

Special Article

Thrombosis

A Major Contributor to Global Disease Burden

G.E. Raskob, P. Angchaisuksiri, A.N. Blanco, H. Buller, A. Gallus, B.J. Hunt, E.M. Hylek, A. Kakkar, S.V. Konstantinides, M. McCumber, Y. Ozaki, A. Wendelboe, J.I. Weitz;
ISTH Steering Committee for World Thrombosis Day

Background—Thrombosis is the common pathology underlying ischemic heart disease, ischemic stroke, and venous thromboembolism (VTE). The Global Burden of Disease Study 2010 (GBD 2010) documented that ischemic heart disease and stroke collectively caused 1 in 4 deaths worldwide. GBD 2010 did not report data for VTE as a cause of death and disability.

Objective—To review the literature on the global burden of disease caused by VTE.

Approach and Results—We performed a systematic review of the literature on the global disease burden because of VTE in low-, middle-, and high-income countries. Studies from Western Europe, North America, Australia, and Southern Latin America (Argentina) yielded consistent results with annual incidences ranging from 0.75 to 2.69 per 1000 individuals in the population. The incidence increased to between 2 and 7 per 1000 among those aged ≥ 70 years. Although the incidence is lower in individuals of Chinese and Korean ethnicity, their disease burden is not low because of population aging. VTE associated with hospitalization was the leading cause of disability-adjusted life-years lost in low- and middle-income countries, and second in high-income countries, responsible for more disability-adjusted life-years lost than nosocomial pneumonia, catheter-related blood stream infections, and adverse drug events.

Conclusions—VTE causes a major burden of disease across low-, middle-, and high-income countries. More detailed data on the global burden of VTE should be obtained to inform policy and resource allocation in health systems and to evaluate whether improved use of preventive measures will reduce the burden. (*Arterioscler Thromb Vasc Biol.* 2014;34:2363-2371.)

Key Words: pulmonary embolism ■ thrombosis ■ venous thromboembolism ■ venous thrombosis

A doubling of life expectancy and quadrupling of the world population during the 20th century have been associated with a transition from infectious to noncommunicable diseases as the major cause of death and disability worldwide.¹⁻³ Cardiovascular disease is a leading contributor to the burden caused by noncommunicable diseases. Thrombosis is the most common underlying pathology of the 3 major cardiovascular disorders: ischemic heart disease (acute coronary syndrome), stroke, and venous thromboembolism (VTE).

The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD Study), which was initiated by the World Health Organization (WHO) and the World Bank, is a systematic scientific investigation aimed at quantifying the comparative magnitude

of health loss because of diseases, injuries, and risk factors by age, sex, and geographic region throughout the world.³⁻⁵ The most recent version of this effort, GBD 2010, documents the number of deaths from 235 causes from 1990 to 2010, using data from 187 countries and 21 regions; these regions are grouped further into 7 super regions.^{4,5} The study also provides estimates of the years of life lost (YLL) because of premature mortality, the years lived with disability (YLD), and the disability-adjusted life-years (DALYs).^{4,5} DALYs estimate how many years of healthy life are lost because of premature death or nonfatal illness or disability and are calculated as the sum of YLL and YLD.⁶

GBD 2010 documented 52.8 million deaths globally in 2010.³ Noncommunicable disease accounted for 34.5 million deaths

The opinions expressed in this article are not necessarily those of the editors or of the American Heart Association.

Reprinted with permission of the International Society on Thrombosis and Haemostasis.

Received on: August 14, 2014; final version accepted on: August 18, 2014.

From the College of Public Health, University of Oklahoma Health Sciences Center (G.E.R., M.M., A.W.); Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Bangkok, Thailand (P.A.); División Hemostasia, Academia Nacional de Medicina, Buenos Aires, Argentina (A.N.B.); Department of Vascular Medicine, Academic Medical Center, Amsterdam, The Netherlands (H.B.); SA Pathology—Department of Hematology, Flinders Medical Center, Adelaide, South Australia, Australia (A.G.); Thrombosis and Thrombophilia Centre, Guy's & St Thomas' NHS Foundation Trust, London, United Kingdom (B.J.H.); Boston University School of Medicine, MA (E.M.H.); Thrombosis Research Institute, London, United Kingdom (A.K.); Center for Thrombosis and Hemostasis, Johannes Gutenberg University, Mainz, Germany (S.V.K.); Department of Laboratory Medicine, University of Yamanashi, Tamaho, Yamanashi, Japan (Y.O.); and McMaster University and Thrombosis and Atherosclerosis Research Institute, Hamilton, Ontario, Canada (J.I.W.).

The International Society on Thrombosis and Haemostasis requests the following citation of the article: ISTH Steering Committee for World Thrombosis. Thrombosis: a major contributor to global disease burden. *J Thromb Haemost.* 2014;12:1580-1590. DOI: 10.1111/jth.12698.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial, and no modifications or adaptations are made.

Correspondence to G.E. Raskob, College of Public Health, University of Oklahoma Health Sciences Center, 801 NE13th St, Oklahoma City, OK 73104. E-mail Gary-Raskob@ouhsc.edu

© 2014 International Society on Thrombosis and Haemostasis.

Arterioscler Thromb Vasc Biol is available at <http://atvb.ahajournals.org>

DOI: 10.1161/ATVBAHA.114.304488

or 2 of every 3 deaths.³ Ischemic heart disease (7.0 million deaths) and stroke (5.9 million deaths) collectively caused 1 in 4 deaths worldwide.³ The 7.0 million deaths from ischemic heart disease represent a 35% increase since 1990. About half of all stroke deaths were from ischemic stroke, which is caused by thrombosis. The 2.8-million deaths from ischemic stroke represent a 25% increase since 1990. Although there is substantial regional variation, ischemic heart disease ranks as the number 1 or 2 causes of YLL in 13 of the 21 regions and ranks in the top 5 causes of death in 17 regions.³ Stroke ranks as the first or second cause of YLL in 8 regions and is in the top 5 causes in 14 regions.³ Ischemic heart disease was the leading cause of DALYs lost worldwide in 2010 (up from fourth rank in 1990, an increase of 29%), and stroke was the third leading cause (up from fifth rank in 1990, an increase of 19%).⁶ More than 60% of new strokes and 45% of deaths from stroke occur in individuals <75 years of age.⁷

GBD 2010 clearly documents the major impact of arterial thrombosis on global disease burden because it is the pathological mechanism underlying most cases of ischemic heart disease and ischemic stroke. However, the study does not report data for VTE as a specific cause of death and disability. A cursory review of the literature from Western Europe and North America suggests that VTE is a major contributor to the burden from noncommunicable diseases. For example, Cohen et al⁸ used an incidence-based epidemiology model to estimate the number of nonfatal symptomatic VTE events, which includes both deep-vein thrombosis (DVT) and pulmonary embolism (PE), and the number of VTE-related deaths across the European Union in 2004 (population 454.4 million). The results yielded estimates of 684019 DVT events, 434723 PE events, and a total of 543454 VTE-related deaths.⁸ In the United States, investigators from the Centers for Disease Control and Prevention used data from the National Hospital Discharge Survey to estimate that there were an average of 547596 adult hospitalizations with a diagnosis of VTE each year during 2007 to 2009 among the population of 301 to 307 million.⁹ If VTE causes a proportionate burden of disease across the other global regions, it would be highly ranked in the causes of death and DALYs worldwide. Given that much of the mortality and morbidity from VTE is potentially preventable,^{10–13} data on the disease burden are important for health systems and policy makers for planning resource allocation, both for healthcare delivery and for setting research priorities.

We therefore performed a systematic review of the literature on the global burden of disease because of VTE. The objective was to review the evidence for disease burden in each of the geographic regions specified in the GBD Study 2010, using the variables of annual incidence rate (number of new cases each year per 1000 population at risk), prevalence (proportion of the population with the condition at a point in time), annual number of deaths, and DALYs.

Methods

Literature Search and Review

A computer search of the literature was performed using OVID Medline, OVID Medline In-Process and other nonindexed citations, and EMBASE, from inception of these databases to May 2014. We used the disease-related key words venous thromboembolism, deep-vein thrombosis, venous thrombosis, vein thrombosis, thrombophlebitis, pulmonary embolism, and lung embolism, together with the additional key words

incidence, prevalence, mortality, case fatality, morbidity, surveillance and epidemiology, years lived with disability (YLD), and disability-adjusted life years (DALY), to search the titles and abstracts of articles in these databases. We also reviewed the bibliographies of published articles. We excluded nonhuman studies, case reports, and clinical trials, as well as nonrelevant publication types, including reports of clinical conferences and editorials. We also excluded articles published in languages other than English; and the current report is confined to the literature published in English. The identified citations from each database were exported to an ENDNOTE library where the citations were deduplicated. The merged list of citations was exported to a Word document that included citation number, title, list of authors, the full abstract, and the journal citation.

The abstracts were reviewed independently by 2 reviewers (A.W., G.R.) who categorized them according to the level of evidence as level A, level B, or other; disagreements were resolved through discussion and consensus. Level A evidence was defined as population-based estimates of the parameters of the disease burden (incidence, prevalence, number of deaths, and DALYs) in the general population (aged ≥18 years) derived from population-based cohort studies or from analysis of national health system databases or private health insurance claims data within a defined population, or derived using a combination of the former methods with appropriate epidemiological modeling methods. Level B evidence was defined as estimates of the burden in specific subpopulations such as the elderly, pregnancy, etc, using the same methods described for level A. The category of other evidence included all other study designs without a defined population to derive the disease burden parameters, such as single hospital based cohort studies or record review, and autopsy studies. Population-based mortality studies based on hospital discharge or other databases, or health department death certificate data, were also assigned to the category of other. This article focuses on the level A evidence for overall disease burden according to global region. Selected level B evidence on the relationship between age and disease burden was also included where relevant. The evidence categorized as other was not systematically reviewed.

To simplify comparison of incidence results across studies and between global regions, all incidence rates were converted to a rate per 1000 individuals per year.

Results

Literature Search

The computerized literature search identified a total of 9603 citations. Of these citations, 8817 (92%) were in the English language. After the deduplication check, a total of 8702 citations remained for review.

The 2 independent reviewers were in agreement on the classified level of evidence for 8671 (99%) of the 8702 reviewed citations; the remaining 31 citations were classified after discussion and consensus between the reviewers. The final classification designated 29 citations as level A evidence,^{14–42} 29 as level B evidence,^{43–71} and the remainder as other. Most of the level A studies evaluated the incidence of VTE or its components, DVT and PE^{14–40}; 2 studies evaluated the prevalence of VTE.^{41,42}

Incidence of VTE

The results of the studies classified as level A evidence of incidence are summarized in Table 1. This evidence comes from only 2 of the 7 global super regions designated by GBD 2010; those designated high income and Southeast Asia, East Asia, and Oceania. Within the high-income super region, 11 level A studies were from the region of Western Europe,^{8,14–23} 10 were from North America, 2 were from Australasia (both from Australia),^{33,34} 1 was from the Southern Latin America region (Argentina),³⁵ and 1 was from the Asia Pacific region (Korea).³⁶ The 3 level A studies from the super region of Southeast Asia, East Asia, and Oceania all came from the region of East Asia^{37–39} (2 studies from Hong Kong and 1 from Taiwan).

Table 1. Studies Comprising Level A Evidence for Burden of Disease From VTE: Incidence per 1000 Population per Year

Reference	Study Design	Global Super Region	Global Region	Country	VTE Incidence	DVT Incidence	PE Incidence
Hald et al ¹⁴	Population-based cohort combined with hospital-based discharge diagnosis, autopsy, and procedure registries	High income	Western Europe	Norway	1.48	NR	NR
Holst et al ¹⁵	Population-based cohort combined with national cause of death registry and national patient registry	High income	Western Europe	Denmark	2.69	NR	NR
Moretti et al ¹⁶	Population-based hospital discharge database	High income	Western Europe	Italy	NR	NR	0.189
Severinsen et al ¹⁷	Population-based cohort in men and women aged 50–64 years combined with the national patient registry	High income	Western Europe	Denmark	1.15	0.65	0.51
Cohen et al ¹⁸	Incidence-based epidemiological model of country-specific nonfatal VTE events and VTE-related deaths	High income	Western Europe	France, Germany, Italy, Spain, Sweden, and United Kingdom	NR	1.48	0.95
Huerta et al ¹⁸	Prospective population-based cohort identified using the General Practice database. Nested case–control analysis also done	High income	Western Europe	United Kingdom	0.745	0.403	0.342
Naess et al ¹⁹	Population-based cohort identified by electronic hospital registries and case-finding search of tertiary care center for discharge diagnoses of VTE	High income	Western Europe	Norway	1.43	0.93	0.50
Gujjarro et al ²⁰	Hospital discharge database of the Andalusian Healthcare Service for 1998–2001	High income	Western Europe	Spain	0.036*	NR	0.15*
Oger ²¹	Population-based cohort study of both hospitalized and outpatient cases within defined populations in 1998 and 1999 using standardized prospective data collection	High income	Western Europe	France	1.83	1.24	0.60
Nordström et al ²²	Population-based cohort of hospital-based venography cases in 1987	High income	Western Europe	Sweden	NR	1.55 men and 1.62 women	NR
Kierkegaard ²³	Population-based cohort of hospital based venography cases	High income	Western Europe	Sweden	NR	0.85 men and 0.68 women	NR
Tagalakis et al ²⁴	Provincial healthcare databases linking hospital discharges and healthcare claims data 2000–2009	High income	North America	Canada (Quebec)	1.22	0.78	0.45
Yusuf et al ⁹	Search of the National Hospital Discharge database 2007–2009	High income	North America	United States	2.39	1.52	1.15
Wiener et al ²⁵	HCUP nationwide inpatient sample of hospital discharges and national cause of death file databases 1998–2006	High income	North America	United States	NR	NR	1.12
Cushman et al ²⁶	Population-based cohort with prospective follow-up of patients combined with search of hospital discharge and Medicare records	High income	North America	United States	1.61	1.17	0.45

(Continued)

Table 1. Continued

Reference	Study Design	Global Super Region	Global Region	Country	VTE Incidence	DVT Incidence	PE Incidence
Stein et al ²⁷	Search of the National Hospital Discharge database	High income	North America	United States	1.30†	1.04†	0.36†
Janke et al ²⁸	Vital statistics data obtained from the Minnesota State Department of Health and hospital discharge data from a State uniform billing claims database 1980–1994	High income	North America	United States	NR	NR	0.60–0.90 men and 0.60 women
Klatsky et al ²⁹	Population-based cohort of a California prepaid health plan for 1978–1985 combined with hospital record review	High income	North America	United States	0.19‡	NR	NR
Silverstein et al ³⁰	Population-based cohort with medical record review and search of computerized databases of diagnoses and procedures, billing data, death certificates and autopsy records	High income	North America	United States	1.17	0.48	0.69
White et al ³¹	Database analysis of the linked California patient discharge data set	High income	North America	United States	NR	0.230§	NR
Anderson et al ³²	Population-based cohort of hospital cases with hospital record review	High income	North America	United States	1.07	0.48	0.23
Shirayev et al ³³	National databases on hospitalization and deaths 2009–2010	High income	Australasia	Australia	NR	NR	0.53
Ho et al ³⁴	Population-based cohort study with cases identified prospectively and also retrospectively through Western Australian Department of Health database	High income	Australasia	Australia	0.83	0.52	0.31
Vázquez et al ³⁵	Population-based cohort within a health maintenance organization	High income	Southern Latin America	Argentina	1.65	1.30	0.64
Jang et al ³⁶	National Health Insurance database in 2008	High income	High income Asia Pacific	Korea	0.138	0.0531	0.0701
Lee et al ³⁷	National health insurance claims database for Taiwan	Southeast Asia, East Asia, Oceania	East Asia	Taiwan	0.159	NR	NR
Cheuk et al ³⁸	Database of Hong Kong Hospital Authority of all hospitalizations, diagnoses, procedures and outcomes 2000–2001	Southeast Asia, East Asia, Oceania	East Asia	Hong Kong	NR	0.171	0.039
Woo et al ³⁹	National vital statistics analysis combined with hospital record review (rate is for 1985)	Southeast Asia, East Asia, and Oceania	East Asia	Hong Kong	0.079	NR	NR

DVT indicates deep-vein thrombosis; HCUP, Healthcare Cost and Utilization Project; NR, not reported; PE, pulmonary embolism; and VTE, venous thromboembolism. *This study evaluated cases where VTE or PE was the primary reason for hospital admission.

†The rates are for the white population. Corresponding incidence rates for blacks were VTE 1.38, DVT 1.07, PE 0.40, and for Asian/Pacific Islanders were VTE 0.26, DVT 0.22, and PE 0.07.

‡The rate is for overall population. Corresponding incidence rates by race were white 0.21, black 0.22, Asian 0.02, and Hispanic 0.09.

§The rate is for a first idiopathic DVT in white population. Corresponding incidence rates by race were black 0.293, Hispanic 0.139, and Asian/Pacific Islander 0.060.

The relationship between increasing age and the incidence of VTE was evaluated in several of the level A studies.^{9,19,21,22,24,30,32,35–38,40} The results of these studies are summarized in Table 2.

The level B studies evaluated the incidence of VTE in various subpopulations, such as during pregnancy or the postpartum period,^{43–54} men or women of selected age categories,^{55–64} subgroups with or without selected risk factors or comorbidities,^{65–70} or special categories of thrombosis.⁷¹ All but one of the level B studies came from the super region designated high income; the exception was from Sub-Saharan Africa (South Africa).⁵¹ Within the high-income super region, 14 of the level B studies were from the region of Western Europe,^{43,44,46,49,54,55,57–59,61–63,65,69} 11 were from North America,^{45,47,50,52,56,60,64,67,68,70,71} 2 were from Australasia (both from Australia),^{48,53} and 1 was from the high-income Asia Pacific region (Japan).⁶⁶

Prevalence of VTE

Two studies were identified that evaluated the prevalence of VTE; both were done in the United States by the same investigators.^{41,42} The national prevalence of VTE was determined during the 5-year period from 2002 to 2006 using a health insurance claims database of 12.7 million enrollees that included both private insurance claims and Medicare claims. The prevalence of VTE was 3.2 per 1000 enrollees in 2002 and 4.2 per 1000 enrollees in 2006.⁴¹ Among patients aged ≥65 years, the prevalence in 2006 was 13.8 per 1000 enrollees, compared with 2.3 per 1000 enrollees in those aged <65 years.⁴¹ The authors used the 2006 data to project the US

national prevalence as 0.95 million cases and to project the future prevalence in 2050 to be 1.82 million cases.⁴¹ The second study found that the prevalence of VTE was highest in black men, followed by white men, white women, and black women.⁴² Hispanic individuals of both sexes had lower prevalence.⁴²

Disability-Adjusted Life-Years

Our search identified 2 studies that evaluated disease burden in terms of DALYs.^{72,73} The methodologically strongest was the study by Jha et al,⁷² as part of the WHO's Patient Safety Program. This study used analytic modeling to estimate the incidence rates of VTE, annual number of cases, and DALYs from VTE associated with hospitalization in high-, middle-, and low-income countries.⁷² The data for the modeling were generated from 2 sources: an extensive literature review and epidemiological studies commissioned by the WHO, which were conducted in 26 hospitals across 8 low- and middle-income countries in the Eastern Mediterranean and North Africa regions (Egypt, Jordan, Kenya, Morocco, South Africa, Sudan, Tunisia, and Yemen)⁷⁴ and in 35 hospitals across 5 countries in Latin America (Argentina, Colombia, Costa Rica, Mexico, and Peru).⁷⁵ This approach enabled the authors to estimate the number of VTE events associated with hospitalization during 2009 for 117.8 million hospitalizations among 1.1 billion citizens of high-income countries, and for 203.1 million hospitalizations among 5.5 billion citizens of low- and middle-income countries.^{72,74,75}

The study reported incidences of VTE per 100 hospitalizations of 3.3 (95% confidence interval, 1.9–4.8) in high-income

Table 2. Incidence Rates per 1000 Population per Year According to Age Category: Studies Comprising Level A Evidence

Reference	Global Region	Country	Age, 40–49 years	Age, 50–59 years	Age, 60–69 years	Age, 70–79 years	Age, ≥80 years
Kröger et al ⁴⁰	Western Europe	Germany	0.30 men* and 0.28 women	...	1.24 men and 0.94 women	...	3.45 men and 3.72 women
Naess et al ¹⁹	Western Europe	Norway	0.20 men †† and 0.17 women	0.72 men and 0.72 women	1.14 men and 0.93 women	1.85 men and 1.45 women	3.73 men and 3.84 women
Oger ²¹	Western Europe	France	1.52 men § and 1.05 women	...	5.33 men and 4.53 women	...	10.81 men and 12.04 women
Nordström et al ²²	Western Europe	Sweden	0.69 men † and 0.97 women	2.85 men and 1.03 women	3.27 men and 2.17 women	5.64 men and 4.29 women	7.65 men and 8.22 women
Tagalakis et al ²⁴	North America	Canada (Quebec)	0.83	1.42	2.57	4.41	6.85
Yusuf et al ⁹	North America	United States	1.43	2.00	3.91	7.27	11.34
Silverstein et al ³⁰	North America	United States	0.90 men † and 0.45 women ‡	0.76 men and 0.83 women	1.63 men and 1.69 women	6.46 men and 3.22 women	9.84 men and 8.49 women
Anderson et al ³²	North America	United States	0.17 †	0.43	1.19	2.32	2.91
Lee et al ³⁷	East Asia	Taiwan	NR	NR	NR	NR	8.31 men and 11.82 women
Cheuk et al ³⁸	East Asia	Hong Kong	0.096 ¶	0.81 ¶	...
Vázquez et al ³⁵	Southern Latin America	Argentina (2006–2012)	NR	NR	NR	NR	5.93
Jang et al. 2011 ³⁶	High income Asia Pacific	Korea (2008)	0.099 men and 0.097 women	0.173 men and 0.131 women	0.381 men and 0.412 women	0.765 men and 1.042 women	1.088 men and 1.092 women

NR indicates not reported.

*Age categories shown are 30 to 49, 50 to 69, and 70 to 90 years.

†Incidence rates are for deep-vein thrombosis (all venous thromboembolism not reported).

‡Age categories shown are 40 to 44, 50 to 54, 60 to 64, 70 to 74, and 80 to 84 years.

§Age categories shown are 40 to 59, 60 to 74, and ≥75 years.

||Rates are shown in graphical form; actual numeric values not provided.

¶Age categories shown are 45 to 64 and ≥65 years.

countries and 3.0 (95% confidence interval, 1.0–4.8) in low- and middle-income countries.⁷² The estimated annual number of cases of VTE was 3.9 million (95% confidence interval, 1.9–6.3) for the high-income countries and 6.0 million (95% confidence interval, 1.2–12.8) for the low- and middle-income countries. VTE was the leading cause of hospital-related DALYs lost overall, being responsible for a full one third (7681) of the total of 22 644 DALYs, and VTE accounted for more DALYs lost than nosocomial pneumonia, catheter-related blood stream infections, and adverse drug events.⁷² VTE was the leading cause of DALYs lost in the low- and middle-income countries and ranked second in the high-income countries.⁷² Premature death was the source of 64% of the DALYs lost in high-income countries and for 66% of the DALYs lost in low- and middle-income countries.⁷²

The second study was conducted by the Australia and New Zealand Working Party on the Management and Prevention of VTE.⁷³ This group used incidence data from Western Australia, together with mortality estimates and disability weighting derived from the literature, much of which comes from other countries, to estimate the DALYs associated with VTE in Australia for the year 2008. The estimated overall loss for Australia in 2008 was 78 408 DALYs.⁷³ The premature mortality (YLL) was 99.7% of the estimated total burden of disease.⁷³

Discussion

The results of our systematic review of the literature suggest several inferences. First, there is substantial evidence that VTE is associated with a major global burden of disease. Second, most of the level A evidence of this burden comes from the super region high income defined by GBD 2010, although some evidence also comes from the super region of Southeast Asia, East Asia, and Oceania (Table 1). Third, the evidence of disease burden is primarily based on the incidence of VTE events, and to a lesser extent on the estimated number of deaths for a region or country. Our review identified only 1 rigorous study estimating the DALYs associated with VTE.⁷² Fourth, there is consistent and strong evidence that the global incidence of VTE increases with increasing age and is especially pronounced in the elderly (Table 2). This finding has major implications for global health because life expectancy continues to improve in low- and middle-income countries, and these countries continue the transition from infectious diseases to noncommunicable diseases as the major cause of death and disability. Finally, the evidence and the above inferences lead us to recommend that VTE be measured as a specific cause of death in future efforts of the GBD project. We expand further on these themes in the paragraphs below.

About the annual incidence of VTE, the studies from Western Europe, North America, Australia, and Southern Latin America (Argentina) yielded consistent findings. These studies reported overall annual incidences ranging from 0.75 to 2.69 per 1000 individuals in the population, with the incidence in most of the studies ranging between 1.07 and 1.83 (Table 1). The study by Oger²¹ reported that the incidence of VTE was similar to that of myocardial infarction in the same country during a similar time frame. Furthermore, the study by Jha et al⁷² estimated 3.9 million cases of hospital-associated VTE during 1 year among 1.1 billion citizens of high-income countries (3.5 per 1000 population),

and 6.0 million cases among 5.5 billion citizens of low- and middle-income countries (1.1 per 1000 population).⁷² Thus, the aggregate evidence from the literature indicates that VTE is a common condition globally across the spectrum of high-, middle-, and low-income regions.

There was a strong and consistent association of increasing incidence of VTE with increasing age. The annual incidence increased to between 2 and 7 per 1000 population among those aged ≥ 70 years in most of the studies and to between 3 and 12 per 1000 population among those aged ≥ 80 years (Table 2). This finding has major implications for healthcare systems and for the care of the elderly. For example, a study of the incidence of VTE among nursing home residents in Kansas reported an incidence of 13 per 1000 residents per year.⁷⁰ Reardon et al⁵⁶ analyzed nursing home records from 19 states in the United States and found that 1 in 25 admissions had a diagnosis of VTE. It is likely that the high incidence of VTE in the elderly reflects the high prevalence of comorbid acquired risk factors in these patients, especially malignancy, heart failure, and immobility associated with surgery or hospitalization for medical illness, which account for the majority of the population attributable risk of VTE in older individuals. In contrast, genetic factors account for only 7% to 22% of the population attributable risk in the elderly.⁷⁶

The significant burden of VTE is not confined to the elderly, and VTE should not be considered a disease of old age. The annual incidence among individuals in their 40s, 50s, and 60s ranged from 0.2 to 5.3 per 1000 population (Table 2), with the incidence in the contemporary studies ranging from 0.8 to 3.9.^{9,24}

The level A studies from Taiwan, Hong Kong, and Korea reported lower annual incidences of VTE or DVT (ranging from 0.079 to 0.171 per 1000 population; Table 1).^{37–39} These results are consistent with the findings of studies in the United States, which reported lower annual incidences of VTE in Asian-Americans than in whites and blacks.³¹ There was also a strong association between increasing age and increased incidence in the studies from Hong Kong, Taiwan, and Korea^{36–38} (Table 2). So, although the overall incidence is lower in individuals of Chinese and Korean ethnicity, their disease burden is not low because of population aging and increased life expectancy. Recent studies undertaken in Asian countries have demonstrated rates of VTE after major surgery and in hospitalized medical patients approaching those observed in Western populations.⁷⁷

The literature review identified limited information on the number of deaths because of VTE. The strongest evidence comes from the study by Cohen et al,⁸ who used an incidence-based model in 6 European countries to estimate that there were 534 454 deaths related to VTE across the European Union in 2004. A similar approach applied to the data from the United States suggested $\approx 300\,000$ deaths from VTE each year.^{78,79} The direct ascertainment of deaths due to VTE is difficult because of the low rate of autopsy in most countries and because autopsy studies have consistently demonstrated that pulmonary embolism is often not diagnosed antemortem and that deaths because of pulmonary embolism are frequently misclassified as cardiac deaths. Furthermore, pulmonary embolism may be the primary cause of death, such as in patients with unprovoked VTE, or a secondary (contributing) cause of death, for example, in the cancer patient or the patient with multiple medical conditions.

Secondary causes may not always be documented or measured in studies of causes of death. For these reasons, estimates of the number of deaths from VTE based on death certificates or hospital discharge data will underestimate the death burden.

Our review found limited information on the DALYs associated with VTE. The study by Jha et al⁷² provides evidence that VTE causes a major burden of disease across low-, middle-, and high-income countries. VTE was the highest ranked cause of DALYs overall among the 7 causes of hospital-associated adverse events. However, because the study only evaluated DALYs related to inpatient adverse events, it underestimates the total contribution of VTE, because a substantial proportion of VTE events occur out of hospital.⁷⁸ Premature death accounts for approximately two thirds of the DALYs lost because of VTE.⁷² Thus, even in patients with underlying chronic or terminal illness (eg, advanced heart failure or cancer), VTE causes earlier death for many of these patients.

Disability was responsible for 34% of the DALYs associated with VTE,⁷² indicating that VTE causes significant YLD because of the nonfatal consequences of DVT and PE. Despite treatment, ≈10% to 20% of patients with DVT develop severe post-thrombotic syndrome, a chronic disorder that decreases quality of life and reduces the capacity to walk and to work.^{80,81} In the most severe cases, patients with post-thrombotic syndrome can develop venous ulcers, which are slow to heal and costly for the healthcare system.^{80,81} Heit et al⁸² reported an incidence of venous ulcers of 1.8 per 1000 population per year. PE is associated with chronic thromboembolic pulmonary hypertension in approximately 4% of patients.⁸³ Patients with this disorder have varying degrees of respiratory and cardiac impairment. Therefore, the long-term consequences of VTE are associated with considerable disability and are likely to produce significant YLD. Consequently, the disease burden of VTE occurs through both YLL and YLD. More recently, the long-term psychological consequences of PE have been documented to include emotional distress, worry, and anxiety because of uncertainty about whether or when a recurrence might occur, and in some cases, symptoms characteristic of post-traumatic stress disorder.⁸⁴ Therefore, in addition to the physical burden, there is also an emotional burden associated with VTE.

VTE may affect more people than those who experience it. First, current prevention strategies must be applied to large numbers of patients at risk. Most of these patients receive anticoagulant thromboprophylaxis, which is associated with major bleeding in 0.2% to 1.1% of patients.^{85–87} Patients with thrombosis, particularly if they have a positive family history, are often tested for hereditary or acquired thrombophilic conditions. If abnormalities are found, this testing is sometimes extended to family members, which may lead to medical interventions and have psychological consequences. The perceived risk of thrombosis affects many more people than those actually afflicted by it.

VTE was not assessed as a cause of death at the disaggregated level in GBD 2010.^{3,5,6} GBD 2010 used 3 criteria for including causes of death at the disaggregated level: potentially large burden, substantial health policy interest, and the feasibility of measurement.⁵ We think that VTE meets all of these criteria. The feasibility of evaluating VTE across the global regions is established by the results of the WHO's Patient Safety Program.^{72,74,75} The WHO is commended for including VTE among the adverse

outcomes assessed in the Patient Safety Program. Future efforts of the GBD study should include evaluation of VTE as a cause of death and the associated DALYs, both for hospital-associated events, which account for 60% of all VTE⁷⁸ and also for events that occur outside the hospital setting, such as unprovoked VTE.

Prevention is the key to reducing death and disability from VTE. This includes thromboprophylaxis in patients at risk (primary prevention), such as those undergoing surgery or those hospitalized with medical illnesses,^{10–12} and prevention of recurrent thromboembolic events in patients with established DVT or PE⁸⁸ (secondary prevention). Effective primary prevention is available for most high-risk patient groups.^{10–12} However, a global audit of the use of primary thromboprophylaxis documented widespread underuse in eligible patients.⁸⁹ There is evidence that a concerted effort by a health system to include VTE risk assessment at the time of hospital admission and the provision of appropriate primary thromboprophylaxis is effective for reducing VTE-related death and readmission with nonfatal VTE.^{90,91} The increased implementation of proven, evidence-based primary prevention against VTE should be a global health priority. The safety and simplicity of extended anticoagulant therapy have improved significantly in recent years,⁸⁸ and this approach to secondary prevention has the potential to markedly reduce the burden from recurrent venous thromboembolic events if appropriately implemented on a global scale. Future research may further refine our ability to optimize the benefit-to-risk profile of anticoagulant treatment at the individual patient level and minimize the side effects of prevention. Strengthening the global effort to prevent VTE is consistent with the World Health Assembly's goal of significantly reducing the global burden from noncommunicable diseases by 2025.⁹²

In conclusion, this literature review found substantial evidence of a major global disease burden from VTE. Although this burden has been less extensively evaluated than the burden from arterial thrombosis, which includes ischemic heart disease and ischemic stroke, the available evidence indicates a major burden of disease across low-, middle-, and high-income countries. Because many of these events are potentially preventable, more detailed data on the burden because of VTE should be obtained to inform public health policy and resource allocation in health systems, especially in regions where evidence is now limited or lacking and to evaluate whether the broader and improved implementation of preventive measures will reduce the disease burden.

Sources of Funding

We accepted no direct funding from government or corporate sources for the preparation of this article.

Disclosures

None.

References

1. Hunter DJ, Fineberg HV. Convergence to common purpose in global health. *N Engl J Med*. 2014;370:1753–1755.
2. Jamison DT, Summers LH, Alleyne G, et al. Global health 2035: a world converging within a generation. *Lancet* 2013;382:1898–1955.
3. Lozano R, Naghavi M, Foreman K, Benjamin EJ, et al. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012;380:2095–2128.

4. Horton R. GBD 2010: understanding disease, injury, and risk. *Lancet* 2012;380:2053–2054.
5. Murray CJ, Ezzati M, Flaxman AD, Lim S, Lozano R, Michaud C, Naghavi M, Salomon JA, Shibuya K, Vos T, Wikler D, Lopez AD. GBD 2010: design, definitions, and metrics. *Lancet* 2012;380:2063–2066.
6. Murray CJ, Vos T, Lozano R, et al. Disability-adjusted life years (DALYs) for 291 diseases and 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012;380:2197–2223.
7. Feigin V, Forouzanfar M, Krishnamurthi R, et al. Global and regional burden of stroke during 1990–2010: findings from the Global Burden of Disease Study 2010. *Lancet* 2014;383: 245–255.
8. Cohen AT, Agnelli G, Anderson FA, Arcelus JJ, Bergqvist D, Brecht JG, Greer IA, Heit JA, Hutchinson JL, Kakkar AK, Mottier D, Oger E, Samama MM, Spannagl M; VTE Impact Assessment Group in Europe (VITAE). Venous thromboembolism (VTE) in Europe. The number of VTE events and associated morbidity and mortality. *Thromb Haemost*. 2007;98:756–764.
9. Yusuf HR, Tsai J, Atrash HK, Boulet S, Grosse SD. Venous thromboembolism in adult hospitalizations—United States, 2007–2009. *MMWR Morb Mortal Wkly Rep* 2012;61:401–404.
10. Kahn SR, Lim W, Dunn AS, Cushman M, Dentali F, Akl EA, Cook DJ, Balekian AA, Klein RC, Le H, Schulman S, Murad MH; American College of Chest Physicians. Prevention of VTE in nonsurgical patients: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed; American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. *Chest*. 2012;141(2 Suppl):e195S–e226S.
11. Gould MK, Garcia DA, Wren SM, Karanicolas PJ, Arcelus JJ, Heit JA, Samama CM; American College of Chest Physicians. Prevention of VTE in nonorthopedic surgical patients: antithrombotic therapy and prevention of thrombosis, 9th ed; American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. *Chest*. 2012;141(2 Suppl):e227S–e277S.
12. Falck-Ytter Y, Francis CW, Johanson NA, Curley C, Dahl OE, Schulman S, Ortel TL, Pauker SG, Colwell CW Jr; American College of Chest Physicians. Prevention of VTE in orthopedic surgery patients: antithrombotic therapy and prevention of thrombosis, 9th ed; American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. *Chest*. 2012;141(2 Suppl):e278S–e325S.
13. Nicolaides AN, Fareed J, Kakkar AK, et al. Prevention and treatment of venous thromboembolism—International Consensus Statement. *Int Angiol*. 2013;32:111–260.
14. Hald EM, Enga KF, Løchen ML, Mathiesen EB, Njølstad I, Wilsgaard T, Braekkan SK, Hansen JB. Venous thromboembolism increases the risk of atrial fibrillation: the Tromsø study. *J Am Heart Assoc*. 2014;3:e000483.
15. Holst AG, Jensen G, Prescott E. Risk factors for venous thromboembolism: results from the Copenhagen City Heart Study. *Circulation*. 2010;121:1896–1903.
16. Moretti AM, Tafuri S, Parisi D, Germinario C. Epidemiology of pulmonary embolism in Apulia from analysis of current data. *Monaldi Arch Chest Dis*. 2010;73:18–24.
17. Severinsen MT, Johnsen SP, Tjønneland A, Overvad K, Dethlefsen C, Kristensen SR. Body height and sex-related differences in incidence of venous thromboembolism: a Danish follow-up study. *Eur J Intern Med*. 2010;21:268–272.
18. Huerta C, Johansson S, Wallander MA, García Rodríguez LA. Risk factors and short-term mortality of venous thromboembolism diagnosed in the primary care setting in the United Kingdom. *Arch Intern Med*. 2007;167:935–943.
19. Naess IA, Christiansen SC, Romundstad P, Cannegieter SC, Rosendaal FR, Hammerstrøm J. Incidence and mortality of venous thrombosis: a population-based study. *J Thromb Haemost*. 2007;5:692–699.
20. Guijarro R, San Roman CM, Perello JJ, Nuno E; Efficiency Group of the Internal Medicine Services of Andalusia; Strategic Plan of SADEMI (Andalusia Society of Internal Medicine). A study of hospital discharges for venous thromboembolism in the south of Spain. An analysis of 19,170 cases from a regional database from 1998 to 2001. *Eur J Intern Med* 2005;16:279–286.
21. Oger E. Incidence of venous thromboembolism: a community-based study in Western France. EPI-GETBP Study Group. Groupe d'Etude de la Thrombose de Bretagne Occidentale. *Thromb Haemost*. 2000;83:657–660.
22. Nordström M, Lindblad B, Bergqvist D, Kjellström T. A prospective study of the incidence of deep-vein thrombosis within a defined urban population. *J Intern Med*. 1992;232:155–160.
23. Kierkegaard A. Incidence of acute deep vein thrombosis in two districts. A phlebographic study. *Acta Chir Scand*. 1980;146:267–269.
24. Tagalakis V, Patenaude V, Kahn SR, Suissa S. Incidence of and mortality from venous thromboembolism in a real-world population: the Q-VTE Study Cohort. *Am J Med*. 2013;126:832.e13–832.e21.
25. Wiener RS, Schwartz LM, Woloshin S. Time trends in pulmonary embolism in the United States: evidence of overdiagnosis. *Arch Intern Med*. 2011;171:831–837.
26. Cushman M, Tsai AW, White RH, Heckbert SR, Rosamond WD, Enright P, Folsom AR. Deep vein thrombosis and pulmonary embolism in two cohorts: the longitudinal investigation of thromboembolism etiology. *Am J Med*. 2004;117:19–25.
27. Stein PD, Kayali F, Olson RE, Milford CE. Pulmonary thromboembolism in Asians/Pacific Islanders in the United States: analysis of data from the National Hospital Discharge Survey and the United States Bureau of the Census. *Am J Med*. 2004;116:435–442.
28. Janke RM, McGovern PG, Folsom AR. Mortality, hospital discharges, and case fatality for pulmonary embolism in the Twin Cities: 1980–1995. *J Clin Epidemiol* 2000;53:103–109.
29. Klatsky AL, Armstrong MA, Poggi J. Risk of pulmonary embolism and/or deep venous thrombosis in Asian-Americans. *Am J Cardiol*. 2000;85:1334–1337.
30. Silverstein MD, Heit JA, Mohr DN, Petterson TM, O'Fallon WM, Melton LJ 3rd. Trends in the incidence of deep vein thrombosis and pulmonary embolism: a 25-year population-based study. *Arch Intern Med*. 1998;158:585–593.
31. White RH, Zhou H, Romano PS. Incidence of idiopathic deep vein thrombosis and secondary thromboembolism among ethnic groups in California. *Ann Intern Med*. 1998;128:737–740.
32. Anderson FA Jr, Wheeler HB, Goldberg RJ, Hosmer DW, Patwardhan NA, Jovanovic B, Forcier A, Dalen JE. A population-based perspective of the hospital incidence and case-fatality rates of deep vein thrombosis and pulmonary embolism. The Worcester DVT Study. *Arch Intern Med*. 1991;151:933–938.
33. Shirave TP, Omari A, Rushworth RL. Trends in pulmonary embolism morbidity and mortality in Australia. *Thromb Res*. 2013;132:19–25.
34. Ho WK, Hankey GJ, Eikelboom JW. The incidence of venous thromboembolism: a prospective, community-based study in Perth, Western Australia. *Med J Aust*. 2008;189:144–147.
35. Vázquez FJ, Posadas-Martínez ML, Vicens J, González Bernaldo de Quirós F, Giunta DH. Incidence rate of symptomatic venous thromboembolic disease in patients from a medical care program in Buenos Aires, Argentina: a prospective cohort. *Thromb J*. 2013;11:16.
36. Jang MJ, Bang SM, Oh D. Incidence of venous thromboembolism in Korea: from the Health Insurance Review and Assessment Service database. *J Thromb Haemost* 2011;9:85–91.
37. Lee CH, Lin LJ, Cheng CL, Kao Yang YH, Chen JY, Tsai LM. Incidence and cumulative recurrence rates of venous thromboembolism in the Taiwanese population. *J Thromb Haemost*. 2010;8:1515–1523.
38. Cheuk BL, Cheung GC, Cheng SW. Epidemiology of venous thromboembolism in a Chinese population. *Br J Surg*. 2004;91:424–428.
39. Woo KS, Tse LK, Tse CY, Metreweli C, Vallance-Owen J. The prevalence and pattern of pulmonary thromboembolism in the Chinese in Hong Kong. *Int J Cardiol*. 1988;20:373–380.
40. Kröger K, Moerchel Ch, Moysidis T, Santosa F. Incidence rate of pulmonary embolism in Germany: data from the federal statistical office. *J Thromb Thrombolysis*. 2010;29:349–353.
41. Deitelzweig SB, Johnson BH, Lin J, Schulman KL. Prevalence of clinical venous thromboembolism in the USA: current trends and future projections. *Am J Hematol*. 2011;86:217–220.
42. Deitelzweig SB, Lin J, Johnson BH, Schulman KL. Venous thromboembolism in the US: does race matter? *J Thromb Thrombolysis*. 2011;31:133–138.
43. Abdul Sultan A, Tata LJ, Grainge MJ, West J. The incidence of first venous thromboembolism in and around pregnancy using linked primary and secondary care data: a population based cohort study from England and comparative meta-analysis. *PLoS One*. 2013;8:e70310.
44. Kane EV, Calderwood C, Dobbie R, Morris C, Roman E, Greer IA. A population-based study of venous thrombosis in pregnancy in Scotland 1980–2005. *Eur J Obstet Gynecol Reprod Bio* 2013;169:223–229.
45. Heyl PS, Sappenfield WM, Burch D, Hernandez LE, Kavanaugh VM, Hill WC. Pregnancy-related deaths due to pulmonary embolism: findings from two state-based mortality reviews. *Matern Child Health J*. 2013;17:1230–1235.
46. Virkus RA, Lokkegaard EC, Bergholt T, Mogensen U, Langhoff-Roos J, Lidegaard O. Venous thromboembolism in pregnant and puerperal women in Denmark 1995–2005. A national cohort study. *Thromb Haemost* 2011;106:304–309.
47. Berg CJ, Callaghan WM, Syverson C, Henderson Z. Pregnancy-related mortality in the United States, 1998 to 2005. *Obstet Gynecol* 2010;116:1302–1309.
48. Sharma S, Monga D. Venous thromboembolism during pregnancy and the post-partum period: incidence and risk factors in a large Victorian health service. *Aust N Z J Obstet Gynaecol*. 2008;48:44–49.

49. Samuelsson E, Hellgren M, Högborg U. Pregnancy-related deaths due to pulmonary embolism in Sweden. *Acta Obstet Gynecol Scand.* 2007;86:435–443.
50. Wen SW, Huang L, Liston R, Heaman M, Baskett T, Rusen ID, Joseph KS, Kramer MS; Maternal Health Study Group, Canadian Perinatal Surveillance System. Severe maternal morbidity in Canada, 1991–2001. *CMAJ* 2005;173:759–764.
51. Fawcus SR, van Coeverden de Groot HA, Isaacs S. A 50-year audit of maternal mortality in the Peninsula Maternal and Neonatal Service, Cape Town (1953–2002). *BJOG* 2005;112:1257–1263.
52. Heit JA, Kobbervig CE, James AH, Petterson TM, Bailey KR, Melton LJ 3rd. Trends in the incidence of venous thromboembolism during pregnancy or postpartum: a 30-year population-based study. *Ann Intern Med.* 2005;143:697–706.
53. Sullivan EA, Ford JB, Chambers G, Slaytor EK. Maternal mortality in Australia, 1973–1996. *Aust N Z J Obstet Gynaecol* 2004;44:452–457; discussion 377.
54. Lindqvist P, Dahlbäck B, Maršál K. Thrombotic risk during pregnancy: a population study. *Obstet Gynecol.* 1999;94:595–599.
55. Santosa F, Moysidis T, Moerchel C, Kroger K, Bufe A. Pulmonary embolism in young people. Trends in Germany from 2005 to 2011. *Hamostaseologie* 2014;34:88–92.
56. Reardon G, Pandya N, Nutescu EA, Lamori J, Damaraju CV, Schein J, Bookhart B. Incidence of venous thromboembolism in nursing home residents. *J Am Med Dir Assoc.* 2013;14:578–584.
57. Schmidt M, Johannesdottir SA, Lemeshow S, Lash TL, Ulrichsen SP, Bøtker HE, Sørensen HT. Obesity in young men, and individual and combined risks of type 2 diabetes, cardiovascular morbidity and death before 55 years of age: a Danish 33-year follow-up study. *BMJ Open.* 2013;3:.
58. Sweetland S, Beral V, Balkwill A, Liu B, Benson VS, Canonico M, Green J, Reeves GK; Million Women Study Collaborators. Venous thromboembolism risk in relation to use of different types of postmenopausal hormone therapy in a large prospective study. *J Thromb Haemost.* 2012;10:2277–2286.
59. Moysidis T, Kröger K, Moerchel C, Santosa F, Gröchenig E. Pulmonary embolism in young males and females in Germany: data from the Federal Statistical Office. *Blood Coagul Fibrinolysis.* 2010;21:511–515.
60. Lutsey PL, Virnig BA, Durham SB, Steffen LM, Hirsch AT, Jacobs DR Jr, Folsom AR. Correlates and consequences of venous thromboembolism: The Iowa Women's Health Study. *Am J Public Health.* 2010;100:1506–1513.
61. Spannagl M, Heinemann LA, Dominh T, Assmann A, Schramm W, Schürmann R. Comparison of incidence/risk of venous thromboembolism (VTE) among selected clinical and hereditary risk markers: a community-based cohort study. *Thromb J.* 2005;3:8.
62. Samuelsson E, Hägg S. Incidence of venous thromboembolism in young Swedish women and possibly preventable cases among combined oral contraceptive users. *Acta Obstet Gynecol Scand.* 2004;83:674–681.
63. Mellekjaer L, Sørensen HT, Dreyer L, Olsen J, Olsen JH. Admission for and mortality from primary venous thromboembolism in women of fertile age in Denmark, 1977–95. *BMJ.* 1999;319:820–821.
64. Kniffin WD Jr, Baron JA, Barrett J, Birkmeyer JD, Anderson FA Jr. The epidemiology of diagnosed pulmonary embolism and deep venous thrombosis in the elderly. *Arch Intern Med.* 1994;154:861–866.
65. Gaborit FS, Overvad K, Nørgaard M, Kristensen SR, Tjønneland A, Severinsen MT. Alcohol intake and risk of venous thromboembolism. A Danish follow-up study. *Thromb Haemost.* 2013;110:39–45.
66. Kunisawa S, Ikai H, Imanaka Y. Incidence and prevention of postoperative venous thromboembolism: are they meaningful quality indicators in Japanese health care settings? *World J Surg.* 2012;36:280–286.
67. White RH, Dager WE, Zhou H, Murin S. Racial and gender differences in the incidence of recurrent venous thromboembolism. *Thromb Haemost.* 2006;96:267–273.
68. Beemath A, Skaf E, Stein PD. Pulmonary embolism as a cause of death in adults who died with heart failure. *Am J Cardiol.* 2006;98:1073–1075.
69. Petrauskienė V, Falk M, Waernbaum I, Norberg M, Eriksson JW. The risk of venous thromboembolism is markedly elevated in patients with diabetes. *Diabetologia.* 2005;48:1017–1021.
70. Gomes JP, Shaheen WH, Truong SV, Brown EF, Beasley BW, Gajewski BJ. Incidence of venous thromboembolic events among nursing home residents. *J Gen Intern Med.* 2003;18:934–936.
71. Stein PD, Matta F, Yaekoub AY. Incidence of vena cava thrombosis in the United States. *Am J Cardiol.* 2008;102:927–929.
72. Jha AK, Larizgoitia I, Audera-Lopez C, Prasopa-Plaizier N, Waters H, Bates DW. The global burden of unsafe medical care: analytic modelling of observational studies. *BMJ Qual Saf.* 2013;22:809–815.
73. Access Economics Pty Limited. *The Burden of Venous Thromboembolism in Australia. The Australia and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism.* Sydney: Health Education and Management;2008.
74. Wilson RM, Michel P, Olsen S, et al; WHO Patient Safety EMRO/AFRO Working Group. Patient safety in developing countries: retrospective estimation of scale and nature of harm to patients in hospital. *BMJ.* 2012;344:e832.
75. Aranzáiz-Andrés JM, Aibar-Remón C, Limón-Ramírez R, Amarilla A, Restrepo FR, Urroz O, Sarabia O, García-Corcuera LV, Terol-García E, Agra-Varela Y, Gonseth-García J, Bates DW, Larizgoitia I; IBEAS Team. Prevalence of adverse events in the hospitals of five Latin American countries: results of the 'Iberoamerican Study of Adverse Events' (IBEAS). *BMJ Qual Saf.* 2011;20:1043–1051.
76. Engbers MJ, van Hylckama Vlieg A, Rosendaal FR. Venous thrombosis in the elderly: incidence, risk factors and risk groups. *J Thromb Haemost.* 2010;8:2105–2112.
77. Angchaisuksiri P. Venous thromboembolism in Asia—an unrecognized and under-treated problem? *Thromb Haemost.* 2011;106:585–590.
78. Heit JA. The epidemiology of venous thromboembolism in the community. *Arterioscler Thromb Vasc Biol.* 2008;28:370–372.
79. Heit J, Cohen AT, Anderson FJ. Estimated annual number of incident and recurrent, fatal and non-fatal venous thromboembolism (VTE) events in the US. *Blood* 2005;106:267A.
80. Kahn SR, Hirsch A, Shrier I. Effect of postthrombotic syndrome on health-related quality of life after deep venous thrombosis. *Arch Intern Med.* 2002;162:1144–1148.
81. Kachroo S, Boyd D, Bookhart BK, LaMori J, Schein JR, Rosenberg DJ, Reynolds MW. Quality of life and economic costs associated with post-thrombotic syndrome. *Am J Health Syst Pharm.* 2012;69:567–572.
82. Heit JA, Rooke TW, Silverstein MD, Mohr DN, Lohse CM, Petterson TM, O'Fallon WM, Melton LJ 3rd. Trends in the incidence of venous stasis syndrome and venous ulcer: a 25-year population-based study. *J Vasc Surg.* 2001;33:1022–1027.
83. Pengo V, Lensing AW, Prins MH, Marchiori A, Davidson BL, Tiozzo F, Albanese P, Biasiolo A, Pegoraro C, Iliceto S, Prandoni P; Thromboembolic Pulmonary Hypertension Study Group. Incidence of chronic thromboembolic pulmonary hypertension after pulmonary embolism. *N Engl J Med.* 2004;350:2257–2264.
84. Noble S, Lewis R, Whithers J, Lewis S, Bennett P. Long-term psychological consequences of symptomatic pulmonary embolism: a qualitative study. *BMJ Open.* 2014;4:e004561.
85. Cohen AT, Spiro TE, Buller H, HR, Haskell L, Hu D, Hull R, Mebazaa A, Merli G, Schellong S, Spyropoulos AC, Tapson V; MAGELLAN Investigators. Rivaroxaban for thromboprophylaxis in acutely ill medical patients. *N Engl J Med* 2013;368:513–523.
86. Goldhaber SZ, Leizorovicz A, Kakkar AK, Haas SK, Merli G, Knabb RM, Weitz JI; ADOPT Trial Investigators. Apixaban versus enoxaparin for thromboprophylaxis in medically ill patients. *N Engl J Med.* 2011;365:2167–2177.
87. Raskob GE, Gallus AS, Pineo GF, Chen D, Ramirez LM, Wright RT, Lassen MR. Apixaban versus enoxaparin for thromboprophylaxis after hip or knee replacement: pooled analysis of major venous thromboembolism and bleeding in 8464 patients from the ADVANCE-2 and ADVANCE-3 trials. *J Bone Joint Surg Br.* 2012;94:257–264.
88. Wells PS, Forgie MA, Rodger MA. Treatment of venous thromboembolism. *JAMA* 2014;311:717–728.
89. Cohen AT, Tapson VF, Bergmann JF, Goldhaber SZ, Kakkar AK, Deslandes B, Huang W, Zayaruzny M, Emery L, Anderson FA Jr; ENDORSE Investigators. Venous thromboembolism risk and prophylaxis in the acute hospital care setting (ENDORSE study): a multinational cross-sectional study. *Lancet.* 2008;371:387–394. Erratum in: *Lancet* 2008;371:1914.
90. Lester W, Freemantle N, Begaj I, Ray D, Wood J, Pagano D. Fatal venous thromboembolism associated with hospital admission: a cohort study to assess the impact of a national risk assessment target. *Heart.* 2013;99:1734–1739.
91. Catterick D, Hunt BJ. Impact of the national venous thromboembolism risk assessment tool in secondary care in England: retrospective population-based database study. *Blood Coagul Fibrinolysis.* 2014;25:571–576.
92. Sixty-Sixth World Health Assembly. Follow-up to the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. May 27, 2013. http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R10-en.pdf. Accessed August 14, 2014.