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Pharmacist's Letter
Hospital

Manage and Prevent Cancer-Associated VTE

You'll get questions about **treating and preventing cancer-associated venous thromboembolism (VTE)**.

It's tricky...since these patients often have an increased risk of thrombosis AND bleeding.

Be prepared to manage these patients...and help avoid errors.

Treatment. Help tailor the anticoagulant choice based on patient-specific factors, such as kidney function, preferred route, and cost.

Often choose a direct oral anticoagulant (DOAC) over a low-molecular-weight heparin (LMWH), such as enoxaparin, based on ease of use.

Most DOACs reduce risk of recurrent VTE in patients with cancer about as well as LMWH...with a similar risk of major bleeding.

Lean toward apixaban or rivaroxaban. Edoxaban requires at least 5 days of initial treatment with an injectable anticoagulant...and there aren't good data yet with dabigatran.

Stick with LMWH for patients with GI or genitourinary cancers...due to concern for higher bleeding risk with DOACs in these cases.

Be aware, warfarin seems less effective than LMWH for cancer-associated VTE. Save warfarin for select cases, such as if cost is an issue. Most DOACs cost about $500/month...LMWH about $700...and warfarin about $10 plus routine INR monitoring.

Treat for at least 3 to 6 months...and as long as the patient is receiving cancer therapy or has active cancer.

Inpatient prophylaxis. If patients with cancer are admitted for major surgery, generally start VTE prophylaxis with LMWH or unfractionated heparin...and continue for at least 7 to 10 days post-op.

Save mechanical methods for patients at high bleeding risk.

For nonsurgical cancer patients, assess the need for VTE prophylaxis as you would for other medical patients.

As an example, consider prophylaxis for a patient with cancer PLUS other risks...heart failure, immobility, obesity, etc.

Outpatient prophylaxis. Be aware, you may see some patients with cancer admitted on long-term PRIMARY VTE prophylaxis.

It's because guidelines now recommend assessing VTE risk when outpatients start chemotherapy. For example, the Khorana score may be used to assess risk for outpatients with a solid tumor or lymphoma.

When prophylaxis is appropriate, anticipate using apixaban, rivaroxaban, or LMWH for up to 6 months...or longer if risk persists. These are the only options shown to reduce the risk of VTE versus placebo.

Avoid errors by documenting indications on med histories...and expect lower doses for prophylaxis, such as apixaban 2.5 mg bid.

Continue to watch for DOAC or warfarin interactions.

See our resource, *Cancer-Associated Thrombosis FAQs*, for dosing, monitoring, and special populations, including multiple myeloma.

Key References:

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