



**ASH Clinical Practice Guideline
on Venous Thromboembolism (VTE):**

What You Should Know

... m a ... ma () a ... a
m v ... ma a a v
m m m (), a mm a a
-v m () a m a m m ()
a v ... a v , a a
v m a a a m ,
m a ... ma , a , a , a
a a v a a



Prophylaxis for Hospitalized and





Optimal Management of Anticoagulation Therapy



Who is covered?

ma a ma a m a a a a a av v
a



Why is it important?

a a m a
v a
a a v av ma
a a a a a ma v

Who is affected?

a av a a a a a a a a
a ma , a , , a a a ma



What are the highlights?

a a a a a a m a v a m
a a a a ma a m v v ma a a
v
a a a a va v a
-a a a a a m - a v ,
a a
a a m - a a a a a
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a a v v ma a a a a m
a a a a

Total number of panel recommendations : 25



Heparin-Induced Thrombocytopenia

What is it?

Heparin-induced thrombocytopenia (HIT) is a life-threatening complication of heparin therapy. It is characterized by a decrease in platelet count (thrombocytopenia) and the presence of HIT antibodies. HIT typically occurs 5 to 14 days after the start of heparin therapy. The pathogenesis involves the formation of antibodies that bind to heparin-platelet factor complex (HIT antibodies), leading to platelet activation and aggregation. This can result in thrombosis and bleeding. HIT is diagnosed based on clinical criteria, including a decrease in platelet count and the presence of HIT antibodies. Treatment involves discontinuation of heparin and the use of alternative anticoagulants.

Who is affected?

HIT can affect anyone who has received heparin therapy, including patients in the hospital and those on long-term therapy. It is more common in patients who have received heparin for the first time.

What are the highlights?

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Total number of panel recommendations : 32



VTE in the Context of Pregnancy

... a ... , v ... , a ... am ... a a ... a ... , a ...
a ... a ... a ... a a ... a ma ... a ...

Who is most at risk?

... a ... -a ... a ... a ... a ... ma ... a m ... a m ... a ...
a ... a ... , ... , a ... a ... , a a ... v ... ,
- ... a ... (... , ... a ... , ...), a ... a ... a ...
a ... m ... a ... m ... , v ... , av ... a ... m ... a ...
... , a ... a ... a ... a ... v ... a ... a ...

Who is affected?

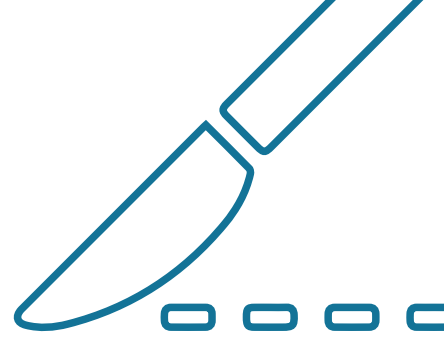
... a ... m ... , ... a ... av ... v ... a ...
av ... a ...
... a ... , ma ... a ... a ... a ... , a ...

What are the highlights?

... va v ... a ... a ... a ... , ... a ... v ...
... a ... m ... ava ... a ... a ... , ... m ... m ...
... a ... a ... m ... v ... a ... m ...
... ma ... a ... , -m ... a ... - ... a ... a ... a ...
... ma ... a ... a ... m ...



Prophylaxis for Surgical Patients



venous thromboembolism (VTE) is a leading cause of death in hospitalized patients. The risk of VTE is increased in patients undergoing surgery, especially those who are immobilized or have major surgery.

Prophylaxis for VTE in surgical patients is essential to reduce the risk of mortality and morbidity. The American Society of Hematology (ASH) has published clinical practice guidelines for the prevention of VTE in surgical patients.

Hematology: The study of blood and blood-forming organs, and the disorders of these organs and tissues.

Surgeon: A medical professional who specializes in surgery, the treatment of disease by operative means.

Hospital Stay: The period of time a patient spends in a hospital, from admission to discharge.

Patient: An individual who is receiving medical care, especially in a hospital or clinic.

These guidelines provide recommendations for the use of pharmacologic and mechanical prophylaxis in surgical patients.



ASH Recommendations for Treatment of Deep Vein Thrombosis and Pulmonary Embolism

venous thromboembolism (VTE) is a leading cause of morbidity and mortality. The American Society of Hematology (ASH) provides evidence-based recommendations for the treatment of VTE.

The primary goal of VTE treatment is to prevent further thrombotic events and reduce the risk of bleeding. Treatment options include anticoagulation, thrombolysis, and inferior vena cava (IVC) filters.

Anticoagulation is the mainstay of VTE treatment. Direct oral anticoagulants (DOACs) are preferred over vitamin K antagonists (VKAs) due to their predictable pharmacokinetics and lower risk of bleeding. Treatment should be initiated as soon as possible after diagnosis.

Thrombolysis is indicated for patients with acute, symptomatic VTE who are at low risk of bleeding. IVC filters are reserved for patients who cannot receive anticoagulation.

Long-term anticoagulation is recommended for patients with a first episode of VTE who are at high risk of recurrence. Duration of treatment should be individualized based on the patient's risk of recurrence and bleeding.



