

DVT prophylaxis

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Many postoperative patients are not immediately ambulatory. In these individuals, it is important to provide prophylactic therapy to reduce the risk of DVT and PE (see Table 1-7). Prophylaxis should be started preoperatively in patients undergoing major procedures because venous stasis and relative hypercoagulability occur during the .operation

Prophylaxis for deep venous thrombosis and pulmonary embolus

Prophylaxis	Surgery type	Patient group ^a
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	Minor	Low risk
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GCS, SQH-12, or IPC	Major	Low or moderate risk
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SQH-8 or LMWHb	Major	High risk
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SQH-8/12 or LMWH + IPC	Major	Highest risk
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aLow risk, age less than 40 years, no risk factors; moderate risk, major surgery & age less than 40 years or minor procedure with risk factors or between 40 and 60 years of age; high risk, major procedure over age 40 or with risk factors, or minor procedure over age 60 or with risk factors; highest risk, age greater than 40 years, multiple risk factors .present, major procedure

GCS, graded compression stockings; IPC, intermittent pneumatic) compression; LMWH, low molecular-weight heparin; SQH-8, subcutaneous heparin every 8 hours; SQH-12, subcutaneous heparin (.every 12 hours

Mechanical prophylaxis includes graded compression stockings and intermittent pneumatic compression devices, either of which are nearly as effective as unfractionated heparin in reducing DVT in most low-risk to moderate-risk patients who are undergoing general surgical procedures. These devices alone are inadequate prophylaxis for high-risk (especially cancer) patients and should be avoided in individuals with peripheral vascular disease

Unfractionated heparin, 5,000 units subcutaneously, starting 2 hours before surgery and continuing every 8 to 12 hours postoperatively, markedly decreases the incidence of DVT after general surgery. No increase in major hemorrhagic complications is observed with this regimen, although the rate of wound hematoma is higher. This in operations that involve prosthetic **ضار** increase may be detrimental materials (i.e., hernia repair with mesh), in which case intermittent .pneumatic compression devices can be a substitute

Low molecular-weight heparins, such as enoxaparin (1 mg/kg subcutaneously every 12 to 24 hours), are derivatives of unfractionated heparin and have become an important class of agents in the prevention and treatment of thromboembolic disease. These agents have a clinical efficacy that is nearly equivalent to that of intravenous heparin and they do not require frequent measurement of coagulation times. Prophylactic efficacy has been demonstrated in patients who have undergone total hip replacement and in those who are undergoing elective abdominal or pelvic operation for malignancy, as well as after major trauma

Warfarin is indicated in some lower extremity orthopaedic procedures and in certain high-risk patients (i.e., antithrombin III deficiency). Dosing is usually targeted to an INR of 2.0 to 3.0. This method of prophylaxis carries a significantly higher rate of major postoperative bleeding (5% to 10%) than low-dose heparin and is usually not indicated in general surgery patients