Hematoma Risk Should Not Preclude the Use of Venous Thromboembolism Prophylaxis

TO THE EDITOR:
We congratulate Patronella et al on their recent article entitled “Thromboembolism in high-risk aesthetic surgery: Experience with 17 patients in a review of 3871 consecutive cases” (Aesthet Surg J 2008;28:648–655), which provides a clear set of guidelines to minimize venous thromboembolic events (VTEs) in ambulatory aesthetic surgery. With regard to prophylaxis and the risk of reoperative hematoma, the authors noted that: “...in the senior author’s experience...if this medication [postoperative prophylactic low-molecular weight heparin] is given in the high-risk patients who are having additional breast procedures, a higher incidence of hematomas can be expected...to avoid the risk of postoperative bleeding and hematoma formation, [postoperative prophylaxis with] enoxaparin should not be administered in patients who undergo mastopexy/breast reduction or breast augmentation as an added procedure.”

Though it was made clear in the article that these statements were the opinion of the senior author, the association between pharmacologic VTE prophylaxis and reoperative hematoma deserves mention here.

The effect of pharmacologic prophylaxis on reoperative hematoma has been examined in a large series of patients undergoing transverse rectus abdominis muscle breast reconstruction, a multisite procedure that entails extensive dissection and undermining of mastectomy flaps, the creation of a flap tunnel, and a large abdominal donor site. In a series of 679 patients, the rate of reoperative hematoma was 0.5% in those receiving postoperative heparin prophylaxis and 1.0% in those who received mechanical prophylaxis only. The difference was not statistically significant, allowing the conclusion that prophylactic heparin does not increase postoperative hematoma risk. Other authors agree, advocating prophylactic heparin in all combined procedures or in procedures lasting more than four hours.

The rate of VTE in aesthetic plastic surgery patients is variable, ranging from 0.49% in facial rhytidectomy to 8.33% in circumferential trunk lift after massive weight loss. Reoperative hematoma rates are known to be low when pharmacologic prophylaxis is administered. Complications in elective aesthetic surgery are particularly objectionable, but here we must determine whether hematoma or VTE is the lesser of two evils. Recently, Davison and Massoumi noted that “a hematoma is a medical stress, an inconvenience, an embarrassment, or [necessitates] an additional procedure, but [unlike pulmonary embolism] rarely does it kill a patient.”

If, based on assessment with the criteria set forth by Davison et al, a patient is truly within the highest-risk categories for perioperative VTE complications, we urge the surgeon to accept the minimal hematoma risk associated with providing potentially life-saving pharmacologic VTE prophylaxis.

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DISCLOSURES
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REFERENCES