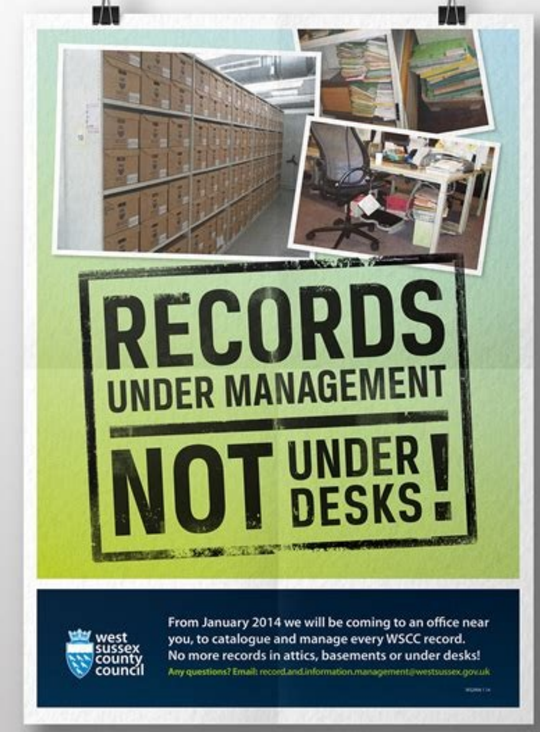
Dvt management guidelines uk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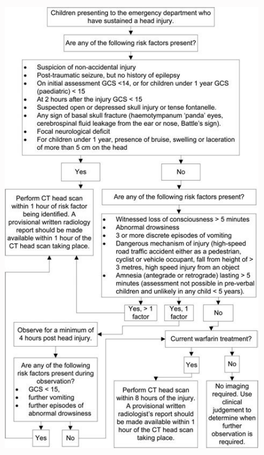
Children presenting to the emergency department who have sustained a head injury.
Are any of the following risk factors present?
Suspicion of non-accidental injury
Post-traumatic seizure, but no history of epilepsy
On initial assessment GCS <14, or for children under 1 year GCS (paediatric) < 15
At 2 hours after the injury GCS < 15
Suspected open or depressed skull injury or tense fontanelle.
Any sign of basal skull fracture (haemotympanum 'panda' eyes, cerebrospinal fluid leakage from the ear or nose, Battle's sign).
Focal neurological deficit
For children under 1 year, presence of bruise, swelling or laceration of more than 5 cm on the head
Yes
No
Perform CT head scan within 1 hour of risk factor being identified. A provisional written radiology report should be made available within 1 hour of the CT head scan taking place.
Are any of the following risk factors present?
Witnessed loss of consciousness > 5 minutes
Abnormal drowsiness
3 or more discrete episodes of vomiting
Dangerous mechanism of injury (high-speed road traffic accident either as a pedestrian, cyclist or vehicle occupant, fall from height of > 3 metres, high speed injury from an object
Amnesia (antegrade or retrograde) lasting > 5 minutes (assessment not possible in pre-verbal children and unlikely in any child < 5 years).
Yes, > 1 factor
Yes, 1 factor
No
Observe for a minimum of 4 hours post head injury.
Current warfarin treatment?
Are any of the following risk factors present during observation?
GCS < 15,
further vomiting
further episodes of abnormal drowsiness
Yes
No
Yes
No
Perform CT head scan within 8 hours of the injury. A provisional written radiologist's report should be made available within 1 hour of the CT head scan taking place.
No imaging required. Use clinical judgement to determine when further observation is required.


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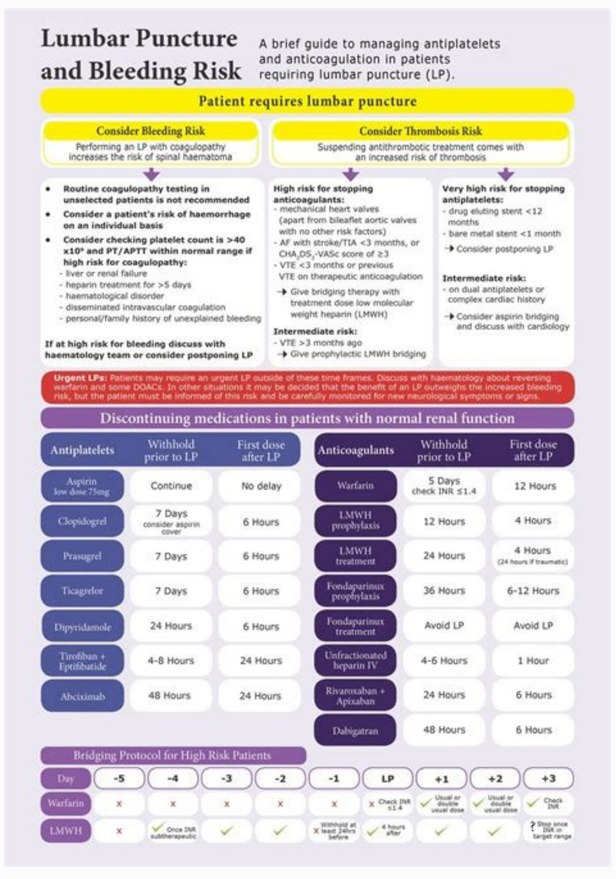
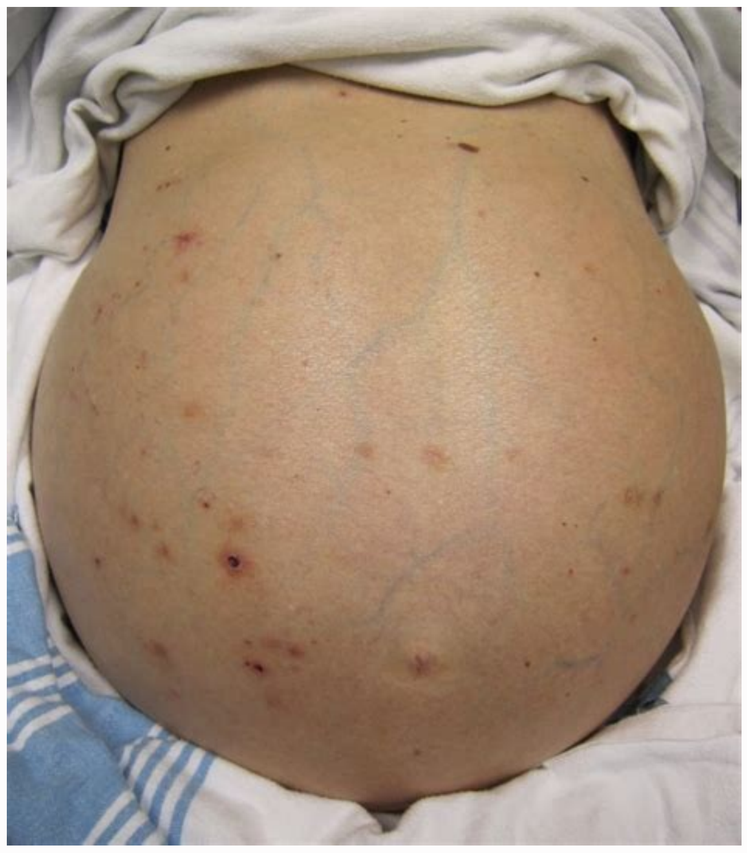

Lumbar Puncture and Bleeding Risk
A brief guide to managing antiplatelets and anticoagulation in patients requiring lumbar puncture (LP).
Patient requires lumbar puncture
Consider Bleeding Risk
Performing an LP with coagulopathy increases the risk of spinal haematoma
Consider Thrombosis Risk
Suspending antithrombotic treatment comes with an increased risk of thrombosis
Routine coagulopathy testing in unselected patients is not recommended
Consider a patient's risk of haemorrhage on an individual basis
Consider checking platelet count is >40 x10⁹ and PT/APTT within normal range if high risk for coagulopathy:
- liver or renal failure
- heparin treatment for >5 days
- haematological disorder
- disseminated intravascular coagulation
- personal/family history of unexplained bleeding
If at high risk for bleeding discuss with haematology team or consider postponing LP
High risk for stopping anticoagulants:
- mechanical heart valves (apart from bileaflet aortic valves with no other risk factors)
- AF with stroke/TIA <3 months, or CHA2DS2-VASc score of ≥3
- VTE <3 months or previous VTE on therapeutic anticoagulation
→ Give bridging therapy with treatment dose low molecular weight heparin (LMWH)
Intermediate risk:
- VTE >3 months ago
→ Give prophylactic LMWH bridging
Very high risk for stopping antiplatelets:
- drug eluting stent <12 months
- bare metal stent <1 month
→ Consider postponing LP
Intermediate risk:
- on dual antiplatelets or complex cardiac history
→ Consider aspirin bridging and discuss with cardiology
Urgent LPs: Patients may require an urgent LP outside of these time frames. Discuss with haematology about reversing warfarin and some DOACs. In other situations it may be decided that the benefit of an LP outweighs the increased bleeding risk, but the patient must be informed of this risk and be carefully monitored for new neurological symptoms or signs.
Discontinuing medications in patients with normal renal function
Antiplatelets
Withhold prior to LP
First dose after LP
Aspirin low dose 75mg
Continue
No delay
Clopidogrel
7 Days consider aspirin cover
6 Hours
Prasugrel
7 Days
6 Hours
Ticagrelor
7 Days
6 Hours
Dipyridamole
24 Hours
6 Hours
Tirofiban + Eptifibatide
4-8 Hours
24 Hours
Abciximab
48 Hours
24 Hours
Anticoagulants
Withhold prior to LP
First dose after LP
Warfarin
5 Days check INR ≤1.4
12 Hours
LMWH prophylaxis
12 Hours
4 Hours
LMWH treatment
24 Hours
4 Hours (24 hours if traumatic)
Fondaparinux prophylaxis
36 Hours
6-12 Hours
Fondaparinux treatment
Avoid LP
Avoid LP
Unfractionated heparin IV
4-6 Hours
1 Hour
Rivaroxaban + Apixaban
24 Hours
6 Hours
Dabigatran
48 Hours
6 Hours
Bridging Protocol for High Risk Patients
Day
-5
-4
-3
-2
-1
LP
+1
+2
+3
Warfarin
x
x
x
x
x
x Check INR ≤1.4
✓ Usual or double usual dose
✓ Usual or double usual dose
✓ Check INR
LMWH
x
✓ Once INR subtherapeutic
✓
✓
x Withhold at least 24hrs before
✓ 4 hours after
✓
✓
? Stop once INR in target range



Dvt management nice guidelines. Dvt uk guidelines. Dvt management guidelines.

This Guidelines summary covers diagnosis and initial management, outpatient treatment for low-risk pulmonary embolism (PE), anticoagulation treatment for suspected or confirmed deep vein thrombosis (DVT) or PE, and information and support for people having anticoagulation treatment This summary only covers key recommendations for primary care. For a complete set of recommendations, see the full guideline This summary has been abridged for print. View the full summary at guidelines.co.uk/455308.article. For people who present with signs or symptoms of DVT, such as a swollen or painful leg, assess their general medical history and do a physical examination to exclude other causes If DVT is suspected, use the 2-level DVT Wells score (Table 1) to estimate the clinical probability of DVT Clinical featurePoints Active cancer (treatment ongoing, within 6 months, or palliative) 1 Paralysis, paresis or recent plaster immobilisation of the lower extremities 1 Recently bedridden for 3 days or more, or major surgery within 12 weeks requiring general or regional anaesthesia 1 Localised tenderness along the distribution of the deep venous system 1 Entire leg swollen 1 Calf swelling at least 3 cm larger than asymptomatic side 1 Pitting oedema confined to the symptomatic leg 1 Collateral superficial veins (non-varicose) 1 Previously documented DVT 1 An alternative diagnosis is at least as likely as DVT -2 Clinical probability simplified score DVT likely 2 points or more DVT unlikely 1 point or less Adapted with permission from Wells et al. (2003) Evaluation of D-dimer in the diagnosis of suspected deep-vein thrombosis DVT=deep vein thrombosis. Offer people with a likely DVT Wells score (2 points or more): a proximal leg vein ultrasound scan, with the result available within 4 hours if possible a D-dimer test if the scan result is negative If a proximal leg vein ultrasound scan result cannot be obtained within 4 hours, offer people with a DVT Wells score of 2 points or more: a D-dimer test, then interim therapeutic anticoagulation and a proximal leg vein ultrasound scan with the result available within 24 hours For people with a positive proximal leg vein ultrasound scan: offer or continue anticoagulation treatment or if anticoagulation treatment is contraindicated, offer a mechanical intervention For people with a negative proximal leg vein ultrasound scan and a positive D-dimer test result: stop interim therapeutic anticoagulation offer a repeat proximal leg vein ultrasound scan 6 to 8 days later and if the repeat scan result is positive, follow the actions above if the repeat scan result is negative, follow the actions below For people with a negative proximal leg vein ultrasound scan and a negative D-dimer test result: stop interim therapeutic anticoagulation think about alternative diagnoses tell the person that it is not likely they have DVT. Discuss with them the signs and symptoms of DVT and when and where to seek further medical help Offer people with an unlikely DVT Wells score (1 point or less): a D-dimer test with the result available within 4 hours or if the D-dimer test result cannot be obtained within 4 hours, offer interim therapeutic anticoagulation while awaiting the result If the D-dimer test result is negative, follow the actions above If the D-dimer test result is positive, offer: a proximal leg vein ultrasound scan, with the result available within 4 hours if possible or interim therapeutic anticoagulation and a proximal leg vein ultrasound scan with the result available within 24 hours If the proximal leg vein ultrasound scan is: positive, follow the actions above negative, follow the actions abo ve When offering D-dimer testing for suspected DVT or PE, consider a point-of-care test if laboratory facilities are not immediately available If using a point-of-care D-dimer test, choose a fully quantitative test When using a point-of-care or laboratory D-dimer test, consider an age-adjusted D-dimer test threshold for people aged over 50 For people who present with signs or symptoms of PE, such as chest pain, shortness of breath or coughing up blood, assess their general medical history, do a physical examination and offer a chest X-ray to exclude other causes If clinical suspicion of PE is low[A], consider using the pulmonary embolism rule-out criteria (PERC) to help determine whether any further investigations for PE are needed If PE is suspected, use the 2-level PE Wells score (Table 2) to estimate the clinical probability of PE For people with a likely PE Wells score (more than 4 points): offer a computed tomography pulmonary angiogram (CTPA) immediately if possible or for people with an allergy to contrast media, severe renal impairment (estimated creatinine clearance[B] less than 30 ml/min) or a high risk from irradiation, assess the suitability of a ventilation/perfusion single photon emission computed tomography (V/Q SPECT) scan or, if a V/Q SPECT scan is not available, a V/Q planar scan, as an alternative to CTPAIf a CTPA, V/Q SPECT or V/Q planar scan cannot be done immediately, offer interim therapeutic anticoagulation (see the section on interim therapeutic anticoagulation for suspected DVT or PE) If PE is identified by CTPA, V/Q SPECT or V/Q planar scan: offer or continue anticoagulation treatment or if anticoagulation treatment is contraindicated, consider a mechanical interventionFor people with PE and haemodynamic instability see the full guideline section on thrombolytic therapy If PE is not identified by CTPA, V/Q SPECT or V/Q planar scan: consider a proximal leg vein ultrasound scan if DVT is suspected if DVT is not suspected: stop interim therapeutic anticoagulation think about alternative diagnoses tell the person that it is not likely they have PE. Discuss with them the signs and symptoms of PE and when and where to seek further medical help Offer people with an unlikely PE Wells score (4 points or less): a D-dimer test with the result available within 4 hours if possible or if the D-dimer test result cannot be obtained within 4 hours, offer interim therapeutic anticoagulation while awaiting the resultIf the D-dimer test result is: positive, follow the actions above negative: stop interim therapeutic anticoagulation think about alternative diagnoses tell the person that it is not likely they have PE. Discuss with them the signs and symptoms of PE and when and where to seek further medical help For people who present with signs or symptoms of both DVT and PE, carry out initial diagnostic investigations for either DVT or PE, basing the choice of diagnostic investigations on clinical judgement Consider outpatient treatment for suspected or confirmed low-risk PE, using a validated risk stratification tool to determine the suitability of outpatient treatment When offering outpatient treatment to people with suspected PE, follow recommendations on diagnosis and initial management When offering outpatient treatment to people with confirmed PE, follow the recommendations in the section on anticoagulation treatment for confirmed DVT or PE Agree a plan for monitoring and follow-up with people having outpatient treatment for suspected or confirmed low-risk PE. Give them: written information on symptoms and signs to look out for, including the potential complications of thrombosis and of treatment direct contact details of a healthcare professional or team with expertise in thrombosis who can discuss any new symptoms or signs, or other concerns information about out-of-hours services they can contact when their healthcare team is not available Follow the recommendations on when to offer interim therapeutic anticoagulation for suspected proximal DVT or PE in the section on diagnosis and initial management If possible, choose an interim anticoagulant that can be continued if DVT or PE is confirmed[C] When using interim therapeutic anticoagulation for suspected proximal DVT or PE: carry out baseline blood tests including full blood count, renal and hepatic function, prothrombin time (PT) and activated partial thromboplastin time (APTT) do not wait for the results of baseline blood tests before starting anticoagulation treatment review, and if necessary act on, the results of baseline blood tests within 24 hours of starting interim therapeutic anticoagulation Offer anticoagulation treatment for at least 3 months to people with confirmed proximal DVT or PE. For recommendations on treatment after 3 months see the full guideline section on long-term anticoagulation for secondary prevention If not already done, carry out baseline blood tests when starting anticoagulation treatment When offering anticoagulation treatment, take into account comorbidities, contraindications and the person's preferencesFollow the recommendations (in the full guideline) on anticoagulation treatment in the sections on: Anticoagulation treatment for DVT or PE with renal impairment or established renal failure Offer people with confirmed proximal DVT or PE and renal impairment (estimated creatinine clearance[B] between 15 ml/min and 50 ml/min) one of: apixaban rivaroxaban LMWH[D] for at least 5 days followed by: edoxaban or dabigatran if estimated creatinine clearance is 30 ml/min or above LMWH[D] or UFH, given concurrently with a VKA for at least 5 days or until the INR is at least 2.0 in 2 consecutive readings, followed by a VKA on its ownNote the cautions and requirements for dose adjustment and monitoring in the medicine's SPC, and follow locally agreed protocols or advice from a specialist or multidisciplinary team Offer people with confirmed proximal DVT or PE and established renal failure (estimated creatinine clearance[B] less than 15 ml/min) one of: LMWH[D] UFH LMWH or UFH concurrently with a VKA for at least 5 days or until the INR is at least 2.0 in 2 consecutive readings, followed by a VKA on its ownNote the cautions and requirements for dose adjustment and monitoring in the medicine's SPC, and follow locally agreed protocols or advice from a specialist or multidisciplinary team Treatment failure If anticoagulation treatment fails: check adherence to anticoagulation treatment address other sources of hypercoagulability increase the dose of anticoagulant or change to an anticoagulant with a different mode of action Give people having anticoagulation treatment verbal and written information about: how to use anticoagulants how long to take anticoagulants possible side-effects of anticoagulants and what to do if these occur how other medications, foods and alcohol can affect oral anticoagulation treatment any monitoring needed for their anticoagulant treatment how anticoagulants may affect their dental treatment taking anticoagulants if they are planning pregnancy or become pregnant how anticoagulants may affect activities such as sports and travel when and how to seek medical help Give people who are having anticoagulation treatment information and an 'anticoagulant alert card' that is specific to their treatment. Advise them to carry the 'anticoagulant alert card' at all times Elastic graduated compression stockings Do not offer elastic graduated compression stockings to prevent post-thrombotic syndrome or VTE recurrence after a DVT. This recommendation does not cover the use of elastic stockings for the management of leg symptoms after DVT If offering elastic graduated compression stockings to manage leg symptoms after DVT, explain how to apply and use them, how long they should be worn and when they should be replaced [A] The clinician estimates the likelihood of PE to be less than 15% based on the overall clinical impression and other diagnoses are feasible [B] Estimated creatinine clearance using the Cockcroft and Gault formula; see the BNF's prescribing in renal impairment [C] At the time of publication (March 2020) direct-acting anticoagulants and some low molecular weight heparins do not have a UK marketing authorisation for the treatment of suspected DVT or PE. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information [D] At the time of publication (March 2020) some low molecular weight heparins do not have a UK marketing authorisation for the treatment of DVT or PE in people with severe renal impairment (estimated creatinine clearance 15 ml/min to 30 ml/min) or established renal failure (estimated creatinine clearance less than 15 ml/min). The prescriber should consult the medicine's summary of product characteristics for details, and follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information Read the related Guidelines in Practice article Published date: 26 March 2020.

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