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# Implementing VTE Learnings Into Clinical Practice

**Announcer:**
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**Dr. Hylek:**
Hi, I'm Elaine Hylek, a Professor of Medicine at Boston University School of Medicine. And we will be talking about venous thromboembolism. So, this is an example of a fatal pulmonary embolus, a saddle embolus that completely occluded the pulmonary artery in a patient.

So, let's start with a patient case. This is a 58-year-old, healthy man, works from home with recent long hours on the computer. Noted a flu-like illness with myalgias and a low-grade fever. He persevered and went on a planned family vacation to Europe and noted a sore calf about 3 days into this trip that he attributed to sightseeing and a lot of walking. He goes to a local pharmacy and takes a pain reliever. The pain persisted and he sought care at a center and was diagnosed with a DVT. And on further questioning, he notes that his brother had a pulmonary embolus in the past and his mother had a DVT.

The acute treatment of venous thromboembolism, a DVT or pulmonary embolism, if we look at the recent CHEST Guideline Update 2021, this is a great resource as is the American Society of Hematology ASH guidelines. In patients with the venous thromboembolism, again DVT of the leg or a pulmonary embolus, we recommend apixaban, dabigatran, edoxaban, or rivaroxaban over a vitamin K antagonist, or VKA, as the acute treatment phase, and that's the first 3 months of therapy. This was a strong recommendation based on moderate-certainty evidence.

With the caveat that in patients with confirmed antiphospholipid syndrome being treated with anticoagulant therapy, here adjust the dose warfarin VKA with a target INR of 2.5 is recommended over the DOACs, or the direct oral anticoagulant. And that is because in the setting of antiphospholipid syndrome, these thrombi were not as efficaciously treated as with warfarin.

So, the treatment options for monotherapy, you have apixaban 10 mg twice a day for 7 days, followed by 5 mg twice daily. With rivaroxaban, it's 15 mg twice a day for 21 days, followed by 20 mg per day. And important to note that rivaroxaban must be taken with food to be absorbed.

Two other DOACs, edoxaban and dabigatran, were studied with a heparin lead in. And because of that study design, they require heparin according to the FDA approval, so that for edoxaban, after a minimum of 5 days of low-molecular-weight heparin, it's edoxaban 60 mg a day or dabigatran 150 mg twice a day, and a reduction in dose with edoxaban based on renal function. And again, this is acute treatment just for the first 3 months.

So, all of our patients want to know: Can I stop this medicine now after 3 months of treatment? And we know from a systematic review and many studies that the recurrence rate depends on the presence of a trigger, and there can be a surgical trigger or a non-surgical trigger. And there's the incidence rates, as you can see, really are quite high after 2 years of 7% for the idiopathic or that clot that you

just can't pinpoint a reason or a cause.

So, for duration of treatment, if it's a provoked clot, there's a low risk of recurrence. This was after surgery, after trauma, after lengthy travel, or oral contraception, or pregnancy. These are temporal risk factors, and you can stop therapy at 3 months. However, for those individuals with cancer, antiphospholipid syndrome, inflammatory bowel disease, cancer, of course, these patients have a high risk of recurrence and really warrant extended prophylaxis with a reduced dose. And here, you can see approved doses for the after 3 months treatment is apixaban 2.5 twice a day or rivaroxaban 10 mg once daily.

Thank you.

**Announcer:**
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