

EDITORIAL

DEEP VENOUS THROMBOSIS: A PREVENTABLE SCOURGE IN SURGICAL PRACTICE

Deep venous thrombosis (DVT) poses a major and common preventable cause of death in surgical practice. However, only a few practicing surgeons in Nigeria have a good knowledge and practice of DVT prophylaxis.¹

DVT can no longer be called a rare condition, as 90.5% of Nigerian surgeons have encountered cases of DVT in their surgical practice while 83.5% have encountered pulmonary embolism (PE), the dreaded acute complication of DVT.¹ The prevalence of DVT among postoperative patients have been found to vary between 2.4% and 9.6%, with case fatality rate after surgery being 60%.²

History and clinical signs alone are insufficient in making a clinical diagnosis. Risk factors identified by surgeons include prolonged immobilization, advanced age and pelvic surgery.¹ Orthopaedic procedures like hip surgeries generally have a higher risk than general surgical procedures. Well's score, a standardized pretest probability assessment which combines risk factors and clinical features to stratify the disease into DVT unlikely (clinical score ≤ 1) and DVT likely (clinical score ≥ 2) is very useful in evaluation.³ Despite the clinical usefulness of the Well's score, only 13.3% of Nigerian surgeons have used it in evaluating patients suspected to have DVT.¹ If clinical score is ≤ 1 , DVT is excluded if a D-dimer assay is negative but a positive D-dimer assay in the same scenario warrants investigation with venous ultrasonography while a positive D-dimer in the presence of a score ≥ 2 suggests DVT and is an indication to commence treatment.¹

It is rather unfortunate that at least a quarter of patients who are at risk of venous thromboembolism in Africa are not receiving prophylaxis.² To make matters worse, 15% of surgeons in Nigeria were reluctant to offer DVT prophylaxis citing bleeding complications, increased cost to patients and having predominantly paediatric patients as their reasons.¹ Depending on the level of risk of DVT and the risk of major bleeding complication, prophylactic mechanical and pharmacological modalities can be used. Mechanical measures include early ambulation / limb physiotherapy as practiced by most of our surgeons and the use of intermittent pneumatic compression. Commonly used pharmacological agents include low molecular weight heparin (LMWH), dabigatran, abixaban and rivaroxaban.⁴ In addition to the traditional systemic anticoagulation commonly used, other treatment modalities include systemic thrombolysis, catheter directed pharmacologic thrombolysis, and thrombectomy.⁵

The need for institutional guidelines has been expressed by our surgeons and this will go a long way in improving DVT knowledge and harmonizing preventive modalities in the sub region.

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