pre-specified criteria. Eligible cases will be prospectively recruited over two months and followed-up in 6 months. Based on epidemiological investigations and data from the Trauma Audit and Research Network, we expect to recruit between 1000 to 2000 patients. Anonymised data will be collected locally and submitted to a secure web-based central database.

Outcome measures: These include all-cause mortality, venous thromboembolism events, haemorrhagic progression, re-admission, surgical intervention, length of stay in admitting unit, neurological status, and Extended Glasgow Outcome Scale during follow-up.

Conclusion: TOP TBI is an important step in the ongoing efforts to optimise the outcomes of patients who have suffered a traumatic brain injury. It is hoped that the results will give insight into contemporary practice in the UK and Ireland and inform future studies.

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Types and timing Of venous thromboembolism Prophylaxis for Traumatic Brain Injury (TOP TBI) Study

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Background: Patients with traumatic brain injury are at significant risk for both developing venous thromboembolisms and haemorrhagic progression. Pharmacological thromboprophylaxis and mechanical thromboprophylaxis may be able to minimise the incidence of venous thromboembolisms. Problematically, pharmacological thromboprophylaxis also has the potential to augment clinically significant intracranial haemorrhage expansion. Compounding this issue is that the evidence for mechanical thromboprophylaxis is not based on neurotrauma populations, and there is insufficient evidence to guide clinicians on the optimum agent, dose, and timing of pharmacological thromboprophylaxis. Based on the need for high quality evidence, we propose the Types and timing Of venous thromboembolism Prophylaxis for Traumatic Brain Injury (TOP TBI) Study.

Aim: To collect high quality and relevant data regarding thromboprophylaxis practice and associated outcomes - including rates of venous thromboembolisms, intracranial haemorrhage expansion and mortality – for TBI patients in the UK and Ireland in order to optimise management for these patients.

Methods: We will adopt a multicentre, prospective, observational cohort design. All neurosurgical units: in the UK and Ireland will be eligible to participate. Patient eligibility will be determined according to