# Thrombosis Risk Factor Assessment

**Choose all that apply**

## Each Risk Factor Represents 1 Point
- Age 41-60 years
- Minor surgery planned
- History of prior major surgery (< 1 month)
- Varicose veins
- History of inflammatory bowel disease
- Swollen legs (current)
- Obesity (BMI > 25)
- Acute myocardial infarction
- Congestive heart failure (<1 month)
- Sepsis (<1 month)
- Serious lung disease including pneumonia (<1 month)
- Abnormal pulmonary function (COPD)
- Medical patient currently at bed rest
- Other risk factors

## Each Risk Factor Represents 2 Points
- Age 60-74 years
- Arthroscopic surgery
- Malignancy (present or previous)
- Major surgery (> 45 minutes)
- Laparoscopic surgery (> 45 minutes)
- Patient confined to bed (> 72 hours)
- Immobilizing plaster cast (< 1 month)
- Central venous access

## Each Risk Factor Represents 3 Points
- Age over 75 years
- History of DVT/PE
- Family history of thrombosis*
- Positive Factor V Leiden
- Positive Prothrombin 20210A
- Elevated serum homocysteine
- Positive lupus anticoagulant
- Elevated antithrombin antibodies
- Heparin-induced thrombocytopenia (HIT)
- Other congenital or acquired thrombophilia
  - If yes: Type:

## Each Risk Factor Represents 5 Points
- Elective major lower extremity arthroplasty
- Hip, pelvis or leg fracture (< 1 month)
- Stroke (< 1 month)
- Multiple trauma (< 1 month)
- Acute spinal cord injury (paralysis) (< 1 month)

## For Women Only (Each Represents 1 Point)
- Oral contraceptives or hormone replacement therapy
- Pregnancy or postpartum (< 1 month)
- History of unexplained stillborn infant, recurrent spontaneous abortion ≥3), premature birth with toxemia or growth-restricted infant

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**Patients’ Name:**

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**Age:**

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**Sex:**

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**Weight:**

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**2005 Caprini Risk Assessment Model**

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# ASPS VTE Task Force
## Risk Assessment and Prevention

Approved by the ASPS Executive Committee in July 2011

Disclaimer: The recommendations were developed to provide strategies for patient management and to assist physicians in clinical decision making. The recommendations should not be construed as a rule, nor should it be deemed inclusive of all proper methods of care or exclusive of other methods of care reasonably directed at obtaining the appropriate results. The recommendations are not intended to define or serve as the standard of medical care. The ultimate judgment regarding the care of a particular patient must be made by the physician in light of all the circumstances presented by the patient, the diagnostic and treatment options available, and available resources.

### Step One: Risk Stratification

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-patient</strong> adult aesthetic and reconstructive plastic surgery who undergo general anesthesia</td>
<td>Should complete a 2005 Caprini risk factor assessment tool in order to stratify patients into a VTE risk category based on their individual risk factors. <strong>Grade A</strong> or Should complete a VTE risk assessment tool comparable to the 2005 Caprini RAM in order to stratify patients into a VTE risk category based on their individual risk factors. <strong>Grade D</strong></td>
</tr>
<tr>
<td><strong>Out-patient</strong> adult aesthetic and reconstructive plastic surgery who undergo general anesthesia</td>
<td>Should consider completing a 2005 Caprini risk factor assessment tool in order to stratify patients into a VTE risk category based on their individual risk factors. <strong>Grade B</strong> or Should consider completing a VTE risk assessment tool comparable to the 2005 Caprini RAM in order to stratify patients into a VTE risk category based on their individual risk factors. <strong>Grade D</strong></td>
</tr>
</tbody>
</table>

### Step Two: Prevention

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>2005 Caprini RAM Score**</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elective Surgery Patients</strong> adult aesthetic and reconstructive plastic surgery who undergo general anesthesia</td>
<td>7 or more</td>
<td>Should consider utilizing risk reduction strategies such as limiting OR times, weight reduction, discontinuing hormone replacement therapy and early postoperative mobilization. <strong>Grade C</strong></td>
</tr>
<tr>
<td>Patients undergoing the following major procedures when the procedure is performed under general anesthesia lasting more than 60 minutes:</td>
<td>3 to 6</td>
<td>Should consider the option to use postoperative LMWH or unfractionated heparin. <strong>Grade B</strong></td>
</tr>
<tr>
<td>- Body contouring,</td>
<td>3 or more</td>
<td>Should consider the option to utilize mechanical prophylaxis throughout the duration of chemical prophylaxis for non-ambulatory patients. <strong>Grade D</strong></td>
</tr>
<tr>
<td>- Abdominoplasty,</td>
<td>7 or more</td>
<td>Should strongly consider the option to use extended LMWH postoperative prophylaxis. <strong>Grade B</strong></td>
</tr>
</tbody>
</table>

For the full task force report and prophylaxis medication, dosage, and timing protocol examples, visit plasticsurgery.org/vte

### Grade Qualifying Evidence Implications for Practice

- **A: Strong Recommendation** Level: 1 evidence or consistent findings from multiple studies of levels II, III, or IV Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.

- **B: Recommendation** Levels: II, III, or IV evidence and findings are generally consistent Clinicians should follow a recommendation but should remain alert to new information and sensitive to patient preferences.

- **C: Option** Levels: II, III, or IV evidence, but findings are inconsistent Clinicians should be flexible in their decision-making regarding appropriate practice, although they may set bounds on alternatives; patient preference should have a substantial influencing role.

- **D: Option** Level: V little or no systematic empirical evidence Clinicians should consider all options in their decision-making and be alert to new published evidence that clarifies the balance of benefit versus harm; patient preference should have a substantial influencing role.

*The 2005 Caprini VTE Risk Assessment Model has been validated in the plastic surgery population.*