

## References

- 1 Beedham W, Peck G, Richardson SE *et al.* Head injury in the elderly – an overview for the physician. *Clin Med* 2019;19:177–84.
- 2 Sharp DJ, Jenkins PO. Concussion is confusing us all. *Pract Neurol* 2015;15:172–86.
- 3 Gardner RC, Dams-O'Connor K, Morrissey MR, Manley G. Geriatric traumatic brain injury: epidemiology, outcomes, knowledge gaps, and future directions. *J Neurotrauma* 2018;35:889–906.
- 4 Thompson HJ, McCormick WC, Kagan SH. Traumatic brain injury in older adults: epidemiology, outcomes, and future implications. *J Am Geriatr Soc* 2006;54:1590–5.
- 5 Flanagan SR, Hibbard MR, Gordon WA. The impact of age on traumatic brain injury. *Phys Med Rehabil Clin N Am* 2005;16:163–77.
- 6 Lilley EJ, Williams KJ, Schneider EB *et al.* Intensity of treatment, end-of-life care, and mortality for older patients with severe traumatic brain injury. *J Trauma Acute Care Surg* 2016;80:998–1004.
- 7 De Bonis P, Pompucci A, Mangiola A *et al.* Decompressive craniectomy for the treatment of traumatic brain injury: does an age limit exist? *J Neurosurg* 2010;112:1150–3.
- 8 Gillespie C, McMahon C. Prognosticating traumatic brain injury (TBI): Analysis of CRASH, IMPACT models and patient age in a cohort of TBI patients. *Neurosurgery* 2019 [Epub ahead of print].

## 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. ■

CATE SETON-JONES

Medical director, Phyllis Tuckwell Hospice Care, Surrey, UK

PATRICIA MACNAIR

Specialty doctor, Phyllis Tuckwell Hospice Care, Surrey, UK

## References

- 1 Stansby G, Donald I. Reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism in medical inpatients. *Clin Med* 2019;19:100–3.
- 2 National Institute for Health and Care Excellence. *Venous thromboembolism in over 16s; reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. NICE guideline [NG89]*. London: NICE, 2018. [www.nice.org.uk/guidance/ng89/chapter/Recommendations#interventions-for-people-having-palliative-care](http://www.nice.org.uk/guidance/ng89/chapter/Recommendations#interventions-for-people-having-palliative-care) [Accessed 27 March 2019].
- 3 White C, Noble SIR, Watson M *et al.* Prevalence, symptom burden, and natural history of deep vein thrombosis in people with advanced cancer in specialist palliative care units (HIDDEN): A prospective longitudinal observational study. *Lancet Haematol* 2019;6:e79–88. [www.sciencedirect.com/science/article/pii/S2352302618302151?via%3Dihub](http://www.sciencedirect.com/science/article/pii/S2352302618302151?via%3Dihub) [Accessed 27 March 2019].