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VTE Prophylaxis in Patients at Risk for a Secondary VTE Event - Options?

Announcer:
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Dr. Kaatz:
Hi, thanks for attending. I'm Scott Kaatz. I'm a hospitalist at Henry Ford Hospital in Detroit, Michigan. I'm also a clinical professor at Michigan State University and Wayne State University. And what we're going to talk about is what do we do for a patient that we've decided, after the first 3 to 6 months of treatment for a DVT or a pulmonary embolism, what should we do for an anticoagulant once we've decided to do that, and if so, what dose should we use?

So let's start with this case. This is a 42-year-old patient with a 2-day hospitalization for pneumonia. It wasn't COVID; they weren't in the ICU. They've completed 6 months of treatment. They feel well. They're doing good. And you decide after you talk with this patient, because they're kind of in that gray zone of provoked and nonprovoked, that you're going to extend the anticoagulation indefinitely. And we say indefinitely because if bleeding risk increases in the future, we have to revisit this issue. So, really, the question is, are you going to continue the patient on a therapeutic dose of direct oral anticoagulant because that's what they were treated with at first, are you going to step down to a lower dose – and we have trials with 2 but not all 4 of the direct oral anticoagulants; apixaban and rivaroxaban we have data for – switch to aspirin or change the patient over to warfarin?

Now, we really have a couple of guidelines that inform this, the American College of Chest Physician guidelines are these guidelines, and then we're going to talk about the American Society of Hematology guidelines, the ASH guidelines. And the American College of Chest Physician guidelines will suggest in these nonprovoked patients, which we're going to classify this patient as because of only a very short hospitalization, that we would reduce the dose to the prophylactic dose or the half-dose, if you will, of apixaban 2.5 mg twice a day or rivaroxaban 10 mg once a day. And they're suggesting that we should do that. When you read the guidelines and get into them a little bit, they're going to make a suggestion for rivaroxaban over aspirin because that's how the comparative randomized trial was done. And with apixaban, you're going to see it talk more versus no treatment because in that trial, they compared it to placebo. And then, they're also going to suggest if the patient, ie, can't afford a DOAC, that you switch to a vitamin K antagonist like warfarin, and that is at the usual therapeutic dose of 2 to 3. We do not drop to lower INRs, those trials were done many, many years ago.

So the Guidelines put in these real sophisticated tables. I've sort of copied this table out, and this table is really talking about in the CHEST, American College of Chest Physician Guidelines, is talking about the comparisons to placebo or aspirin, as I already mentioned. And what you do is that you will save about 4.6 fewer symptomatic VTEs. These trials were followed up for about a year, but with very little increase in bleeding and almost no increase in major bleeding. So you save a lot of clots for not a lot of bleeding. That's why these guidelines recommend that, and less bleeding, ie, any bleeding if you use the lower dose than the standard dose. The ASH guidelines take a little different twist on that. And they're still talking about the lower dose, you can see that under the first major bullet here, same doses. But they really hedge, and they suggest either continuing therapeutic dose or decreasing to the lower dose. And they reiterate again, if you're going to be using warfarin, that it's an INR of 2 to 3. And then what they have here is they have this table, and

I've put the table in so you have sort of the raw quote, if you will, data out of the guidelines.

But I've sort of summarized it on the right side and really very little difference between immortality, nonfatal pulmonary embolism, all DVTs or major bleeding when we compare therapeutic dose to reduced dose. I'll tell you what I do, because there's that signal in the several trials of less bleeding, even though there was no difference in major bleeding, and I think patients get really bothered when they see any bleeding. So my standard is that I start out with most patients, is I drop to the lower dose, except in patients with cancer and then if those patients have cancer, I stay on the higher dose and that's really not based on any trials yet, but those patients are really higher risk. So it makes sense to me, and I've talked to a lot of specialists in cancer that tend to do the same thing.

I hope this was helpful on what you do to treat your patient after 3 to 6 months of therapy, when you're going to do continued treatment. Thank you very much.

Announcer:
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