The International Consensus and the ACCP Sixth Consensus had a great impact on the clinical acceptance of LMWHs. These recommendations have been instrumental in initiating further clinical trial to answer key questions regarding thromboprophylaxis and in setting a new standard for patient care. Also, the key to cost containment in management of DVT/PE is to (1) define the etiology (blood coagulation protein or platelet defect), institute appropriate long-term therapy as indicated, and assess appropriate family members as indicated if a hereditary defect is found and (2) use LMWH as inpatient management. saving a minimum of 210,000.00 dollars per 1000 patients simply from cost savings of recurrence, saving 17 lives per 1000 patients, and saving exorbitant costs of care for patients with recurrence and development of chronic venous insufficiency. The use of outpatient LMWH will save 4,900,000.00 dollars per 1000 patients if applied to the 70% of patients with DVT who fit the criteria of no comorbid condition requiring hospitalization and who arrive early enough to allow a diagnosis to be sent home or hospitalized for 24 hours or less. The simple defining of defects leading to unexplained thrombosis will add another 3,000,000.00 dollars in savings per 1000 patients with DVT and approximately 350,000.00 dollars per 100 patients with thrombotic stroke. In those with transient ischemic attacks, defining the defect and instituting appropriate
antithrombotic therapy, thereby potentially saving approximately 30% from developing a thrombotic stroke, amounts to approximately 350,500.00 dollars (= 30% of 1,168,500.00 dollars) in savings per 100 patients.

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