history of venous thromboembolism does not indicate a greater than average risk of venous thromboembolism in relation to an event such as a plane flight. Thrombophilia screening is therefore unhelpful in an intending traveller. Conversely, an unequivocal family history of venous thromboembolism indicates increased risk. Thrombophilia screening is then appropriate to evaluate whether heritable contributors to the increased risk can be identified and whether they have been transmitted to the intending traveller.

### Prophylaxis in high-risk travellers

Travellers at high risk of venous thromboembolism are candidates for anticoagulant prophylaxis during the period of increased risk imposed by lengthy air travel. Those at particular risk include, for example, passengers with a history of venous thromboembolism, active cancer or recent surgery, especially orthopaedic surgery to the lower limbs. There is no evidence that aspirin protects against venous thromboembolism. Either subcutaneous low molecular weight heparin or oral warfarin reduces the risk of venous thromboembolism. Low molecular weight heparin injected immediately before flight, in the recommended dose for prophylaxis in high-risk settings, is considerably more convenient than anticoagulation with warfarin.

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# Flying and thromboembolism: a patient's perspective

Hannah Baird, a 38-year-old professional manager, developed a problem after the five-hour flight from Sydney to Perth.

HB: I had a deep vein thrombosis a few years ago so I wanted to reduce the risks of recurrence by drinking lots of water and moving around the cabin as much as possible. However, after standing for about 10 minutes I was asked by the flight attendant to return to my seat.

The next day my left calf was a bit sore. There was no swelling so I thought it was just some muscle stiffness from sitting down for a long time. I went for a walk to try and loosen it up, but that made no difference.

There was a low level ache in my calf that came and went. After two days my leg was more painful and swollen and the ache more continuous. As it was more difficult to walk, I went to an accident and emergency department.

AP: *What did the hospital say?*

HB: The doctors thought it was unlikely I had a deep vein thrombosis as my calf swelling was minimal. I had an ultrasound and was told that I had 'phlebitis'. The treatment was a daily dose of enoxaparin for six weeks. I was given one demonstration of how to inject myself and then I was discharged with no follow-up. I was told to find a general practitioner and get a referral for a nuclear medicine scan.

The hospital said that I should not fly for a month, however given the impracticalities of not returning home to Sydney they agreed that flying after one week was possible. I could do little else but rest in my hotel, as it was difficult to walk.

AP: *How did you manage the treatment?*

HB: The injections stung a bit. I suffered bruising after my first injection, but I got better at injecting myself in the abdomen every morning. About two weeks into the six-week course my leg had improved.

At the end of the course I had a lot of syringes and needles. My local general practice would not take them because of the cost of disposal, nor could I find a pharmacy to take them. My local council has a needle disposal service, but it only operates between 9 am and 5 pm, Monday to Friday. That's not much good for people who work full-time.

AP: *Did you have further assessments?*

HB: I have no family history of thrombosis, I don't smoke and I was not taking oestrogens so my general practitioner referred me to a specialist for investigation. The specialists described my initial blood tests as 'strange', so just repeated them. These repeat tests did not show any clotting problems.

AP: *What advice were you given for future flights?*

HB: The specialist recommended that I wear stockings, drink water, no alcohol and inject a small dose of enoxaparin before and after flights, trains or car journeys of over two hours. Everybody tells you to wear support stockings, but

the problem is, where do you find them? Nobody seems to know. I had to ring around a lot of places before I found somewhere that could supply them.

AP: *Any other comments on your experience?*

HB: When I was in Western Australia I had to use taxis to get between my hotel, the hospital, the general practitioner, the X-ray rooms, etc. Some people may have difficulty getting to their appointments if they are unable to use public transport and cannot afford a taxi.

It would be helpful to get advice about when you can resume physical activity while you are being treated for a thrombosis. I like to go to the gym, but I was unsure when it would be safe to start exercising again. About a year later I had a pulmonary embolism, so I am now on warfarin for life.

# Book review

**Therapeutic Guidelines: Endocrinology. Version 4.**

*Melbourne: Therapeutic Guidelines Limited; 2009. 366 pages. Price $39, students $30, plus postage. Also available in electronic format as eTG complete.*

***Chee Koh**, Academic General Practice Registrar, Department of General Practice, University of Sydney, Westmead Hospital*

Like previous editions, this book aims to provide 'busy health practitioners' with therapeutic information that is 'clear, practical, authoritative and succinct'.

The layout and structure of the book remains largely unchanged from the previous edition. However, the chapter 'Getting to know your drugs' has returned to the front of the book.

Merits of the book include:

- its use of simple language and clear, concise presentation of information
- comprehensive and up-to-date chapters on diabetes and its management
- timely updates on topics such as obesity and male hypogonadism.

The book has some shortcomings. There is no chapter on the use of hormones for transgender conditions – even in my training practice in a regional setting I am starting to see occasional, but increasing numbers of, transgender patients seeking quite complex advice about hormone therapy and issues surrounding its use. Also, the book's textbook-like structure detracts from it being the quick reference guide that busy doctors love to have handy.

Despite the shortcomings, this latest edition remains an invaluable guide in clinical practice, and has remained true to its core values since its inception.