



ASH Clinical Practice Guideline on Venous Thromboembolism (VTE):

What You Should Know

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Prophylaxis for Hospitalized and





Optimal Management of Anticoagulation Therapy



Who is covered?

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a



Why is it made?

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v a
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a a a a a ma v

Who is affected?

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What are the highlights?

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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 initiation of heparin therapy. The pathogenesis involves the formation of antibodies that bind to heparin-platelet factor 4 (PF4) complexes, leading to platelet activation and aggregation. This can result in thrombotic events, such as deep vein thrombosis (DVT) and pulmonary embolism (PE). 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, but it is most commonly seen in patients who have received heparin for the treatment of venous thromboembolism (VTE) or acute coronary syndrome (ACS).

What are the highlights?

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Total number of panel recommendations : 32



VTE in the Context of Pregnancy

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Who is most at risk?

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Who is affected?

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What are the highlights?

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ma a a m



Treatment of Pediatric VTE

Who is covered?

All children and adolescents

Why is it made?

To reduce the risk of bleeding and thrombosis in children and adolescents with VTE. The guideline is based on a systematic review of the literature and clinical expert opinion. The guideline is intended to be used in conjunction with the ASH Clinical Practice Guideline on Venous Thromboembolism (VTE): What You Should Know.

Who is affected?

Children and adolescents with VTE, including those with acute and chronic VTE, and those with VTE who are on anticoagulation therapy.

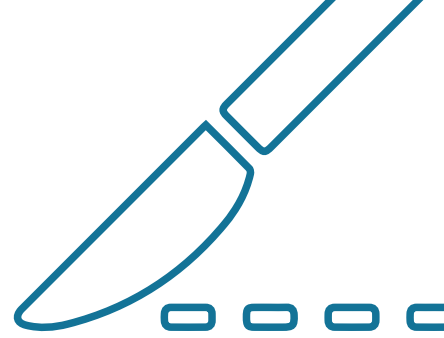
What are the highlights?

1. For children and adolescents with acute VTE, the guideline recommends the use of low-molecular-weight heparin (LMWH) or unfractionated heparin (UFH) as the initial treatment. 2. For children and adolescents with acute VTE who are on anticoagulation therapy, the guideline recommends the use of LMWH or UFH as the preferred treatment. 3. For children and adolescents with acute VTE who are on anticoagulation therapy, the guideline recommends the use of LMWH or UFH as the preferred treatment.

Total number of panel recommendations : 30



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 major surgery, especially those who are immobilized or have underlying medical conditions. Prophylaxis is essential to reduce the risk of VTE in these patients.

There are several options for VTE prophylaxis, including mechanical methods (such as compression stockings and intermittent pneumatic compression) and pharmacologic methods (such as low-dose aspirin, unfractionated heparin, low-molecular-weight heparin, and direct oral anticoagulants). The choice of prophylaxis depends on the patient's individual risk factors and the type of surgery.

Hematology: The American Society of Hematology (ASH) provides evidence-based recommendations for VTE prophylaxis in surgical patients.

Surgery: Major surgery, especially orthopedic and abdominal surgery, is associated with a high risk of VTE.

Hospital Stay: Patients who are hospitalized for more than 7 days are at an increased risk of VTE.

Patient: Patients with underlying medical conditions, such as cancer, heart failure, and chronic kidney disease, are at an increased risk of VTE.

For more information, visit www.ash.org/VTEguideline.



ASH Recommendations for Treatment of Deep Vein Thrombosis and Pulmonary Embolism

venous thromboembolism (VTE) is a leading cause of death in the United States. The most common types of VTE are deep vein thrombosis (DVT) and pulmonary embolism (PE). DVT occurs when a blood clot forms in a deep vein, usually in the legs. PE occurs when a blood clot travels from another part of the body to the lungs.

The American Society of Hematology (ASH) has published clinical practice guidelines for the treatment of DVT and PE. These guidelines are based on the best available evidence and are intended to help healthcare providers make decisions about the best treatment for their patients.

The first recommendation is that all patients with DVT or PE should receive anticoagulation therapy. The preferred first-line therapy is a direct oral anticoagulant (DOAC), such as apixan, rivaroxaban, or edoxaban. If a DOAC is not available or not tolerated, a vitamin K antagonist (VKA), such as warfarin, is the preferred alternative. The duration of treatment should be at least 3 months, and longer if there are ongoing risk factors for recurrence.

For patients with DVT or PE who are unable to take oral anticoagulants, parenteral anticoagulation is recommended. This can be achieved with low-molecular-weight heparin (LMWH) or unfractionated heparin (UFH). LMWH is preferred over UFH because it is easier to use and has a lower risk of bleeding.

For patients with DVT or PE who are unable to take anticoagulants, inferior vena cava (IVC) filters are recommended. These filters are placed in the IVC to catch any clots that may travel to the lungs. However, IVC filters are not recommended for patients who are able to take anticoagulants.



