

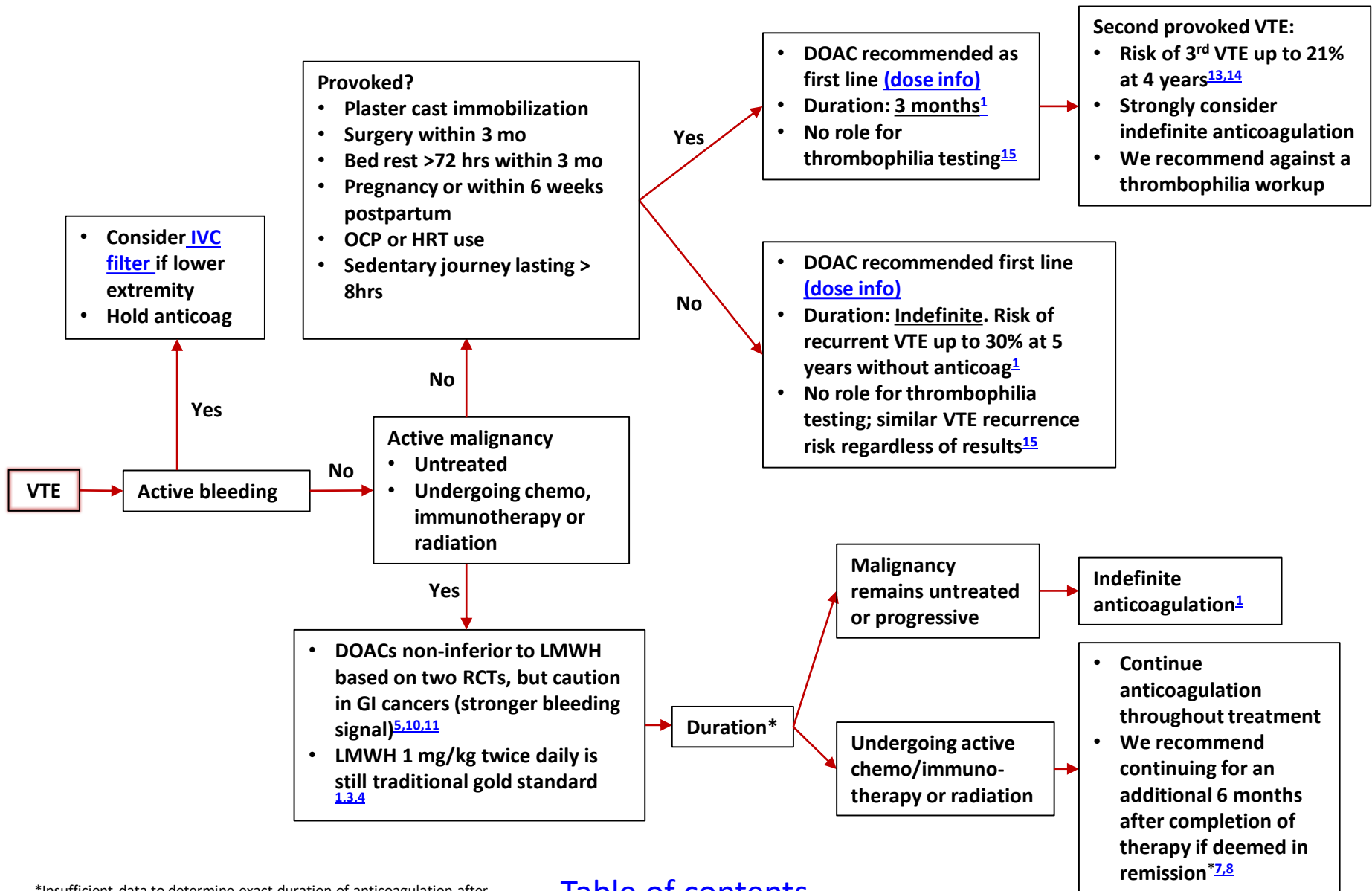
# Venous thromboembolism (VTE) treatment basics

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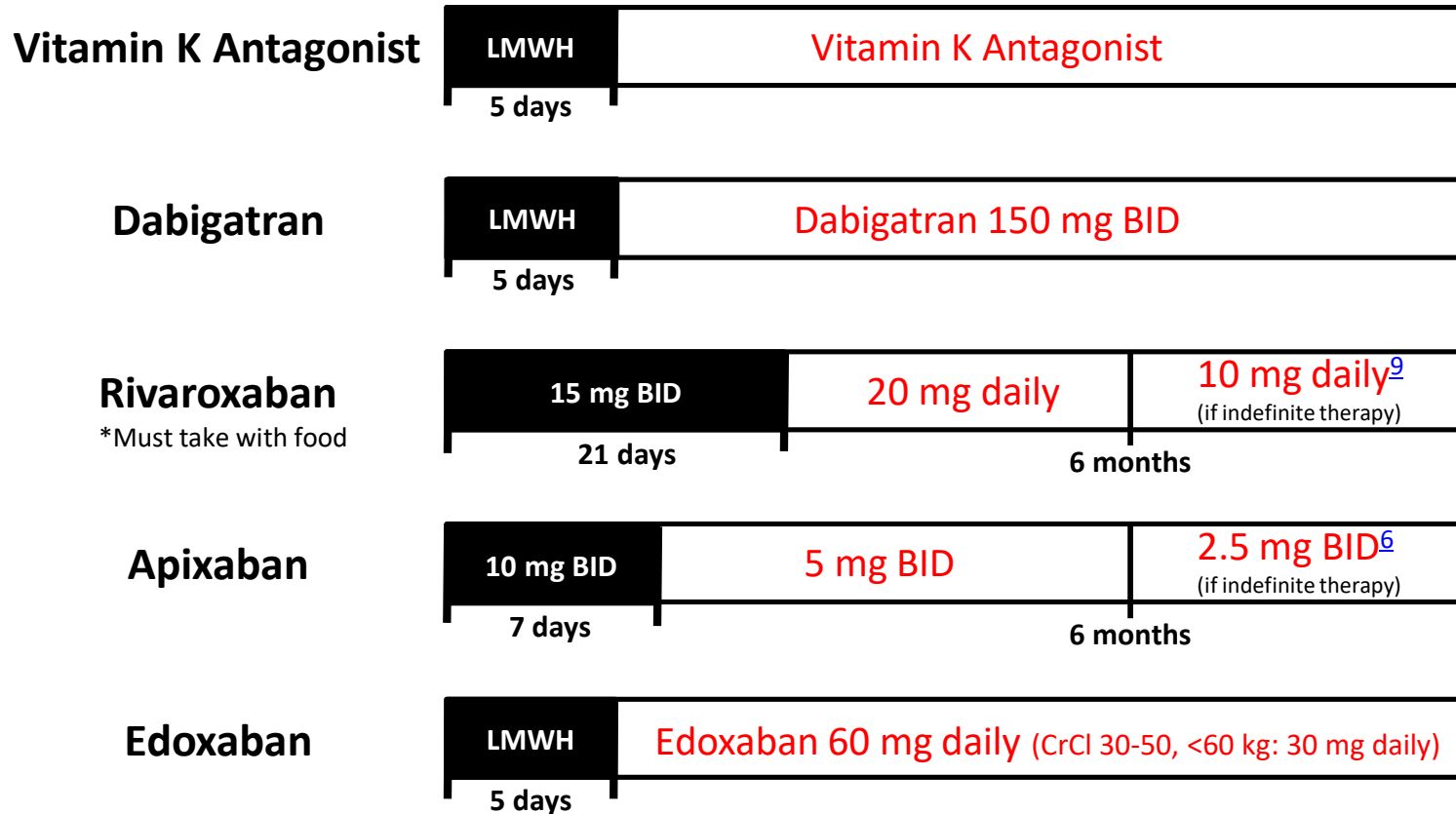
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# Venous thromboembolism treatment



\*Insufficient data to determine exact duration of anticoagulation after cancer treatment and establishment of remission

# Oral anticoagulant dosing for VTE



## Special scenarios:

- **CKD:** Apixaban preferred, and **FDA approved even in ESRD**; use 2.5 mg BID in dialysis and consider checking apixaban peak/trough
- **Obesity:** Patients >120 kg or BMI >40 were generally **excluded** from major trials, but post-marketing data suggests safety up to 150 kg. Consider checking DOAC peak/trough.
- **History of gastric bypass, bowel resection or other major GI surgery:** DOAC absorption can be significantly altered; consider checking DOAC peak/trough if using.

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# Bleeding risk calculators

## Important notes:

- No bleeding risk tools have been validated for VTE treatment, only for prophylaxis and atrial fibrillation
- Observational studies suggest net clinical benefit of anticoagulation even with very high bleeding risk
- No RCTs exist demonstrating benefit of *withholding* anticoagulation based on high bleeding risk

HAS-BLED (atrial fibrillation) 1 point each	IMPROVE (VTE prophylaxis for inpatients)
HTN (SBP >165 mmHg)	Active gastroduodenal ulcer (4.5)
Renal disease (ESRD, Cr >2.26, or transplant)	Bleeding within past 3 months (4)
Liver disease (cirrhosis, AST/ALT >3x upper limit, Tbili >2x upper limit)	Admission platelets < 50 x10 <sup>9</sup> cells/L (4)
History of stroke	Hepatic failure (INR >1.5) (2.5)
History of bleeding or predisposition to bleeding	ICU/CCU stay (2.5)
Labile INR	Central venous catheter (2)
Alcohol or illicit drug use	Rheumatic disease (2)
Taking antiplatelet or NSAID	Active malignancy (2)
Age > 65	Age: 40-84 (1.5), ≥ 85 (3.5)
	Renal disease: GFR 30-59 mL/min (1), <30 mL/min (2.5)
<b>High risk</b>	<b>High risk</b>
<b>≥ 3</b>	<b>≥ 7</b>

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