of one or several hemostatic parameters will enable accurate assessment of thrombotic risk. Application of global hemostatic tests such as ETP, which reflect integrated activity of the coagulation network, could provide better insight into hemostatic balance in these patients, but prospective studies are needed. Until then, assessment of thrombotic risk and decision regarding antithrombotic prophylaxis in CS patients should be based both on careful history taking to cover all clinical risk factors (age, obesity, hypertension, diabetes/impaired glucose tolerance, dyslipidemia, smoking, previous vascular complications, immobility, malignancy, pregnancy and drugs) and results of coagulation testing (PT, aPTT, fibrinogen, D-dimer, FVIII) (Table 2). In the future, more randomized controlled trials are needed to investigate the efficacy of anticoagulant treatment for prevention of postoperative VTE in patients with CS.

### Table 2. Individual vascular risk assessment

<table>
<thead>
<tr>
<th>Clinical risk factors (see text above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of hypercorticism (clinical and biochemical evaluation)</td>
</tr>
<tr>
<td>Clinical examination of the cardiovascular system</td>
</tr>
<tr>
<td>Hematology and coagulation parameters (full blood count, aPTT, PT, fibrinogen, FVIII and D-dimer)</td>
</tr>
<tr>
<td>ECG</td>
</tr>
<tr>
<td>Echocardiography and Doppler studies</td>
</tr>
</tbody>
</table>

### Key issues

1. CS is associated with increased cardiovascular morbidity and mortality due to clustering of cardiovascular risk factors including hypercoagulability. If present, vascular structural changes, due to glucocorticoid excess, may be irreversible predisposing to persistently increased cardiovascular risk in these patients.

2. The mechanisms of blood hypercoagulability in CS include high levels of factor VIII and von Willebrand factor, evidence of enhanced thrombin generation and decreased fibrinolytic activity. These changes may persist for months after curative surgery.

3. Risk of unprovoked and post-operative VTE is increased in CS, especially in CD. Guidelines for thromboprophylaxis in patients undergoing curative surgery are as yet lacking.

4. Further studies are needed to establish protocols for cardiovascular risk evaluation and protection in these patients.

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### REFERENCES