MMG015 GUIDELINES FOR THE USE OF PRIMARY THROMBOPROPHYLAXIS IN THE PALLIATIVE CARE SETTING
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Why we need this Guideline

Primary thromboprophylaxis is the use of anticoagulation in patients to prevent venous thromboembolism (VTE) in those that are considered to be at high risk of developing VTE but have not previously had VTE.

More recently the issue of preventing venous thromboembolism has become a high priority in healthcare. In January 2010 the National Institute for Clinical Excellence (NICE) extended their guidance on thromboprophylaxis from surgical patients to medical patients and included specialist populations such as intensive care, acute stroke, cancer and palliative care.¹

The role of primary thromboprophylaxis in palliative care has remained a controversial issue, due to the heterogeneous population of palliative care patients, and the limited evidence base regarding which patients would benefit from thromboprophylaxis. A number of unanswered questions remain including the true incidence of VTE and the later risk of developing a pulmonary embolism (PE), the duration of treatment, the potential burden of treatment and the overall benefit of treatment to patients within this population.² However more recent studies have suggested that thromboprophylaxis is acceptable to patients³ and a growing number of specialist palliative care units have developed guidelines.⁴

What the Guideline is trying to do

The aim of this guidance is to aid clinical decision making regarding primary thromboprophylaxis for VTE in patients with malignant and non-malignant conditions in the palliative care setting.

Which stakeholders have been involved in the creation of this Guideline

Medicines Management Committee

Any required definitions/explanations

VTE – Venous Thromboembolism

NHFT - Northamptonshire Healthcare NHS Foundation Trust

S/C - subcutaneous

Key duties

Medicines Management Committee

Will approve and review these guidelines

Doctors

Are responsible for:

- Undertaking the initial risk assessment of the patient on admission
- Assessing the risk of bleeding in patients considered for VTE prophylaxis
- Prescribing appropriate VTE prophylaxis
- Monitoring and reviewing the need for treatment as the patient’s condition changes.
- Liaison with acute trusts for patients identified with potential signs and symptoms of VTE if appropriate

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Nursing staff

- Are responsible for:
  - Monitoring the patient for change in mobility and notifying the doctor of any significant change
  - Administering thromboprophylaxis as prescribed.

Primary Thromboprophylaxis in Palliative care

Risk of VTE in Non-Malignant Conditions

It is thought that 70 - 80% of hospital-acquired fatal PEs occur in medical patients. Medical patients tend to be older and 40% have more than one risk factor for VTE including previous VTE, cancer, stroke, heart failure, chronic obstructive airways disease, sepsis and bed rest. The baseline risk of VTE is estimated to be around 15% for those who are acutely unwell in medical beds

Medical patients will have an increased risk of VTE if they have had or are expected to have significantly reduced mobility for 3 days or more, or are expected to have ongoing reduced mobility relative to their normal state and have one or more of the risk factors listed below:

- Active cancer or cancer treatment
- Age over 60 years
- Dehydration
- Known thrombophilias
- Obesity (BMI over 30 kg/m2)
- One or more significant medical comorbidities (for example: heart disease, metabolic, endocrine or respiratory pathologies, acute infectious diseases or inflammatory conditions)
- Personal history or a first degree relative with a history of VTE
- Use of hormone replacement therapy
- Use of oestrogen-containing contraceptive therapy
- Varicose veins with phlebitis.

Guidance for the Specialist Palliative Care Setting

The guidance that follows has been developed based on the recommendations of NICE and of the data extrapolated from studies involving patients from medical and oncology populations.

The need for thromboprophylaxis should be made on an individual patient basis.

Completing the VTE assessment on SystmOne may aid your decision making (see Appendix 1 for screenshots)

Consider offering pharmacological thromboprophylaxis to all patients admitted to the specialist palliative care unit with a potentially reversible cause e.g. infection, hypercalcaemia or spinal cord compression unless there is a contraindication. If the patient has capacity, seek the patient’s

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consent. If they lack capacity act in their best interests until capacity returns and re-discuss at that point.

If the cause is thought to be irreversible but prognosis is likely to be greater than weeks e.g. spinal cord compression, prolonged thromboprophylaxis can be considered.

If thromboprophylaxis is deemed appropriate then weigh the patient if possible. The dose of enoxaparin is dependent on weight and renal function.

If CrCl is > or = 30ml/min give enoxaparin 40mg S/C once daily. If CrCl is < 30ml/min give enoxaparin 20mg S/C once daily.

If patient <50kg give enoxaparin 20mg od, if 50-100kg give 40mg od, if 100-150kg give 40mg twice daily and if >150kg give 60mg twice daily.14,15

Do not routinely offer thromboprophylaxis to patients when assessment on admission confirms they are to be admitted for terminal care.

If a recent platelet count is not available i.e. in last 4 weeks and there is no obvious contraindication, commence enoxaparin and check platelet count at the earliest opportunity. Discontinue if platelets are less than 50 and exert caution with platelets less than 75.

Review the decision for continuation of thromboprophylaxis daily, or if patient’s condition changes or if side effects develop, taking into account the views of patients, their families and/or carers and the multidisciplinary team.

Completion of the thromboprophylaxis screening tool will be checked at the weekly MDT meeting. This meeting will also provide another opportunity to discuss ongoing thromboprophylaxis.

Due to the lack of evidence regarding duration of treatment this needs to be a medical decision taking into account the views of the patient and their carers. It may be appropriate to continue prophylaxis long term in certain cases e.g. spinal cord compression.

**Contraindications to thromboprophylaxis**

- Active major bleeding and conditions with a high risk of uncontrolled haemorrhage including recent haemorrhagic stroke
- Thrombocytopenia – do not give if platelet count <50
- Active gastric or duodenal ulceration
- Acute bacterial endocarditis
- Hypersensitivity to enoxaparin, LMWHs
- Already receiving therapeutic oral anticoagulants (with a therapeutic INR where appropriate)
- Within 12 hours of loco-regional anaesthesia e.g. nerve block

**Cautions**

- Severe renal impairment – dose adjust if CrCl <30 give 20mg
- Severe liver impairment

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- Platelet count < 75
- Extreme caution in patients with a history of Heparin Induced Thrombocytopenia (HIT)
- Caution in conditions with increased risk of bleeding i.e:
  * Impaired haemostasis
  * History of peptic ulcer
  * Recent ischaemic stroke
  * Uncontrolled hypertension
  * Diabetic retinopathy
  * Recent neuro or ophthalmic surgery
  * Anaemia
  * Major trauma
  * Spinal and epidural infusions
- Cerebral metastases
- Frequent falls or high risk of falls

**Information to provide patients and carers**

NICE recommends offering patients and/or carers verbal and written information before commencing VTE prophylaxis the risks and possible consequences of VTE including

- the importance of VTE prophylaxis and its possible side effects
- how patients can reduce their risk of VTE (such as keeping well hydrated and, if possible exercising and becoming more mobile)

Be aware that heparins are of animal origin and this may be of concern to some patients. Synthetic alternatives are available.

Explain to patients they may have an increased risk of deep vein thrombosis due to their underlying condition or superimposed reduced mobility due to their current illness e.g. infection. Explain this would be routinely offered in the hospital setting to try and reduce their risk of deep vein thrombosis and possibly pulmonary embolism. If appropriate explain pulmonary embolism could cause symptoms or be fatal. The prophylaxis would be reviewed regularly or when a change in clinical condition occurs, and stopped if any complications such as bleeding occurred or their mobility improved to their baseline state.

**NICE have produced an information leaflet which is available at**
https://www.nice.org.uk/guidance/cg92/ifp/chapter/About-this-information

**Training requirements associated with this Guideline**

**Mandatory Training**

Training required to fulfil this Guideline will be provided in accordance with the Trust’s Training Needs Analysis. Management of training will be in accordance with the Trust’s Statutory and Mandatory Training Policy’

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Specific Training not covered by Mandatory Training
Ad hoc training sessions based on an individual’s training needs as defined within their annual appraisal or job description.

How this Guideline will be monitored for compliance and effectiveness
The table below outlines the Trusts’ monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

<table>
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<th>Aspect of compliance or effectiveness being monitored</th>
<th>Method of monitoring</th>
<th>Individual responsible for the monitoring</th>
<th>Monitoring frequency</th>
<th>Group or committee who receive the findings or report</th>
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<td>How patients are assessed for their risk of developing venous thromboembolism (VTE) including timescales</td>
<td>Audit of documentation of VTE risk assessment in patient records.</td>
<td>Clinical director for Palliative care</td>
<td>Annually (Quarter 2)</td>
<td>MMC</td>
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<td>Prophylactic treatment regime for high risk patients</td>
<td>Audit of prescriptions of patients identified as being at risk of VTE following risk assessment</td>
<td>Clinical director for Palliative care</td>
<td>Annually (Quarter 2)</td>
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<td>If there is mandatory training associated with this document state the mandatory training here</td>
<td>Training will be monitored in line with the Statutory and Mandatory Training Policy.</td>
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Where a lack of compliance is found, the identified group, committee or individual will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is represented showing how any gaps have been addressed.

Equality considerations
See MMP001 Control of Medicines Policy.
Reference Guide


14. Guide for the Use of Thromboprophylaxis in Obese and Low Body Weight Patients Kettering General Hospital Foundation Trust

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NeLM Q&A 326.1 What doses of thromboprophylaxis are appropriate for adult patients at extremes of body weight?
### Document control details

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<th>Dr Fiona Wiseman Consultant in Palliative Medicine</th>
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<tr>
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Appendix 1 – VTE questionnaire on SystmOne

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