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/comprehensive-anticoagulation-management-for-vte/17971/

Released: 01/19/2024
Valid until: 01/19/2025
Time needed to complete: 1h 00m

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

Comprehensive Anticoagulation Management for VTE

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE 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. Patel:
Hi, my name is Manesh Patel and I'm at Duke University. And I'm back again to talk to you about VTE therapy and a comprehensive process to do it. And again, I'm joined by some of my great friends and colleagues, Elaine Hylek from Boston. Elaine, thanks for joining me.

Dr. Hylek:
Sure.

Dr. Patel:
And then Renato Lopes, who works both at DCRI and also works in Brazil at times, who's a wonderful researcher and clinician who takes care of these patients too. Renato, thanks for joining me.

Dr. Lopes:
Thanks for having me, Manesh.

Dr. Patel:
Well, you know, when we think about a comprehensive approach to oral anticoagulant therapy for patients with VTE, or venous thromboembolism, I guess Renato, I'll start with you. Are there things that personalize how you think about the patient? You know, is it whether it's a venous clot in their leg? Or is it a large PE? How do you know about dose? How do you think about how long you treat the patient? How do you personalize that therapy?

Dr. Lopes:
Yeah, so that's a great question, Manesh. We could actually talk days about this. It's a very complex question. But I think, in summary, I think we need to look at, of course, the classic risk factors. How many of these patients are at risk for having recurrent events? Because I think that's going to be very critical to define for how long we treat these patients. So, are we talking to – are we seeing a patient that has trends in risk factors that might go away after a few months? Or are we really talking about patients that have a high risk of having recurrent events? Such for example, vascular disease, the traditional cardiovascular risk factor, antiphospholipid syndrome, an active cancer, renal disease, those are all situations, elderly patients. Is this the first VTE versus the third VTE event? We know that the second, the third, the fourth VTE events are usually more severe or more likely to be fatal. And therefore, we might change our mind in terms of for how long should we treat these patients.

So, those are some of the classic things that we always look to define, really, how comfortable I am to really treat this patient alone versus in a comprehensive approach and multidisciplinary approach, call the other specialists or vascular surgeons or hematologists to

help in doing this assessment or what else should we think about. Also, to think about and be reassured about the dosing, we have different dosing regimens for VTE treatment. Remember, in A-Fib, we are very concerned about adjusting doses for renal impairment; this is not the case for the VTE patients, because typically they are younger and they don't need that kind of adjustment.

And obviously, then the key question that nobody has a definitive answer is for how long should we treat these patients? What we learned in the last years is that the recurrent events or the rate of recurrent event in the first year, it's about 10% per year, which is very, very high. In a way, that now the standard is after an initial course of 3, 6, or even 12 months, we tend now to do at least 12 months of an additional treatment, because we have safer drugs that can be highly effective in reducing the risk of recurrent event and a very minimal cause of bleeding. And obviously, take care of these really high risks, particularly the first year after a VTE event. So, those are some of the considerations that we need to think about when treating these patients.

Dr. Patel:
Thanks, Renato, lots to think about. But certainly, you highlighted those risk factors, both are traditional and others that might make you extend therapy, including recent illness, prior VTE, obviously renal function, cancer, a variety of other things, recognizing we're not going to dose adjust; we're going to use them as studied, because that's the way we do it in VTE, given what we know.

Well, Elaine, tell me about how if I do all those things to make sure the patient is getting personalized therapy, how do I make sure they have access to it? How do I make sure that continue therapy? Are there things you guys do, or places do, that make sure that we're comprehensively making sure our patients stay on the therapy and get the therapy?

Dr. Hylek:
So, I can certainly share with you some of the programs that I, you know, am familiar with. Some of the anticoagulation clinics have actually transitioned a little bit to engage at least the initial prescription for DOACs just to make sure that the patients understand you don't need to be monitored on these medications. You know, making sure, as I had stated, that the insurance coverage is in place for them when they leave the hospital.

So, these are all important, but let's not forget that these are blood thinners and it's also important to set expectations with a patient and the family members around bleeding. Bleeding is very infrequent. These drugs have been extensively studied. These clots need to be treated during emergencies. But patients should know when to maybe seek care at the emergency room. Are they seeing black stools, black bile? I mean, these are the things that doctors and nurses and pharmacists need to educate the patient and the family.

Regarding the duration of therapy, as we've discussed, it's upwards of 30% at 5 years. So, for individuals with an unprovoked or we don't know why you have this clot, there's going to be a long period of time that you might have surgeries, you might need to have different procedures. And that's why it's important to stay engaged with your internal medicine doctors, your cardiologists, your hematologists about, you know, when can I just stop my medicine? Is it okay? And these are all of the practical questions that, you know, our patients will get guidance on what to do because these medicines are very fast acting. Within 2 to 3 hours, you have a full anticoagulation effect, much different than warfarin. And in addition to that, they have a fairly rapid offset. So, it's different when you have procedures, it's actually much easier, in many ways. So, I think educating the patients, say, let's not increase the risk of bleeding. We shouldn't be prescribing ibuprofen and non-steroidal anti-inflammatory drugs with any anticoagulant. You know, make sure you understand why is this patient also taking aspirin? Is it necessary? Because these dual therapies, the combination therapy, can increase the risk of bleeding. And that's what we don't want to have happen.

Dr. Lopes:
And Manesh, if you allow me just to add one thing, because I think we've seen a shift. In the past, we focused a lot on this term, provoked and unprovoked, and we all use that. But I think now if we look at the data, and we are really focusing more into the: Are there persistent risk factors versus trends in risk factors? Because those are the key elements that when we are personalizing the treatment, we need to think about in terms of for how long I'm going to treat these patients, based on how many factors, how many persistent risk factors are present in each individual patient?

Dr. Patel:
Yeah, I think that's really helpful, Renato, because I do believe, you know, some of these concepts have changed some for us. And we are getting to the point where we now know that there's a change for some of those things.

I guess I'll end by saying the last thing for comprehensive oral anticoagulants or strategy or DOAC strategy for VTE is to make sure you have some feedback loop, you have some quality engagement project, where people who are prescribing it or systems that are trying to treat our patients, we know how often they're filling their medications, we know that they're getting the right dose, and we also see that we're using therapies, at least at proven doses in sort of these indications. And you guys are absolutely right, you know, why one person flies 4 hours and another person flies 4 hours and one gets a clot and another one doesn't, is really parts of the medical world we're all

searching to understand. But some of that is probably multiple hits, meaning you also may be a little heavier, you might have some diabetes, you might have some other risk factors. So, as they add up, putting those into context of continuing patients and getting that data will be valuable.

Listen, this has been a great conversation. I appreciate you both joining me, and thank you all for joining in watching as we talked about comprehensive systems to make sure our patients with VTE get anticoagulant therapy.

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

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