DVT Prophylaxis In Psychiatry: Why Do We Discriminate? A Literature Review

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Learning Objectives:
Determine venous thromboembolism risk factors specific to mental healthcare patients. Highlight evidence based guidelines for deep venous thrombosis prophylaxis in Psychiatry. Identify areas of m uncertainty. Benefits and risks of venous thromboembolism prophylaxis in mental healthcare settings.

Case Summary:
Deep venous thrombosis (DVT) and pulmonary embolism are an important cause of morbidity and mortality in hospitalized patients. There is a vast body of literature available on the importance of use of DVT prophylaxis in medical-surgical patient population with various evidence based guidelines and scoring systems available to follow but the issue of DVT prophylaxis is rarely discussed in inpatient psychiatric settings. This review aims to help separate evidence from opinion by sharing evidence based findings compiled after a literature review highlighting venous thromboembolism (VTE) risk factors specific to mental healthcare patients, the availability of evidence based guidelines in psychiatry on this subject, and identifies areas of uncertainty pertaining to DVT prophylaxis in psychiatry. To our knowledge we are one of the very few to perform a literature review of clinical studies to assess the need for DVT prophylaxis in psychiatric patient population and the availability of evidence based scoring systems to assess risk in this patient population. Although VTE risk factors for psychiatric patients are similar to other hospitalized patients but there is very little published evidence investigating VTE incidence and the role of pharmacological or mechanical prophylaxis in mental healthcare settings. Literature review suggests that 70-80% of the hospitalized patients that develop DVT are asymptomatic and indeed venous thromboembolism especially in psychiatric patients has a risk of being easily overlooked contributing to increase in morbidity and mortality in this patient population. In majority of inpatient psychiatric settings although patients are free to mobilize but many psychiatric specific VTE risk factors like excessive sedation secondary to medication, immobility secondary to physical restraints, catatonia, isolation behavior, use of antipsychotics, older age are often overlooked and not accounted for which adds to the burden of risk of development of VTE in this group. VTE prophylaxis for all hospitalized psychiatric patients is inappropriate but it does not eliminate the need for tools, guidelines, scales to assess this unique patient population. There is also no published evidence that has investigated the potential harm of VTE prophylaxis in this psychiatric setting.

Conclusions:
This is a neglected area of research and there is a strong need for an evidence-based scoring system to assess for venous thromboembolism risk in psychiatric inpatient population. Chronic mental health patients in general have a lower life expectancy then the general population. Screening, diagnoses and treatment of any VTE in this patient population would contribute to improved quality of life with decrease in morbidity and mortality.