Transcript Details

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What Options Are Available Prophylactically for My Acute and Post-Acute Medically Ill Patients?

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

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Dr. Tafur:
Hello, my name is Alfonso Tafur. I'm a physician at Endeavor Health, and I started the practice of vascular medicine almost 10 years ago here, and we've had a fantastic journey on changing the implementation process of these pharmacological options that we have had and then these milestones that we've gone through to understand what opportunities we have to date.

For the hospital-specific setting, I would focus on the MEDENOX and ARTEMIS trial because fondaparinux and enoxaparin were categorically positive studies. Now, what we really learn here is that everybody gets 10 days plus/minus for prophylaxis if they need it. And the concept of they need it, here in MEDENOX and ARTEMIS we selected 2 patients who had additional risk factors being in the hospital. So heart failure, pneumonia, history of thrombosis. And the difference on symptoms, the latest to this team, enoxaparin versus placebo was a negative trial, now, when they selected only 2H as a cutoff. So right patient, right medication, right duration, this was our learning journey here. What do the guidelines say about it? I'm happy to say, I mean, there's a lot of harmony between multiple guideline statements on this on which are the medications that we can use. So low-molecular-weight heparin, unfractionated heparin, fondaparinux. Less strong show of a voice for directorial anticoagulants in the hospital setting, and a good harmony also between all of these guidelines on making sure that the right patient gets selected. So high thrombosis risk with lower bleeding risk, otherwise we have to go to other choices or even no choice, actually, to that individual.

From the bucket of hospital-type patient, let's go to the journey that they have when they leave the hospital. So in that setting, we had the EXCLAIM trial, enoxaparin. And suffice it to say that enoxaparin was a positive study, rivaroxaban versus placebo, MAGELLAN and MARINER positive trials. APEX, although shortly in the United States betrixaban no longer available, was a positive trial. Apixaban, negative trial, but it actually had a trend towards the same rhetoric. So we've learned that these medications were effective, and the journey here was on reducing the chances of bleeding by better patient selection. So whereas enoxaparin gave us 8 in 1,000 patients absolute bleeding risk, when we recruit to patients without a major bleeding likelihood on the MARINER trial, we're talking about less than 3 in 1,000 individuals for major bleeding risk.

So what do the guidelines end up saying about this concept? Well, as you may have noticed, many of the guidelines are older now than the better data that we have. So as guidance touch based on this, they will give higher value to inpatient versus outpatient without contraindication. Whereas the newest guidelines, the IUA, have a strong assessment to say we can use these medications in selected individuals, at least with a moderate degree of certainty. So in my practice at least, this is a strong proponent of that.

From the journey of in-hospital, we've relearned all of these mild stepping stones in COVID. So COVID, a bit different in the outpatient when they leave the hospital, with the MICHELLE trial. Again, same rhetoric. Patient selection was key. We used the improved score to

give them extended prevention, namely about 30 days after discharge. Whereas active did not select patients ordered and called. So what do you see here? Positive trial for rivaroxaban extended prevention, apixaban did not show us the same data without patient selection.

So what do the guidelines say about this? We have NIH/IUA/ISTH guidelines on this topic. A lot of cohesiveness in saying that in the non-ICU-hospitalized patients for trials that I didn't mention, for the myriad of trials that we have in that realm, we use higher doses, therapeutic doses in selected individuals. That is not true in the ICU and at discharge in the newest COVID guidelines. In ISTH, rivaroxaban became an option in selected patients based on the improved score or improved D score. In my humble opinion, ISTH makes this beautiful statement in which we can get into all of those pockets at the same time.

So in summary, I think we've gone through a long trajectory and milestones together, and in paraphrasing Jim Collins, it’s about “first who and then what” for the choices that we have.

Thank you much.

Announcer:
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