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Collaboration Is Key— Strategies for a Multidisciplinary Approach to Anticoagulation Management with VTE

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

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Dr. Patel:
Hi, my name is Manesh Patel. I'm from Duke, and I'm excited to have you join us as we think about multidisciplinary care for our patients with venous thromboembolism. I'm joined by two friends and colleagues. It's going to be an exciting few minutes as we go through a lot of things. I have Elaine Hylek joining us from Boston. Elaine, thanks for joining me.

Dr. Hylek:
Thank you.

Dr. Patel:
And Renato Lopes, who works both at Duke and in Brazil, but one of our DCRI colleagues and a researcher and clinician who takes care a lot of these patients too. Renato, thanks for joining us.

Dr. Lopes:
Thanks for having me, Manesh.

Dr. Patel:
So, you know, these are common patients that we see with venous thromboembolism. And I guess, Elaine, the first thing when we think about multidisciplinary approach is just, are there times when you think your patient who has a VTE needs more of a workup? This is a very common question. You know, there are patients that have certain medical conditions, are there times when you think I need more of a workup, but I might need to consult somebody else to help me with this?

Dr. Hylek:
Well, you know, Manesh, I think the most important factor initially when you see the patient is: Was this a provoked clot or was this not? And I think that really drives care. So, is there an oral contraceptive pill? Was there lengthy airplane travel? Was there prolonged immobility? Was there a recent hospitalization? Remember that many of the DVTs in the community occur within, you know, 6 weeks of a hospitalization. So, I think all of those are really critically important. Because then I know, am I going to be treating this patient for 3 months? Or am I going to have to, you know, get additional input from a hematologist about, you know, potentially almost lifelong treatment for these patients? You know, inquire if there's a family history.

Regarding cancer, we're all worried about cancer, but there certainly have been studies that patients should be up to date on their cancer screening for that older population. You don't really go out and do, you know, CAT scans, of, you know, everyone if there’s a clot. The most important thing, and this has been shown in randomized trials, is that patients should be up to date on their cancer

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screening. And that that would really be the best thing to do for these patients.

A common question for us at BU is always: Should we be doing this big hypercoagulability workup? And I think most of the experts and guidelines say that no, that's really not necessary. However, you might be thinking of doing that for, you know, women who are in that age group, may have had miscarriages. I think, you know, younger women probably warrant a workup for antiphospholipid syndrome. But you know, remember that these clots increase with age; and age is a very powerful risk factor, as is family history.

Dr. Patel:
That's really helpful, Elaine. Renato, you know, some of the times when we talk to hematology or pharmacy colleagues is when cancer is actually present, and we have cancer-associated VTE. Help me a little bit about, you know, the evidence or how comfortable should we feel about patients who have cancer and using DOACs instead of warfarin and how long?

Dr. Lopes:
Well, that's a great question, Manesh, because, as you know, when we prove the DOACs really came across and streamlined the treatment for VTE, the key question that all the scientific community and us physicians also were asking was, how about a prothrombotic status, like cancer, would DOACs really work in that scenario? And we didn't have a lot of data about NOACs; we had a lot of good data showing that in this particular setting, the standard of care is not warfarin, the standard of care is actually low-molecular-weight heparin. And so, we needed really to have some data and some trials done comparing DOACs with low-molecular-weight heparin. And we've done those trials. And basically, I think that if we could summarize, although we don't have a lot of time to go with the details, is that yes, DOACs are at least as effective; particularly some of the DOACs, not all of them were tested. So, we had data with rivaroxaban, we have data with edoxaban, and we have data with apixaban, that those agents, the factor Xa inhibitors, are at least as effective as low-molecular-weight heparin, if not more, in preventing recurring VTE, in the cancer setting.

There was one drawback, which was an increase in GI bleeding compared to low-molecular-weight heparin that we've seen mainly with riva and with edoxaban. This was not seen in the Caravaggio trial with apixaban, which was very consistent with what we've seen also with apixaban in the A-Fib scenario, not increasing the risk of GI bleeding.

But in summary, I think the good news is that, yes, we feel comfortable now using DOACs for treating patients with VTE. They are associated with cancer, and we need to be careful about bleeding, because depending on the DOAC that you're going to use and depending on the type of cancer, particular GI tract, we might consider using low-molecular-weight heparin since we have less GI bleeding overall comparing to NOACs as a class.

Dr. Patel:
Thanks, Renato, that is really helpful because what we've learned, at least Elaine highlighted, we don't have to do a lot of workup in many of these patients, maybe some of the younger ones or the ones that are sort of hanging out, or let's say, have markers of underlying other issues, hematology might help us or we might think about it. For our cancer patients, as you just highlighted, there's great evidence we should feel comfortable.

Elaine, maybe I'll come to you for the final question about some of our multidisciplinary. So, we've talked about general medicine, and cardiologists, hematologists, but what about pharmacy colleagues and our nurse practitioners? Many of them help us take care of a lot of our patients with anticoagulation. How do you engage with your pharmacy colleagues at BU? Or how do you think about how you use them to work with OAC patients?

Dr. Hylek:
So, I mean, when you think about the transition from that initial period of apixaban twice a day and the rivaroxaban dosing twice a day that has to switch at 21 days, and the apixaban dose that you use through 7 days, it's critical to have some type of a pathway. We very much engage our pharmacy colleagues. Any patient that is certainly on the inpatient setting, we make sure that the patients understand that they need to do this dose switch on day 8 or day 22. Blister packs often are used to make sure that there's absolutely no way that the patient might take the incorrect dose. But a multidisciplinary team I think is critical to make sure the insurance coverage is in place and to make sure that everyone is on the same page, including the patient and the family and the nurses. So, we very much, very much endorse a multidisciplinary team.

Dr. Lopes:
And just to add, Manesh – sorry for that, but just to add, I think Elaine touched on a very important point about the dosing of the treatment for VTE is not necessarily the dose that we use for atrial fibrillation, which is the standard dose that we are very familiar with. There are different schemes. There are different initial phases, 1 week, 3 weeks for different doses and different DOACs. There are also the need for use, at least for certain period of time, a parenteral heparin for some of the DOACs like edoxaban and dabigatran. With rivaroxaban and apixaban, we don't need this initial phase with parenteral heparin. So, there are differences between the way we give

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these drugs, the dose that we give, and that having this effort being coordinated, I think is very important.

Dr. Patel:
Yeah, thanks. I think both of you have kind of hit the nail on the head. It takes a team, and the team has to be broad, from disease specific but then also to getting the therapy, getting the right dose, and making sure the patient gets it. So, thank you both for joining me on this conversation around the multidisciplinary approach to working up and managing our VTE patients.

Dr. Hylek:
Thank you.

Dr. Lopes:
Thanks.

Announcer:
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