Journal of Anaesthesiology and Critical Care

Extended Abstract

Vol. 2, Iss. 4

2019

**Critical Care 2019; Iliac artery aneurysm: Incidence of deep vein thrombosis in post elective colorectal cancer surgery patients in Hospital Kuala Lumpur - Mohd Abdul Hadi Mohd Anuar- University Malaya Medical Centre, Malaysia**

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Overall incidence rate for colorectal cancer was 21.3 cases per 100,000 population and venous thromboembolism occurs in 100/100,000 population/year. Abdominal and pelvic malignancy surgery and prolonged immobilization after surgery further increase risk for DVT. Colorectal cancer patients going for a curative surgery are categorized in a moderate risk group to develop DVT. Today, DVT prophylaxis has proven significant reduction of surgery related DVT risk and its complications. Early mobilization after surgery in modern practice has proven to reduce risk of DVT, resulting in shorter hospitalization. Sufficient data is not available for this group of patients in Malaysia. This single centre, non-randomized cohort study was designed to evaluate the incidence of DVT in colorectal cancer surgery patients receiving shorter duration of DVT prophylaxis as a result of shorter average length of hospital stay. 57 patients were recruited and 1 excluded from the study. Only 1 (1.8%) patient was diagnosed with symptomatic DVT at day 7 post-operation despite receiving standard local practice of DVT prophylaxis and none were diagnosed with asymptomatic DVT. No relation between shorter duration of DVT prophylaxis as a result of shorter hospital stay with risk of developing DVT was seen within the study period. Hence, early mobilization and return to pre-morbid activities are essential in preventing DVT for these patients.

Pneumonic thromboembolism (PE) is the second-most basic reason for death in patients with cancer and around 80% of PE result from profound venous apoplexy (DVT) of the lower extremities. Therefore, PE and DVT have been viewed as successive conditions, and they are assembled and by and large called venous thromboembolism (VTE).

An imminent observational examination in 2373 patients experiencing general, urological, or gynaecological medical procedure detailed that 50 patients (2.1%) were decided as influenced by clinically unmistakable VTE, and 12 occasions happened inside 5 days of surgery.4 Another report of the Japanese Society of Anaesthesiologists in Japanese patients indicated that postoperative VTE would in general happen on the first postoperative day in quite a while who had hazard factors, for example, dangerous sickness or weight. Lethal PE is known to essentially happen when getting up just because after medical procedure. DVT causing such lethal PE may have just happened before medical procedure, making postoperative anticoagulant treatment generally incapable in forestalling such early deadly PE. Thusly, it is imperative to do preoperative screening for DVT.

There have been a few reports of a high commonness of DVT after stomach malignant growth medical procedure when all is said in done. Among patients with colorectal malignant growth, the assessed pervasiveness of DVT after medical procedure is 20%. Nonetheless, the preoperative pervasiveness and the hazard factors have not been explained in detail. Just a couple of studies have concentrated on patients with gastroenterological malignant growth, in spite of the fact that it is the most widely recognized hazard factor for PE. As far as anyone is concerned, just one examination with few patients has been done in patients with colorectal malignant growth, and the covariates used to recognize the free hazard factors were restricted. What's more, the nutty gritty anatomical conveyance of DVT has not been accounted for. As of late, lower-extremity venous ultrasonography has been viewed as a valuable technique for diagnosing DVT on the grounds that it is effectively open, non-invasive, and has a high affectability (93%-96%) and explicitness (98%-99%). The point of the current examination was to explain the pervasiveness, anatomical dispersion, and the

*This work is partly presented at 12th International Conference on Anesthesiology and Critical Care, November 11-12, 2019 Istanbul, Turkey*

hazard factors for DVT of the lower furthest points in patients with colorectal disease before medical procedure.

The investigation convention was endorsed by the Ethical Advisory Committee of Yokohama City University School of Medicine. In this investigation, all procedures conformed to rules of the Declaration of Helsinki. From January 2013 to March 2017, an aggregate of 1095 patients experienced CRC medical procedure at Yokohama City University Medical Centre. Of these, 10 were rejected from the investigation as a result of crisis medical procedure, 54 were avoided in light of the fact that preoperative lower-limb ultrasonography was not done, 21 were prohibited in light of the fact that preoperative serum d-dimer levels were not estimated, and four were barred in view of postoperative emergency clinic demise. The staying 1006 patients were taken on this review study. Ultrasonography and serum d-dimer level estimations were completed as a preoperative assessment inside a mean of about a month prior CRC medical procedure.

Patients' sexual orientation, weight, weight list, and information on the patient's' clinical history and ailment were recorded. TMN stages were recorded by the eighth TMN order of threatening tumors. Execution status (PS) was surveyed utilizing the size of the Eastern Cooperative Oncology Group (ECOG). Pressure ultrasonography (CUS) is including the femoral, popliteal, and calf veins was done by standard systems (grayscale, B-mode, shading Doppler) preoperatively utilizing a high-end scanner. In patients who experienced preoperative chemotherapy for rectal malignant growth, ultrasonography was done preoperatively. All assessments were completed by one of a few clinical technologists who were both prepared in the presentation of venous ultrasonography and confirmed as clinical sonographers by the Japan Society of Ultrasonographers in Medicine. On the off chance that a vein was widened by hypoechoic blood clot and indicated incomplete or no compressibility without securities, we analyzed intense DVT. In the event that the vein was incompressible, limited and unpredictable and demonstrated echogenic blood clot appended to the venous dividers with advancement of insurances, we analyzed ceaseless DVT. To analyze preoperative organizing, contrast-enhanced helical processed tomography (CT) was normally done if an iodine differentiate operator was accessible. Simultaneously, we checked whether asymptomatic PE was available unexpectedly.

As per the Japanese Guidelines for Prevention of Venous Thromboembolism,17 most patients with colorectal malignant growth are arranged in the high-risk bunch for postoperative DVT. For high-risk patients, physical medicines, for example, irregular pneumatic pressure (IPC) or anticoagulant treatment, are suggested in the rules. In this way, for patients in whom preoperative DVT was not identified, graduated pressure stockings and IPC or anticoagulant treatment were done at the specialist's tact from the morning of medical procedure until the patient had the option to walk sufficiently. Patients with distal DVT were commonly given anticoagulant treatment utilizing low-molecular-weight heparin (LMWH). For patients with proximal DVT, a brief sub-par vena cava channel (IVCF) was set before medical procedure at the cardiologist's attentiveness.

gastroduodenal vein (1.5%) and substandard mesenteric course (uncommon). Their introduction is exceptionally shifted, yet the across the board utilization of clinical imaging prompts numerous cases being found by chance.