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Prophylaxis of Medically Treated Patient With Cancer and Reduced Mobility in Hospital

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

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Dr. Khorana:
Hi, my name is Alok Khorana, and I'm a Medical Oncologist and Director of the GI Cancer Program at the Cleveland Clinic in Cleveland, Ohio, with a special interest in cancer-associated thrombosis. And today I'll be discussing the Prophylaxis of Medically Treated Patient with Cancer and Reduced Mobility in Hospital.

There has certainly been an alarming rise in cancer-associated VTE. The graph on the left is a graph from a very large, Danish cohort registry that looked at rates of VTE in the cancer population shown in red, and the non-cancer population, shown in blue over a long period of two decades from 97 to 2017. And in this study, as you can see, the non-cancer population had relatively stable rates of VTE, but the cancer population has a substantial rise during that same timeframe. It was always higher than the non-cancer population, but rose even to a greater degree in the cancer population.

And similar results were observed in a large inpatient database analysis by Lyman and colleagues published in 2018, looking at rates of DVT, PE, and VTE in hospitalized cancer patients, and then specifically in hospitalized cancer patients on chemotherapy, who had the highest rates. And all of these groups demonstrated a increasing risk VTE, with rates peaking at about 8% per hospitalization in the last year of study.

Now VTE in cancer population is very problematic for patients, and has several negative consequences. It's associated of course with the need for prolonged therapeutic anticoagulation, which in turn carries an increased risk of bleeding. It has a high risk of recurrent VTE, high VTE-related and all healthcare costs. It can delay or interrupt anti-cancer therapy, worsen patients' quality of life, worsen

overall survival, as well as short-term mortality. Of course, it's associated with symptoms, morbidity, and the need to do emergency room visits and/or be hospitalized. And so, reducing risk of VTE in high-risk settings is quite important.

These high-risk settings include the postsurgical setting for which there's a lot of data to support postsurgical prophylaxis; the medical inpatient setting, these are patients who are admitted to the hospital with a diagnosis of cancer and are acutely ill from a medical illness and may or may not have reduced mobility; and in the outpatient setting.

The studies establishing benefit to cancer patients were not cancer-only studies but studies that included all acutely medically ill patients admitted to the hospital. These studies were MEDENOX, PREVENT, and ARTEMIS, which each used a different type of anticoagulant, enoxaparin, dalteparin, and fondaparinux, respectively, but each of which showed a substantial absolute and relative risk reduction for inpatient VTE in this setting.

More recent trials from large Canadian consortium confirmed a high risk of VTE in the inpatient setting, and found that the risk was even

greater depending on the risk or as identified by a validated tool. And the benefit for thromboprophylaxis, as shown on the right, was the greatest in high-risk patients, suggesting that even in contemporary cancer population, there's still benefit to thromboprophylaxis when patients are in the hospital with an acute medical illness, and with or without reduced mobility.

As a result, again guidelines continue to recommend a thromboprophylaxis for hospitalized cancer patients. And the recommendation from ASCO states that hospitalized patients who have active malignancy and an acute medical illness or reduced mobility should be offered pharmacologic thromboprophylaxis in the absence of bleeding or other contraindications.

In the International Advisory Panel from ITAC also recommends prophylaxis with low-molecular-weight heparin or fondaparinux, or with unfractionated heparin in hospitalized patients with cancer and reduced mobility.

As a result, it's important that clinicians educate their patients about the warning signs and symptoms of DVT or PE; many cancer patients are unaware, assess the risk for VTE and bleeding in high-risk settings, such as in the hospital, and consider thromboprophylaxis if patients are not at high risk for bleeding. And this burden should not fall on cancer providers alone, but should also fall on health systems who should also have plans to educate patients, create risk assessment programs, and have the infrastructure to offer thromboprophylaxis to the at-risk population.

Thank you very much for your attention.

Announcer:
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