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How Do We Translate Real-World VTE Data Into Everyday Clinical Practice for Ongoing Anticoagulation?

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum. Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Cohen:
Hello. I'm Dr. Ander Cohen on CME at ReachMD, and I would like to talk to you today about the efficacy and safety of managing patients with venous thrombosis in the long term. And what we need to keep in mind is that VTE is often a chronic illness. And for somewhere between a third and a half of patients, depending on their background, they will have recurrent VTE, or they'll be at significant risk of recurrent VTE. And these patients we need to consider for extended therapy.

But we have a lot of options now for extended therapy, and as you know, DOACs seem to be the dominant therapy here, and that's because of their improved safety profile. So we've seen in the acute and long-term management, that DOACs reduce major bleeding by about 40% but also have very good efficacy.

But in the extended setting, there were 3 studies on DOACs versus placebo for extended VTE treatment. And we can see that for each of the studies, we can look at the efficacy and safety profile. In this particular analysis, what is a network meta-analysis of net clinical benefit. And we can see with the rivaroxaban, there was about a 5-fold increase in clinically relevant bleeding. With dabigatran, there was a 3-fold increase. But with apixaban, in the lower dose 2.5 BID or the standard dose 5 BID, there was no significant increase in major bleeding. And this safety profile is a very strong factor in choosing anticoagulation.

If we look more closely at where that data came from, it came from the AMPLIFY extension study. And in the AMPLIFY extension study we saw a very good efficacy with around an 80% reduction in thrombotic episodes, or recurrent thrombotic episodes, but no significant increases in clinically relevant bleeding.

So in the non-cancer setting, we have good therapies, and we also have reduced doses. We could use rivaroxaban 10 mg, or we could use apixaban 2.5 mg. But we more recently published some further data comparing DOACs with low-molecular-weight heparin in the longer-term management of cancer-associated thrombosis. And in this real-world data, we can see that there are reduced recurrences when apixaban was compared to low-molecular-weight heparin, and reduced bleeding. And not just GI bleeding, but intracranial hemorrhage and other major bleeding. And so now we have more long-term data in patients with cancer-associated thrombosis, requiring extended therapy. And this real-world data is important because it looks at a much more heterogeneous group of patients.

Now, in the future, we're going to have to choose the right dose for the right patient. So, fortunately with the DOACs, we have options as to what is the right dose, both rivaroxaban and apixaban. And we've done two studies with apixaban comparing the lower dose, 2.5 mg BID, with the higher dose, 5 mg BID. The EVE study has been published, and that study showed good evidence of safety when the lower dose was compared to the higher dose. And we have a much bigger study, the API-CAT study, which is an efficacy and safety study in cancer-associated thrombosis requiring extended therapy, and we'll publish that next year.

So the overall message is that DOACs continue to be the treatment of choice for patients with extended therapy, and choosing the right DOAC, like, for instance, apixaban, is important in maintaining efficacy and safety.

So thank you very much for tuning in and I look forward to seeing you next time.

Announcer:
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