Community Health Services

CLINICAL GUIDELINES ANTICOAGULATION IN PALLIATIVE CANCER IN-PATIENTS

Background

- Cunningham et al¹ have suggested that:
 - "Ensuring that people with cancer receive appropriate thromboprophylaxis is an important clinical governance issue."
 - "All patients with cancer admitted to hospital should undergo formal risk assessment for VTE upon admission"
- This is a difficult area with no guidelines designed specifically for a palliative care/ hospice population. Discussions in the field are ongoing (www.palliativedrugs.com 'Bulletinboard' January 2007)
- There is no evidence that prophylaxis improves survival²; symptoms; or clinical outcomes
- Cancer patients are at increased risk of clotting and bleeding³
- Any use of these guidelines needs to be tailor made to the needs of the individual patient taking into account the risks and benefits (eg are they at risk of bleeding? / are they taking any prothrombotic drugs?)
- Warfarin is not recommended for patients with extensive or metastatic disease, or poor performance status⁴.
- The National Patient Safety Agency first produced guidance on this topic in 2007⁵ and since produced a "How to Guide" on VTE risk Assessment.⁶ It emphasises that where appropriate, patients should be made aware of the risks, and their views sought.
- NICE have produced a clinical guideline (No. 92) on reducing the risk of VTE in patients admitted to hospital and this document is encompassed in these local guidelines⁷.
- The proposed CQUIN payment framework now links payment to risk assessment of VTE.

Primary prevention⁸

- Document the risk/benefit assessment for all in-patients using a modified version of the National Risk Assessment Model (DH2010) – Appendix 1
- Consider all hospitalized / non-ambulatory cancer patients (eg: cord compression, fracture, acute medical illness*) for VTE prophylaxis in the absence of bleeding or other contraindications;
- In the acute setting thromboprophylaxis is generally for less than 2 weeks¹⁰
- Low molecular weight heparin is the preferred anticoagulant, from August 2010 locally dalteparin is the LMWH of choice.
- LMW heparin is acceptable to patients (in both primary and secondary prevention)^{11 12}
- Platelet counts need to be monitored on LMWH. For example between 5-10 days.

* PCF3 suggests medical illness likely to render them bedbound \geq 3 days

* other papers (one in cancer and one in general surgical patients) suggest \geq 4 days¹³ ¹⁴

Provisos

- In renal failure (CrCl <30 ml/min) doses of LMWH need to be reduced and individual cases should be discussed with the renal team
- Routine prophylaxis of ambulatory cancer patients is not recommended.⁷
- Thromboprophylaxis is less relevant to cancer patients in the last few weeks of life
- Patients on the LCP (ie: in the last few days of life) should not routinely be offered prophylaxis.⁷
- Aspirin alone does not constitute adequate thromboprophylaxis in people with cancer¹⁵.
- There is no clear guidance on what to do regarding thromboprophylaxis when these patients go home, a decision should be made by the MDT after discussion with the patient and/or family following resolution of the acute episode. This should be clearly communicated with the primary care team.

Secondary prevention

- Patients with DVT/PE and cancer at increased risk of death¹⁶
- LMW heparin is more effective with less bleeding risk than oral anticoagulation.
- For patients considered to be at high risk of bleeding (eg those with extensive disease, cerebral metastases, or brain cancer) full dose LMWH for 7 days followed by a long term decreased fixed dose should be considered⁴
 - Study continued for 3 months, on treatment dose Tinzaparin.¹⁷
 - Study only continued for 6 months, on treatment dose of 1 month then 75% of treatment dose for 5 months Dalteparin.¹⁸
 - Study continued for 3 months, on treatment dose for 1 week then 10 000 IU for 3 months Dalteparin¹⁹(this is greater than a prophylactic dose and less than a treatment dose as per BNF 56).
- Long-term full-dose LMWH should be the drug of choice in the secondary prophylaxis of venous thromboembolism in patients with cancer of any stage, performance status, or prognosis⁴.
- The optimum duration of treatment is unclear (generally > 6months) however because of the thrombotic tendency is ongoing, indefinite treatment is generally recommended⁴.
 - Evidence suggests treatment dose for 3-6 months yet it has been shown that people with active malignancy remain at a higher risk of recurrence beyond 6 months²⁰
 - For patients with permanent risk factors at least 6 months anticoagulation is recommended. "Further trials are still necessary to assess prolonged therapy beyond 6 months."²¹
 - One study demonstrated palliative care patients with advanced cancer and VTE (n=62) being treated for up to 243 days (median 97 days) with LMWH²². Most patients continued treatment until the last few days of life. There were no major bleeding events. Doses were as per CLOT and Montreal regime (as above).
- For patients with contraindications to anticoagulation an IVC filter should be considered⁴
- Local formulary use of Enoxaparin as per current BNF guidance

Continuing anticoagulation for pre-existing conditions Check clinical indication for use²⁰

- Review recent INR control
- Review patient understanding and preference

Flow-chart for Thromboprophylaxis for palliative care in-patients



Appendix 1: Adapted from the National Risk Assessment Model (DH 2010)⁶⁷

PALLIATIVE CARE, IN-PATIENT, RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

Is the patient on the Liverpool Care of the Dying Pathway?			

MOBILITY- all patients (tick one box)	tick		tick		tick
Mobility <u>reduced</u>		Mobility <u>reduced</u> &		Mobility <u>not</u>	
compared to usual &		UNLIKELY to		<u>reduced</u>	
LIKELY to recover		recover			

THROMBOSIS RISK			
Patient related	tick	Admission related	tick
Cancer or cancer treatment		Probably immobile > 3 days	
>60		Cord compression	
Dehydration		Hip/lower limb fracture	
Thrombophilia		Abdominal/pelvic pathology	
Obesity		Recent surgery	
Significant comorbidity			
Previous history of VTE			

BLEEDING RISK			
Patient related	tick	Admission related	tick
		Provide the second seco	
Active bleeding		Recent neuro or eye surgery	
Bleeding disorde		Procedure with bleeding risk	
Thrombocytopaenia		Spinal analgesia	
Severe hypertension			
Acute stroke			
Already on warfarin]	
Cerebral tumour/metastases			

PATIENT INVOLVEMENT- all patients	tick		tick
Discussed with patient		Not discussed with patient Why	

DECISION (as per FLOW CHART)	tick		tick
Primary prophylaxis		Secondary prophylaxis	
Low Molecular Weight Heparin appropriate		Low Molecular weight Heparin NOT appropriate	

References

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⁴ Noble SIR, Shelley MD, Coles B et al. Systematic review and metanalysis: management of venous thromboembolismin patients with advanced cancer. Lancet Oncology 9(6): 577-584

⁵ NPSA Patient safety alert number 18, March 2007

⁶ NPSA How to Guide Venous Thromboembolism Risk Assessment February 2011

⁷ NICE January 2010. Venous thromboembolism: reducing the risk. Reducing the risk of venous thromboembolism (DVT and PE) in patients admitted to hospital. NICE clinical guideline 92.

⁸ American society of clinical oncology guideline: Recommendations for venous thromboembolism prophylaxis and treatment in patients with cancer. Journal of clinical oncology 2007; 25 (34): 1-16 (146 references)

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¹⁹ Monreal et al. Fixed-dose low-molecular weight heparin for secondary prevention of venous thromboembolism in patients with disseminated cancer: a prospective cohort. Journal of Thrombosis and Haemostasis. 2004; 2: 1311-1315.

²⁰ Hutten BA et al. Incidence of recurrent thromboembolic and bleeding complications among patients with venous thromboembolism in relation to both malignancy and achieved international normalised ratio: a retrospective analysis. Journal of Clinical Oncology. 2000; 18: 3078-3083

²¹ Guidelines on oral anticoagulation (third edition) 2005. British Committee for Standards in Haematology <u>http://www.bcshguidelines.com/pdf/OAC_guidelines_190705.pdf</u>

²² Noble SIR et al. The use of long-term low-molecular weight heparin for the treatment of venous thromboembolism in palliative care patients with advanced cancer: a case series of 62 patients. Palliative Medicine. 2007; 21: 473-476