### Risk assessment

**VTE risk factors**

- Active bleeding
- Active cancer or cancer treatment
- Immobilisation for any reason
- History of VTE
- Recent major surgery or injury
- Suspected or proven peripheral arterial disease
- Total anaesthetic + surgical time > 90 minutes
- Uncontrolled hypertension
- Use of anticoagulant post-surgery
- Known acute DVT or PE
- Diabetes (HbA1c > 7%) or type 2 diabetes

**Concurrent use of anticoagulants (such as an oral antithrombotic):** Increased risk of the following bleeding events

- Major bleeding
- Significant failure of an anticoagulant

**Unusual leg size or shape**

- Suspected or proven peripheral arterial disease

**Known acute DVT or PE**

- Continue mechanical prophylaxis until mobility no longer significantly reduced.

**Uncontrolled hypertension**

- Avoid or use caution when applying AES over venous ulcers or wounds.

**Patients already having an anticoagulant or antiplatelet therapy**

- Do not add any new anticoagulant or antiplatelet agents.

- Continue existing therapy, as per preference (such as warfarin with INR > 2 or low molecular weight heparin).

**Do not allow patients to become dehydrated**

- Unless clinically indicated.

### VTE prophylaxis

**For all patients**

- Offer low dose subcutaneous enoxaparin or unfractionated heparin, or if weight-based, enoxaparin or unfractionated heparin according to renal function.

- Monitor regular laboratory tests for bleeding risk.

**Mechanical VTE prophylaxis**

- Anti-embolism stockings
- Anti-embolism foot compression devices
- Lower limb plaster casts
- Encourage patients to wear stockings day and night from admission until they no longer need them.

**Foot impulses and intermittent pneumatic compression devices**

- Consider using foot impulses and intermittent pneumatic compression devices in patients with a history of VTE.

**Risk assessment**

- 1. Assess level of mobility, VTE and bleeding risk.

**Anti-embolism Stockings (AES)**

- Use caution when applying AES over venous ulcers or wounds.

**Foot impulses and intermittent pneumatic compression devices**

- Ensure patient has been advised how to use foot impulses and intermittent pneumatic compression devices.

**VTE prophylaxis during pregnancy and post partum**

- Consider mechanical and pharmacological prophylaxis as per separate guidelines.

### Pharmocological VTE prophylaxis

**Enoxaparin and unfractionated Heparin dosing in pregnant women**

- **Enoxaparin:**
  - Thrush: 30mg SC on days 1 to 5 post partum, 30mg SC on days 6 to 14 post partum.
- **Unfractionated Heparin:**
  - Thrush: 5000 units SC BID on days 1 to 5 post partum.

**Enoxaparin and unfractionated Heparin**

- Patients with a history of VTE or bleeding risk.

- Consider adjusting doses according to pregnancy and postpartum bleeding risk.

### Pharmacological VTE prophylaxis

**Enoxaparin and unfractionated Heparin prophylaxis**

- Check baseline patient condition before the initiation of therapy.

**VTE prophylaxis during pregnancy**

- Consider mechanical and pharmacological prophylaxis as per separate guidelines.

**Patients with increased bleeding risk**

- Consider also assessing potential prophylaxis in these susceptible patients.

### Mechanical VTE prophylaxis

**Anti-embolism Stockings (AES)**

- Use caution and clinical judgement when applying AES over venous ulcers or wounds.

**Foot impulses and intermittent pneumatic compression devices**

- Complete a formal review at discharge and document any need for extended prophylaxis on the discharge summary and ensure that it is prescribed.

### Before discharge

**VTE prophylaxis during pregnancy**

- Offer low dose subcutaneous enoxaparin or unfractionated heparin in pregnancy and post partum.

**Critical Care**

- Define VTE and bleeding risk.

### Pregnancy and up to 6 weeks post-partum

- For further information refer to "Thromboprophylaxis and Thrombectomy in Pregnancy Guidelines" as SMARTnet.

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Disclaimer: It is your responsibility to check against SMARTnet that this is the most recent issue of this document.