The Optimal Pathway for the Prevention of Recurrent VTE

Anticoagulation UK

Bristol-Myers Squibb

Pfizer

Summarised below are the recommendations from an Expert Working Group which identified actions to optimise the management of patients at risk of recurrent VTE. The full consensus statements can be found overleaf.

1 TO 3 MONTHS

1. Following diagnosis, **patients at risk of recurrent VTE should have pre-scheduled appointments with a VTE specialist.** The first appointment should be scheduled within four weeks and a further appointment between one and three months after.

3 TO 6 MONTHS

2. Between three to six months after diagnosis, a **full treatment review should take place** to decide if the patient requires long-term anticoagulation for the prevention of recurrent VTE. **This review should be scheduled at the time of discharge.**
3. For people who are at risk of recurrence, healthcare professionals should discuss the **risks and benefits of continuing anticoagulation therapy** at their three to six month meeting. **Healthcare professionals should consider using a risk calculator to aid the decision-making process.**
4. At this point, healthcare professionals should consider the **psychological implications** of remaining on anticoagulation. They should also consider a patient's risk of bleeding and **ensure the person receives the most appropriate treatment to help avoid the risk of recurrence.**

1 YEAR

5. **A review should take place annually** for all people receiving long-term anticoagulation. **People with comorbidities or who present with additional health challenges should be reviewed more frequently.** Reviews may take place in a primary care setting with GPs responsible for assessing anticoagulation.
6. At every annual review, people should be provided with **clear and up to date information about the chronic nature of VTE and how to reduce further risk of a VTE episode.**

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ONGOING SUPPORT

At every stage of the pathway, healthcare professionals should provide people with appropriate information and tools to support them to understand the chronic nature of VTE. This includes anxiety management materials and information on the risks and benefits of anticoagulation therapy.

At every stage of the pathway, patients should have continuous access to and receive support from healthcare professionals including: VTE specialists, GPs and community pharmacists. Continuous messaging around the importance of medicines adherence should also be made at every appointment and review.

Developing optimal standards of care for the prevention of recurrent venous thromboembolism (VTE): consensus statement

In 2018, an Expert Working Group meeting was held entitled 'Secondary Prevention in VTE: Developing Optimal Standards of Care for the Prevention of Recurrent VTE'. This Expert Working Group meeting was initiated, organised and funded by the Bristol-Myers Squibb-Pfizer Alliance, working in partnership with Anticoagulation UK. It brought together interested individuals from across England to identify actions for improvements in the management of patients at risk of recurrent VTE. Attendees agreed to a number of recommendations for the optimal standard of care for patients at risk of recurrent VTE.

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CONSENSUS STATEMENTS

STATEMENT 1: People with provoked or unprovoked venous thromboembolism at risk of recurrence should attend a follow-up appointment with a VTE specialist in the first one to four weeks following diagnosis (if they were not originally seen by an anticoagulation VTE specialist at confirmation of diagnosis). Between one and three months post-diagnosis, a follow up appointment should take place. These reviews should be scheduled at the time of discharge.

STATEMENT 2: A full review should take place between three to six months post-diagnosis to decide on the need for long-term anticoagulation for the prevention of recurrent venous thromboembolism. This review should be scheduled at the time of discharge.

STATEMENT 3: For people with no major provoking factor and who are at risk of recurrence, healthcare professionals should discuss the risks and benefits of continuing anticoagulation therapy and the associated bleeding risk at their three to six month review. Decisions to continue long-term anticoagulation may be based on clinical judgement but, in some cases and particularly where there are a number of comorbidities or factors, healthcare professionals should consider using a risk calculator (which could include the DASH prediction score, Dynamic Vienna prediction model or HERDOO2 score) or blood test to aid the decision-making process.

STATEMENT 4: Healthcare professionals should consider the psychological implications for people who remain on anticoagulation due to their risk of recurrence, as well as for those who have stopped anticoagulation, and provide appropriate support.

STATEMENT 5: If a healthcare professional has clinical concerns relating to a person's risk of bleeding (for example frail elderly people), they should ensure that the person receives the most appropriate treatment to prevent a recurrence. This may include dose reductions in line with treatment licenses.

STATEMENT 6: A review should take place annually for all people receiving long-term anticoagulation for secondary prevention in venous thromboembolism. People with comorbidities or those who present with additional health challenges at any point should be reviewed more frequently. From the first year post-diagnosis, reviews may take place in a primary care setting with GPs being responsible for assessing anticoagulation.

STATEMENT 7: At every annual review, people should be provided with clear information about the chronic nature of venous thromboembolism. The risk of recurrence without treatment, as well as the risk reduction with continued anticoagulation, should be explained to help the person to understand the importance of continuing to take their anticoagulation.

STATEMENT 8: At every stage of the pathway, healthcare professionals should provide people with appropriate information and support tools to help them to understand the chronic nature of venous thromboembolic disease, the risks and benefits of continuing anticoagulation therapy, the associated bleeding risk and also the possible complications associated with venous thromboembolism (including post-thrombotic syndrome). Healthcare professionals should make clear that feelings of anxiety are not uncommon and provide people with support materials and tools to manage their anxiety, where appropriate. Tools could include online self-help resources, relaxation and breathing techniques. Where additional support is required after the use of such tools, people should be triaged to see a specialist.

STATEMENT 9: At every stage of the pathway, it is important to ensure that people are supported with continuous quality interactions with, and access to, healthcare professionals who can provide information and support on their anticoagulation care. This includes VTE specialists, GPs and community pharmacists. Continuous messaging around the importance of medicines adherence should also be made at every appointment and review. Opportunities to have specific medicines adherence focussed discussions in primary care include medicines use reviews and new medicine service consultations undertaken by community pharmacists.

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