

## References

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## Venous thromboembolism

Editor – You recently published an article<sup>1</sup> summarising the new recommendations for medical inpatients within the updated National Institute for Health and Care Excellence (NICE) venous thromboembolism (VTE) prevention guidelines.<sup>2</sup> We welcome the opportunity to highlight a major concern with regards to these recommendations, which affect every patient over the age of 16 admitted to hospital.

The guidelines recommend offering ‘pharmacological VTE prophylaxis for a *minimum of 7 days* to [medical and the majority of surgical patients] whose risk of VTE outweighs their risk of bleeding.’ In reply to concerns raised at consultation, it was stated that the NICE committee agreed that there was limited evidence for the most effective duration of low molecular weight heparin (LMWH) in these patients and 7 days was the *average* duration of LMWH in the clinical trials evaluated throughout the guideline. Clinical practice has changed significantly in the 20 years since these trials were published and the populations in these clinical trials were highly selected, with prolonged medical inpatients stays and at higher risk of VTE than the majority of current medical admissions.<sup>3,4</sup> The median length-of-stay for acute medical inpatients in our hospitals is 2 days and using the Department of Health VTE tool the majority of these patients are currently prescribed pharmacological thromboprophylaxis only while an inpatient. There is currently no evidence to support this group of patients having a further 5 days of LMWH prophylaxis at home. There would be additional significant cost to the NHS in dispensing time, sharps bins/disposal/training, resources of district nurses (the latter required for 20–30% of patients), and drug costs; without an evidence base for benefit/harm in this setting.

A survey of National VTE Exemplar Centres in October 2018 found that 95% (n=24) reported not adopting this new recommendation (in a personal communication of Roopen Arya accepted for publication). If we do not challenge NICE guidance where recommendations are based on limited data, then we dissuade patients through the provision of non-evidence-based interventions requiring reallocation of scarce resources. ■

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## Head injury in the elderly

Editor – I welcomed the review on head injury in the elderly<sup>1</sup> for highlighting this growing issue. In addition to the excellent points made I would like to add the following. The first, and most important issue is that of terminology, which denotes diagnosis and has far reaching implications. The term ‘head injury’ should, in my opinion, be reserved for episodes of trauma to the head without resultant intracranial consequences eg scalp laceration. The consequences of head injury listed in Table 3 of the review all relate to intracranial complications (except skull fracture) and all can lead to, or are intrinsically, a form of brain injury. Use of the term acquired brain injury, traumatic brain injury or intracranial injury would highlight the potential severity of outcomes, and therefore help to reduce the variance in accurate assessment and appropriate management of brain injury in the elderly which currently exists. A similar argument has been made previously regarding the term concussion.<sup>2</sup>

Lack of identification of brain injury is an issue across all pathways and may be a particular problem in more vulnerable groups (including paediatric, elderly, learning disabled, substance misuse and offender populations). As a result, the right care may not be delivered at the right time. Inaccurate or missing codes mean that vast swathes of data are not collected, impeding efforts to characterise cohorts and outcomes, and plan for appropriate resourcing and service delivery.

Secondly, assessment of impairments and planning for follow-up and rehabilitation receives scant attention in the review. While I accept that the focus of the review is on acute management and anticoagulation management, I believe that the stated intention of the review is not fully met without more detail related to assessment of rehabilitation and care needs. Significant neurological impairments may result from acquired brain injury and can considerably affect function and safety.<sup>3–5</sup> Cognitive impairment and balance are of particular note. Selected elderly individuals can achieve similar outcomes to younger patients with neurorehabilitation,<sup>6–8</sup> while those who are not appropriate for rehabilitation require careful assessment and discharge planning, with environment and care needs appropriately supported. ■

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## Thromboemboprophylaxis

Editor – While venous thromboembolism (VTE) prophylaxis has been proven to benefit medical hospital inpatients, your review<sup>1</sup> raises the uncertainty about particular sub groups of patients and whether they will really benefit. Palliative care inpatients with advanced disease are one such group that needs more careful scrutiny.

Recommendations from the National Institute for Health and Care Excellence (NICE) guideline *Venous thromboembolism in over 16s; reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism*<sup>2</sup> states that pharmacological VTE prophylaxis should be considered for hospitalised palliative care patients. They also advise to take into account any temporary increases in thrombotic risk, risk of bleeding, likely prognosis and the views of the person and their family members.

The NICE guideline is, overall, clear concise and thus commendable but there are questions about whether it can be extrapolated to other providers of NHS care such as hospices. While hospices deliver evidence-based practice and are legitimate providers of care to the NHS, most are charitable organisations rather than NHS units, and thus they are not officially under the same initiative as acute trusts.

There is more to consider in deciding whether to use thromboprophylaxis in a hospice or specialist palliative care inpatient unit. Many trials undertaken on thromboprophylaxis are not representative of palliative care practice as they exclude patients with a prognosis under 3 months, thus excluding the

majority of patient found in hospice inpatient units. Neither have any trials been done specifically on patients with advanced cancer, despite it being well recognised that advanced cancer is an acquired thrombophilia.

In a recent report in *The Lancet Haematology*,<sup>3</sup> a prospective multicentre observational study showed 34% of patients on admission to a specialist palliative care inpatient unit already had a femoral vein thrombosis. Perhaps the time point to commence thromboprophylaxis is prior to admission or prior to reaching a diagnosis of advanced or end-stage cancer. Having a confirmed deep vein thrombosis (DVT) also did not affect their survival. The only significant difference in DVT-attributable symptoms between those with a confirmed DVT and those with no DVT in this study was lower limb oedema but in palliative care patients there are many causes for lower limb oedema. The data suggested that DVT has only a minimal symptom burden for hospice patients. Based on this data, pharmacological prophylaxis or management of confirmed VTE with injections of low molecular weight heparin or burdensome mechanical prophylaxis is highly unlikely to improve symptoms and may bring more harm than benefits. It therefore should probably not be started in palliative care patients with advanced disease admitted to a hospice inpatient setting, where care is focussed on quality of life. Palliative care is about symptom management as opposed to improved survival.

As palliative care clinicians, we must examine closely what each of the interventions we recommend or start actually brings to the patient. However as your guideline supports, every patient should be viewed as an individual and treated with a care plan tailored to their clinical needs and specific issues. ■

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