Venous Thromboembolism (VTE) Prophylaxis for Hospitalized Adult Patients

This practice algorithm has been specifically developed for MD Anderson using a multidisciplinary approach and taking into consideration circumstances particular to MD Anderson including the following: MD Anderson’s specific patient population; MD Anderson’s services and structure; and MD Anderson’s clinical information. Moreover, this algorithm is not intended to replace the independent medical or professional judgment of physicians or other health care providers. This algorithm should not be used to treat pregnant or lactating women.

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**Patient admitted to hospital**

**Assess for VTE risk factors at time of admission**

**HIGH RISK**
- Abdominal or pelvic surgery for cancer
- Major surgery with one or more VTE risk factors
- Hip or knee arthroplasty; hip fracture surgery

**MODERATE RISK**
- Patients with one or more VTE risk factors

**LOW RISK**
- Minor surgery with expected length of stay less than 24 hours
- Fully ambulatory with NO active cancer diagnosis and expected length of stay less than 48 hours

**Is patient a candidate for Pharmacological prophylaxis?**

- **Yes**
  - Pharmacological Prophylaxis AND Mechanical Prophylaxis
  - Optional ambulation

- **No**
  - Initiate mechanical prophylaxis and reassess for contraindications daily
  - Optional ambulation

**Is patient a candidate for Pharmacological prophylaxis?**

- **Yes**
  - Pharmacological Prophylaxis and OPTIONAL Mechanical Prophylaxis

- **No**
  - Ambulation and OPTIONAL Mechanical Prophylaxis

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1. See Appendix A for VTE risk factors
2. Note: excludes patients already on anticoagulants
3. See Appendix B for Pharmacological Options for VTE Prophylaxis
4. See Appendix B for Pharmacological Options for VTE Prophylaxis
5. See Appendix C for Mechanical Options for VTE Prophylaxis
6. See Appendix D for Relative Contraindications to Pharmacological Options for VTE Prophylaxis

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Department of Clinical Effectiveness V5
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APPENDIX A: VTE Risk Factors

- Active cancer (or suspicion of cancer)
- Age 60 or older
- Prior VTE
- Advanced stage of cancer
- Medical comorbidities (infection, renal disease, pulmonary disease, congestive heart failure, arterial thromboembolism)
- Familial and/or acquired hypercoagulability
- Major surgery (abdominal, pelvic, orthopedic surgery)
- Central venous catheter/IV catheter
- Chemotherapy (especially bevacizumab, thalidomide/lenalidomide plus high-dose dexamethasone)
- Exogenous estrogen compounds (hormone replacement, contraceptives, tamoxifen/raloxifene, diethylstilbestrol)
- Erythropoietin stimulating agents
- Poor performance status
- Nephrotic syndrome
- Major trauma
- Spinal cord injury
- Smoking
- Obesity (BMI greater than 30)
- Pregnancy

APPENDIX B: Pharmacological Options for VTE Prophylaxis

1. Unfractionated Heparin 5,000 units subcutaneously every 8 hours
2. Enoxaparin 40 mg subcutaneously every 24 hours
3. Enoxaparin 30 mg subcutaneously every 12 hours
4. Enoxaparin 30 mg subcutaneously every 24 hours (creatinine clearance less than 30 mL/minute)
5. Dalteparin 5,000 units subcutaneously every 24 hours
6. For BMI greater than or equal to 50: Enoxaparin 40 mg subcutaneously every 12 hours
7. For patients intolerant to heparin products: Fondaparinux 2.5 mg subcutaneously every 24 hours (contraindicated if total body weight less than 50 kg and/or CrCl less than 30 mL/minute)

NOTE: Apixaban and Rivaroxaban are not recommended for cancer patients

APPENDIX C: Mechanical Options for VTE Prophylaxis

- Sequential compression devices (SCDs)
- Graduated compression stockings (TED hose)

APPENDIX D: Relative Contraindications to Pharmacological Options for VTE Prophylaxis

- Active bleeding (cerebral, GI, GU)
- Thrombocytopenia (platelets less than 50 K/microliter)
- Anticipated thrombocytopenia
- Heparin-induced thrombocytopenia (HIT)
- Recent major surgery at high risk of bleeding
- Recent CNS bleed
- Recent GI bleed
- Intracranial or spinal lesion at high risk of bleeding
- Underlying coagulopathy
- Patient on protocol that prohibits anticoagulation
- End of life care
- Uncontrolled hypertension (greater than 200 mmHg/120 mmHg)
- Neurosurgery within 24 hours
SUGGESTED READINGS


NOTE: Consider Clinical Trials as treatment options for eligible patients.

DEVELOPMENT CREDITS

This practice consensus algorithm is based on majority expert opinion of the VTE workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following clinical staff:

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