KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION
ETHICS AND MEDICOLEGAL COMMITTEE

MEDICOLEGAL BULLETIN

Week 29:Venous Thromboembolism After Gynecological Surgery – Risk Assessment, Prophylaxis, and Medicolegal Liability

1.REAL LIFE CASE SCENARIO

A 46-year-old woman with obesity underwent abdominal hysterectomy for a large fibroid uterus. She had limited mobility after surgery. On postoperative day four, she developed sudden breathlessness and tachycardia; CT pulmonary angiography confirmed pulmonary embolism. The family alleged that no venous thromboembolism (VTE) risk assessment or prophylaxis had been undertaken. The clinical question was whether the complication was unavoidable; the legal question was whether a reasonable prevention and response pathway had been followed. This is an illustrative scenario, not a reported court case.

2.MEDICOLEGAL RISKS IN SUCH CASES

Allegations may include failure to identify obesity, prior VTE, cancer, immobility, thrombophilia or other risk factors; omission of indicated mechanical or pharmacological prophylaxis; delayed mobilisation; inadequate reassessment after bleeding risk changes; failure to investigate new dyspnoea, chest pain, hypoxaemia or unilateral leg swelling; and poor discharge instructions. VTE can occur despite appropriate prophylaxis: its occurrence alone does not establish negligence.

3. WHAT GOOD CLINICAL AND MEDICOLEGAL PRACTICE EXPECTS

Assess both VTE risk and bleeding risk before surgery, and reassess after surgery when clinical circumstances change. Consider procedure, operative duration, malignancy, mobility, patient factors and contraindications. Use a recognised local protocol or risk-assessment method (for example, a Caprini-based pathway where adopted). Select mechanical prophylaxis, pharmacological prophylaxis, or both according to individual risk. Ensure prompt escalation for suspected DVT or pulmonary embolism. A generic “all hysterectomy patients need the same injection” approach is not appropriate.

4. DOCUMENTATION – THE DOCTOR’S STRONGEST DEFENSE

Record: procedure and patient-specific risk factors; VTE and bleeding risk assessment; selected prophylaxis and rationale; drug, dose, route, timing and duration if prescribed; contraindications or reasons for withholding; mobilisation plan; reassessment following haemorrhage or surgery; warning symptoms explained at discharge; and actions/timings when VTE is suspected. If pharmacological prophylaxis is withheld because of active bleeding, document the reason and the plan for reassessment.

5.PRACTICAL SAFE PRACTICE – WHAT TO DO

Use a perioperative VTE checklist. Encourage early safe mobilisation and hydration as clinically appropriate. Apply intermittent pneumatic compression where indicated and available. Consider LMWH when indicated and haemostasis is adequate; adjust to renal function, weight, neuraxial anaesthesia timing and local protocol. In high-risk cancer surgery, consider extended postoperative prophylaxis according to current oncology guidance. Suspected PE with haemodynamic compromise requires urgent resuscitation and multidisciplinary escalation; do not delay assessment while waiting for routine tests.

6. COMMON MISTAKES TO AVOID

- Prescribing prophylaxis without checking active bleeding or contraindications
- Omitting prophylaxis because the patient is "young" or surgery was "routine"
- Failing to reassess risk after prolonged immobility or postoperative complications
- Ignoring unexplained tachycardia, dyspnoea or desaturation
- Failing to coordinate anticoagulant timing with spinal/epidural procedures
- Giving no discharge advice about VTE symptoms
- Documenting prophylaxis that was not actually administered

7.CLINICAL -LEGAL PEARL

The defensible question is not "Did a clot occur?" but "Was the risk recognised, prevention reasonably selected, and deterioration acted upon promptly**?"**

8.LEGAL AND GUIDELINE INSIGHT

Under the Indian Supreme Court's general medical-negligence principles in Jacob Mathew v. State of Punjab (2005), an adverse outcome alone does not establish negligence; conduct is assessed against reasonable professional standards. This is a general principle, not a VTE-specific judgment. Clinically, use current institutional protocols informed by recognised guidance such as NICE NG89 (VTE prevention) and relevant ACOG guidance for gynecologic surgery. The appropriate prophylaxis depends on individual risk and bleeding concerns.

9.TAKE-HOME MESSAGE

VTE prevention is a process, not merely a prescription: Assess risk → Balance bleeding risk → Select prophylaxis → Mobilise → Reassess → Educate → Document. A well-recorded, individualised plan protects patients and makes subsequent clinical decisions understandable.

Next Week's Topic: Surgical Specimen Mislabeling and Lost Histopathology – When a Laboratory Error Becomes a Gynecologist's Legal Problem

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