Current Practices in Venous Thromboembolism Prophylaxis in Otolaryngology – Head & Neck Surgery

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Abstract

The goal of our study was to identify what types of VTE prophylaxis are currently being used by practicing otolaryngologists. A better understanding of risk factors and the incidence of VTE has led to the establishment of clear, specialty specific guidelines. However, the vast majority (88.3%) stated they would find institutional VTE prophylaxis guidelines helpful. It seems likely that patient and specialty specific factors are at least partly responsible for differences in rates of VTE among the surgical specialties, which calls into question the usefulness of a set of standardized institutional guidelines. Although our response rate is low, several studies have shown that low response rate does not necessarily lead to sampling bias, and that low response rates lead to minimal differences in accuracy.

Methods

A survey of 26 questions was e-mailed to 4,376 otolaryngologists whose contact information was obtained from the American Academy of Otolaryngology – Head & Neck Surgery (AAOHNS) website. Only those Academy members who had indicated an interest in Head & Neck Surgery or General Otolaryngology were invited to participate. An initial survey invitation was sent to all participants with two follow-up survey invitations sent to those failing to respond. Survey data was collected using Survey Monkey.

Results

• 4,376 surveys were sent and 676 were returned for a response rate of 15.4%.
• 345 respondents (51%) were in academic practice and 310 (45.9%) were in private practice.
• 379 (56.1%) respondents did not undergo any fellowship training, while 136 (20.1%) had Head & Neck Oncology training and 100 others (14.8%) underwent some other fellowship training.
• Preoperative VTE prophylaxis was used by 308 (44.9%), either with intermittent pneumatic compression (78.3%), compression stockings (40.7%), or low molecular weight heparin (26.1%) (See Figure 1).
• Intraoperative VTE prophylaxis was used by 535 (83%) respondents, either with intermittent pneumatic compression (91.8%), compression stockings (35.9%), or low molecular weight heparin (12.3%) (See Figure 1).
• Postoperative VTE prophylaxis was used by 540 respondents (85.4%), either with early ambulation (87.8%), intermittent pneumatic compression (85.4%), compression stockings (43.3%), or low molecular weight heparin (42.4%). (See Figure 1).
• 547 respondents (80.9%) had guidelines for thromboembolism prophylaxis at their institution.
• 528 of these respondents (96.5%) routinely, often, or occasionally follow their institutional guidelines (See Figure 2).
• The most common reasons for failure to adhere to these guidelines included low risk of developing VTE, cited by 141 (69.1%), and high risk for bleeding, cited by 84 (41.2%) (See Figure 3).

Conclusions

• There exists a wide variety of strategies for the prevention of VTE among practicing otolaryngologists. Many otolaryngologists who responded feel that specialty-specific guidelines would be helpful.
• The most commonly cited reasons for failure to follow institutional VTE prophylaxis guidelines are elevated bleeding risk and low patient risk of developing VTE.
• It seems likely that patient and specialty specific factors are at least partly responsible for differences in rates of VTE among the surgical specialties, which calls into question the usefulness of a set of standardized institutional guidelines.

Introduction

Venous thromboembolic disease (VTE), including deep venous thrombosis (DVT) and pulmonary embolism (PE) is a significant problem among hospitalized post-surgical patients, and results in significant morbidity, mortality, and resource expenditure. The primary means of preventing VTE is providing patients with adequate prophylaxis, either mechanical or pharmacologic. A better understanding of risk factors and the incidence of VTE has led to the establishment of clear, specialty specific guidelines in several surgical specialties, such as orthopedics, vascular surgery, and gynecology. The true incidence of DVT and PE among the otolaryngology population remains poorly defined.

No standardized guidelines currently exist for the field of otolaryngology, and little is known about the current VTE prophylaxis strategies utilized by practicing otolaryngologists. The goal of our study was to identify what types of VTE prophylaxis are currently being used by otolaryngologists.

Respondent Adherence to Institutional VTE Guidelines

Reasons for Failure to Adhere to VTE Guidelines

References