

**UCSD MEDICAL CENTER
DIVISION OF TRAUMA
PROTOCOLS AND GUIDELINES**

=====
Guidelines for DVT Protocol
=====

PATIENT GROUPS

Low Risk: No risk factors.

High Risk: Presence of ≥ 1 of following:

- Likelihood of bedrest > 3 days, head injury, spine or pelvic fracture, lower extremity fracture.
- Laparotomy, Thoracotomy or Laparoscopy.
- Co-morbid risk factors including: history of prior DVT or PE, obesity, known sepsis, malignancy or hypercoagulable state, pregnancy.

Extreme Risk: Presence of ≥ 1 of following:

- Severe head injury with therapeutic paralysis and aggressive ICP control $> 5-7$ days.
- Spinal fracture with para/quadruplegia.
- Unstable pelvic fracture with bedrest > 6 weeks.
- Multiple lower extremity fractures.
- Patient in High Risk group where usual measures cannot be employed.

SCREENING MEASURES:

Low Risk: No routine screening.

High Risk: Patient screening with venous duplex 2 times in 1st week, then weekly by the Radiology Lab. If patient needs a study prior to placing Venodynes, call Radiology Department Duplex Lab. If they are not available on weekends, call IPG technician.

Extreme Risk: Patients with no IVC filter will be screened as the **High Risk** patients but with 2 duplex studies in the first week.

PROPHYLACTIC MEASURES:

Low Risk:

- Mandatory ambulation in 1st 24-36 hours.
- In-bed mobility and lower extremity exercises.
- NO pneumatic hose or anti-coagulation.

High Risk:

Bilateral lower extremity pneumatic hose and subcutaneous low molecular weight heparin, 5000 U Q12H in patients with no contraindications.

Extreme Risk:

Severe head injury

- Head injury requiring therapeutic paralysis for $> 5-7$ days combined with lower extremity or pelvic fracture will receive prophylactic IVC filter placed after consensus between Neurosurgery and Trauma at the earliest time felt to be safe from the view of head injury management. In general IVC filter will not be placed prior to the 4th or 5th hospital day.
- Isolated head injury requiring therapeutic paralysis for $> 5-7$ days will be considered for prophylactic IVC filter unless strong contraindications exist including young age, likelihood of future pregnancy, feasibility of anticoagulation or patient preference. IVC filter placed after consensus between Neurosurgery and Trauma as above.

- If IVC filter is not chosen, systemic anticoagulation will be used if not contraindicated. Short term in-hospital anticoagulation will be achieved with IV heparin, titrated to PTT. Long term will be achieved with Coumadin, in most cases at low dose.
- Continue pneumatic compression hose in all patients unless therapeutically anticoagulated.
- **Spinal cord injury** combined with lower extremity or pelvic fracture and isolated spinal cord injuries will receive prophylactic IVC filter placed after a consensus between Neurosurgery and Trauma.
- If IVC filter is not used, systemic anticoagulation will be used if not contraindicated. Short term in-hospital anticoagulation will be achieved with IV heparin, titrated to a PTT 2-2.5 times the absolute baseline. Long term will be achieved with Coumadin titrated to INR=2.0.

All Other Extreme Risk Patients:

Consider prophylactic IVC filter. In general, IVC filter will be used unless strong relative contraindications exist, such as young age, likelihood of future pregnancy, feasibility of anticoagulation and patient preference. If IVC filter not chosen, systemic anticoagulation will be used if not contraindicated. Short term in-hospital anticoagulation will be achieved with IV heparin, titrated to PTT. Long term management will be achieved with Coumadin, in most cases low dose.

- Continue pneumatic compression hose.