VENOUS THROMBOEMBOLISM IN ORTHOPAEDICS

Over the past decade venous thromboembolism has become a topic of growing interest for the orthopaedic surgeon as a preventable disease which contributes to morbidity and mortality among hospitalised patients especially for those on prolonged bed rest, fractures of the pelvis and femur and those undergoing hip arthroplasty.

Various guidelines exist worldwide such as NICE guidelines in U.K, (1), ACCP (2) AAOS, (3) guidelines in U.S, and Sign guidelines-Scottland (4). Most of the guidelines are based on systematic reviews of the best available evidence. When minimal evidence is available, recommendations are based on a surgeon's experience and opinion on what constitutes good practice.

The time tested adage still prevails i.e. Preventation is better than cure, therefore preventive methods are advocated. This should follow venous thrombosis risk assessment followed by appropriate institution of prophylactic measures such as early mobilisation, wearing of graduated compressive stockings, continuous motion machines, Intermittent Pneumatic Compressions (IPC). The last (IPC) should be avoided if the patient has severe peripheral arterial disease, congestive cardiac failure or superficial or deep vein thrombosis. Pharmaceutical prophylaxis has been advocated and is used for high risk patients on this subject. For patients undergoing elective hip replacement consensus guidelines recommend prophylaxis upto 35 days post surgery (3). Orthopaedic surgeons have remained sceptical about clinical relevance of extended prophylaxis and are concerned about potential risk adverse outcome especially bleeding (3).

The safety and efficacy of new anticoagulants are often initially evaluated in major orthopaedic surgery patients who are widely recognised as being high risk for venous thromboembolism (VTE). Above mentioned guidelines advocate use of anticoagulants such as low molecular weight heparin; VIT K antagonist, and various drugs that block the coagulation cascade at different levels such as direct factor XA inhibitors and thrombosis inhibitors (5). The paper on this topic by Imbaya *et al* in this current journal gives us an idea on current status on this topic.

In South Saharan African regime the only guidelines available are from South Africa and we need studies in our local set up to see the nature and extent of the VTE problem and thereby make our informed guidelines.

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