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‘Out of date policy documents must not be relied upon’

### Approval Committee

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<th>Version</th>
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<th>Review Date</th>
<th>Document Author</th>
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<td>2</td>
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<td>Kareena Marotta &amp; Jason Mainwaring</td>
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The RBCH VTE Prevention Guidelines have been adapted from NICE Clinical Guideline 92 – Venous thromboembolism: reducing the risk in patients admitted to hospital – January 2010
Introduction

An estimated 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year\(^1\). Treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service.

VTE is a condition in which a blood clot (a thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, sometimes over a long term because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes).

The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted and on any predisposing risk factors (such as age, obesity and concomitant conditions).

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Definitions and abbreviations

Definitions

- Major bleeding: a bleeding event that results in one or more of the following:
  - death
  - a decrease in haemoglobin concentration of \( \geq 2 \) g/dl
  - transfusion of \( \geq 2 \) units of blood
  - bleeding into a retroperitoneal, intracranial or intraocular site
  - a serious or life-threatening clinical event
  - a surgical or medical intervention

- Significantly reduced mobility: bedbound, unable to walk unaided or likely to spend a substantial proportion of the day in bed or in a chair

Abbreviations

- CrCl: creatinine clearance
- BMI: body mass index
- DVT: deep vein thrombosis
- FBC: full blood count
- HIT: heparin-induced thrombocytopaenia
- HRT: hormone replacement therapy
- INR: international normalised ratio (standardised laboratory measure of blood coagulation)
- LMWH: low molecular weight heparin
- PE: pulmonary embolism
- SC: subcutaneous
- UFH: unfractionated heparin
- VTE: venous thromboembolism
Assessing risks of VTE and bleeding

Patients who are at risk of VTE

<table>
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<th>Surgical patients and patients with trauma</th>
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<td>• If mobility significantly reduced for ≥ 3 days or</td>
<td>• If total anaesthetic + surgical time &gt; 90 minutes or</td>
</tr>
<tr>
<td>• If expected to have ongoing reduced mobility relative to normal state plus any VTE risk factor</td>
<td>• If surgery involves pelvis or lower limb and total anaesthetic + surgical time &gt; 60 minutes or</td>
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<td>• If acute surgical admission with inflammatory or intra-abdominal condition or</td>
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<td>• If expected to have significant reduction in mobility or</td>
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<tr>
<td></td>
<td>• If any VTE risk factor present</td>
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</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

1 For women who are pregnant or have given birth within the previous 6 weeks see page 16

Patients who are at risk of bleeding

All patients who have any of the following

• Active bleeding
• Acquired bleeding disorders (such as acute liver failure)
• Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR > 2)
• Lumbar puncture / epidural / spinal anaesthesia within the previous 6 hours or expected within the next 12 hours
• Acute stroke
• Thrombocytopenia (platelets < 75 x 10⁹/l)
• Uncontrolled systolic hypertension (≥ 230/120 mmHg)
• Untreated inherited bleeding disorders such as haemophilia or von Willebrand’s disease)

It is essential that the patient’s risks of VTE and bleeding are assessed and documented on the drug chart on a regular basis and whenever the patient’s clinical condition changes. Once the patient has been VTE risk assessed and appropriate thromboprophylaxis prescribed this should be entered on the VTE verification tool. It is important to stop prophylaxis with LMWH etc as soon as appropriate, taking into account the patient’s level of mobility before admission. The risk versus benefit of prophylaxis should be considered e.g. risk of patient falls which could then result in bleeding.
For all patients

- Do not allow patients to become dehydrated unless clinically indicated
- Encourage patients to mobilise as soon as possible
- Do not regard aspirin or other antiplatelet agents as adequate prophylaxis for VTE
- Consider offering temporary inferior vena caval filters to patients who are at very high risk of VTE (such as patients with a previous VTE event or active malignancy) if mechanical and pharmacological VTE prophylaxis contraindicated

For patients having elective surgery

**Oral contraceptives and HRT**
- Advise women to consider stopping oestrogen-containing contraceptives or HRT 4 weeks before surgery

**Pre-existing antiplatelet therapy**
- Assess risks and benefits of stopping pre-existing antiplatelet therapy 1 week before surgery
- Consider involving the multidisciplinary team in the assessment

**Anaesthesia**

- Consider regional anaesthesia, in addition to other methods of VTE prophylaxis, as it carries a lower risk of VTE than general anaesthesia. Take into account patient preferences, suitability for regional anaesthesia and any other planned method of VTE prophylaxis
- If regional anaesthesia is used, plan the timing of pharmacological prophylaxis to minimise risk of epidural haematoma. If antiplatelet or anticoagulant agents are being used or their use is planned, refer to the Summary of Product Characteristics (SPC) for guidance about safety and timing of these agents in relation to regional anaesthesia
- Do not routinely offer pharmacological or mechanical VTE prophylaxis to patients having surgery with local anaesthesia by local infiltration with no limitation of mobility
Using VTE prophylaxis

Pharmacological VTE prophylaxis

- Base the choice of pharmacological VTE prophylaxis on local policies, clinical condition (for example, renal failure) and patient preference

**In patients with a CrCl > 20mL/min**

LMWH: **Dalteparin** 5000units SC daily

**In patients with a CrCl < 20mL/min**

Up to 10 days - LMWH: **Dalteparin** 5000units SC OD

Over 10 days - **Unfractionated Heparin** 5000units SC BD

- For medical and surgical patients continue prophylaxis until patient no longer at increased risk of VTE. Consider the patients level of mobility before admission. Usual maximum is 14 days for medical patients
- Extended prophylaxis
  - for major cancer surgery in the abdomen or pelvis continue LMWH for 28 days after surgery
  - for hip replacement continue LMWH for 35 days after surgery
  - for knee replacement continue LMWH for 10 days after surgery

- **Monitor for HIT** (Heparin Induced Thrombocytopenia)
  - if dalteparin prophylaxis is required for > 5 days, check baseline FBC and check again between days 5 to 7 and between days 10 to 14 for outpatients and discharges and day 6 and day 14 for inpatients to exclude heparin-induced thrombocytopenia
  - if platelet count is < 150 x 10^9/L or lower than baseline platelet count by > 50%, stop dalteparin, investigate for HIT and switch to alternative prophylaxis (discuss with Haematologist)

Information for patients about VTE prophylaxis

- Consider offering synthetic alternatives to heparin to patients who have concerns about using animal products, since heparin is of animal origin
- Before starting VTE prophylaxis, offer verbal and written information on:
  - risks and possible consequences of VTE
  - importance of VTE prophylaxis and its possible side effects
  - correct use of VTE prophylaxis
  - how to reduce risk of VTE
- On discharging patients give verbal information on signs and symptoms of VTE. Written information on:
  - Signs and Symptoms of VTE
  - Who to contact
  - Is documented on EIDF

The rationale for choice of heparins at RBCH

- There is evidence to suggest that dalteparin does not accumulate in prophylactic doses when used short term.
- Dalteparin is licensed for prophylaxis of VTE at the usual dose of 5000units daily
- Calculated creatinine clearance (CrCl) should be used where acute renal impairment is suspected, since eGFR was developed as a measure for GPs to monitor chronic renal impairment
- There is a creatinine clearance calculator on the intranet under Doctor’s Information

See Appendices III and IV
Mechanical VTE prophylaxis

- Base the choice of mechanical VTE prophylaxis on clinical condition, surgical procedure and patient preference. Choose any one of:
  - anti-embolism stockings (thigh or knee length)
  - foot impulse devices
  - intermittent pneumatic compression devices (thigh or knee length)

Anti-embolism stockings

- Do not offer anti-embolism stockings to patients with:
  - suspected or proven peripheral arterial disease
  - peripheral arterial bypass grafting
  - peripheral neuropathy or other causes of sensory impairment
  - local condition in which stockings may cause damage, such as fragile ‘tissue paper’ skin, dermatitis, gangrene or recent skin graft
  - known allergy to material of manufacture
  - cardiac failure
  - severe leg oedema or pulmonary oedema from congestive heart failure
  - unusual leg size or shape
  - major limb deformity preventing correct fit
- Use caution and clinical judgement when applying anti-embolism stockings over venous ulcers or wounds
- Measure legs and use correct stocking size. Staff who fit stockings should be trained in their use and should show patients how to use them
- If oedema or postoperative swelling develops, ensure legs are re-measured and stockings refitted
- If arterial disease suspected, seek expert opinion before fitting stockings
- Use stockings that provide graduated compression and produce a calf pressure of 14 – 15 mmHg
- Encourage patients to wear the stockings day and night from admission until they no longer have significantly reduced mobility
- Remove stockings daily for hygiene purposes and to inspect skin condition. If patient has significant reduction in mobility, poor skin integrity or sensory loss, inspect skin two or three times per day, particularly over heels and bony prominences
- Discontinue use of stockings if there is marking, blistering or discolouration of skin, particularly over heels and bony prominences, or if patient has pain or discomfort. If suitable, offer intermittent pneumatic compression or foot impulse devices as an alternative
- Show patients how to use anti-embolism stockings correctly and ensure they understand that this will reduce their risk of developing VTE
- Monitor use of anti-embolism stockings and offer assistance if they are not being worn correctly

Foot impulse and intermittent pneumatic compression devices*

- Do not offer these devices to patients with a known allergy to the material of manufacture
- Encourage patients on the ward who have these devices to use them for as much of the time as is possible and practical, both when in bed and when sitting in a chair

* these are referred to on the RBCH VTE Risk Assessment as impulse or compression devices
VTE prophylaxis for patients already having antiplatelet or anticoagulant therapy to treat other conditions

- Consider offering additional mechanical or pharmacological VTE prophylaxis if patient is at risk of VTE. Take into account risk of bleeding and of comorbidities such as arterial thrombosis
  - **If the risk of VTE outweighs the risk of bleeding**, consider offering pharmacological VTE prophylaxis according to the reason for admission
  - **If the risk of bleeding outweighs the risk of VTE**, offer mechanical VTE prophylaxis
- Do not offer additional pharmacological or mechanical VTE prophylaxis to patients who are taking vitamin K antagonists and who are within their therapeutic range, providing anticoagulant therapy is continued
- Do not offer additional pharmacological or mechanical VTE prophylaxis to patients who are having full anticoagulant therapy (for example, LMWH or UFH)
Medical patients

Balance risks of VTE and bleeding before offering VTE prophylaxis. See page 4.

General medical patients

Does risk of VTE outweigh risk of bleeding?

Yes

Is pharmacological VTE prophylaxis contraindicated?

Yes

Has patient been admitted for stroke?

Yes

See page 10

No

No

Offer pharmacological VTE prophylaxis with:
- LMWH or UFH*

Continue until patient no longer at increased risk of VTE

Reassess risks of bleeding and VTE within 24 hours of admission and whenever clinical situation changes

Yes

Consider offering mechanical VTE prophylaxis with any one of:
- anti-embolism stockings (thigh or knee length)
- foot impulse devices
- intermittent pneumatic compression devices (thigh or knee length)

* for patients with renal failure
Stroke

Patients admitted for stroke

Do not offer anti-embolism stockings for VTE prophylaxis

Does patient have major restriction of mobility, previous history of VTE, dehydration or comorbidity (such as malignant disease)?

Yes

Haemorrhagic stroke excluded?

Yes

Low risk of bleeding (haemorrhagic transformation of stroke or bleeding into another site)?

Yes

Consider offering prophylactic-dose LMWH or UFH*

When acute event over and patient’s condition stable

Stop LMWH or UFH*

No

Reassess within 24 hours of admission and whenever clinical situation changes

No

Consider offering foot impulse or intermittent pneumatic compression device until patient can have pharmacological VTE prophylaxis

Reassess at 2 weeks – discuss with stroke consultant

No

Low risk of bleeding (haemorrhagic transformation of stroke or bleeding into another site)?

Discuss with stroke consultant

No

Yes

* for patients with renal failure
Cancer and patients with a central venous catheter

**Patients with cancer**

Is patient having oncological treatment and ambulant?

- Yes: Do not routinely offer pharmacological or mechanical VTE
  - Yes: Offer LMWH or UFH*
    - Continue until patient no longer at increased risk of VTE
  - No: Reassess within 24 hours of admission and whenever clinical situation changes
- No: VTE risk increased?
  - Yes: Consider offering LMWH or UFH*
  - No: Reassess within 24 hours of admission and whenever clinical situation changes

**Patients with central venous catheters**

Is patient ambulant?

- Yes: Do not routinely offer pharmacological or mechanical VTE
  - Yes: Consider offering LMWH or UFH*
  - No: Reassess within 24 hours of admission and whenever clinical situation changes
- No: VTE risk increased?
  - Yes: Consider offering LMWH or UFH*
  - No: Reassess within 24 hours of admission and whenever clinical situation changes

---

* for patients with renal failure
Palliative care

Balance risks of VTE and bleeding before offering VTE prophylaxis. See page 4.

Patients in palliative care

If patient has potentially reversible acute pathology

Consider offering LMWH or UFH*

Review decisions about VTE prophylaxis daily, taking into account potential risks and benefits and views of the patient, family and / or carers and multidisciplinary team

If patient in terminal care or end-of-life care pathway

Do not routinely offer pharmacological or mechanical VTE prophylaxis

* for patients with renal failure
Balance risks of VTE and bleeding before offering VTE prophylaxis. See page 4.

**Non-orthopaedic surgery**

- **Gastrointestinal surgery**
- **Gynaecological, thoracic and urological surgery**
- **Other surgery**
- **Vascular surgery**
- **Day surgery**

Bariatric surgery

If VTE risk increased

Offer mechanical VTE prophylaxis at admission
Continue until mobility no longer significantly reduced

If risk of major bleeding low

Add LMWH
Continue until mobility no longer significantly reduced (generally 5 – 7 days)

If major cancer surgery in the abdomen or pelvis

Continue LMWH or UFH* for 28 days after surgery

Vascular surgery

If VTE risk increased

Offer mechanical VTE prophylaxis at admission
If peripheral arterial disease present, seek expert opinion before fitting anti-embolism stockings
Continue until mobility no longer significantly reduced

If risk of major bleeding low

Add LMWH or UFH*
Continue until mobility no longer significantly reduced, including after discharge (generally 5 – 7 days)

* for patients with renal failure

1. Choose any one of:
   - anti-embolism stockings (thigh or knee length)
   - foot impulse devices
   - intermittent pneumatic compression devices (thigh or knee length)

2. Many vascular surgical patients are already having antiplatelet or anticoagulant therapy. For VTE prophylaxis in these patients see page 8
Orthopaedic surgery

Elective hip or knee replacement or hip fracture (transfer from PGH)

At admission
Offer mechanical VTE prophylaxis with any one of:
- anti-embolism stockings (thigh or knee length), used with caution (see page 7)
- foot impulse devices
- intermittent pneumatic compression devices (thigh or knee length)
Continue until mobility no longer significantly reduced

1 – 12 hours after surgery
Provided there are no complications, offer pharmacological VTE prophylaxis:
- LMWH started 6 – 12 hours after surgery or UFH*

Continue pharmacological VTE prophylaxis for:
- THR or hip fracture: 35 days of LMWH or
- TKR: 10 days of LMWH

Other orthopaedic surgery

At admission
Assess patient's risk of VTE

If VTE risk increased

Other orthopaedic surgery

Upper limb surgery

At admission
Assess patient's risk of VTE

Do not routinely offer VTE prophylaxis

After assessing risks and discussing with patient:
- Consider offering mechanical VTE prophylaxis with any one of:
  - anti-embolism stockings (thigh or knee length), used with caution (see page 7)
  - foot impulse devices
  - intermittent pneumatic compression devices (thigh or knee length)
- Consider offering LMWH 6 – 12 hours after surgery

Continue mechanical VTE prophylaxis and LMWH until patient's mobility no longer significantly reduced

* for patients with renal failure
Balance risks of VTE and bleeding before offering VTE prophylaxis. See page 4.

**Critical care**

1. Patient admitted to critical care unit
2. Assess risks of VTE and bleeding on admission to critical care unit
3. Offer VTE prophylaxis according to reason for admission
4. Reassess risks of VTE and bleeding and review decisions about VTE prophylaxis daily – more frequently if clinical condition is changing rapidly
5. Take into account known views of the patient, family and / or carers and multidisciplinary team

Take into account planned interventions and other therapies that may increase risk of complications
Pregnancy and post-partum

See separate guidelines:

Reducing the risk and management of venous thromboembolism (VTE) in pregnancy
Planning for discharge

- Offer patients and / or their families or carers verbal and written information on:
  - signs and symptoms of DVT and PE
  - importance of seeking medical help and who to contact if DVT, PE or other adverse event suspected
- Ensure this is documented on the patients' eIDF

See Appendix III

- If discharged with VTE prophylaxis, also offer patients and / or their families or carers information on:
  - correct use and duration of VTE prophylaxis at home
  - importance of using VTE prophylaxis at home correctly and for recommended duration
  - signs and symptoms of adverse events related to VTE prophylaxis
  - who to contact if they have problems using VTE prophylaxis at home

See Appendix IV

- If discharged with anti-embolism stockings, ensure that the patient:
  - understands the benefits of wearing them
  - understands the need for daily hygiene removal
  - is able to remove and replace the stockings or has someone who can do this
  - knows what to look for, such as skin marking, blistering or discolouration, particularly over heels and bony prominences
  - knows who to contact if there is a problem

- If discharged with pharmacological or mechanical VTE prophylaxis ensure that:
  - the patient is able to use it or has someone who can do this
  - the patient's GP is notified
Monitoring, diagnosing and managing heparin-induced thrombocytopenia (HIT)

HIT is an iatrogenic complication, mainly of heparin therapy, seen less often with LMWH therapy. HIT (also called HIT-II) can occur between days 5 and 21 of heparin therapy, typically 5 to 10 days after commencing treatment, and is complicated by arterial or venous thrombosis.

Monitoring for HIT
- All patients should have a baseline platelet count on admission prior to starting thromboprophylaxis with dalteparin. Platelet count should be repeated on the 5th to 7th and 10th to 14th day of prophylaxis for outpatients/discharged patients and day 6 and day 14 for inpatients.
- If the platelet count is < 150 x 10^9/L or less than 50% of baseline platelet count, stop heparins, start patient on a non-heparin anticoagulant drug and investigate for HIT (discuss with Haematologist)
- Do not substitute warfarin for heparins

Diagnosis of HIT
- Suspect HIT when following criteria are met:
  - patient receiving heparin or enoxaparin treatment or prophylaxis
  - thrombocytopenia < 150 x 10^9/L observed between 5th and 21st day of heparin or dalteparin treatment or prophylaxis
  - in surgical patients, thrombocytopenia may not be evident in the post-operative period. HIT should be suspected if platelet count is less than 66% of baseline platelet count between 5th and 21st day of heparin or dalteparin treatment or prophylaxis
  - patient develops symptoms or signs of venous or arterial thrombosis in presence of thrombocytopenia
  - other causes for thrombocytopenia have been excluded
- When HIT is suspected clinically, send appropriate blood samples (one citrated and one serum) for HIT screening (DiaMed Heparin/PF4 antibody test) and confirmatory (PF4 Enhanced ELISA) tests
- Contact coagulation laboratory on extension 4787 for sampling and result enquiries during normal working hours. Screening test can be done during on-call hours. Liaise with Haematology Biomedical Scientist on call for sampling and result enquiries

Management of HIT
- Stop heparin or dalteparin prophylaxis or treatment (including hep-flush) as soon as HIT is suspected
- Do not transfuse platelets for thrombocytopenia
- Exclude lower limb DVT with bilateral sonovenograms
- If no HIT-associated venous or arterial thrombosis has been diagnosed, give prophylaxis with danaparoid until platelet count is normal again. Consider anticoagulation for up to a month even if patient has no evidence of thrombosis at diagnosis as thrombotic complications can occur for up to 30 days after the onset of HIT even after platelet count has returned to normal (discuss with Haematologist)
- Treat venous thrombosis (DVT or PE) with intravenous danaparoid (as below) alone until platelet count is normal. After normal platelet count has been established, commence 5 day overlapping therapeutic schedule with warfarin and danaparoid. Stop danaparoid when INR > 2.0 on consecutive days. The total treatment duration of VTE is 3 to 6 months
- Treat arterial thrombosis (stroke, coronary artery disease, peripheral arterial disease) according to appropriate protocols substituting heparins with danaparoid
Danaparoid in the management of suspected or proven HIT

- Treatment

Danaparoid is a very effective treatment in cases of suspected or confirmed HIT either for thromboprophylaxis or treatment of a venous thrombosis.

**Suspected or proven HIT but no VTE**

- Wt ≤ 90 kg  
  Danaparoid 750 units s.c. bd
- Wt > 90 kg  
  Danaparoid 1250 units s.c. bd

**Suspected or proven HIT and VTE (or an arterial thrombosis)**

1. Give an IV bolus dose as follows:

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<th>IV Dose</th>
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<td>&lt; 60 kg</td>
<td>1500 units (2 ampoules)</td>
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<tr>
<td>60 to 75 kg</td>
<td>2250 units (3 ampoules)</td>
</tr>
<tr>
<td>75 to 90 kg</td>
<td>3000 units (4 ampoules)</td>
</tr>
<tr>
<td>&gt; 90 kg</td>
<td>3750 units (5 ampoules)</td>
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2. This is followed by preparing an intravenous continuous infusion by adding 2250 units of danaparoid to 250 mLs of sodium chloride 0.9% giving a concentration of 9 units per mL.

Infusion rates would be as follows:-

- 400 units / hour (44 mLs per hour) for 4 hours,
  then reduced to 300 units / hour (33 mLs / hour) for a further 4 hours,
  followed by a maintenance rate of 200 units / hour (22 mLs / hour).

Generally anti-Xa monitoring is not required unless:-

- The patient weighs > 90 kg
- There is significant renal impairment with a creatinine clearance of < 20 mLs / min. If this applies it might be better to initially start with only 50% bolus and continuous infusion doses until Anti-Xa levels are obtained to guide ongoing treatment.
  If anti-Xa monitoring is undertaken best to aim for a level between 0.5 and 1.0 units/mL.

- **Elimination of Danaparoid and half life**

Renal excretion and half life 17 to 28 hours (mean 25 hours) assuming normal renal function.

- **Side Effects**

  - Bleeding
  - Occasionally allergic reactions including at the injection site
  - HIT can be seen in < 10% of treated patients presumably due to cross reactivity with the heparin specific antibodies
• **Treatment of bleeding related to Danaparoid use**
  
  - Stop the infusion
  - Protamine only partially reverses the effect
  - For major bleeds consider the use of a Prothrombin Complex Concentrate such as Octaplex at doses up to 30 units/kg. The maximum dose at one time would be 3000 units.

• **Contra-indications**
  
  - Allergy to danaparoid or sulfites
  - Significant bleeding disorder
  - Active bleeding
  - Uncontrolled severe hypertension

**Audit**

The Trust Thrombosis Team will review thromboprophylaxis within the Trust. This is reported to Trust Performance Management Group and to the Trust Thrombosis Committee. Monthly data is submitted to the department of health. All patients who develop a hospital acquired VTE will be investigated using VTE Root Cause Analysis and an AIRS form will be completed.

**References**


E. Warkentin TH. Think of HIT. *Haematology* 2006; 1: 408-414.


G. British National Formulary (BNF) 58; September 2009.

H. Ortel TL. Heparin-induced thrombocytopenia: when a low platelet count is a mandate for anticoagulation. *Haematology* 2009; 225-231.
Appendices

I. Risk assessment for venous thromboembolism (VTE) for adult patients admitted to hospital (page 2 of the Acute Prescription and Administration Record):

II. Guide to using the VTE Risk Assessment Form:

III. Preventing blood clots in hospital (patient information leaflet):

IV. Going home – instructions for preventing blood clots (patient information leaflet):

V. GP letter for extended thromboprophylaxis:

VI. GP information on heparin-induced thrombocytopenia (HIT):
   http://rbhintranet/policies/vte/gp_information_hit.pdf

VII. Blood form labels for patients going home on extended thromboprophylaxis:

Consultation Process

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### EQUALITY IMPACT ASSESSMENT – SCREENING FORM

| 1. Title of document/service for assessment | VTE Prevention Guidelines |
| 2. Date of assessment | July 2012 |
| 3. Date for review | July 2014 |
| 4. Directorate/Service | Trust-wide |
| 5. Approval Committee | MGC |

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<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation, to include heterosexual, lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability – learning disabilities, physical disabilities, sensory impairment and mental health issues</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>7. Does this document affect an individual’s human rights?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>8. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

9. If the answers to any of the above questions is ‘yes’, then:

<table>
<thead>
<tr>
<th></th>
<th>Tick</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate that such a disadvantage or advantage can be justified or is valid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjust the policy to remove disadvantage identified or better promote equality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If neither of the above possible, submit to Diversity Committee for review.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Screener(s)

Print name: Jacqui Bowden

11. Date Policy approved by Committee | July 2012 |

12. Upon completion of the screening and approval by Committee, this document should be uploaded to papertrail.