This document, written by the Bristol-Myers Squibb-Pfizer Alliance, summarises key statements that were agreed during a Bristol-Myers Squibb-Pfizer Alliance organised Expert Working Group Meeting. Anticoagulation UK worked in partnership with the Bristol-Myers Squibb-Pfizer Alliance on the meeting.

DEVELOPING OPTIMAL STANDARDS OF CARE FOR THE PREVENTION OF RECURRENT VENOUS THROMBOEMBOLISM (VTE): CONSENSUS STATEMENT

Summary of consensus statements agreed at an Expert Working Group meeting to identify actions for improvements in the management of patients at risk of recurrent VTE

Meeting Overview

On Thursday 8th February 2018, an Expert Working Group meeting was held at the King's Fund in London 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 (also referred to as secondary VTE). The aim of the meeting was for attendees to agree recommendations for the optimal standard of care for patients at risk of recurrent VTE.

Rationale

Over the past decade, significant improvements have been made in the management of primary VTE prevention and assessing primary VTE risk has become standard practice in a hospital setting. It is important to make sure that momentum is maintained so that patients at risk of recurrent VTE are also optimally managed for their individual risk. After an initial episode of VTE – either a deep vein thrombosis (DVT) or a pulmonary embolism (PE) – a patient's risk of recurrence is higher than someone who has never experienced one. Despite the continued risk of recurrent VTE in some patients, there is little guidance recommending what should occur at or beyond the three month point, after the first VTE episode has occurred. This Expert Working Group meeting was therefore convened to consider these issues and develop consensus on the optimal standard of care for the management of patients at risk of recurrent or secondary VTE.

Consensus Statements

During the discussion, participants identified and agreed a number of actions for improvements in the management of patients at risk of recurrent VTE. To drive these improvements forward, attendees agreed on the following statements.

Initial Treatment (up to one month post-venous thromboembolism diagnosis)

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.

- *The appointment at one and three months post-diagnosis provides an opportunity for healthcare professionals to provide more information and support, to assess clinical anxiety and may also support adherence to medication.*

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Decision on long-term anticoagulation (three to six months post-diagnosis)

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.**

- *It was agreed that decisions on long-term anticoagulation may be made at three months if the decision is straight forward. Delegates agreed that an example of a straight forward clinical decision may be a deep vein thrombosis (DVT) that was obviously provoked and was the first occurrence of VTE.*
- *Attendees agreed that the decision-making process is usually complex, and requires expertise and time. The decision on whether long term anticoagulation is needed for the prevention of recurrent VTE should be based on a number of factors including:*
  - *The initial presentation (whether the person suffered a pulmonary embolism (PE) or DVT);*
  - *Whether the VTE was provoked or unprovoked;*
  - *The person's co-morbidities;*
  - *The person's age;*
  - *The person's history of recurrences; and*
  - *The person's preference.*
- *Participants also agreed that in most cases, the decisions should be made by secondary care specialists or those in settings such as a dedicated VTE centre.*

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.**

- *Attendees agreed that support could come in the form of visual aids, which highlight the rate of recurrence reduction and bleeding risk associated with anticoagulation to support informed decision making. Risks should be presented in a way that is easily translatable to everyday activities.*
- *Attendees also agreed that the difference in bleeding risk management between various treatment options should be explained.*

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.**

Annual Review of Anticoagulation

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-**

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diagnosis, reviews may take place in a primary care setting with GPs being responsible for assessing anticoagulation.

- *Attendees suggested that if GP confidence building was needed, the GP could consult with a VTE specialist (such as a VTE specialist nurse or pharmacist) in a dedicated VTE clinic within a primary or community care setting.*

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.

- *Standardised visual aids should be made available to show the risk of recurrence. These should be provided in a similar format to the National Institute for Health and Care Excellence (NICE) Patient Decision Aid on Atrial Fibrillation (AF)-Related Stroke.[1] The aid should show people the reduced risk of recurrence on anticoagulation versus the risk of recurrence if they are not on anticoagulation. The aid should also show people the bleeding risk associated with anticoagulation, however ongoing anticoagulation would continue to be appropriate if the VTE recurrence risk still outweighed the bleeding risk.*
- *Information should be made available within any setting where ongoing VTE management is being undertaken by GPs, nurse specialists or pharmacists.*

Information for Patients and Medicines Adherence

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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Information from Anticoagulation UK on Self-Care and Management

Prevention of Recurrent VTE

Patients affected by a DVT or PE are at a higher risk of recurrence and it is in their interest to understand what they can do to help reduce this risk. Anticoagulation UK has provided the below information on the prevention of recurrent VTE:

- *Be aware of symptoms to look out for and if concerned, seek advice immediately*
- *Keep hydrated at all times*
- *Stop smoking – smoking affects our cardiovascular system*
- *Reduce long periods of sedentary behaviour (for example, when travelling for long periods) make adjustments to working environment if desk bound, and keep moving*
- *Increase physical activity – seek to find activities that you enjoy to aid fitness and mobility*
- *Maintain a healthy weight*
- *Advise healthcare professionals of your previous blood clots when being considered for any surgery or other clinical procedures, such as going to the dentist*

Expert Working Group Members

The meeting was attended by the following people:

- Dr Alexander Cohen, Vascular Physician and Epidemiologist, Guy's and St Thomas' NHS Foundation Trust (Chaired the Expert Working Group Meeting)
- Astrid Ullrich, Ambassador for Anticoagulation UK (Speaker at the Expert Working Group Meeting)
- Dr Frances Akor, Consultant Pharmacist in Anticoagulation, Imperial College Healthcare NHS Trust
- Professor Paul Bennett, Head of Psychology Department, Swansea University
- Dr Karen Breen, Consultant Haematologist, Guy's and St Thomas' NHS Foundation Trust
- Diane Eaton, Project Manager, Anticoagulation UK
- Dr Arun Kallat, Consultant Clinical Lead for Elderly Medicine, Bolton NHS Foundation Trust
- Joanne Loades, Clinical Associate, National Association of Primary Care
- Dr Tim Nokes, Consultant Haematologist and Clinical Director for Oncology and Blood Services, Plymouth Hospitals NHS Trust
- Sue Rhodes, VTE Specialist Nurse and Anticoagulant Lead, Great Western Hospitals NHS Foundation Trust
- Emma Palmer, Policy, Advocacy and Government Affairs Manager, Bristol-Myers Squibb
- Andrew Jones, Policy and Public Affairs Manager, Pfizer UK
- Laura Thorne, Associate Director, Four Communications (Speaker at the Expert Working Group Meeting)
- Rebecca Godfrey, Senior Account Executive, Four Communications

[1] National Institute for Health and Care Excellence (NICE). June 2014. 'Patient decision aid. Atrial Fibrillation: medicines to help reduce your risk of a stroke – what are the options?' Available: https://www.nice.org.uk/guidance/cg180/resources/cg180-atrial-fibrillation-update-patient-decision-aid-243734797 [Accessed: October 2018]