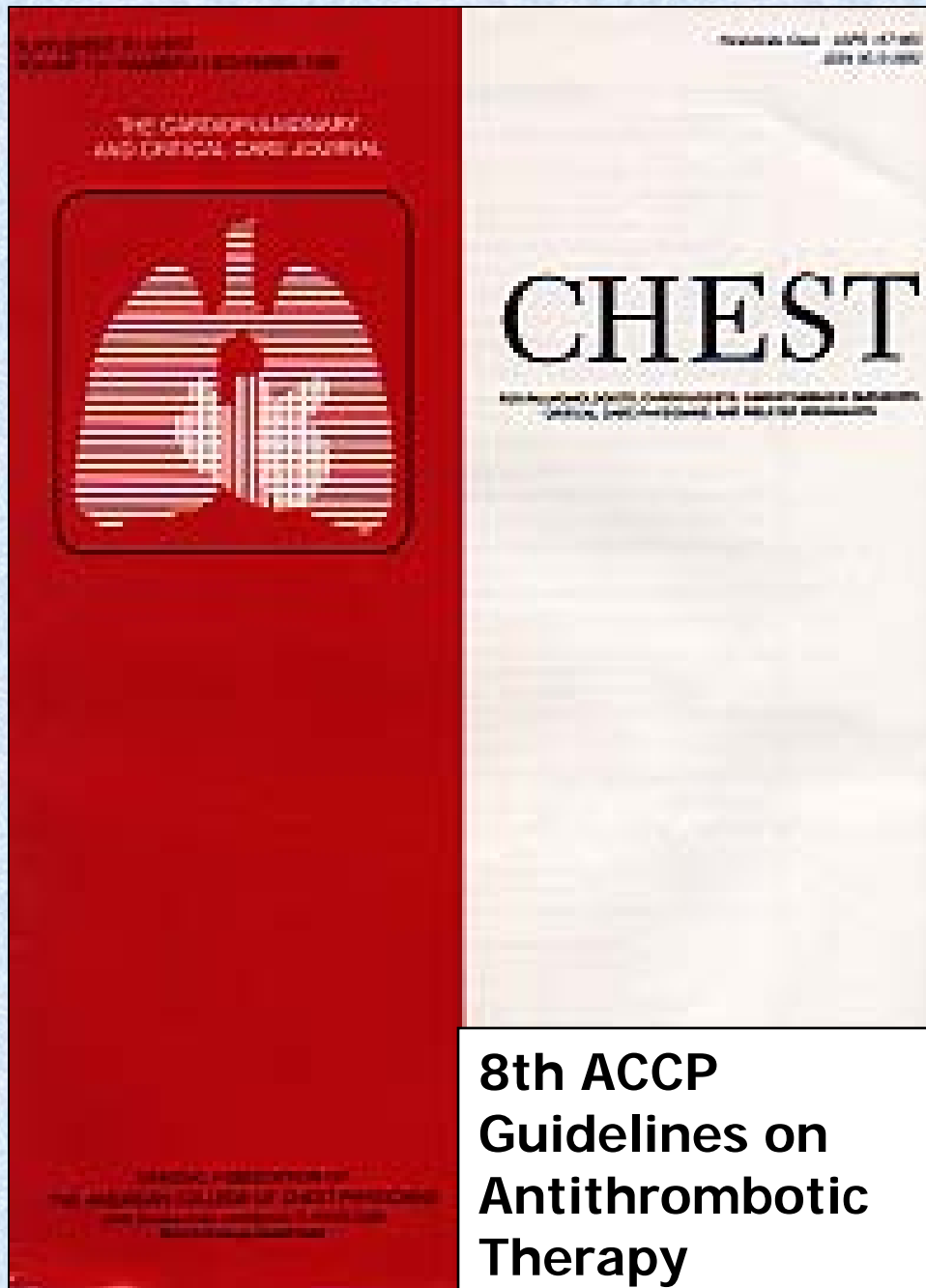


Thromboprophylaxis . . .

- **What is the evidence?**
 - Hundreds of **randomized trials**
 - Thromboprophylaxis reduces:
 - DVT
 - PE
 - all-cause mortality
 - costs

Thromboprophylaxis . . .

- **What is the evidence?**
 - Thromboprophylaxis is the **number 1 ranked patient safety strategy** in hospitalized patients
 - More than 25 published **evidence-based guidelines** since 1986 showing clear evidence of benefit and safety



Prevention of Venous Thromboembolism

W. Geerts

D. Bergqvist

G. Pineo

J. Heit

C.M. Samama

M. Lassen

C. Colwell

Chest – June 2008

Thromboembolism Risk Groups

- **General surgery**
- Vascular surgery
- **Gynecologic surgery**
- Urologic surgery
- **Thoracic surgery**
- Bariatric surgery
- **Laparoscopic surgery**
- Coronary bypass surgery
- **Hip arthroplasty**
- Knee arthroplasty
- **Knee arthroscopy**
- Hip fracture surgery

- **Spine surgery**
- Lower extremity injuries
- **Neurosurgery**
- Major trauma
- **Spinal cord injuries**
- Burn patients
- **Medical patients**
- Cancer patients
- **Central venous catheters**
- Critical care patients
- **Long distance travel**

ACCP Guidelines on Thromboprophylaxis

For each patient group:

1. risks of VTE
2. prophylaxis evidence
3. graded recommendations

Thromboprophylaxis in Moderate Risk Patients

Patients

Medical

Surgical – general, gynecologic, urologic, neurosurgery

Options

Low molecular weight heparin

Low dose heparin

Fondaparinux

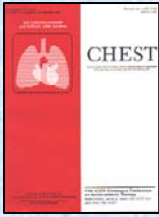
Mechanical if high bleeding risk

Duration

Until discharge

Thromboprophylaxis in High Risk Patients

Patients	Major orthopedic – hip and knee arthroplasty, hip fracture repair Major trauma
Options	Low molecular weight heparin Fondaparinux Warfarin (INR 2-3) Mechanical if high bleeding risk
Duration	At least 10 days (2-5 weeks)

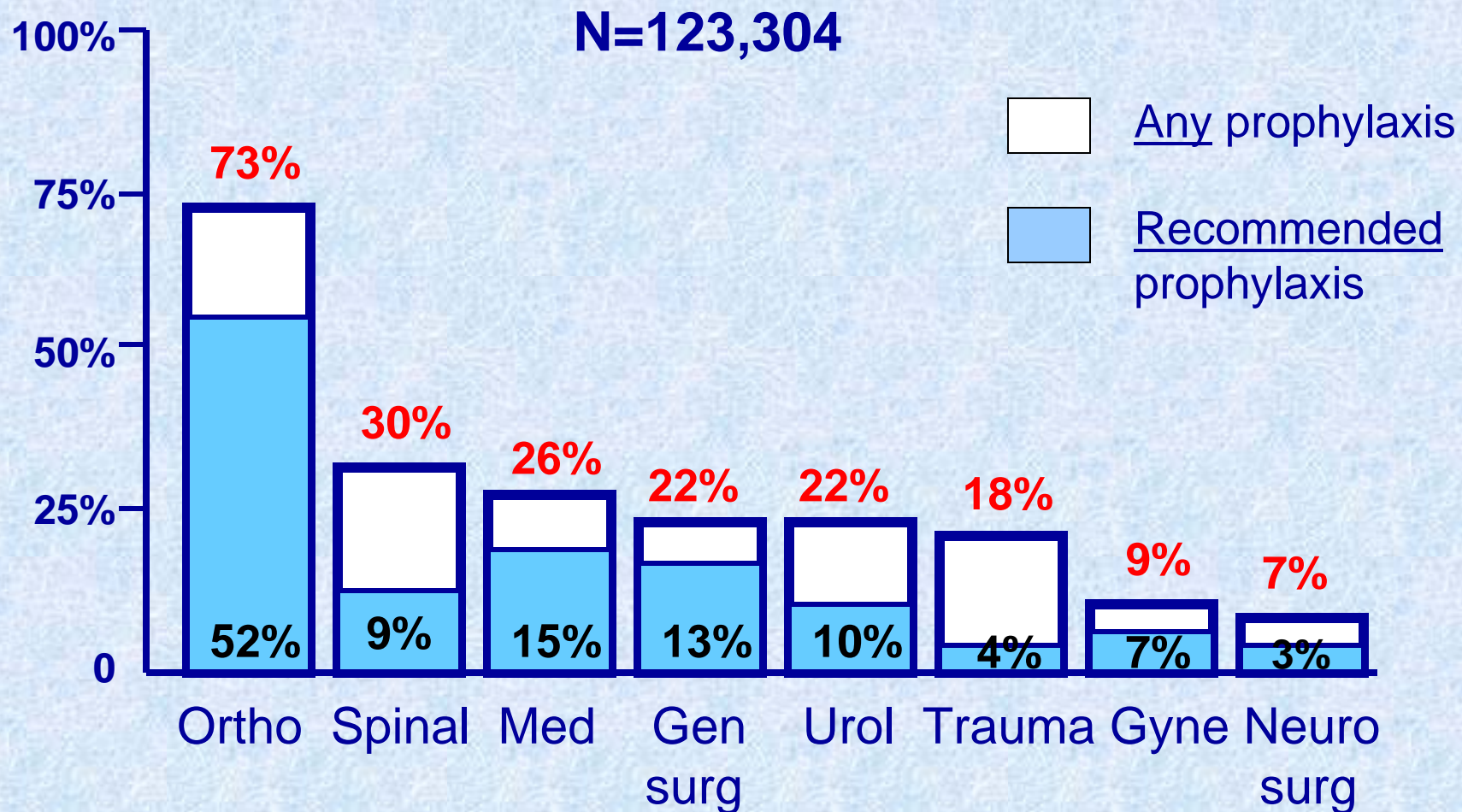


8th ACCP Guidelines on Antithrombotic Therapy

1.2 VTE Prophylaxis Policy

1.2.1 We recommend that **every general hospital** develop a **formal, active strategy** that addresses the prevention of VTE [Grade 1A].

ANY and RECOMMENDED Thromboprophylaxis Use



Yu – Am J Health-Syst Pharm 2007;64:69



Joint Commission
on Accreditation of Healthcare Organizations
Setting the Standard for Quality in Health Care

Setting the Standard for Quality in Health Care



National Standards for Prevention and Care of VTE: VTE Performance Measures (2008)

VTE Risk Assessment/Prophylaxis

All patients should receive **VTE prophylaxis within 24 hours of hospital admission or surgery end time** (or have documentation why no prophylaxis was given).

NQF

www.qualityforum.org/projects/ongoing/vte/comments/index.asp

Thromboprophylaxis in Hospitals

1. We know **who's at risk** for VTE.
2. We know the **consequences** of unprevented VTE.
3. We know **how to prevent VTE** with effective, safe, simple, and inexpensive interventions.
4. But **we don't do it** nearly as often as we should!

So . . . Just do it! (we're ALL part of the solution)