



S I G N

PROPOSED REVIEW OF SIGN GUIDELINE 2005
CONSULTATION FORM

Title of guideline	SIGN 62: Prophylaxis of venous thromboembolism
Date of publication	2002
SIGN scoping search – sources	<p>MeSH headings for the condition specified, plus any common variations as free text</p> <p>Sources: Guidelines: NICE; National Library for Health guidelines finder; National Guidelines Clearinghouse; GIN Web site. Technology appraisals: NICE; UK HTA database (Southampton); INAHTA database. Cochrane reviews: Cochrane library. Other good quality systematic reviews: UK HTA database (Southampton); DARE. Individual studies: Embase and Medline, date of publication - 2005.</p>
SIGN scoping search - summary	<p>Guidelines – 7 HTAs – 2 Cochrane reviews – 2 Other good quality systematic reviews – 4</p>
Other guidelines/HTAs	<ul style="list-style-type: none"> ▪ Australia. National Institute of Clinical Studies. Interventions to improve uptake of venous thromboembolism prophylaxis in hospitals. 2003. ▪ British Thoracic Society. BTS guidelines for the management of suspected acute pulmonary embolism. ▪ Finnish Medical Society Duodecim. Deep venous thrombosis. In: EBM Guidelines. Evidence-Based Medicine [CD-ROM]. Helsinki, Finland: Duodecim Medical Publications Ltd.; 2005. ▪ Germany. Association of Scientific Medical Societies. Prevention of Venous Thromboembolism in Surgery and Perioperative Care. 2003. [In German] ▪ Michigan Quality Improvement Consortium. Outpatient management of uncomplicated deep venous thrombosis. Southfield (MI): Michigan Quality Improvement Consortium; 2003. ▪ Sweden. Interventions to improve uptake of venous thromboembolism prophylaxis in hospitals. Management of venous thromboembolism. 2003. [In Swedish] ▪ United States of America. Institute for Clinical Systems Improvement (ICSI). Venous thromboembolism prophylaxis for surgical/trauma patients. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003. ▪ NICE is preparing a guideline on the prevention of venous thromboembolism in patients undergoing orthopaedic surgery and other high-risk surgical procedures. As of June 2005, evidence is still being gathered. Proposed publication date is 2007. ▪ Fondaparinux (Arixtra) - prevention of venous thromboembolism after orthopedic surgery (Alert). Swedish Council on Technology Assessment in Health Care (SBU) 2004. ▪ Kwok L. Ximelagatran for prevention and treatment of venous thromboembolism. Ottawa: Canadian Coordinating Office for Health Technology Assessment (CCOHTA) 2004.
<p>Main conclusions from new evidence</p> <p><i>current guideline content given in italics</i></p>	<ul style="list-style-type: none"> ▪ Fondaparinux therapy for 5 to 9 days shows a lower risk for DVT, as diagnosed by lower extremity venography, compared to low-molecular-weight heparin. <i>Guideline says fondaparinux is more effective than LMWH in reduction of asymptomatic DVT but is not more effective in reduction of symptomatic DVT, PE or mortality. No recommendation made.</i> ▪ Ximelagatran's efficacy is comparable to that of warfarin and low-molecular-weight heparin for prevention after major orthopedic surgery. Ximelagatran

	<p>may replace, at least partly, the anticoagulants used in the management of VTE. <i>Not discussed in guideline</i></p> <ul style="list-style-type: none"> ▪ There is no reliable evidence that graded compression stockings or pneumatic compression boots prevent DVT after stroke. <i>Guideline suggests that selected use of graduated compression stockings may be justified for some high risk patients (C) and compression stockings for patients with haemorrhagic stroke (D).</i> ▪ Postmenopausal HRT is associated with an increased risk of VTE, and this risk may be highest in the first year of use. SERMs are associated with a similar increase in risk. <i>HRT risk is acknowledged in all relevant recommendations. Use of SERMs not discussed.</i> ▪ There was little or no consistent evidence of an increased incidence of VTE in air travellers. <i>Guideline acknowledges lack of evidence and makes general recommendations about minimising risk (D).</i> ▪ The clinical impact of anticoagulant-related major bleeding in patients with VTE is considerable, and clinicians should take this into account when deciding whether to continue long-term oral anticoagulant therapy in an individual patient. <i>Guideline recommends the combination of UFH or LMWH with mechanical prophylaxis as a possible effective alternative in some surgical patients (D).</i> ▪ Long-term, low-intensity warfarin therapy is a highly effective method of preventing recurrent venous thromboembolism. <i>Guideline only recommends long term warfarin in selected patients (D).</i>
New areas that could be added to the guideline	<ul style="list-style-type: none"> ▪ Patients taking SERMs ▪ Use of ximelagatran
Summary of the recommendations that could be updated	<ul style="list-style-type: none"> ▪ use of GECS in stroke patients ▪ long term use of warfarin ▪ long haul flights
Results of consultation	
Contributions from:	<ul style="list-style-type: none"> ▪ Urologist ▪ Neurologist ▪ Orthopaedic surgeon ▪ Anaesthetist x2 ▪ Obstetrician ▪ Nurse ▪ Vascular physician
1(a) Is there still a requirement for an evidence-based guideline on this topic?	
<p>Yes- 6</p> <ul style="list-style-type: none"> ▪ Recent systematic review showing benefit of longer versus shorter term A/C after VTE ▪ Some new trials of LMWH in stroke for VTE prophylaxis (TDPAS) ▪ MRC trial of GECS in stroke (CLOTS) ▪ Publication of HTA review of GECS imminent ▪ Orthopaedics needs revision due to ximelagatran and fondaparinux 	
1(b) If no, should the guideline be withdrawn?	
2(a) Based on the information given above, and your own clinical judgement, does the guideline require revision in the light of new evidence? <i>Please give details.</i>	
<ul style="list-style-type: none"> ▪ Yes – more emphasis on LMWH and discussion regarding role of fondaparinux, aspirin should not be recommended ▪ need to add in information about patients taking SERMs, use of ximelagatran, use of GECS in stroke patients, long term use of warfarin, information on long haul flights. ▪ Best value for effort – not sure whether best done by full or limited review. ▪ Brief selective revision 	
2(b) Do you agree with the assessment of the impact of the new evidence and its likely effect on recommendations?	
Yes -2	

Yes, but not all, eg ximelagatran likely to be withdrawn globally due to s/e
Yes – fondaparinux, SERMs (anasbrazole preferred to tamoxifen), travel NOT long-term warfarin (management)

3 Please list any additions to the remit of the guideline that you think would be beneficial

Perioperative management of patients on warfarin

4 Please tick your preferred option for reviewing this guideline

a. there is no new evidence that will affect existing recommendations and the guideline should not be reviewed at this time

b. some recommendations will change in the light of the new evidence and selected elements of the guideline should be reviewed

c. the entire guideline should be reviewed

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