Ruolo dei DOACS nel 2019

Le attuali linee guida nazionali ed internazionali

Sandro Barni

Modulo dichiarazione conflitto di interessi

Relationship	Company/Organization
	Genomic Health
	Bayer AG
	Eli Lilly
	Mylan
	Leo Pharma

Definizione

- **"…le linee guida (LG) sono «raccomandazioni di comportamento clinico, elaborate mediante un processo di revisione sistematica della letteratura e delle opinioni di esperti, con lo scopo di aiutare i medici e i pazienti a decidere le modalità assistenziali più appropriate in specifiche situazioni cliniche"….**

Field MJ, Lohr KN (eds).
Guidelines for Clinical Practice: from development to use.1992,
Institute of Medicine, National Academy Press,Washington, DC.

Le Linee Guida Esaminate

AIOM 2018

ANMCO 2016

ASCO 2015

ASH 2018

ESMO 2011

NCCN 2018

NICE 2012-15 e 2018

Linee guida

TROMBOEMBOLISMO VENOSO NEI PAZIENTI CON TUMORI SOLIDI

Edizione 2017

Ruolo degli anticoagulanti orali diretti (DOAC)

Ad oggi, nei pazienti con cancro, non vi è indicazione all'uso dei DOAC per la terapia del TEV per I seguenti motivi:

1. I DOAC sono risultati non inferiori agli AVK nei pazienti senza cancro, ma non vi sono dati sufficienti per dimostrare che non sono inferiori agli AVK nei pazienti con cancro.
2. Non vi sono evidenze che dimostrino che i DOAC siano ugualmente efficaci o superiori alle EBPM nei pazienti con cancro.
3. La percentuale di pazienti oncologici inclusi nei trial clinici di registrazione dei DOAC per la terapia delTEV è bassa, inoltre i pazienti arruolati in tali studi sono molto selezionati per cui risulta difficile estrapolare i dati alla popolazione generale oncologica.
4. Negli studi suddetti vi sono poche informazioni, nei pazienti oncologici arruolati sul tipo di neoplasia, lo stadio clinico, il tipo di trattamento chemioterapico. Inoltre la definizione di 'cancro attivo' differisce da uno studio all'altro.

Ruolo degli anticoagulanti orali diretti (DOACs)

5. Data la superiorità della EBPM sugli AVK nella terapia del TEV nei pazienti oncologici, studi prospettici randomizzati sono in corso al fine di paragonare EBPM e DOAC.
6. I dati di sicurezza nella popolazione con insufficienza renale ed epatica non permettono di escludere problemi di accumulo nei pazienti con cancro.
7. Gli inibitori e gli induttori del CYP3A4, rispettivamente, aumentano e riducono le concentrazioni dei DOAC, per cui l'uso di questi farmaci è gravato da interferenze farmacologiche non trascurabili con chemioterapici, inibitori delle tirosinchinasi e altri farmaci utilizzati in terapia di supporto nei pazienti con cancro .

In sintesi, non vi è ancora indicazione all'uso dei DOAC per la profilassi primaria del TEV nei pazienti concancro per la mancanza di dati (siamo in attesa dei risultati dei trial clinici in corso
Inoltre, in particolare, I punti 6 e 7 sopra indicati dovranno essere molto attentamente valutati.

Ruolo dei DOACS nel 2019

NEL TRATTAMENTO DELLA VTE

Linee guida

TROMBOEMBOLISMO VENOSO NEI PAZIENTI CON TUMORI SOLIDI

Edizione 2018

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Edoxaban for the Treatment of Cancer-Associated Venous Thromboembolism

CONCLUSIONS

Oral edoxaban was noninferior to subcutaneous dalteparin with respect to the composite outcome of recurrent venous thromboembolism or major bleeding. The rate of recurrent venous thromboembolism was lower but the rate of major bleeding was higher with edoxaban than with dalteparin. (Funded by Daiichi Sankyo; Hokusai VTE Cancer ClinicalTrials.gov number, NCT02073682.)

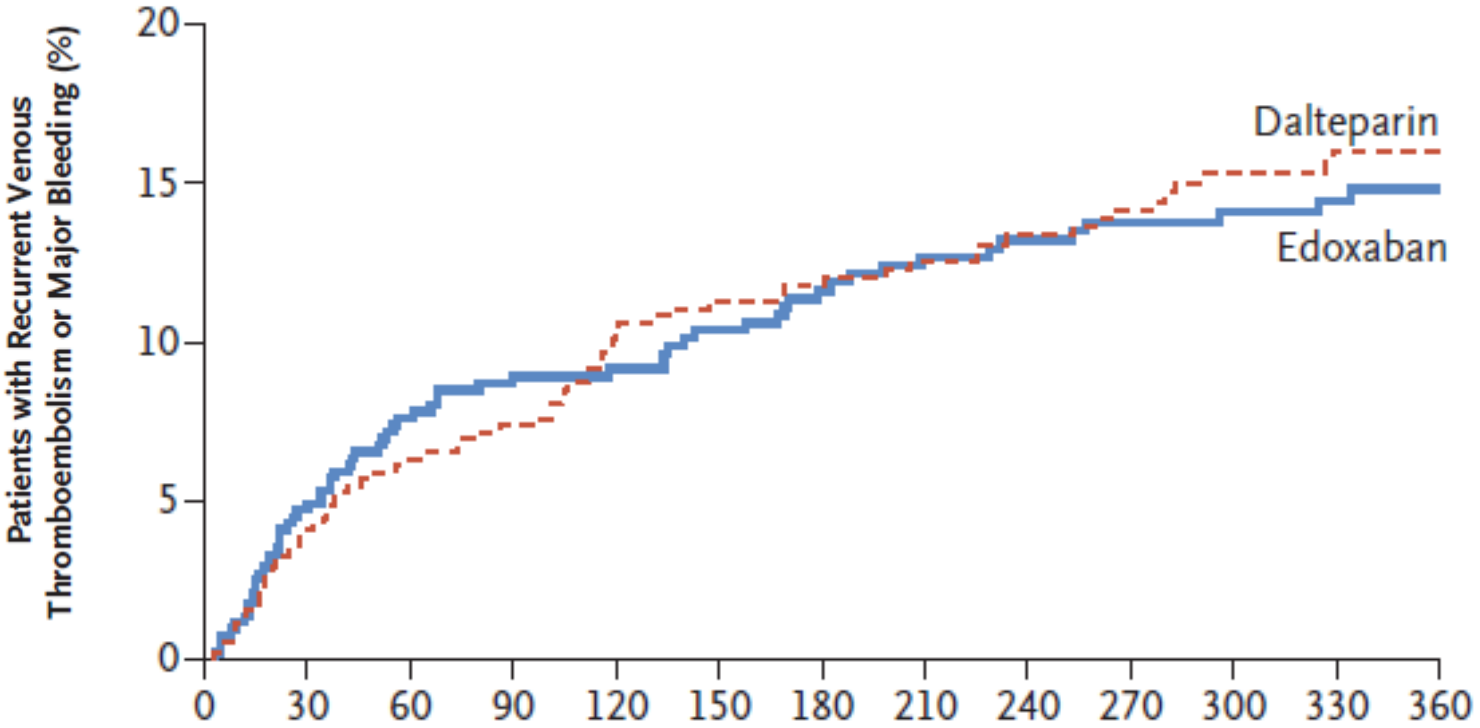
This article was published on December 12, 2017, at NEJM.org.

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Edoxaban for the Treatment of Cancer-Associated Venous Thromboembolism

Gary E. Raskob, Ph.D., Nick van Es, M.D., Peter Verhamme, M.D., Marc Carrier, M.D., Marcello Di Nisio, M.D., David Garcia, M.D., Michael A. Grosso, M.D., Ajay K. Kakkar, M.B., B.S., Michael J. Kovacs, M.D., Michele F. Mercuri, M.D., Guy Meyer, M.D., Annelise Segers, M.D., Minggao Shi, Ph.D., Tzu-Fei Wang, M.D., Erik Yeo, M.D., George Zhang, Ph.D., Jeffrey I. Zwicker, M.D., Jeffrey I. Weitz, M.D., and Harry R. Büller, M.D., for the Hokusai VTE Cancer Investigators*



No. at Risk

Edoxaban	522	472	429	407	388	360	345	328	310	295	270	237	161
Dalteparin	524	485	449	420	385	364	352	340	324	313	276	241	171

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Edoxaban for the Treatment of Cancer-Associated Venous Thromboembolism

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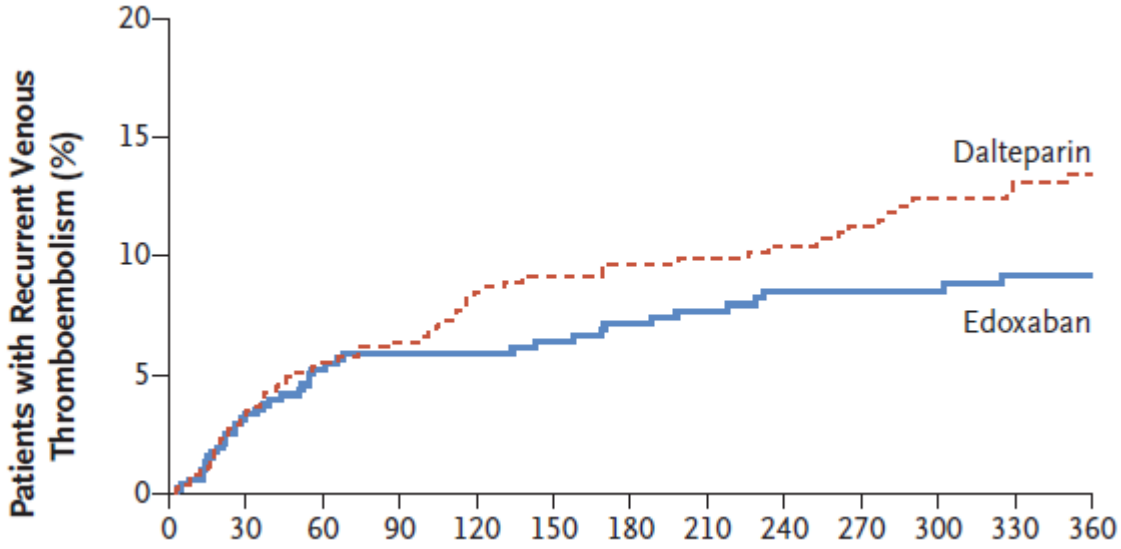
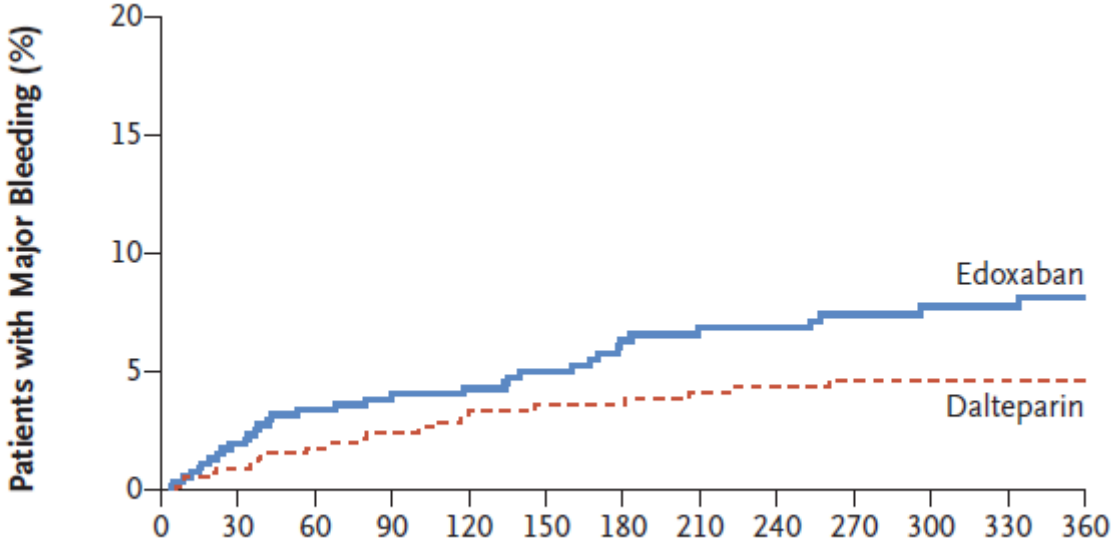




JOURNAL OF CLINICAL ONCOLOGY RAPID COMMUNICATION

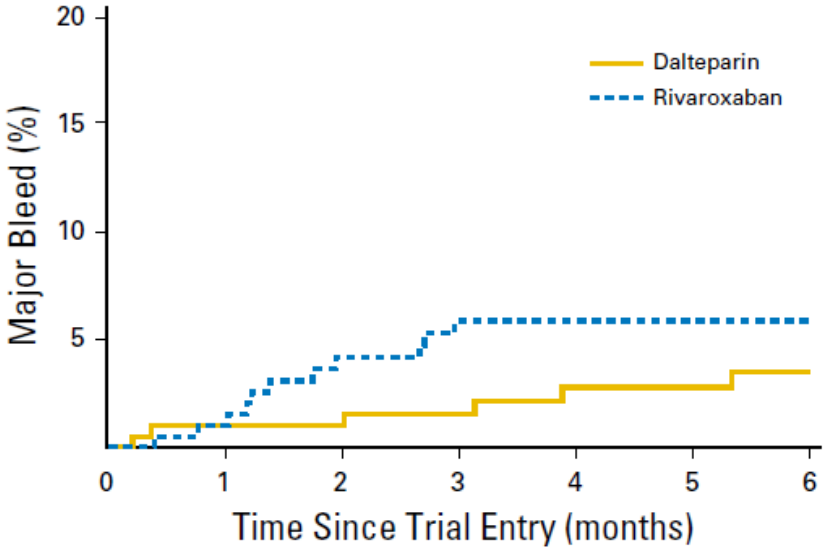
Comparison of an Oral Factor Xa Inhibitor With Low Molecular Weight Heparin in Patients With Cancer With Venous Thromboembolism: Results of a Randomized Trial (SELECT-D)

Conclusion

Rivaroxaban was associated with relatively low VTE recurrence but higher CRNMB compared with dalteparin.

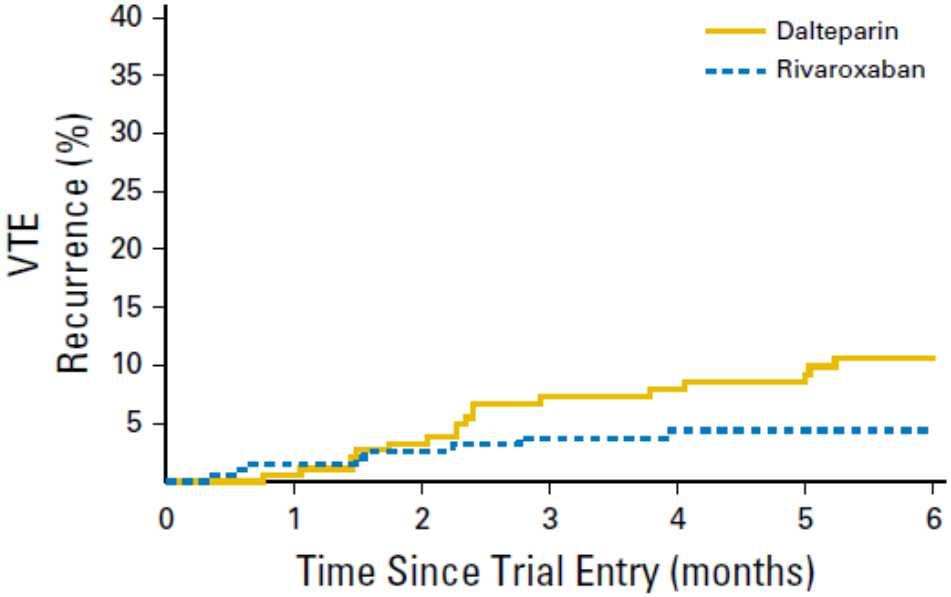
Published at jco.org on May 10, 2018.

Comparison of an Oral Factor Xa Inhibitor With Low Molecular Weight Heparin in Patients With Cancer With Venous Thromboembolism: Results of a Randomized Trial (SELECT-D)



No. at risk:

Dalteparin	203	176	147	122
Rivaroxaban	203	172	149	134



No. at risk:

Dalteparin	203	171	139	115
Rivaroxaban	203	174	149	134

Le Linee Guida 2018

Qualità Globale delle evidenze	Raccomandazione	Forza della raccomandazione clinica
MOLTO BASSA	Nel paziente oncologico in fase attiva con trombosi venosa il trattamento con nuovi anticoagulanti orali (Edoxaban e Rivaroxaban) può essere presa in considerazione come prima opzione terapeutica (102 103)	**Positiva debole**

National Comprehensive Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Cancer-Associated Venous Thromboembolic Disease

Version 2.2018 — August 27, 2018

NCCN.org

Continue

THERAPEUTIC ANTICOAGULATION FOR VENOUS THROMBOEMBOLISM

- Anticoagulation options recommended for management of VTE in patients with cancer include regimens involving only one agent (monotherapy options) as well as regimens that use more than one type of agent (combination therapy options). This section lists the recommended regimens, including dosing and duration, as well as a list of contraindications and warnings to help guide treatment selection.[1]
- Select regimen based on: Renal failure (C_{cr} <30 mL/min), inpatient/outpatient, FDA approval, cost, ease of administration, monitoring, bleeding risk assessment, and ability to reverse anticoagulation. (See Contraindications and Warnings on VTE-E, 4 of 5).
- Baseline laboratory testing: CBC, renal and hepatic function panel, aPTT, and PT/INR.
- Follow institutional standard operating procedures (SOPs) for dosing schedules. If no SOPs then use the American College of Chest Physicians (ACCP) recommendations.[2]
- Following initiation of anticoagulant: Hemoglobin, hematocrit, and platelet count at least every 2–3 days for the first 14 days and every 2 weeks thereafter or as clinically indicated.

Monotherapy Options

Agent(s)	Dosing Details[c]
LMWH – preferred for first 6 months in patients with proximal DVT or PE and for prevention of recurrent VTE in patients with advanced metastatic cancer.	
• Dalteparin (category 1)	200 units/kg SC daily for 30 days, then 150 units/kg once daily for 2–6 months[a,3,4]
• Enoxaparin	1 mg/kg SC every 12 hours[d,5-8]
Rivaroxaban	15 mg orally BID for 21 days, then 20 mg daily[9-12]
Fondaparinux	5 mg [<50 kg]; 7.5 mg [50–100 kg]; 10 mg [>100 kg] SC daily[13,14]
Unfractionated heparin (UFH) (category 2B)	
• UFH IV then SC	IV 80 units/kg load, then 18 units/kg/h, target aPTT of 2–2.5 x control or per hospital SOPs, then SC 250 units/kg every 12 hours[15]
• UFH SC	SC 333 unit/kg load, then SC 250 units/kg every 12 hours[15,16]
For patients who refuse or have compelling reasons to avoid LMWH,[b] the following direct oral anticoagulants (DOACs) are acceptable alternatives for management of VTE:	
• Apixaban	10 mg orally BID for 7 days, then 5 mg BID[17,18]

THERAPEUTIC ANTICOAGULATION FOR VENOUS THROMBOEMBOLISM

Combination Therapy Options

Combinations with Warfarin

Agents	Dosing Details	
	Parenteral Dosing for 5–10 Days	Warfarin Dosing for at Least 6 Months[c]
LMWH + warfarin options:	LMWH dosing options:	• Warfarin (2.5–5 mg every day initially, subsequent dosing based on INR value; target INR 2–3)[20-22] ‣ If warfarin is selected for chronic anticoagulation, initiate warfarin concurrently with the parenteral agent used for acute therapy and continue both therapies for at least 5 days and until the INR ≥2 for 24 hours. ‣ During the transition to warfarin monotherapy, the INR should be measured at least twice weekly. Once the patient is on warfarin alone, the INR should be measured initially at least once weekly. Once the patient is on a stable dose of warfarin with an INR between 2 and 3, INR testing can be gradually decreased to a frequency no less than once monthly.
• Dalteparin + warfarin	• Dalteparin 200 units/kg SC daily[19]	
• Enoxaparin + warfarin	• Enoxaparin 1 mg/kg SC every 12 hours[5]	
Fondaparinux + warfarin	Fondaparinux dosing: 5 mg [<50 kg]; 7.5 mg [50–100 kg]; 10 mg [>100 kg] SC daily[13,14]	
UFH + warfarin options:	UFH dosing options:	
• UFH IV + warfarin	• UFH IV 80 units/kg load, then 18 units/kg/h, target aPTT of 2–2.5 x control or per hospital SOPs[15]	
• UFH SC + warfarin	• UFH SC 333 units/kg load, then 250 units/kg every 12 hours[15]	

Combinations with Edoxaban

Agents	Dosing Details	
	Parenteral Dosing for 5–10 Days[d]	Edoxaban Dosing
LMWH + edoxaban (category 1)	LMWH dosing options: • Dalteparin 200 units/kg SC daily[19] • Enoxaparin 1 mg/kg SC every 12 hours[5]	After completion of at least 5 days of parenteral anticoagulant, switch to edoxaban 60 mg daily (or 30 mg in patients with Cockcroft-Gault estimated creatinine clearance 30–50 mL/min or weight <60 kg or concomitant potent p-glycoprotein inhibitors or inducers), continuing for at least 6 months[c,23,24]
UFH + edoxaban	UFH dosing options: • UFH IV 80 units/kg load, then 18 units/kg/h, target aPTT of 2–2.5 x control or per hospital SOPs[15] • UFH SC 333 units/kg load, then 250 units/kg every 12 hours[15]	

ANTICOAGULANT OPTIONS: CONTRAINDICATIONS AND WARNINGS

Agent(s)	Contradictions and Warnings
LMWH	• Use with caution in patients with renal dysfunction. Consider dose adjustments or alternative therapy for patients with severe renal disfunction (CrCl <30 mL/min). • Follow package insert for renal dysfunction and body weight dosing. • Anti-Xa monitoring (peak and trough) of LMWH has been recommended for patients with severe renal dysfunction, although limited data are available to support the clinical relevance of anti-Xa levels. • Absolute contraindication: recent/acute HIT • Relative contraindication: past history of HIT
Fondaparinux	• Contraindicated in patients with CrCl <30 ml/min • Use with caution in patients with moderate renal insufficiency (CrCl 30–50 mL/min), weight <50 kg, or age >75 y
UFH	• Absolute contraindication: recent/acute HIT • Relative contraindication: past history of HIT
Warfarin	Relative contraindications: • Concomitant inhibitors and inducers of CYP2C9, 1A2, or 3A4
Apixaban, dabigatran, edoxaban, and rivaroxaban	Contraindications: • Stage IV chronic kidney disease: ▸ Apixaban[f]: CrCl <25 mL/min ▸ Dabigatran, edoxaban, and rivaroxaban: CrCl <30 mL/min • Active/clinically significant liver disease: ▸ Apixaban or edoxaban: ALT/AST >2 x ULN; total bilirubin >1.5 x ULN ▸ Dabigatran or rivaroxaban: ALT/AST >3x ULN • Strong dual inhibitors/inducers of CYP3A4 and P-glycoprotein (P-gp): see prescribing information for rivaroxaban[9] and apixaban[17] • Inducers/inhibitors of P-gp: see prescribing information for dabigatran[25] and edoxaban[23] Relative contraindications, use with caution: • DOACs have been associated with urinary and intestinal tract bleeding, and should be used with caution in patients with urinary or gastrointestinal tract lesions, pathology, or instrumentation. • Use with caution in patients with compromised renal or liver function. • For patients receiving nephrotoxic or hepatotoxic chemotherapy consider monitoring patients more closely with laboratory testing. • Consider drug-drug interactions.

[f]Although stage IV chronic kidney disease is not listed as a contraindication in the FDA-approved label for apixaban, the NCCN Panel avers that there are insufficient data to support safe apixaban dosing in these patients, especially those who are on hemodialysis.

References

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

ANTICOAGULANT OPTIONS: CONTRAINDICATIONS AND WARNINGS

Apixaban, dabigatran, edoxaban, and rivaroxaban	Contraindications:
	• Stage IV chronic kidney disease:
	  ▸ Apixaban[f]: CrCl <25 mL/min
	  ▸ Dabigatran, edoxaban, and rivaroxaban: CrCl <30 mL/min
	• Active/clinically significant liver disease:
	  ▸ Apixaban or edoxaban: ALT/AST >2 x ULN; total bilirubin >1.5 x ULN
	  ▸ Dabigatran or rivaroxaban: ALT/AST >3x ULN
	• Strong dual inhibitors/inducers of CYP3A4 and P-glycoprotein (P-gp): see prescribing information for rivaroxaban[9] and apixaban[17]
	• Inducers/inhibitors of P-gp: see prescribing information for dabigatran[25] and edoxaban[23]
	Relative contraindications, use with caution:
	• DOACs have been associated with urinary and intestinal tract bleeding, and should be used with caution in patients with urinary or gastrointestinal tract lesions, pathology, or instrumentation.
	• Use with caution in patients with compromised renal or liver function.
	• For patients receiving nephrotoxic or hepatotoxic chemotherapy consider monitoring patients more closely with laboratory testing.
	• Consider drug-drug interactions.

Trial Protocol Design Paper

Apixaban and dalteparin in active malignancy associated venous thromboembolism

The ADAM VTE Trial

Robert McBane II; Charles L. Loprinzi; Aneel Ashrani; Juliana Perez Botero; Roberto A. Leon Ferre; Stanislav Henkin; Charles J. Lenz; Jennifer G. Le-Rademacher; Waldemar E. Wysokinski

Mayo Clinic, Rochester, Minnesota, USA

Summary

Currently, low molecular weight heparin (LMWH) is the guideline endorsed treatment of patients with cancer associated venous thromboembolism (VTE). While apixaban is approved for the treatment of acute VTE, there are limited data supporting its use in cancer patients. The rationale and design of this investigator initiated Phase IV, multicenter, randomized, open label, superiority trial assessing the safety of apixaban versus dalteparin for cancer associated VTE is provided (ADAM-VTE; NCT02585713). The main aim of the ADAM-VTE trial is to test the hypothesis that apixaban is associated with a significantly lower rate of major bleeding compared to dalteparin in the treatment of cancer patients with acute VTE. The primary safety outcome is rate of major bleeding. Secondary efficacy objective is to assess the rates of recurrent VTE or arterial thromboembolism. Cancer patients with acute VTE (n=300) are randomized to receive apixaban (10 mg twice daily for 7 days followed by 5 mg twice daily thereafter) or dalteparin (200 IU/Kg daily for 30 days followed by 150 IU/kg daily thereafter) for 6 months. Stratification factors used for randomization include cancer stage and cancer specific risk of venous thromboembolism using the Khorana score. Participating centers are chosen from the Academic and Community Cancer Research United (ACCRU) consortium comprised of 90 oncology practices in the United States and Canada. Based on the hypothesis to be tested, we anticipate that these trial results will provide evidence supporting apixaban as an effective treatment of cancer associated VTE at lower rates of major bleeding compared to LMWH.

Keywords

Cancer, venous thromboembolism, apixaban, dalteparin

Ruolo dei DOACS nel 2019

NELLA PREVENZIONE DELLA VTE

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Apixaban to Prevent Venous Thromboembolism in Patients with Cancer

CONCLUSIONS

Apixaban therapy resulted in a significantly lower rate of venous thromboembolism than did placebo among intermediate-to-high-risk ambulatory patients with cancer who were starting chemotherapy. The rate of major bleeding episodes was higher with apixaban than with placebo. (Funded by the Canadian Institutes of Health Research and Bristol-Myers Squibb–Pfizer Alliance; AVERT ClinicalTrials.gov number, NCT02048865.)

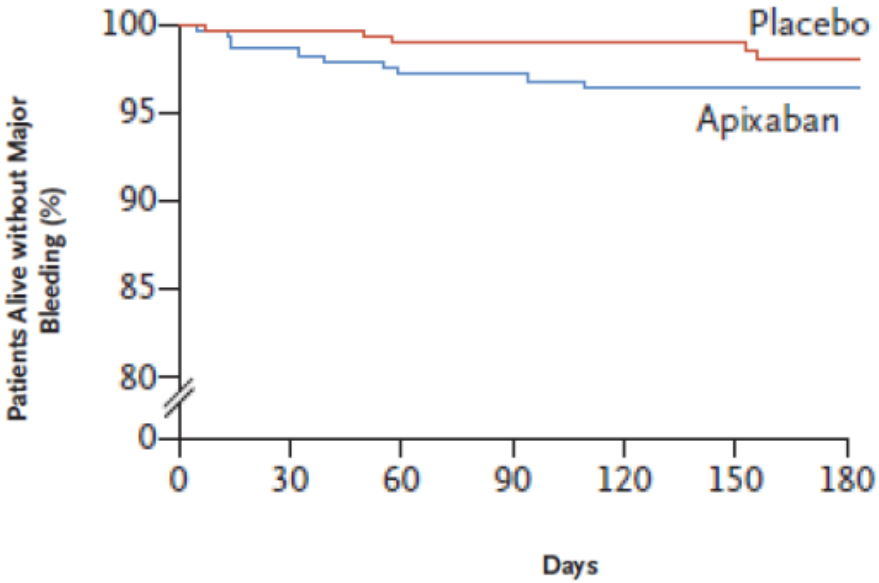
This article was published on December 4, 2018, at NEJM.org.

The NEW ENGLAND JOURNAL of MEDICINE

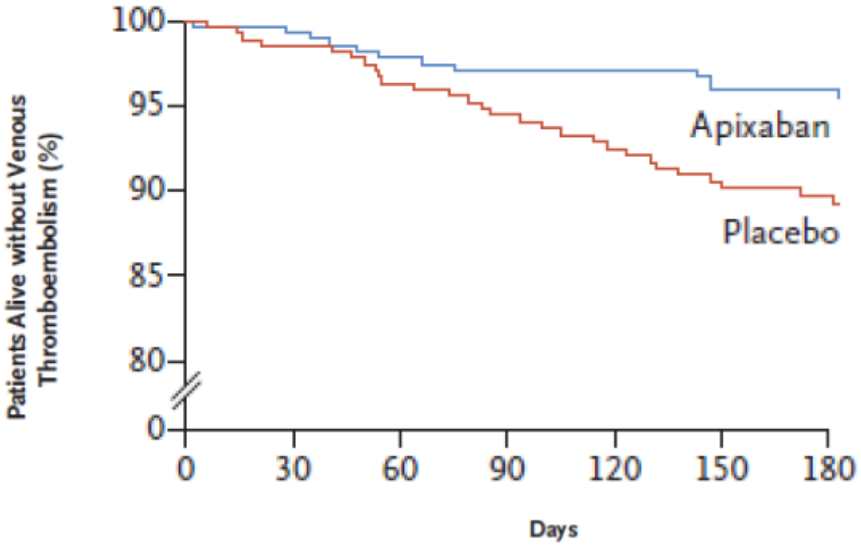
ORIGINAL ARTICLE

Apixaban to Prevent Venous Thromboembolism in Patients with Cancer

Marc Carrier, M.D., Karim Abou-Nassar, M.D., Ranjeeta Mallick, Ph.D., Vicky Tagalakis, M.D., Sudeep Shivakumar, M.D., Ariah Schattner, M.D., Philip Kuruvilla, M.D., Danny Hill, M.D., Silvana Spadafora, M.D., Katerine Marquis, M.D., Mateya Trinkaus, M.D., Anna Tomiak, M.D., Agnes Y.Y. Lee, M.D., Peter L. Gross, M.D., Alejandro Lazo-Langner, M.D., Robert El-Maraghi, M.D., Glenwood Goss, M.D., Gregoire Le Gal, M.D., David Stewart, M.D., Timothy Ramsay, Ph.D., Marc Rodger, M.D., Debra Witham, B.Sc.N., and Philip S. Wells, M.D., for the AVERT Investigators*



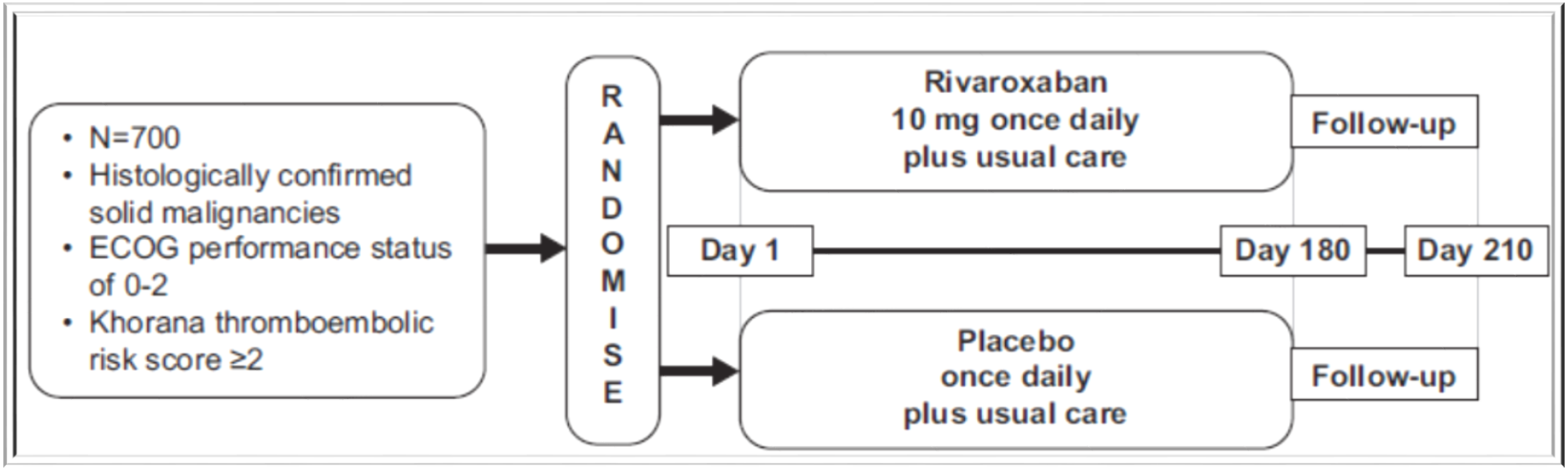
No. at Risk							
Apixaban	288	275	266	258	249	246	233
Placebo	275	269	262	253	249	245	229



No. at Risk							
Apixaban	288	276	265	256	249	244	229
Placebo	275	268	259	244	237	228	215

This article was published on December 4, 2018, at NEJM.org.

Rivaroxaban for the Primary Prevention of Venous Thromboembolism



CASSINI study design. ECOG, Eastern Cooperative Oncology Group.

ASH Annual Meeting 2018 SAN DIEGO

LBA-1 Rivaroxaban Thromboprophylaxis in High-Risk Ambulatory Cancer Patients Receiving Systemic Therapy: Results of a Randomized Clinical Trial (CASSINI)

Session: Late-Breaking Abstracts Session

Alok A. Khorana

Conclusions: Rivaroxaban significantly reduced VTE and VTE-related death during the on-treatment period but not during the full study period; over one-third of events occurred post discontinuation of study drug. The incidence of major bleeding was low. The Khorana risk score cut-off of ≥ 2 identified cancer patients at high risk of thrombotic events both at baseline (4.53%) and during study (8.79% with additional 1.66% arterial events in placebo group). These results should inform future recommendations regarding thromboprophylaxis in at-risk ambulatory cancer patients.

CLINICAL GUIDELINES

blood advances

American Society of Hematology 2018 guidelines for management of venous thromboembolism: prophylaxis for hospitalized and nonhospitalized medical patients

DOACs in acutely ill medical patients

Recommendation 11

In acutely ill hospitalized medical patients, the ASH guideline panel *recommends* using LMWH over DOACs as VTE prophylaxis (strong recommendation, moderate certainty in the evidence of effects ⊕⊕⊕◯).

Recommendation 12

In acutely ill hospitalized medical patients, the ASH guideline panel *recommends* inpatient VTE prophylaxis with LMWH only, rather than inpatient and extended duration outpatient VTE prophylaxis with DOACs (strong recommendation, moderate certainty in the evidence of effects ⊕⊕⊕◯). **Remark:** If patients are on a DOAC for other reasons, this recommendation may not apply.

blood advances

American Society of Hematology 2018 guidelines for management of venous thromboembolism: prophylaxis for hospitalized and nonhospitalized medical patients

DOACs in acutely ill medical patients

Any DOAC vs LMWH

Question: Should any DOAC vs LMWH be used for VTE prophylaxis in acutely ill hospitalized medical patients?

Other EtD criteria and considerations. The panel assumed that avoidance of death, VTE-related death, PE, DVT, and bleeding was critical or important to patients for decision making. The panel judged that DOACs would lead to cost savings in hospital because of lower DOAC drug cost compared with LMWH. Compared with LMWH, DOACs are probably acceptable and definitely feasible.

CLINICAL GUIDELINES

blood advances

American Society of Hematology 2018 guidelines for management of venous thromboembolism: prophylaxis for hospitalized and nonhospitalized medical patients

DOACs in acutely ill medical patients

Any DOAC extended beyond hospital discharge vs non-DOAC in hospital only

Question: Should any DOAC extended beyond hospital discharge vs non-DOAC VTE prophylaxis administered in hospital only be used in acutely ill medical patients?

Other EtD criteria and considerations. The panel assumed that avoidance of PE, DVT, and bleeding events was critical or important for decision making to patients. Although the panel judged that extending prophylaxis with a DOAC was probably acceptable and feasible, it could increase inequity because of access to and cost of extended out-of-hospital use.

CLINICAL GUIDELINES

blood advances

American Society of Hematology 2018 guidelines for management of venous thromboembolism: prophylaxis for hospitalized and nonhospitalized medical patients

DOACs in acutely ill medical patients

The panel suggested that future research should address:

- DOAC use among medical inpatients or for extended prophylaxis after discharge in larger trials assessing symptomatic VTE and bleeding end points, and in more selected patients based on predicted risk of VTE and of bleeding; and
- Evaluation of lower-dose DOAC regimens in medical inpatients or for extended use after discharge, to determine whether this might mitigate bleeding risk while preventing VTE.[143]

Position paper ANMCO: Uso dei nuovi anticoagulanti orali nella terapia e nella prevenzione della tromboembolia polmonare

G Ital Cardiol 2016;17(9 Suppl 1):29S-67S

Terapia anticoagulante - nuovi anticoagulanti		
In alternativa a EBPM + AVK, è raccomandato rivaroxaban (15 mg bid per 3 settimane, seguito da 20 mg/die) o apixaban (10 mg bid per 7 giorni, seguito da 5 mg bid).	I	B
Dopo trattamento in fase acuta con EBPM, in alternativa adAVK, è raccomandato dabigatran (150 mg bid o 110 mg bid nei pazienti di età ≥80 anni o in terapia con verapamil) o edoxaban.	I	B
I NAO non sono raccomandati in caso di insufficienza renale di grado severo.	III	A

Position paper ANMCO: Uso dei nuovi anticoagulanti orali nella terapia e nella prevenzione della tromboembolia polmonare

G Ital Cardiol 2016;17(9 Suppl 1):29S-67S

7. CONTROVERSIE SULL'UTILIZZO DEI NUOVI ANTICOAGULANTI ORALI: IL PAZIENTE ONCOLOGICO, IL PAZIENTE FRAGILE, IL PAZIENTE CON INSUFFICIENZA RENALE, IL PAZIENTE OBESO

Per i pazienti oncologici, invece, il potenziale beneficio dei NAO dovrà essere supportato da trial clinici dedicati, per cui non è ancora possibile consigliare, sulla base dei dati disponibili, un loro esteso utilizzo in questo ambito.

VOLUME 33 · NUMBER 6 · FEBRUARY 20 2015

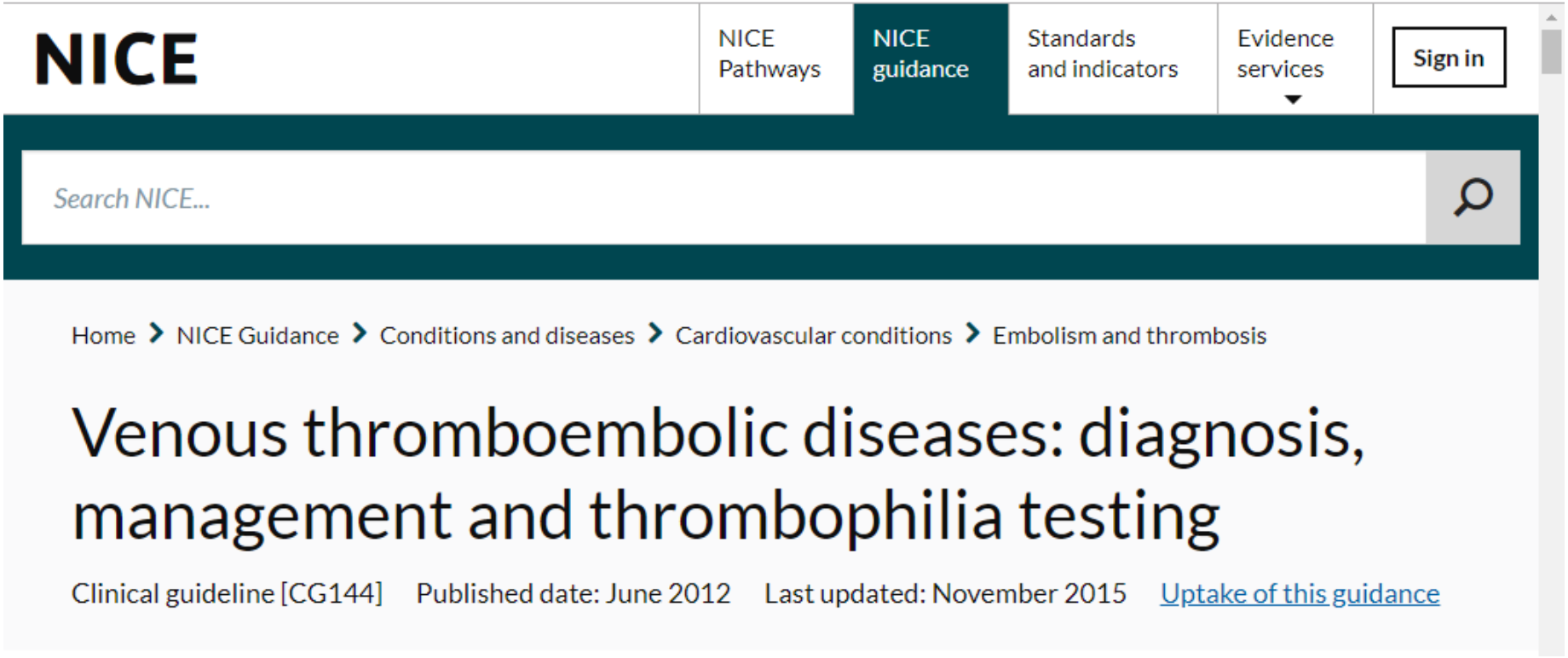
JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

Venous Thromboembolism Prophylaxis and Treatment in Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update 2014

Key Recommendations

Use of novel oral anticoagulants is not currently recommended for patients with malignancy and VTE.



Nessun accenno ai DOACS

National Institute for Health and Care Excellence

Final

Venous thromboembolism in over 16s

Reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism

NICE guideline NG89 (volume 1)

Methods, evidence and recommendations

March 2018

Review question: What is the effectiveness of different pharmacological and mechanical prophylaxis strategies (alone or in combination) for people with cancer having day procedures?

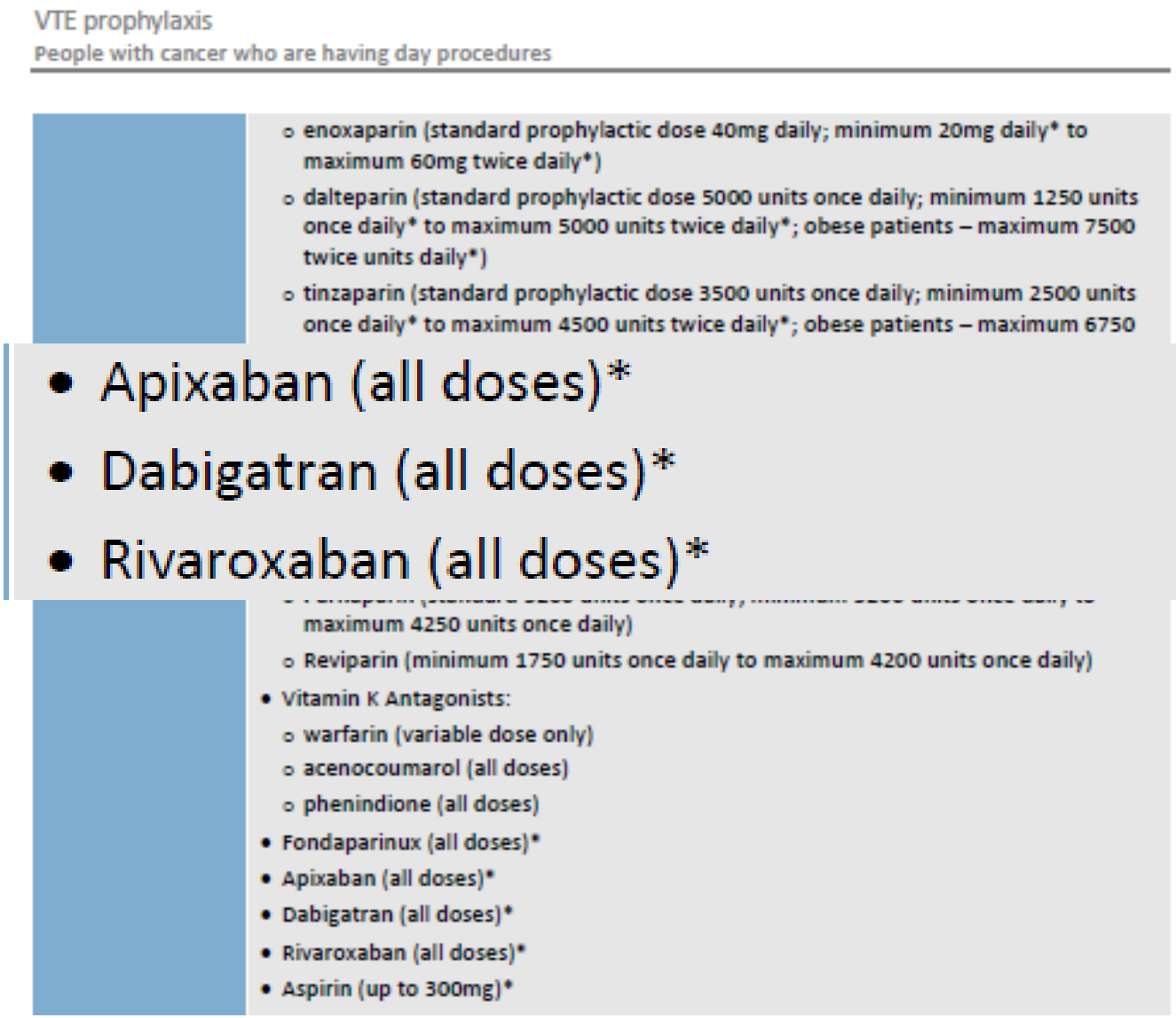
VTE prophylaxis

People with cancer who are having day procedures

- enoxaparin (standard prophylactic dose 40mg daily; minimum 20mg daily* to maximum 60mg twice daily*)
- dalteparin (standard prophylactic dose 5000 units once daily; minimum 1250 units once daily* to maximum 5000 units twice daily*; obese patients – maximum 7500 twice units daily*)
- tinzaparin (standard prophylactic dose 3500 units once daily; minimum 2500 units once daily* to maximum 4500 units twice daily*; obese patients – maximum 6750 twice daily*)

- LMWH, licensed in countries other than UK:
  - Bemiparin (standard 2500 units daily; minimum 2500 units daily to maximum 3500 units daily)
  - Certoparin (3000 units daily)
  - Nadroparin (standard 2850 units once daily; minimum 2850 units once daily to maximum up to 57 units/kg once daily)
  - Parnaparin (standard 3200 units once daily; minimum 3200 units once daily to maximum 4250 units once daily)
  - Reviparin (minimum 1750 units once daily to maximum 4200 units once daily)
- Vitamin K Antagonists:
  - warfarin (variable dose only)
  - acenocoumarol (all doses)
  - phenindione (all doses)
- Fondaparinux (all doses)*
- Apixaban (all doses)*
- Dabigatran (all doses)*
- Rivaroxaban (all doses)*
- Aspirin (up to 300mg)*

Review question: What is the effectiveness of different pharmacological and mechanical prophylaxis strategies (alone or in combination) for people with cancer having day procedures?



clinical practice guidelines

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Management of venous thromboembolism (VTE) in cancer patients: ESMO Clinical Practice Guidelines

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On behalf of the ESMO Guidelines Working Group*

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Nessun accenno ai DOACS

CONSIDERAZIONI PERSONALI

- Oggi abbiamo sufficienti dati di sicurezza e di efficacia dei NOACS nel trattamento della TEV in pazienti non neoplastici.
- I dati in prevenzione sono on-going ma ancora insufficienti

CONSIDERAZIONI PERSONALI

- Per Edoxaban e Rivaroxaban abbiamo sufficienti dati di sicurezza e di efficacia nel trattamento della TEV.
- Le Linee Guida AIOM danno una raccomandazione positiva (debole) come pure ASH e NCCN.

CONSIDERAZIONI PERSONALI

- Ancora oggi in Italia gli oncologi medici non sono autorizzati a prescrivere i DOACS.
- Ora che ci sono LG AIOM che li raccomandano anche nel paziente neoplastico sono certo che AIOM discuterà con AIFA e porrà rimedio a questo inconveniente.

Grazie della cortese attenzione

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