GUIDELINES FOR PREVENTION OF VENOUS THROMBOEMBOLISM (VTE)
IN HOSPITALIZED PATIENTS

PART 1: RISK ASSESSMENT AND GENERAL RECOMMENDATIONS


HIGH RISK FOR VTE
- Active malignancy
- Prior VTE
- Thrombophilia
- Acute spinal cord injury
- Trauma
- Hip replacement
- Knee replacement
- Hip fracture repair
- Burns

AT RISK FOR VTE
- Acute medical illness, including critical illness
- Recent (< 1 month) surgery
- Immobility/bedrest/bathroom privileges only for >3 days
- Age > 40
- Obesity (BMI > 30)
- Central venous access
- Pregnancy/post-partum
- Estrogen/hormonal therapy
- Erythropoesis-stimulating agents
- Multiple transfusions

NOT AT RISK FOR VTE
- Fully ambulatory with no risk factors for VTE

CONTRAINDICATIONS TO PHARMACOLOGIC PROPHYLAXIS?
- Active bleeding within 48-72 hours
- Hypertensive crisis
- Coagulopathy
- Platelet count < 25,000
- Use of rTPA for stroke within 24 hrs
- Recent head trauma or CNS hemorrhage
- Multiple trauma with high bleeding risk
- Proven or suspected peri-spinal hematoma
- At high risk for bleeding according to clinical judgment

Cost considerations:
- Low dose unfractionated heparin (LDUH) 5000 units SQ: $1.11/dose;
- Enoxaparin 40mg SQ: $5.90/dose;
- Renal failure (CrCl<30):
  - Dose adjustments not necessary for LDUH; enoxaparin 30mg SQ Q24H;
  - Fondaparinux contraindicated;
- History of HIT:
  - Consider fondaparinux 2.5 mg SQ daily (contraindicated if CrCl < 60)

THESE GUIDELINES ARE NOT INTENDED TO SUPERCEDE CLINICAL JUDGEMENT

UWMedicine VTE Prophylaxis Taskforce
HMC VTE Committee and UWMC VTE Committee
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