A New NCCN Guideline: Venous Thromboembolic Disease

A pancreatic cancer patient comes to the office with new shortness of breath and a drop in her oxygen saturation to 89%. You thought she was doing better because the computed tomography (CT) scan performed 2 weeks ago shows a 25% reduction in the size of her liver metastases. You go through the motions—spiral CT, D-dimer, EKG—but you already know the patient has a pulmonary embolus. You’ve seen it a million times.

Diagnosing deep venous thrombosis (DVT) and pulmonary embolism is simpler that it was 15 years ago. However, the approach to treatment and, particularly, the approach after the acute event has resolved continue to vex clinicians and patients. Relegating patients with advanced cancer to daily injections or blood tests as often as 3 times a week is burdensome to them and complicated for you to coordinate. And do you really want to place a filter in a patient in the last stages of cancer who will only live a few more weeks? Or, for that matter, do you want to require a young person likely to be cured of his or her cancer to then carry a lifelong filter in the inferior vena cava?

Managing the risk of thrombosis, bleeding, and anticoagulant therapy is difficult. This is true not only because each patient has different risk factors and prognoses but also because the variety of tests and algorithms available to assess these factors has grown. In many ways, venous thromboembolism (VTE) decision-making is more complicated than choosing which chemotherapy agents to administer. A quick PubMed search of “DVT and clinical trials” retrieved 1060 articles published in the past 5 years alone.

Accordingly, this issue highlights a new NCCN guideline, Venous Thromboembolic Disease, chaired by Dr. Lawrence Wagman at City of Hope Cancer Center. The guideline helps the clinician calculate the risk of blood clots, recommends treatment for different clinical scenarios, including catheter-related thrombosis and heparin-induced thrombocytopenia (HIT), and discusses when to use inferior vena cava filters. The panel also addresses cancer-related long-term anticoagulation, recommending low-molecular-weight heparin based on evidence. However, the panel also considers other anticoagulants, such as warfarin, based on clinical factors such as renal function and patient factors such as convenience and cost. As with the other NCCN guidelines, this approach helps guide clinicians while permitting patient-directed treatment choices.

We also include a suite of manuscripts to complement the guidelines. Despite the number of patients with central venous catheters (CVC), confusion about care remains, especially for complications. Fibrin sheaths can prevent laboratory draws and chemotherapy administration; how long anticoagulation therapy can continue when symptomatic catheter thrombosis is detected and whether patients with thrombophilic disorders can have a CVC remain uncertain. Linenberger’s article takes an evidence-based, practical approach to these issues. Articles highlighting IVC filters, management of PE, and the choice and duration of chronic VTE therapy are also in this issue.

NCCN now publishes (and updates at least annually) 108 practice guidelines. We hope the new VTE guidelines become a standard resource for all providers who care for patients with cancer-related thrombosis and that the accompanying articles provide clinical pearls about this common complication.

Reference