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Palliative Care Pharmacy PHAST PHACT

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TODAY'S TOPIC:

Managing Cancer-Related VTEs

Question #3: When should anticoagulants be deprescribed?

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If you have a topic you would like the pharmacy team to answer, please send your suggestions to: pruskowskija@upmc.edu

Background:

As previously mentioned, patients with cancer are at higher risk for venous thromboembolisms (VTEs) due to cancer's hypercoagulable state. VTE recurrent rates are up to 21% of patients (which are 3-4 times higher than the general population) – which is despite anticoagulation.

Often, we should consider when to deprescribe these agents. Patient can experience either intolerable adverse drug reactions (ex: bleeding) or administration burden (ex: daily injections); their prognosis and/or goals of care are not reflected within their medication regimen; and/or their risks generally outweigh benefits of therapy.

Importance:

Palliative care providers care for patients suffering from cancer, therefore should be aware of the rational pharmacological management of this diagnosis. We also often care for patients near or at the end of life, therefore implementing a rational approach to deprescribing of these mediations is important.

The Literature:

There has not yet been a study to explore this concept, so we will need to extrapolate the risks and benefits from other studies:

- Circulation. 2012 Jul 24;126(4):448-54.
  Development of a clinical prediction rule for risk stratification of recurrent venous thromboembolism in patients with cancer-associated venous thromboembolism.
  - Methods: Retrospective cohort study and a validation study in patients with cancer-associated VTE to derive a clinical prediction rule that stratifies VTE recurrence risk
  - Results: Cohort included 543 patients
    - best classification performance included 4 independent predictors (sex, primary tumor site, stage, and prior VTE)

- Patients with a score ≤ 0 had low risk (≤ 4.5%) for recurrence and patients with a score >1 had a high risk (≥ 19%) for VTE recurrence
- Table 2: Ottawa Score for Recurrent VTE Risk Associated Thrombosis

Variable	Regression Coefficient	Points
Female	0.59	1
Lung cancer	0.94	1
Breast cancer	−0.76	−1
TNM* stage I	−1.74	−2
Previous VTE	0.40	1
Clinical probability		
Low (≤0)	. . .	−3 to 0
High (≥1)	. . .	1 to 3

VTE indicates venous thromboembolism.
*TNM (tumor-nodes-metastasis staging system) for solid tumors only.

- Conclusion: "By identifying VTE recurrence risk in cancer patients with VTE, we may be able to tailor treatment, improving clinical outcomes while minimizing costs."
- *Discussion:* From this study it can also be inferred that the risk varies considerably according to whether the cancer is active, progressive, metastatic, being treated, or cured

So… What does this all mean Jenn?

- Most consensus guidelines recommend to continue extended therapy in patients with active cancer, and re-evaluate yearly (yes I know… yearly) – so you may not want to consider deprescribing anticoagulants until there is a significant shift in the overall risk/benefit ratio
- Overall the following parameters should be considered when deciding whether to continue or deprescribe anticoagulants due to cancer-related VTEs:
  - Patient specific parameters: patient's overall prognosis and goals of care, role of chemotherapy, and if there are other causes of hypercoagulability (pathological fracture, use of hormonal agents, etc.). Also can be helpful to gauge patient's preferences (oral versus injectable medication), and the patient's insurance coverage (as some of these treatments can be expensive)
  - Medication specific parameters: safety, tolerability, price, simplicity
  - Operational considerations: who will take responsibility for monitoring
- Consider using the published risk tool above to help make this decision

Geriatric Considerations:

- As per previous PCP Phact Phacts within this mini-series, consider a patient's weight and renal function when dosing these agents

Stay tuned for future PCP Phast Phact on anticoagulants!

CLINICAL PEARL:
In lieu of evidence-based guidelines, anticoagulants should be deprescribed when: 1. Patient's goals of care transition to more comfort focused or prognosis shortens; 2. Risk outweigh benefits.