Guidelines on Prophylaxis of Venous Thromboembolism on Transfer from Secondary Care

1. BACKGROUND

Following publication of NICE CG92 all patients admitted to hospital must be assessed for risk of venous thromboembolism. This includes in-patients, day cases and some out-patients.

Patients are regarded as being at risk of VTE if they meet the following criteria (from NICE CG92)

<table>
<thead>
<tr>
<th>1. Medical patients who</th>
</tr>
</thead>
<tbody>
<tr>
<td>− have had or are expected to have significantly reduced mobility for 3 days or more or</td>
</tr>
<tr>
<td>− are expected to have ongoing reduced mobility relative to their normal state and have</td>
</tr>
<tr>
<td>one or more of the VTE risk factors (see below)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>2. Surgical patients and patients with trauma who</td>
</tr>
<tr>
<td>− have had a surgical procedure with a total anaesthetic and surgical time of more than</td>
</tr>
<tr>
<td>90 minutes, or 60 minutes if the surgery involves the pelvis or lower limb</td>
</tr>
<tr>
<td>− are a acute surgical admission with inflammatory or intra-abdominal condition</td>
</tr>
<tr>
<td>− are expected to have significant reduction in mobility</td>
</tr>
<tr>
<td>− have one or more of the risk factors shown below</td>
</tr>
</tbody>
</table>

**VTE risk factors**

- Active cancer or cancer treatment
- Age > 60 years
- Critical care admission
- Dehydration
- Known thrombophilias
- Obesity (BMI > 30 kg/m2)
- One or more significant medical comorbidities (for example: heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)
- Personal history or first-degree relative with a history of VTE
- Use of HRT
- Use of oestrogen-containing contraceptive therapy
- Varicose veins with phlebitis
- For women who are pregnant or have given birth within the previous 6 weeks (see NICE guidance or RCOG Guideline 37a for specific risk factors).
For patients regarded as being at risk of VTE, bleeding risk will also be assessed and a clinical decision made on the type of prophylaxis, if any, that should be offered to the patient.

For many patients, prophylaxis will be required only during hospital stay but for some, where risk of VTE remains significant (i.e. patients whose mobility remains reduced relative to normal state) prophylaxis may be required following discharge.

2. CHOICE OF VTE PROPHYLAXIS
Within Hull and East Riding the following methods of are used for VTE prophylaxis.

<table>
<thead>
<tr>
<th>Mechanical prophylaxis</th>
<th>Pharmacological prophylaxis (see Appendix for more information)</th>
</tr>
</thead>
</table>
| Includes anti-embolism stockings, foot impulse devices, intermittent pneumatic compression devices | Dalteparin
(low molecular weight heparin, LMWH)
Standard dose – 5000 units once daily by subcutaneous injection |
| Fondaparinux
(rarely - alternative to dalteparin)
Standard dose – 2.5mg once daily by subcutaneous injection | Dabigatran
Only for prophylaxis of VTE following total hip or knee replacement, or lower limb cast [unlicensed use].
Standard dose - 220mg once daily (for 8 days for TKR, 26 days for THR, 4-6 weeks following lower limb cast)
Dose reduced to 150mg once daily (or rarely 75mg once daily) in patients 75 years and over, CrCl 30-50ml/min, patients taking amiodarone, Verapamil. |

**Dabigatran is classified as RED drug for this indication** – full supply by secondary care
3. PROCEDURE WITHIN HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

On admission all patients will be assessed for risk of VTE and prescribed prophylaxis as per NICE CG92. Patients will be reassessed and a decision made regarding need for continued prophylaxis on discharge.

Patients likely to require VTE prophylaxis on discharge include those with following risks:
- Elective knee and hip replacement
- Hip fracture
- Other orthopaedic surgery (including day surgery)
- Major trauma
- Lower limb casts
- Reduced mobility following any surgical procedure or medical admission
- Pregnancy and/or 6 weeks following delivery as per RCOG Guideline 37a.

If VTE prophylaxis is required following discharge, HEY will:
- Provide GP with information on:
  - Risk assessment for VTE
  - Details of mechanical and/or pharmacological treatment provided
  - Baseline blood tests required for pharmacological treatments
  - Details of follow up required by GP or secondary care
- Supply up to 30 days of VTE prophylaxis (and sharps bin if subcutaneous injection)
  OR
- Supply complete course of treatment for patients on Dabigatran
- Make referral to district nursing team for administration of subcutaneous injection, if necessary
- Educate patient on VTE prophylaxis, as per NICE CG92.

4. STANDARD FOLLOW UP REQUIRED

For all patients on VTE prophylaxis:
- Consider contraindications, cautions, drug interactions and adverse effects of drugs prescribed for VTE prophylaxis, during routine clinical care of patient and prescribing of any new drug treatment.
  (see www.bnf.org or www.medicines.org.uk for further information).

Dalteparin or Fondaparinux:
- Prescribe additional sharps bin on FP10, if required
- For some patients, it will not be possible to determine the duration of reduced mobility at point of discharge (e.g. patients with reduced mobility following medical admission, who are discharged to Intermediate Care). For these patients prophylaxis should be prescribed while patient remains at risk of VTE, usually until patient returns to normal state of mobility. For patients who do not require follow up with specialist, GP should assess mobility and on-going need for prophylaxis.
APPROVAL PROCESS

<table>
<thead>
<tr>
<th>Written by:</th>
<th>Marie Miller, Interface Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation process:</td>
<td>MMIG</td>
</tr>
<tr>
<td>Approved by:</td>
<td>HEY Thrombosis Committee (Dec 14)</td>
</tr>
<tr>
<td>Ratified by:</td>
<td>HERPC (Jan 15)</td>
</tr>
<tr>
<td>Review date:</td>
<td>Jan 18</td>
</tr>
</tbody>
</table>
APPENDIX: FURTHER INFORMATION ON PHARMACOLOGICAL PROPHYLAXIS

DALTEPARIN

Indications (for VTE prophylaxis)
- Peri- and post-operative surgical thromboprophylaxis, including lower limb casts
- The prophylaxis of proximal deep venous thrombosis in patients bedridden due to a medical condition
- Thromboprophylaxis during pregnancy and following delivery

Dose – by subcutaneous injection
For prophylaxis 5000 units once daily, reduced to 2500 units once daily in dialysis patients.

Duration
Prophylaxis is normally continued until patients’ mobility returns to normal state. Examples of typical duration are given below, but they will vary according to type of surgery or medical problem and patient’s recovery.
- For day surgery – 5 days
- For fracture clinic – usually 4-6 weeks
- For orthopaedic surgery – usually 4 weeks
- In pregnancy – during pregnancy or up to 6 weeks following delivery (dependent on level of risk)
- For medical prophylaxis – usually discontinued on discharge but may continue for several weeks (licensed for up to 14 days).

Contraindications/cautions
Dalteparin is contraindicated in known hypersensitivity to dalteparin, other LMWH or heparins including history of confirmed or suspected immunologically mediated heparin induced thrombocytopenia (type II); acute gastroduodenal ulcer; cerebral haemorrhage; known haemorrhagic diathesis; serious coagulation disorders; septic endocarditis; injuries to and operations on the central nervous system, eyes and ears; patients who have suffered a recent (within 3 months) stroke unless due to systemic emboli.

Patients with other bleeding risks – a clinical decision must be made on whether to initiate or continue pharmacological thromboprophylaxis based on risks of VTE and risks of bleeding.

Drug interactions
Anticoagulant/ antiplatelet agents – concomitant use will lead to enhancement of the anticoagulant effect by anticoagulant/antiplatelet agents

As a general guide
- Dalteparin should not be prescribed concomitantly with desirudin, fibrinolytic agents, GP IIb/IIIa receptor antagonists, heparin, fondaparinux, heparinoids, apixaban, dabigatran, rivaroxaban, other Low Molecular Weight Heparins (LMWH) or with warfarin, once INR is in therapeutic range
- Dalteparin may be prescribed concomitantly with aspirin, clopidogrel, dipyridamole, NSAIDs dependent on clinical assessment of risk of VTE / risk of bleeding.
- Dalteparin should NOT be prescribed with more than one other anticoagulant/antiplatelet

Monitoring
Monitor FBC, BCP and coagulation (PT and APTT) at baseline to check for contraindications to anticoagulation and that renal function is adequate.
Monitoring of Anti-Xa Levels is not usually required but may be considered for specific patients who are at increased risk for bleeding or rethrombosis.
FONDAPARINUX

Indications (for prophylaxis)
- Prevention VTE in adults undergoing major orthopaedic surgery of the lower limbs and abdominal surgery, immobilised due to other surgery (unlicensed)
- Prevention of Venous Thromboembolic Events (VTE) in adult medical patients who are judged to be at high risk for VTE and who are immobilised due to acute illness
- In HEY, used rarely, as an alternative to dalteparin

Dose – by subcutaneous injection
2.5mg once daily reduced to 1.5mg once daily in patients with creatinine clearance of 20-50ml/min

Duration
Prophylaxis is normally continued until patients’ mobility returns to normal state. Examples of typical duration are given below, but they will vary according to type of surgery or medical problem and patient’s recovery.

For day surgery – 5 days
For fracture clinic – usually 4-6 weeks
For orthopaedic surgery – usually 4 weeks (licensed for 24 days)
For medical prophylaxis – usually discontinued on discharge but may continue for several weeks (licensed for 14 days).

Contraindications/cautions
Fondaparinux is contraindicated in hypersensitivity to the active substance or to any of the excipients, active clinically significant bleeding, acute bacterial endocarditis, - severe renal impairment defined by creatinine clearance < 20 ml/min.

Use with caution patients with Heparin Induced Thrombocytopenia (HIT) type II; pregnancy; breast-feeding women.

Patients with other bleeding risks – a clinical decision must be made on whether to initiate or continue pharmacological thromboprophylaxis based on risks of VTE and risks of bleeding.

Drug interactions
Anticoagulant/antiplatelet agents – concomitant use will lead to enhancement of the anticoagulant effect by anticoagulant/antiplatelet agents

As a general guide
- Fondaparinux should not be prescribed concomitantly with desirudin, fibrinolytic agents, GP IIb/IIIa receptor antagonists, heparin, heparinoids, apixaban, dabigatran, rivaroxaban, or other Low Molecular Weight Heparins (LMWH) or with warfarin, once INR is in therapeutic range
- Fondaparinux may be prescribed concomitantly with aspirin, clopidogrel, dipyridamole, NSAIDs dependent on clinical assessment of risk of VTE / risk of bleeding.
- Fondaparinux should NOT be prescribed with more than one other anticoagulant/antiplatelet

Monitoring
Monitor FBC, BCP and coagulation (PT and APTT) at baseline to check for contraindications to anticoagulation and that renal function is adequate.
Monitoring of Anti-Xa Levels is not usually required but may be considered for specific patients who are at increased risk for bleeding or rethrombosis.
DABIGATRAN

Indications (for VTE prophylaxis)
- Prevention of VTE in adult patients who have undergone elective total hip replacement surgery or total knee replacement surgery
- Prevention of VTE in adult patients with lower limb casts (unlicensed)

Dose (for VTE prophylaxis)
Standard dose: 220mg once daily
Dose reduced to 150 mg once daily in patients 75 years or over; patients with creatinine clearance of 30-50 ml/min, patients concomitantly prescribed verapamil, amiodarone
Dose reduced to 75mg once daily in patients with moderate renal impairment AND concomitantly treated with dabigatran and verapamil

Duration
Post total knee replacement – 8 days
Post total hip replacement – 26 days
For fracture clinic – 4-6 weeks

Contraindications/cautions
Dabigatran is contraindicated in patients with hypersensitivity to the active substance or to any of the excipients; severe renal impairment (CrCl < 30 ml/min); active clinically significant bleeding; organic lesion at risk of bleeding; spontaneous or pharmacological impairment of haemostasis; hepatic impairment (elevated liver enzymes > 2 ULN) or liver disease expected to have any impact on survival; concomitant treatment with systemic ketoconazole, itraconazole, tacrolimus and cyclosporin; pregnancy; breast-feeding

Patients with other bleeding risks – a clinical decision must be made on whether to initiate or continue pharmacological thromboprophylaxis based on risks of VTE and risks of bleeding.

Drug interactions
Anticoagulant/ antiplatelet agents – concomitant use will lead to enhancement of the anticoagulant effect by anticoagulant/antiplatelet agents

As a general guide
- Dabigatran should not be prescribed concomitantly with warfarin, desirudin, fibrinolytic agents, GP IIb/IIIa receptor antagonists, heparin, Low Molecular Weight Heparins (LMWH), fondaparinux, heparinoids, apixaban, rivaroxaban, NSAIDS with half life > 12 hours.
- Dabigatran may be prescribed concomitantly with aspirin, clopidogrel, prasugrel, dipyridamole, NSAIDs dependent on clinical assessment of risk of VTE / risk of bleeding.
- Dabigatran should NOT be prescribed with more than one other anticoagulant/antiplatelet

Pharmacokinetic interactions
- P-glycoprotein inhibitors – ketoconazole, itraconazole, tacrolimus and cyclosporin – contraindicated
- Amiodarone, Verapamil, quinidine – reduce dose
- P-glycoprotein inducers- rifampicin, carbamazepine, St John’s Wort, protease inhibitors – may reduce effect

Monitoring
Monitor FBC and U&E at baseline.