Department of Health & Social Care

*From Caroline Dinenage MP*
*Minister of State for Care*

*39 Victoria Street*
*London*
*SW1H 0EU*

*020 7210 4850*

Your Ref: 8041/CH

PFD-1151078

Ms Alison Patricia Mutch
HM Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

14th Nov 2018

Dear Ms Mutch,

Thank you for your correspondence of 27 September to Matt Hancock about the death of Ms Mary Barbara Ryder. I am replying as Minister with responsibility for patient safety and hospital care quality.

Firstly, I would like to say how saddened I was to read of the circumstances surrounding Ms Mary Ryder's death. If you have the opportunity, please pass on my sincerest condolences to Ms Ryder's family and loved ones.

My officials have made enquiries with the National Institute for Health and Care Excellence (NICE) on the matter of concern you have raised.

I am advised that NICE has considered carefully the concern raised but does not find that its guidelines require amendment. I hope this reply will explain NICE's position.

NICE's guideline on '*Venous thromboembolism (VTE) in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism*'[1], NG89 published in March 2018, includes a section on abdominal surgery that recommends to consider extending pharmacological VTE prophylaxis (which may be low molecular weight heparin (LMWH, such as Clexane) or fondaparinux sodium) to 28 days postoperatively for people who have had major cancer surgery in the abdomen.

*1.14.3 Add pharmacological VTE prophylaxis for a minimum of 7 days for people undergoing abdominal surgery whose risk of VTE outweighs their risk of bleeding,*

[1] https://www.nice.org.uk/guidance/ng89

*taking into account individual patient factors and according to clinical judgement. Choose either:*

- *LMWH[4]or*
- *fondaparinux sodium[5]. [2018]*

*1.14.4 Consider extending pharmacological VTE prophylaxis to 28 days postoperatively for people who have had major cancer surgery in the abdomen. [2018]*
*I am further advised that this guideline also says that all medical, surgical and trauma patients at risk of VTE (that is, deep vein thrombosis (DVT) and pulmonary embolism (PE)) and bleeding should be reassessed at the point of consultant review or if their clinical condition changes (Recommendation 1.1.8).*

In addition, NICE has published a guideline on '*Venous thromboembolic diseases: diagnosis, management and thrombophilia testing*'[2], CG144, last updated in 2015, which includes recommendations on investigating for possible PE and on when to offer a D-dimer test and computed tomography pulmonary angiogram (CTPA).

The guideline recommends offering a D-dimer test in patients in whom PE is suspected and with an *unlikely* two-level PE Wells score (clinical prediction rule for estimating the probability of DVT and PE – see Recommendation 1.1.10 and table 2 of the guideline).

The guideline goes on to recommend that patients with active cancer and confirmed proximal DVT or PE should be offered LMWH, and to continue the LMWH for six months. At six months, the risks and benefits of continuing anticoagulation should then be assessed (Recommendation 1.2.2).

Based on the information available, NICE's assessment is that the guidelines make appropriate recommendations on this topic, and do not need to be amended at this time.

I hope this reply is helpful. Thank you for bringing these concerns to our attention.

Yours

**CAROLINE DINENAGE**

[1] https://www.nice.org.uk/guidance/cg144