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An informative read of news, studies, facts & help

Grampians Regional Palliative Care Team

VENOUS THROMBOEMBOLISM IN ADVANCED CANCER

The Australian & New Zealand Society of Palliative Medicine held its biennial conference in Queenstown, NZ recently. As usual many interesting issues were raised and papers presented by both local and international speakers.

One excellent presentation was given by Prof Miriam Johnson, Professor in Palliative Medicine, Hull York Medical School, UK. Her 1999 MD thesis was on "Venous thromboembolism (VTE) in advanced cancer" so she has much experience both clinically and through on-going research. She also gave an excellent talk on palliative care for heart failure patients, another of her research interests, but more of that later perhaps.

I will summarise some of the important messages from her work.

1. We know people with cancer have a significantly increased risk of DVT and pulmonary embolus (PE) because:
    - secretion of cancer-related procoagulants (increase with advanced disease)
    - some chemotherapy agents
    - surgery
    - relative immobility (in some)

2. The prevalence of both symptomatic & undiagnosed VTE in advanced cancer is thought to be as high as 52%.

3. VTE has a significant negative impact on survival & quality of life.

4. Management of patients with VTE & advanced cancer is challenging because:
    - increased risk of bleeding and recurrent VTE with anticoagulation (especially with warfarin)
    - these risks increase as cancer progresses due to:
        - patient immobility
        - compression of venous return by tumour masses
        - highly vascular ulcerating lesions
        - thrombocytopenia
        - worsening disseminated intravascular coagulation (DIC)
    - the term 'advanced cancer' refers to patients with widely differing features including tumour histology, performance status, metastatic disease burden, mobility & prognosis. These variables affect an individual patient's risk of VTE or bleeding.

5. Very important to involve patients in their own management plans as for some, the advantages of anticoagulants will outweigh the risks (or vice versa).

6. **Warfarin:**
    - in the cancer population, warfarin is associated with bleeding rates up to 21.2% and secondary VTE rates up to 27% - about twice the rates seen with low molecular weight heparin (LMWH) such as enoxaparin ('Clexane').
    - maintaining a stable INR is difficult due to poor nutritional status, liver metastases, multiple and variable medications, variable oral intake & drug absorption, and significant drug- drug interactions.
    - frequent INR testing is burdensome & inconvenient for many patients with advanced illness.
    - thus **warfarin should be avoided in advanced disease** (unless patient chooses to continue).

7. **LMWH (eg Clexane):**
    - is the anticoagulant of choice in patients with advanced cancer
    - usually requires only once daily subcut administration
    - many patients find it preferable to warfarin (see above)
    - majority of patients or carers can learn how to give it

8. **Recurrent VTE despite LMWH:**
   - firstly this is seen as a poor prognostic sign
   - focus on reducing symptom burden without causing new problems!
   - recheck patient's weight and adjust dose accordingly
   - check anti-factor Xa levels & increase dose if subtherapeutic
   - consider bd dosing
   - consider changing to unfractionated heparin (UFH) i.v or s.c.

   Clearly any options need to be considered in the light of the patient's condition/prognosis/wishes etc.

9. **VTE in patients with bleeding:**
   - try to stop bleeding if possible (? palliative radiotherapy, haemostatic dressings etc)
   - consider reduced dose of Clexane (even to a prophylactic dose)
   - mild, nuisance bleeding should not prevent anticoagulation in a patient with symptomatic VTE
   - monitor patient including Hb
   - bd dosing may smooth out peaks in anticoagulant levels
   - for more serious & potentially life-threatening bleeding then anticoagulation not appropriate

10. **Renal failure**
    - avoid LMWH (or monitor anti-factor Xa)
    - UFH should be used
    - 12 hrly s.c. injections with APPT checked 4-6 hrs post dose (titrate dose to target range)
    - platelet counts on alternate days

11. **Duration of therapy**
    - minimum of 3-6 months is recommended
    - beyond this 'indefinite' therapy is traditionally recommended in patients with metastatic disease because risk of recurrent VTE is high

12. **Thromboprophylaxis in the palliative care unit**
    - there is little research to guide us
    - consider prophylactic Clexane for those admitted with potentially reversible pathology and whose goal is to return home
    - do not offer thromboprophylaxis to those admitted for terminal care
    - regularly review decision
    - we are likely to be missing some patients who could benefit
    - symptoms to look for:
      - new leg swelling/pain/redness
      - new or worse breathlessness/pleuritic chest pain

Research in this difficult area of palliative medicine continues particularly through The Thrombosis Research in Advanced Disease (TRAD) Alliance in the UK (www.tradalliance.org).

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With best wishes for a Happy Christmas and
a safe and relaxing New Year –
Jade, Greg, David, Eve, Regina, Lawrence, & Bernadette

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