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The CEC VTE Prevention Program aims to reduce the incidence of hospital related VTE by ensuring that all patients are assessed for VTE risk and given appropriate prophylaxis. The program provides local health districts, individual facilities and clinicians with the tools and resources required to address this patient safety issue, as well as the support and advice required to implement the elements into workflow. The VTE Prevention program is a component of CEC's Medication Safety and Quality program.VTE Prevention Program - OverviewYouTube video (high resolution). Length: 2:49 minutes Sometimes blood can pool and thicken inside normal, healthy veins and block the flow of blood through the body. This is known as a blood clot, or medically as a Venous Thromboembolism (VTE). It includes blood clots that form in the deep veins, known as deep vein thrombosis (DVT), and clots that become lodged in the lungs, known as a pulmonary embolism (PE). VTE is one of the leading causes of preventable death in Australia. It causes more deaths than breast cancer, bowel cancer or road traffic accidents. Approximately 14,000 Australians develop a VTE each year. Around 5,000 of these cases result in death1. Hospitalisation is strongly associated with the development of VTEs - the majority of which are preventable. Effective prevention is achieved through assessment of risk factors and the provision of appropriate prophylaxis.ReferencesAccess Economics. The burden of venous thromboembolism in Australia: Report by Access Economics Pty Limited for The Australia and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism, May 2008. Accessed 1 April 2014. The CEC has created a quality improvement toolkit for VTE Prevention. This toolkit provides step-by-step guidance to help you to identify where your local practice can be improved and how to implement lasting changes to improve VTE outcomes. Refer to CEC VTE Prevention toolkit for more details. The CEC VTE Prevention Program aims to reduce the incidence of hospital related VTE by ensuring that all patients are assessed for VTE risk and given appropriate prophylaxis. The program provides local health districts, individual facilities and clinicians with the tools and resources required to address this patient safety issue, as well as the support and advice required to implement the elements into workflow. The VTE Prevention program is a component of CEC's Medication Safety and Quality program.VTE Prevention Program - OverviewYouTube video (high resolution). Length: 2:49 minutes Sometimes blood can pool and thicken inside normal, healthy veins and block the flow of blood through the body. This is known as a blood clot, or medically as a Venous Thromboembolism (VTE). It includes blood clots that form in the deep veins, known as deep vein thrombosis (DVT), and clots that become lodged in the lungs, known as a pulmonary embolism (PE). VTE is one of the leading causes of preventable death in Australia. It causes more deaths than breast cancer, bowel cancer or road traffic accidents. Approximately 14,000 Australians develop a VTE each year. Around 5,000 of these cases result in death1. Hospitalisation is strongly associated with the development of VTEs - the majority of which are preventable. Effective prevention is achieved through assessment of risk factors and the provision of appropriate prophylaxis.ReferencesAccess Economics. The burden of venous thromboembolism in Australia: Report by Access Economics Pty Limited for The Australia and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism, May 2008. Accessed 1 April 2014. The CEC has created a quality improvement toolkit for VTE Prevention. This toolkit provides step-by-step guidance to help you to identify where your local practice can be improved and how to implement lasting changes to improve VTE outcomes. Refer to CEC VTE Prevention toolkit for more details. Med J Aust Published online: 27 January 2019 THE first Australasian guidelines for the diagnosis and management of venous thromboembolism (VTE) have been produced, with a summary published online today by the Medical Journal of Australia. Led by Associate Professor Huyen Tran, Head of the Haemostasis and Thrombosis Unit at Alfred Health and Monash University in Melbourne, a working group from the Thrombosis and Haemostasis Society of Australia and New Zealand developed the guidelines, which are available in full at . VTE, which includes deep vein thrombosis (DVT) and pulmonary embolism (PE), is the third most common cardiovascular disease globally, with an annual incidence of over 10 million people. In Australia, at least 17 000 people develop VTE each year (annual incidence, 0.83 per 1000 population), Tran and colleagues wrote. The lifetime risk of VTE is 8%, with 1% of people aged over 80 years experiencing their first VTE. This disease is a major cause of health-related economic loss for the patient and the community (estimated to be $1.7 billion for Australia in 2008). It is a chronic and frequently recurrent disease. Coauthor Associate Professor Harry Gibbs, Deputy Director of General Medicine at Alfred Health, said three important new recommendations were for oral factor Xa inhibitors (rivaroxaban or apixaban) upfront rather than injections of low molecular weight heparin; every VTE patient receives 3 months (6 weeks for those with distal DVT) of anticoagulation with a decision then to be made about whether to continue long-term; and, that low-intensity anticoagulation over the long term is both safe and effective and is suitable for many patients. The major change to guidelines was a recommendation to use a factor Xa inhibitor, such as rivaroxaban or apixaban, rather than warfarin for the treatment of acute VTE. Other recommendations from the guidelines: the diagnosis of VTE should be established with imaging; it may be excluded by the use of clinical prediction rules combined with D-dimer testing; proximal DVT or PE caused by a major surgery or trauma that is no longer present should be treated with anticoagulant therapy for 3 months; proximal DVT or PE that is unprovoked or associated with a transient risk factor (non-surgical) should be treated with anticoagulant therapy for 36 months; proximal DVT or PE that is recurrent (two or more) and provoked by active cancer or antiphospholipid syndrome should receive extended anticoagulation; distal DVT caused by a major provoking factor that is no longer present should be treated with anticoagulant therapy for 6 weeks; for patients continuing with extended anticoagulant therapy, either therapeutic or low dose direct oral anticoagulants can be prescribed and is preferred over warfarin in the absence of contraindications; routine thrombophilia testing is not indicated; and, thrombolysis or a suitable alternative is indicated for massive (haemodynamically unstable) PE.

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