Network(s)
Midlands Trauma Networks
Publication:
Document name: **Thromboprophylaxis Guideline**
Document purpose: This document contains local guidelines for the BBCHW Trauma Network regarding patients at risk of thromboprophylaxis.
Author: Midlands Trauma Networks
Publication date: June 2016 Date reviewed: October 2018 Review due date: June 2020 Ref No. 4
Target audience: BBCHWTN Major Trauma Centre, Trauma Units, Local Emergency Hospital
Action required: Dissemination to MTC, TU, LEH personnel for action.
Contact details for further information: Midlands Critical Care, Trauma and Burns Networks 15 Frederick Road Birmingham B15 1JD
Document status: The controlled copy of this document is maintained by the Midlands Critical Care & Trauma Networks. Any copies of this document held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

All patients should be risk assessed for VTE according to local guidelines. In general:-

1. ALL lower limb/pelvic/abdo/chest/spine/head admissions should receive antiembolism stockings unless contra-indicated. These should be applied certainly to the "good" leg(s) and to the "bad" leg if the injuries permit this to be done safely.
2. ALL lower limb/pelvic/abdo/chest admissions should appropriate chemical thromboprophylaxis unless contra-indicated.
3. Spinal and head-injured patients need special consideration, preferably in consultation with the neuro/spinal surgeons, but should receive appropriate chemical thromboprophylaxis unless contra-indicated.
4. ALL upper limb patients will need at the least an assessment of risk. If in doubt they should receive antiembolism stockings unless contra-indicated. If there is particular risk, especially if they are immobile (e.g. following a flap reconstruction) they should receive appropriate chemical thromboprophylaxis unless contra-indicated.
5. Where chemical thromboprophylaxis is contra-indicated by active bleeding or a high risk of bleeding (e.g. conservatively managed solid organ injury) or another reversible reason the contra-indicating risk MUST be reviewed regularly and frequently so that appropriate chemical thromboprophylaxis can be started as soon as safely possible.
6. In some high-risk patients where chemical thromboprophylaxis is contra-indicated a caval filter may be appropriate. This is a decision that needs to be made at a senior level. Make sure that VTE prophylaxis is something you discussed regularly.
7. Chemical thromboprophylaxis should be stopped 12 hours before surgery and restarted 6—12 hours post-surgery. **If a patient is postponed for theatre then this requires an active decision to give any dose that would otherwise have been omitted.**
8. Hip fracture patients require their chemical thromboprophylaxis continued to 35 days post-surgery EVEN IF THEY GO HOME rather than to a rehab unit.
9. Make sure that, as with any decision about patient management, decisions about VTE prophylaxis are recorded in the notes.
10. Chemical thromboprophylaxis doses may need to be reduced for renal impairment