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Risk Assessment: Who's Most Susceptible for a Secondary VTE Event?

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

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Dr. Kaatz:
Hi, I'm Scott Kaatz. I'm a hospitalist at Henry Ford Hospital in Detroit, Michigan, and it's really my pleasure to discuss quite briefly initial treatment and management of venous thromboembolic disease. We'll use the term VTE, and we're really going to talk about what we do with secondary prevention, or after we do the initial, first round of anticoagulation, which is usually about 3 months.

So let's start out with a case. This is a 42-year-old male with a pulmonary embolism several days after a 2-day hospitalization, and they were hospitalized for pneumonia. The pneumonia was not COVID; they weren't in the intensive care unit. Now they've been treated with a direct oral anticoagulant, a DOAC, for about 3 to 6 months and they feel good, no signs of reoccurrence. They've not had any bleeding and they are not at high risk for bleeding. So the real question is, should we continue anticoagulation at this standpoint?

So we're going to talk about 2 different guidelines that help inform us, the American Society of Hematology Guideline, also called ASH, and the American College of Chest Physician Guidelines, or ACCP, or sometimes we call those the CHEST Guidelines because they're published in that society's journal, which is CHEST. So on the left you see this box and the initial treatment talks about the first 5 to 21 days, and we have similar but not exact terminology over on the right and I've highlighted the color so they can match the diagram. And the reason it's the first 5 to 21 days, as we know, with warfarin we have to overlap with a heparin or low-molecular-weight heparin for at least 5 days. And then we know with some of the direct oral anticoagulants, we either use lead-in with unfractionated heparin, heparin/fondaparinux for 5 days, or we go a higher dose for, in apixaban's case, it's 7 days and a higher dose for 21 days with rivaroxaban. So that's why you have this color-coding. What we're really going to do is do this transition from the light blue to the red, is what we're going to talk about. After 3 to 6 months of treatment, what do we do? Do we extend treatment? And if we do, with what dose and with which drug?

So how do we define what is a provoked and unprovoked, if you will, VTE? Because that's really important because the guidelines are going to say, for clearly provoked with major risk factors like surgery, then you only treat for 3 months. If you have no provoking factors, kind of like our patient because they're only in the hospital for a couple of days, then you think about indefinite. And the real gray area is this, what we call minor risk factors or transient minor risk factors, kind of like our patient. And our patient that's hospitalized is right at the border. The guidelines actually define that as 3 days or more under hospitalization. But I think what's really important, and I'm a hospitalist, there are people that are in the hospital for 3 or 4 days and aren't very sick, and then there are people in the hospital for a lot of days that are really sick, and so you have to use a little bit of clinical judgment there. But here is just, sort of, some of the definitions from the guidelines and these really come from what have been used in trials to help define this. So the guidelines – and I'll break this down, it basically says what I just said – clearly provoked, we do not treat past 3 months, unprovoked we treat longer. And then the gray zone, and you can go back and look at that table that I just showed you to give you some guidance on what those are.

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Now, some people have suggested that we should use a risk assessment and there are multiple different ones, there's ones called HERDOO2, DASH, sometimes we use D-dimers, etc. And the guidelines really are stating that we don't have good information that one is better than the other or that they've been really sorted out really well, and the ASH guidelines suggest actually, probably not using one and not using D-dimer testing, or looking for residual vein thrombosis, ie, a follow-up ultrasound of the leg for DVT to make those decisions. And personally, I don't use those also. I put them in the category provoked, unprovoked, and then the gray zone is what we get worried about.

And so, same case, we're at 3 to 6 months. So what about using a lab test, a hypercoagulable workup to help guide us? And very new at the time of this recording, guidelines came out and suggested that we should think about doing that in these patients like the patient I described.

However, I have to tell you, is that these are fairly controversial, and they state, as highlighted in the red box on the bottom, that this is based on really low-level evidence. A lot of pushback to these guidelines, and I congratulate the guidelines' writers for taking such a hard subject. But what we have is that I'm thinking about it now, but I'm not still doing it routinely in my practice. And here is just a bit more of those guidelines highlighting that to really suggest but maybe not do. And so my bottom lines on this is that stop if it's clearly provoked; unprovoked, don't stop; and lots of shared decision-making in between.

Thank you very much.

Announcer:
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