

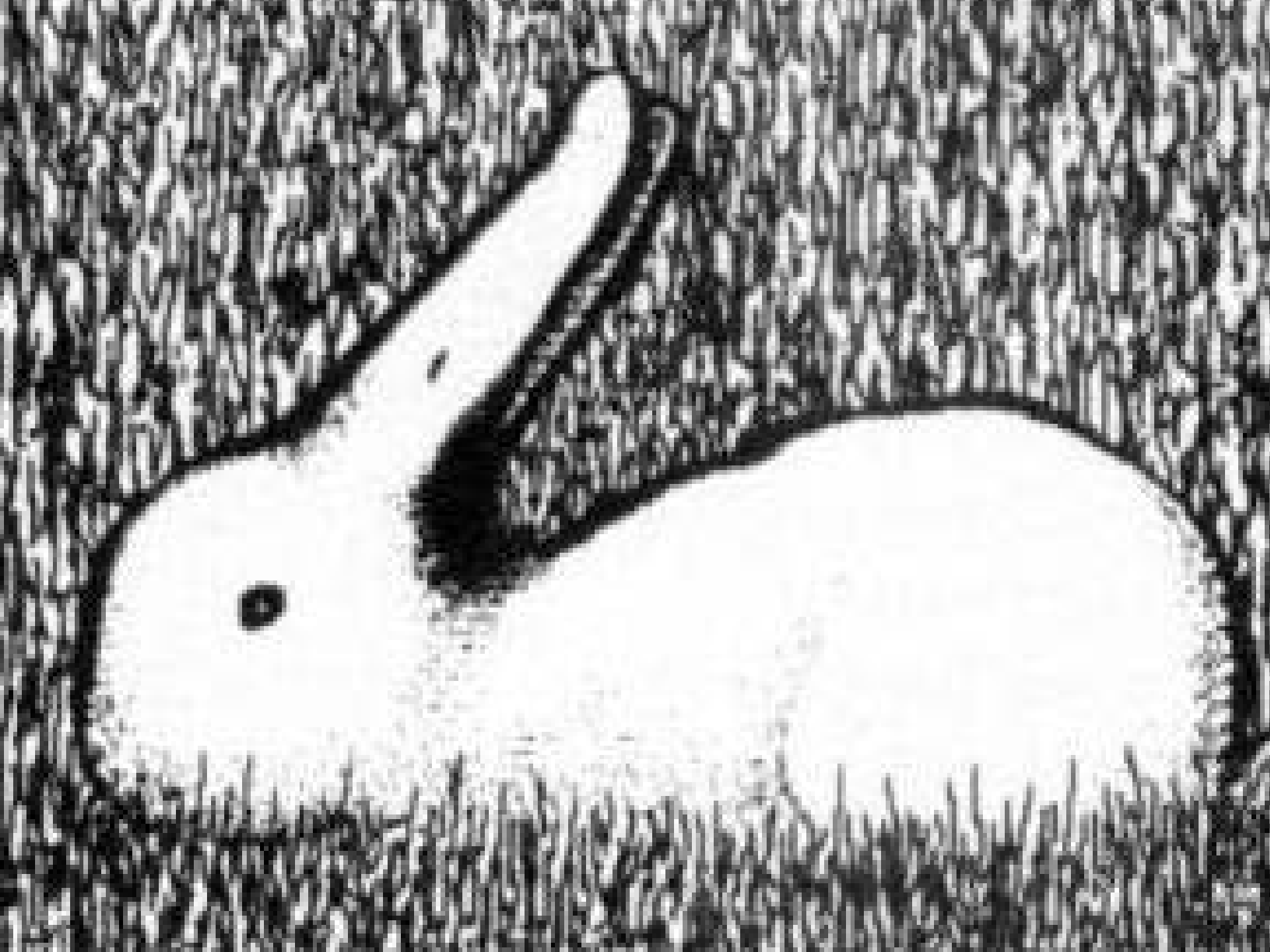
Cancer associated thrombosis – palliative care and the end of life

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Treatment at the end of life

- Can be challenging to know what treatments are appropriate
- Benefit vs burden
- Patients preference
- Medical opinions can vary
- Patient / family opinion may differ from medical opinion
- Different people can have different perspectives





Perspective can change over time

Everyday examples

- Driving to work
- Flying on holiday
- Letting your kids walk to the shop

Everyday examples at work

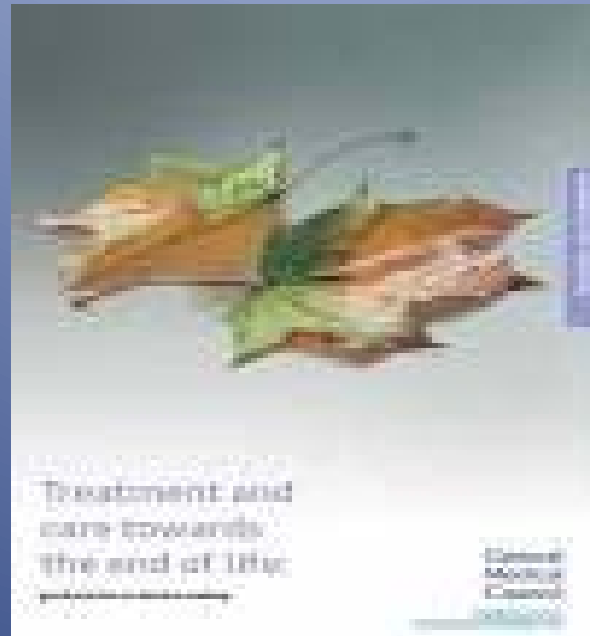
- Palliative chemotherapy
- Blood transfusion
- Surgery for fracture
- Radiotherapy for SCC
- Use of clexane when there is risk of bleeding and clotting
- Use of tranexamic acid when there is risk of bleeding and clotting

- We may know HOW to treat a certain problem but at end of life we must also weigh up if that is the right course of action for the patient

We must refrain from doing things merely because we know how to do them'

Dr Theodore Fox, speech to the Royal College of Physicians, 1951

GMC – Treatment and care towards the end of life



GMC

- Choosing between options – best interests
- Patients have rights to decide how much weight to attach to the benefits, burdens, risks and the overall acceptability of any treatment.
- A different decision may be made in each case since patients assessment of likely benefits and burdens and what priority to give to these will differ

Use of prophylactic clexane

- VTE (DVT/PE) can cause significant symptoms and be life threatening
- Preventing this in hospital is a clinical priority
 - DoH and NICE
- Evidence to support its use in hospitals
- Safe and effective

Regional risk assessment tool

- Consider
 - Is mobility reduced compared to baseline?
 - Risk of thrombosis
 - Risk of bleeding
- Use until acute illness has resolved
- No evidence for longterm use even in patients with ongoing high risk
- Increased risk of bleeding after 28days

Venous Thromboembolism (VTE) Risk Assessment for Hospitalised Adults (excluding obstetric patients)

Patient Name: _____

H&C Number: _____ DOB: _____

Step 1: Assess for level of mobility – All patients

	Tick		Tick		Tick
Surgical patient		Medical patient expected to have ongoing reduced mobility relative to normal state		Medical patient NOT expected to have significantly reduced mobility relative to normal state	
Assess for thrombosis and bleeding risk below (Complete steps 2 – 5)				Risk assessment complete (Go to step 5)	

Step 2: Review thrombosis risk

Any tick for thrombosis risk factors should prompt consideration for thromboprophylaxis

Patient related	Tick	Admission related	Tick
Active cancer or cancer treatment		Significantly reduced mobility for 3 days or more	
Age >60		Hip or knee replacement	
Dehydration		Hip fracture	
Known thrombophilias		Total anaesthetic + surgery time > 90 minutes	
Personal history/first degree relative with history of VTE		Surgery involving pelvis or lower limb with anaesthetic + surgery time > 60 minutes	
One or more significant medical comorbidities (eg. heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)		Acute surgical admission with inflammatory or intra-abdominal condition	
Obesity (BMI >30kg/m ²)		Critical care admission	
Use of hormone replacement therapy		Surgery with significant reduction in mobility	
Use of oestrogen-containing oral contraceptive therapy		The above risk factors are not exhaustive, additional risks may be considered. Other:	
Varicose veins with phlebitis			
Pregnancy or <6 weeks post partum (see obstetric risk assessment for VTE)			

Step 3: Review bleeding risk

Any tick should prompt staff to consider if bleeding risk is sufficient to preclude pharmacological intervention

Use of oestrogen-containing oral contraceptive therapy		The above risk factors are not exhaustive, additional risks may be considered. Other:
Varicose veins with phlebitis		
Pregnancy or <6 weeks post partum (see obstetric risk assessment for VTE)		

Step 3: Review bleeding risk			
Any tick should prompt staff to consider if bleeding risk is sufficient to preclude pharmacological intervention			
Patient related	Tick	Admission related	Tick
Active bleeding		Neurosurgery, spinal surgery or eye surgery	
Acquired bleeding disorder (such as acute liver failure)		Lumbar puncture/epidural/spinal anaesthesia expected in the next 12 hours	
Concurrent use of anticoagulants known to increase risk of bleeding (such as warfarin with INR >2)		Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours	
Acute stroke		Other procedure with high bleeding risk	
Thrombocytopenia (Platelets <75x10 ⁹ /l)		The above risk factors are not exhaustive, additional risks may be considered. Other:	
Uncontrolled hypertension (>230/120mmHg)			
Untreated inherited bleeding disorder (such as haemophilia and von Willebrand's disease)			

Step 4: Tick the appropriate risk category							
	Tick		Tick		Tick		
Risk of VTE		High risk of VTE with low bleeding risk		High risk of VTE with significant bleeding risk		Low risk of VTE	
Thromboprophylaxis prescribed on kardex?	Yes		Type prescribed	Pharmacological eg. LMWH			
	No			Mechanical			

Step 5: Signature	
VTE risk assessed on admission	Signature: _____ Print Name: _____ Date: _____ Time: _____
VTE risk should be re-assessed within 24 hours and whenever clinical condition changes	
For further information on pharmacological and mechanical prophylaxis, refer to Trust Thromboprophylaxis Policy	

Palliative care patients

- Risk of VTE increased 6 or 7 fold in cancer
- Risk increases further with chemo, hormone treatment, immobility, hospitalisation
- One study suggests that around 50% of hospice inpatients with advanced cancer will have VTE

NICE GL for hospitalised palliative care patients

- VTE prophylaxis should be considered if potentially reversible acute pathology is present with no contraindications
- It should not be routinely offered to patients assessed to be dying
- Consistent with trust guidelines

What about hospices

- High risk group of patients but will not be appropriate in all patients
- No guidance or risk assessment used in hospices but it is used in palliative care patients in hospital.
- Systematic review of the evidence revealed the need for guidance for hospices

Regional Audit 2010

- 13% of patients of patients admitted to a specialist palliative care unit on VTE prophylaxis (from hospital)
- Further 5% commenced on admission
- Documentation of decision was only evident in 12%. No documentation of verbal or written information shared.
- Risk of VTE was moderate to high in 88% of hospice inpatients

- 42% of patients had potentially reversible pathology causing temporary reduction in mobility eg. infection, opioid toxicity, dehydration, SCC, hypercalcaemia
- 35% met NICE criteria but did not receive it
- Clexane was not stopped in a number of patients who were dying

Recommendation

- Guidance needed to help facilitate individualised decisions, considering possible benefits and risks of treatment
- Guidance needed on when to continue clexane commenced in hospital, when to initiate clexane, and when is the appropriate time to stop

Case examples

- PM
- 39 year old lady
- Ovarian ca
- Admitted with ascites
- Normal mobility
- Would you start clexane?

- Not commenced proph clexane
- 4 days after admission – nausea and vomiting
- Clexane decision not reviewed
- 5 days later developed PE

- BF
- 76 year old man
- Metastatic rectal ca
- In hospice for symptom control
- Proph clexane prescribed
- Returned to baseline
- No evidence of DVT
- Would you discharge with clexane?

- Discharged without clexane
- Developed femoral DVT 10 days after discharge

- JK
- 85 year old man
- Gastric ca
- DVT – 6 months therapeutic clexane with ongoing prophylactic (risk of recurrence)
- GI bleeding causing symptomatic anaemia needing 2 units monthly (Hb 86)
- Would you continue prophylactic clexane?

- Discussion with pt and wife – risk and benefit
- Decision made to stop clexane
- 2 weeks later developed femoral DVT
- Treated with therapeutic clexane
- Hb dropped from 124 to 104 in 10 days
- Clinical condition deteriorated and patient died 3 weeks after last Hb check
- No further transfusions given
- No large bleeds

- GB
- 77 year old lady
- Oesophageal ca with stent
- PE Feb 16 – therapeutic clexane
- Sept 16 haematemesis. Clexane stopped and tranexamic acid 1g bd commenced. 4 days later DVT – 40mg clexane prescribed
- Subsequently tranexamic acid stoppped and clexane reduced to 20mg. 2 further significant GI bleeds Nov and Dec. Transfused 5 units Dec Hb 114

- Reviewed End March
- Hb 80
- Admitted to hospice for 2 units
- Discussion about ongoing clexane
- Would you continue?

- EH
- 72 year old lady
- Laryngeal ca – Tracheostomy
- Oesophageal ca
- Bleeding via tracheostomy
- XRT and tranexamic acid
- Bleeding settled
- ?clexane ?tranexamic acid

- DMcA
- 63 year old lady
- Vulval ca with recurrence
- DVT and PE
- On therapeutic clexane
- 2 large bleeds from wound
- What would you do about Clexane?

- Clexane withheld for a few days. Bleeding settled
- ?restart therapeutic or prophylactic

- WH
- 80 year old man
- Renal cell ca with mets to lung and trachea
- Haemoptysis treated with XRT and tranexamic acid
- Fast AF
- Would you anticoagulate?

- Warfarin considered
- Tranexamic acid stopped and clexane 20mg commenced
- Cardiology review
- No further AF
- Clexane stopped

- MG
- 82 year old lady
- Glioblastoma. Recent progression and increasing oedema
- General deterioration
- Admitted for EOLC
- Would you commence proph clexane



Regional Guidelines for hospice patients

- Assess risk of VTE
- Consider bleeding risk
- Consider if there is a temporary increase in risk of VTE (recent surgery, reversible acute medical illness, fracture, SCC)
- Weigh up risk/ benefit including burden of injection and monitoring bloods

- Consider carefully in brain mets or tumour with high risk of bleeding
- Caution with NSAIDS/ steroids
- Don't give to dying patient
- Check bloods before commencing
- Adjust dose if necessary depending on weight and renal function
- Don't give if platelets < 50

- Short term treatment while inpatient
- Provide information
- Consider views of patients and relatives
- Document decisions
- Review decision regularly

Current National research project

- To assess the incidence of DVT in hospice patients
- Blinded study
- All patients admitted are scanned
- Identify what proportion of patients with DVT develop symptoms or serious complications due to DVT

Summary

- Not always clear what is right or wrong
- Little evidence
- Significant potential risk with both actions
- Important to consider





Any Questions???