Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/treatment-of-patient-with-low-risk-of-genitourinary-bleed-for-established-vte-with-cancer/14724/

Released: 02/17/2023
Valid until: 02/17/2024
Time needed to complete: 1h 07m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Treatment of Patient With Low Risk of Genitourinary Bleed for Established VTE With Cancer

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

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Connors:
Hello, I'm Dr. Jean Connors, a Hematologist at Brigham and Women's Hospital and Dana Farber Cancer Institute. And I'm a hematologist who deals in coagulation and anticoagulation as Medical Director of the Hemostatic Antithrombotic Stewardship Program, and Anticoagulation Management Services for Cancer Patients at the Dana Farber Cancer Institute, and for patients without cancer at Brigham and Women's Hospital. I'm delighted to have you join us today for my discussion on Treatment of Patients with Low Risk of Genitourinary Bleeding When They Have Established Thrombosis in the Setting of Cancer.

And so, I'm going start with a case. This is a case of a 61-year-old woman with breast cancer with metastases to the bones, currently being treated with abemaciclib. She presents with new left lower extremity swelling. She has no chest pain or shortness of breath, and has a normal EKG. She is diagnosed with a proximal DVT involving the femoral and popliteal veins. The emergency department calls you to ask what should be done next. Your treatment approach includes: admitting her for I.V. unfractionated heparin, admitting for low-molecular-weight heparin treatments, send her home with low-molecular-weight heparin, send her home with edoxaban, or send her home with apixaban.

And so we now have the luxury of having data that were specifically obtained from patients with cancer-associated VTE in phase 3 randomized controlled trials of the direct oral anticoagulants compared with the standard of care low-molecular-weight heparin. In all of the studies listed here, the low-molecular-weight heparin comparator was dalteparin. And you can see in these studies that we have - the first ones that came out in 2018, HOKUSAI-VTE cancer, which used edoxaban, and had 1,000 patients, SELECT-D rivaroxaban in 406 patients, ADAM-VTE where the

primary endpoint was safety, and not efficacy, 300 patients using apixaban versus dalteparin, CARAVAGGIO 1,170 patients half randomized to apixaban, CASTA-DIVA and CANVAS, which was a pragmatic clinical effectiveness trial that randomized to DOAC of the prescriber's choice versus a low-molecular-weight heparin. And with these studies, we have data for more than 3,690 patients, showing the efficacy and safety of DOACs to treat cancer-associated VTE.

When we look at this metaanalysis that was published in Journal of Hematologic - Hematology and Oncology, we can see that if we take all of these studies, and we look and compare those randomized to any direct oral anticoagulant versus low-molecular-weight heparin, that preventing recurrent VTE favoring - favors DOACs in this metaanalysis. And so that if you want to prevent VTE in your patient DOAC is preferable. And you can see the absolute effect rates here with low-molecular-weight heparin versus DOAC for recurrent VTE.

Now when we look at the primary safety outcome for this metaanalysis, which was major bleeding from all of these trials, we can see a

little bit of heterogeneity in the results. Such that, some trials, low-molecular-weight heparin was favored when we're looking at major bleeding. And for other trials, it was about similar between the DOAC and the low-molecular-weight heparin. And these trials that were similar or better, used apixaban in CARAVAGGIO, and about 60% of the patients assigned to DOAC in CANVAS used apixaban as well. And so, there really appears to be no significant difference there for major bleeding.

However, when we look at what we call, clinically relevant non-major bleeding, that is bleeding that is not major, does - is not a drop in hemoglobin of 2 grams per deciliter, or a bleed in a critical space, but it is bleeding that brings a patient to medical attention, you can see that no matter what trial and no matter what DOAC, low-molecular-weight heparin had a lower rate of clinically relevant non-major bleeding.

When we look at data from the CARAVAGGIO trial, in a post-hoc analysis, looking at the types of cancer and major bleeding, you can see differences in the types of cancer. Now, some of these types of cancers were represented at a low rate. And so you can see in this table on the left-hand side that colorectal cancers comprised about 20% of the population, and lung cancer about 16 to 18%, and breast cancer like our patient, about 13%. Genitourinary cancers were pretty well represented, almost at the same level of patients with breast cancer. But when we look at the major bleeding, and we look at dalteparin in the blue versus apixaban in the orange or gold, you can see that for genitourinary tract cancers, there's a higher risk of bleeding with apixaban than dalteparin. However, our patient with breast cancer has a very low risk of major bleeding with either anticoagulant.

So in this case, our patient with metastatic breast cancer with - who has a new left lower extremity DVT, the correct answer from my point of view is send this patient home with apixaban. She is clinically stable with no signs or symptoms of a pulmonary embolus. She has a normal EKG, indicating a normal heart rate and no evidence of right heart strain by EKG, and she can be treated as an outpatient. Direct oral anticoagulants are recommended as first-line treatment for patients with cancer-associated VTE now, by almost all society guidelines, including ASH, ITAC, ESMO, NCCN, and others. She has a low risk of bleeding with a DOAC, particularly GU tract bleeding as evidenced by the data we saw in the CARAVAGGIO study, and this makes DOACs an optimal choice. The reason edoxaban is not a DOAC of choice in this case is simply because edoxaban was studied in the phase 3 RCT with 5 days of a parenteral agent and injectable low-molecular-weight heparin that just makes it more cumbersome and burdensome for the patient. Apixaban, we add 10 milligrams twice a day for the first 7 days, followed by 5 milligrams twice daily for the duration of the anticoagulation treatment period will - is a good choice for this patient. Abemaciclib, which by the way, has been associated with increased the VTE risk in patients with breast cancer has been shown not to have a significant effect on the metabolic pathways of apixaban in the CYP3A4 or P-glycoprotein transporters, so we do not have to worry about drug-drug interactions.

So for this patient's ease of anticoagulation and lifestyle benefits, you can send her home with apixaban or an alternative direct oral anticoagulant such as rivaroxaban, that does not require a parenteral agent lead-in.

I want to thank you for your attention, and I hope you watch the rest of the videos in our series. Thank you.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, Inc. and is part of our MinuteCME curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.