

PROPHYLAXIS FOR VENOUS THROMBOEMBOLISM IN SURGICAL PATIENTS: WHO KNOWS DOES THE TIME, NOT WAITING TO HAPPEN!!!

Profilaxia para tromboembolismo venoso em pacientes cirúrgicos: quem sabe faz a hora, não espera acontecer!!!

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In recent years we have seen an unprecedented advance in technical and professional training in surgery. There were years when the huge leap in quality of the equipment, coupled with the development of new skills and great technical ability of surgeons, improved surgery greatly in many aspects. Most notable are the clinical evaluation and preoperative examinations, surgical time, postoperative recovery, use of perioperative medications, hospitalization time and, more importantly, significant improvement in results with greatly reduced morbidity and mortality on procedures. These advances have changed greatly also on the digestive tract surgery with sophisticated techniques that improved the prognosis of operations on liver, pancreas, bowel transplants, bariatric surgery, and gastrointestinal cancer.

Despite all this progress, a very important aspect has been sadly overlooked: prophylaxis for venous thromboembolism (VTE) in patients undergoing these procedures. VTE is the leading preventable cause of death in hospitalized medical and surgical patients. Its incidence is much higher than that usually seen clinically, and about 50% to 60% of cases are asymptomatic or mildly symptomatic, making it very difficult to their perception and diagnosis. In general surgery the incidence of VTE without prophylaxis varies widely depending on the type of transaction and the risk factors of the patient; it affects around 20% to 25%. In oncological and bariatric surgery the incidence increases to 30% to 35%.

Pulmonary embolism occurs in approximately 650,000 people per year in the U.S., with about 200,000 deaths. About 80% of these cases are related to hospitalization and procedures. A study in 2002 showed that two out of three cases of VTE could be avoided if the recommendations for prophylaxis were followed in accordance with the existing guidelines.

The literature data are quite worrying. A 2008 U.S. survey showed that only 30% of surgical patients received appropriate VTE prophylaxis. In Brazil, data from the ENDORSE study (2008)¹ showed 46% of correct prophylaxis in surgical patients admitted to reference hospitals.

The reasons for non-use or misuse of VTE prophylaxis are many; however, in some surgical patients are: incorrect stratification of VTE risk, focus on the underlying disease, fear of bleeding, and ignorance or disbelief in the evidence in favor of prophylaxis.

Several studies have tried to show options to correct

this flaw in the treatment of our patients; however, the best way seems to be the professionals' awareness regarding the incidence and risks for the patient and the availability of tools for proper assessment of these risks with clear guidelines and easy implementation to prevent VTE.

In this issue of the ABCD, Malafaia et al.², describe a tool with guidelines for both risk assessment and application of methods for pharmacological and mechanical prophylaxis for VTE. It is presented as a guideline and was based on the most current techniques for making guidelines, to formulate key questions and answers, constructed on evidence-based literature pretty solid. This guideline is in perfect harmony with the new guidelines published by the American College of Chest Physicians (ACCP February 2012)³ that are globally accepted and developed the most rigorous standards of evidence-based medicine by the renowned Mc Master University in Canada. Despite this similarity, Malafaia et al.² presents adaptations to our reality. Of course, this guideline is not intended to replace the assessment, judgment and experience of the physician responsible for the patient; their goal is to help surgeons to make decisions better suited for each patient at the time of treatment. It has answers to key questions and to doubts that often appear in surgical practice, as the choice of prophylaxis, the best time of onset and duration.

This initiative of the CBDC, in achieving this guideline, is worthy of praise and hopefully serve as an example for other Brazilian medical associations. It can lessen the burden that this enemy - often invisible - carries on over the treatment and, unfortunately, often takes away the lives of our patients.

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