

Response to Commentary and Critique to “VTE Prophylaxis Therapy: Clinical Practice vs Clinical Guidelines” by Abukhalil et al [Response to Letter]

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Dear editor

We thank Dr. Güven for his knowledgeable comments regarding our article “VTE Prophylaxis Therapy: Clinical Practice vs Clinical Guidelines” and for agreeing that we found similar results requiring adherence to clinical guidelines in healthcare institutions, even though the methodology in both studies was slightly different.

First, we understand the concern about BMI limitation, which we have listed as a limitation of the study; however, in the sample calculation for the Padua score in the study sample, only a small number of patients had a PADUA score of 3. Furthermore, they had a normal BMI, constituting approximately 7% of the patients; even adding 1 to their Padua score will not have a statistically significant effect on the study results, as suggested in the comment provided in the letter.

In the second comment, the Padua and IMPROVE models helped stratify hospitalized patients based on VTE and bleeding risk and have been externally validated.^{1–3} The overuse of anticoagulants in the study was mainly seen in patients with low Padua scores. Furthermore, similar overutilization of anticoagulants was recently reported in a regional study.⁴ In our study, a Padua total score of 4 was considered the cutoff point for initiating prophylaxis in certain patients, indicating a high risk of developing VTE. For the IMPROVE bleeding score, a total score of 7 was considered a cut-off point for the risk of bleeding. Patients with a Padua score ≥ 4 and a bleeding score < 7 were candidates for VTE pharmacotherapy prophylaxis if no other contraindications were present.^{5,6} According to the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines, For acutely ill hospitalized medical patients at increased risk of thrombosis who are bleeding or are at high risk for major bleeding, mechanical thromboprophylaxis with graduated compression stockings or intermittent pneumatic compression is recommended over pharmacological prophylaxis. Furthermore, for critically ill patients who are bleeding or are at high risk for major bleeding mechanical thromboprophylaxis with GCS and/or IPC, at least until the bleeding risk decreases.⁷

Disclosure

The author reports no conflicts of interest in this communication.

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