CG144: Venous thromboembolic diseases

Dr Roshan Agarwal, a member of the Guideline Development Group, discusses the venous thromboembolic diseases guidance and the link between VTE and cancer.

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Podcast transcript

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“Hello and welcome to this podcast from NICE. This month sees the launch of a new piece of guidance on venous thromboembolic (VTE) diseases.
Joining me to discuss the guidance is Dr Roshan Agarwal, who is a member of the Guideline Development Group responsible for putting this guidance together and also a medical oncologist.”
Q1: “So what do we mean by VTE diseases?”
RA: “VTE encompasses a blood clot that can occur either in the legs or in the lungs and the two things are related. So patients who have blood clots in the legs obviously get swelling and pain and that causes problems, but one of the greater problems associated with these blood clots is that they can dislodge and go off into the lungs and that can be potentially fatal.”
Q2:“How common are these diseases?”
RA: “So, the estimates are about a 1,000 patients a week are getting VTE and of these 10 patients per week may be dying as a result of their blood clot.”
Q3: “And what type of patients are most at risk of developing these clots?”
RA: “There’s a wide spectrum of patients, common reasons for having a blood clot include having a recent operation, having been involved in an accident or having to be bed bound for a long period of time, people are aware of the risks of long haul travel and of oral contraceptive pills.
“A small proportion of patients also have an inherited tendency to form blood clots.
“One of the things that comes across in our guidance that is very important is that one in 10 patients may also have an underlying cancer, and I think that is really important to recognise.”
Q4: “Now this is the first time that this link between cancer and VTE has been made aware in national guidance. What does NICE recommend?”
RA: “What we are saying with regards to the possibility of an underlying cancer is twofold.
“We know from recent trial evidence that it is better to treat patients who have a blood clot and a cancer with a drug called heparin and this is given as an injection once a day and to do it for six months.
“This reduces the risk of the blood clot coming back compared to treating patients who don’t have cancer for approximately three months with a drug called warfarin. Because there is such a stark difference between the treatment that is best for patients with cancer and not with cancer, it’s also very important that when patients present with a blood clot we know who may have an underlying cancer.”

Q5: “Is this the first time then that patients are effectively being risk-assessed for their risk of cancer when they present?”
RA: “This is a novel suggestion. The important thing to recognise here is that what we are suggesting is a distinct set of tests to try and identify cancer so that people are not over or under investigated and more importantly the reason for doing these tests is so that the patients get the best treatment for their blood clots.”
Q6: “What does the guidance recommend in terms of diagnose, assessment and treatment that would be a change in practice?”
RA: “I think that is, perhaps, the most important element of this guidance. We are setting a clear benchmark that will ensure that patients are having the same excellent care wherever they are within the NHS, and what we are recommending is that patients after they are suspected of having blood clots get started in having treatment within 4 hours.
“It is equally importantly, that they have their investigative tests including scans within 24 hours. So I think this will make a major difference to our patients who are often quite scared about the potential consequences and will ensure that patients are rapidly treated and not over treated because scans are being delayed and not undertreated because they don’t get the appropriate tests.”
Q7: “How can we encourage people to follow this guidance? Will there be anything in the way of incentives?”
RA: “Our job with this guidance was in the first instance to provide a benchmark based on the up to date evidence that is available because this is constantly evolving.
“Now that we have this I think we have the basis to develop some quality standards which we allow NHS trusts to implement this guidance and for us to judge against them which of these trusts are performing well and otherwise.”
Q8: “In this time of cuts to the NHS and budgets, do you think that there are potential savings to be gained by implementing this guidance?”
RA: “Absolutely, I think that the whole point of this guidance is to ensure that we do in the NHS is cost effective and provides the best clinical care.
“So this guidance will ensure that patients do not undergo unnecessary wasteful tests, nor are they treated with inappropriate drugs and I think that has potentials for cost saving.
“Overall, there has been a cost report and that suggests that this will not impose an excess burden on NHS finances.”
“Roshan, thank you very much for your time.”
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