Clinical Practice Guideline for VTE Prophylaxis in TBI Patients

Low Risk	Moderate Risk	High Risk
• No High Risk Criteria	• No High Risk Criteria BUT on anti-platelet medications.	• SDH or EDH > 8mm • Contusion or IVH > 2cm • Multiple Contusions per lobe. • SAH with abnormal CTA (i.e. aneurysmal bleed) • Craniotomy • ICP monitor
Initiate pharmacologic prophylaxis* within **24hrs** after injury if CT stable**.[1]	Initiate pharmacologic prophylaxis* within **48hrs** after injury if CT stable**.	Initiate pharmacologic prophylaxis* within **72hrs** after injury if CT stable**. [2,34]

Table 1: Modified Berne-Norwood Criteria (From TQIP Best Practices)[5]

*Chemoprophylaxis dosing recommendations:
- Lovenox 30 mb BID if BMI <30
- Lovenox 0.5mg/kg BID if BMI ≥30
- If CrCl <30, avoid lovenox. Use heparin 5,000 units TID

** Stability of CT is determined/documented by neurosurgery

References:

1. Phelan et al. A randomized, double-blinded, placebo-controlled pilot trial of anticoagulation in low-risk traumatic brain injury: The Delayed Versus Early Enoxaparin Prophylaxis I (DEEP 1) study. J Trauma Acute Care Surg 2012;73(6):1434-1441.
2. Ley et al. Updated guidelines to reduce venous thromboembolism in trauma patients: A Western Trauma Association critical decisions algorithm J Trauma Acute Care Surg 2020;89(5) 971-981.
3. Spano et al. Anticoagulant chemoprophylaxis in patients with traumatic brain injuries: A systematic review. J Trauma Acute Care Surg 2020;88(3):454-460.
4. ICP monitor paper
5. American College of Surgeons Committee on Trauma. ACS TQIP Best Practices in the Management of Traumatic Brain Injury. Released 2015.

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