

Thromboprophylaxis (TP) for hospice in-patients; current practice

Suzie Gillon

Keri-Michele Lodge

Jason Ward

Anne Nunn

Simon Noble

Miriam Johnson



TP for patients admitted to hospital

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MEDICAL SCHOOL

- Major national priority
- DoH. Letter from the CMO, 24 March 2010. Available at: www.dh.gov.uk
- NICE clinical guideline 92. Venous thromboembolism, 2010. Available at: www.nice.org.uk
- DoH. Using the CQUIN payment framework – an addendum to the 2008 policy guidance for 2010/11. Available at: www.dh.gov.uk



What about hospice in-patients?

- Not solely terminal care; over 50% discharge
- Reversible causes of deterioration; earlier involvement in patient care
- Only 7% SPC units have TP guidelines (Noble 2007)
- Not perceived as a significant problem by clinicians
- Outcome measures in studies not appropriate
- Studies don't include our patients
- "A big PE is a nice way to go" (Noble 2008)



NICE guidance 2010

- Chapter 28. Palliative care
- Consider TP for people admitted with potentially reversible pathology
- Do not offer TP to those admitted for terminal care or on LCP
- Review decisions regularly



currently

- Currently UK palliative care patients may get TP or not purely depending upon the setting of admission (hospital or hospice)
- An evidence base is needed in advanced disease



Method

- 3 hospices (St. Gemma's Hospice, Leeds, St. Catherine's Hospice, Scarborough, St. Anne's Hospice, Newport)
- Retrospective case note review; 100 consecutive admissions to each in-patient unit
- Pan Birmingham Cancer Network TP guidance for palliative care patients applied for admission documentation
- Data extracted: VTE risk according to PBCN guidance; those at temporary increased risk; c/i to TP; TP stopped, TP started; documented reasons



Results

- n = 300, (145 male).
- mean age = 70 (22-96).
- primary diagnosis cancer = 260
- non-cancer diagnosis = 40.
- VTE risk
 - o Low – 0
 - o Moderate – 227
 - o High - 73



Results 2

Contraindications to TP

- o Total: 129/300 (43%)
- o Active Bleeding
/ Platelets < 50; 12 (9.3%)
- o Dying; 96 (74.4%)
- o On anticoagulant; 21 (16.3%)

Transfer from hospital on TP

- o 13 patients. TP stopped O/A in all 13



Results 3

- temporary additional VTE risk; 26/300 (8.6%)
 - 10 infection; 12 pain; 4 SCC
- 15/26 had documented c/i to TP
- 3 patients were started on TP
- Overall 16/300 (5%) had a documented decision re TP (stopping or starting)



Summary

- Nearly 10% had a reversible increased VTE risk.
- Almost half had a contraindication to TP
- Documentation of clinical decision making was poor

- PBCN risk assessment is now routine in these 3 hospices and a prospective evaluation is ongoing (currently at 310 evaluated patients).



But...

- It is unknown whether such applied guidance, developed by consensus only, is valid
- Question 1: would it be better for hospice inpatients to have TP unless contraindicated (TP for 57.5%)?
- Question 2: Is the concept of 2 weeks TP appropriate for hospice patients with advanced disease?



This is a beginning...

- An RCT is needed
- ... what are the relevant outcomes...?
- ... and how to measure them?
- ... and how to recruit?
- We all see a few patients a year





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