RCH Trust Thrombosis prevention and Anticoagulation Policy Steering Group (TPAS)

Meeting held 5.15 pm on 1st August 2013

Minutes

1) Apologies: A Cornelius, S Adcock, R Kincaid, S Gupta, J Trugian, S Matthews, NMarshall, S Harris,R Palmer J Trudgeon

   Present: K Adie (KA), J Blundell (JB) J Glinn (JG) A Lee (AL) A McSorley (AM) A Slade (AS) M D Creagh (DC) ?Eva Molnar

2) Minutes and actions from August 2012 were agreed wrt:

   Thrombosis Practitioner (established within DVT Clinic July 2013)

   Revision to Trust Clinical Guideline wrt to updated guidance and noval direct oral anticoagulants, license and NICE approval and subsequently updated to the Trust Document Library (with medical staff education) January 2013.

3) VTE CQUIN

   The VTE CQUIN 2012-2013, based on 95% risk assessment (RA) was successful.

   For 2013-2014 the RA target continues, together with a requirement for RCA of hospital acquired VTE ("HAT") RCA.

   Current RA performance:

   Monthly business unit UNIFY data collection July 97.0%

   Monthly Pharmacy June audit for initial/admission RA of 92% with appropriate prescribing 93%. There has been an issue, wrt to the NHSLA inspection, of lack of signature and date for RA, though this was present to the prescription and so could be considered as one process. Education of juniors and currently RA not signed/dated for 8.6%. For the 24 hours RA re-assessment this is done in 46.1% (see below).

   HAT RAC

   Commended 22/7/13, utilising DATIX and reporting to respective Divisions for action.

4) NHSLA

   As above, ahead of the assessment there was concern re the need for evidence of RA process by signature and date, together with poor performance for 24 hr re-assessment as proscribed by the Trust Policy (and NICE). A plan of action is place. At the inspection there was a pass for the VTE criterion and the Trust attained Level 2. The plan is for on-going education and RA as part of module in EPMA update December 2013, completion of which will be necessary for continuing prescription/drug issue.

   Patient information on admission/discharge – (Thrombosis Practitioner)

5) Clinical Governance

   Continuing F1/2 education programme and consultant mandatory training

   Thrombosis facilitator/practitioner established July 2013 (AM)

   The use of rivaroxaban in PE NICE TA287 has been considered by CAPC for use, with the recommendation for implementation through the DVT Clinic. A GASP audit is in process.

Updated/new guidance

Trust Guidance on travel and venous thrombosis (update 2013)
http://intra.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Haematology/GuidanceOnTravelAndVenousThrombosis.pdf

Clinical Guideline forthe Diagnosis Treatment and Ongoing Management Of VTE in pregnancy, labour and post natal period (new July 2013)
http://intra.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/MidwiferyAndObstetrics/CGDiagnosisTreatmentOngoingManagementOfVTE.pdf

Audit:

A pilot for Acute GP/primary care VTE screening using d-dimer has led to a proposal for revision to primary care screening with e-access to Wells score (KCC re-assessment of screening/diagnostic pathway)

6) Proposed update to the Trust Thrombosis Prevention and Anticoagulation CG

Corrections were accepted

Additions/revisions:

Fondarinux addition wrt to VTE and ACS licensed use (p7)

Referances to the (new) noval anticoagulants to include apixiban, as NICE'd for AF and so may be in use in primary care, together with a list of drug interactions.

A: JG to review NOAC interactions (p10)

Monitoring of NOAC recommendations (for malabsorption and compliance) (p11).

GPIIa/IIIb inhibitors (abciximab, eptifibatide and tirofiban) (p12):

A:JG has re-written

Obesity – thromboprophylaxis and therapeutic LMWH (p20):
This has arisen primarily from enquiries from the Bariatric Surgery Service. Advice had been sought from Medicines Information, the manufacturers SPC, published evidence and colleagues elsewhere. A review from the UK Clinical Pharmacy Association 2010 for prophylaxis had been circulated and it was agreed to incorporate this to the guidance

A: DC to propose change to Mr I Finley Lead Consultant for the Bariatric Surgery Service (see addendum)

For VTE therapeutic heparin with dalteparin is dose limited for 100kg, other than for pregnancy where pharmacokinetics differ. For enoxaparin "No dosage adjustments are recommended in obesity or low body weight" and "once daily subcutaneous doses of 1.5 mg/kg in healthy volunteers suggests that no dosage adjustment is necessary in obese subjects (BMI 30-48 kg/m^2) compared to non-obese subjects", however there are advocates for either limiting single injections to 150mg, use of bd schedules and, or measurement of anti-Xa levels (as some do for dalteparin rg 200u/kg bd). A non weight restricted dose schedule might also result in a renal impaired subject receveing a greater anti-Xa dose with enoxaparin than with dalteperin. The Group were not aware of cases of VTE recurrence in obsese patients with the use of dalteparin and it was suggested that an audit of practice and outcomes for pt by weight and BMI should be undertaken to inform a further review of this issue

No weight adjustment is recommended for the NOACs.

A: To continue with current maximum weight limited once daily dalteparin schedule.
AM/DVT Clinic to lead on audit on weight BMI and outcomes

Update for use of NOAC's in PE (rivaroxaban) and NICE implementation via DVT Clinic (p29)

Review of (LMWH therapy) cancer VTE within 6 months (P30)

A: AM to liaise with site specific CNS to develop a programme, based on disease response.

AS suggested revision re for Cardiac thrombolysis and the use of tenecteplase "is uncommonly required, given standard practice of primary angioplasty" so updated (p32)

NOACs surgery and invasive procedures (p65): The SPC licensed recommendations were reviewed together with additional but similar information from the manufacturers and reviews for endoscopy practice and guidance such as that from the European Heart Rhythm Association Practical Guide for non-valvular atrial fibrillation NOAC use www.NOACforAF.eu.
A derived schedule for pre-operative cessation of therapy was agreed
VTE thromboprophylaxis was agreed.
It was agreed that for patients at high risk of thromb-embolism, full dose anticoagulation can be re-introduced from 48hrs (*rivaroxaban bd schedule)* and for low risk from from day 5, provided no significant bleeding.

Therapeutic dalteparin "bridging" for surgery and invasive procedures (p72): A cross reference to the once daily 200u/kg pre-operative dosing was added together with a Table: Post-procedure bridging with dalteparin (non-high bleeding risk procedures), based on 100 units per kg twice daily.

7) Correspondance

Extended LMWH in hip fracture – ongoing concerns have been raised from CoE. NICE recommendation is incorporated in the current Trust CG

A: It was suggested this might be taken on through the governance processes. KA to liaise with colleagues

The TIA clinic have submitted to the CAPC for the use of NOAC in acute TIA and non valvular AF. Dr Harrington had requested guidance on a subsequent switch to warfarin. AS felt that this was inappropriate as "prior stroke or transient ischaemic attack" was a NICE TAG qualifying recommendation for the NOAC's and also wrt to published guidance (2012 focused update of the ESC Guidelines for the management of atrial fibrillation)

Dr Schuh from the Mermaid screening/diagnostic procedures has sought advice wrt their warfarin practice of no interuption provided INR<4.0, MDC though a similar practice was appropriate for NOACs and rather as per licensed recommendation for epidural.

Drs Murray and Fortun have proposed a Trust Clinical Guideline For Managements Of Patients Taking Anticoagulants In Endoscopy. This covers NOAC patients for elective and emergency endoscopy ie with haemorrhage and broadly is line with the proposed revised Trust Thrombosis Prevention and Anticoagulation CG. They have been asked for their comment.

A: Dr Murray invited to join the group.

8) Date for next meeting January 2014 5.15pm

Addendum (October 2013)

Re 6) Obesity – thromboprophylaxis and therapeutic LMWH (p20)

Discussed within the Bariatric Team and with Mr Finlay as lead. No perceived VTE problem, the patients commonly being mobilised and home on day1 with standard dose prophylaxis. Collection of outcome data is in process, whilst the recently instituted systematic RCA of each hospital aquired VTE (within 3 months of an admission) will identify future cases.

A: No change to current practice

Membership:

Dr M D Creagh (DC)	Consultant, Clinical Lead for Thrombosis and Chairperson
Dr V Barnard	ST2 in Medicine and Junior Doctor Representative
Dr R Bland	Consultant in Elder Care
Dr J Blundell (JB)	Consultant Haematologist
Dr A Edwards	Consultant in Radiology
Mr J Glinn (JG)	Head of Pharmaceutical Clinical Services
Dr S Gupta (SG)	Consultant in MAU
Dr S Harris (SH)	Consultant in Paediatrics
Dr S Iles	Consultant in Respiratory Medicine
Dr N Marshall (NM)	Consultant Anaesthetist
Mr R Kincaid (RK)	Consultant in Orthopaedics
Mr A McSorley (AM)	Nurse Practitioner DVT Clinic
Ms R Palmer (RP)	Community Pharmacist Advisor
Ms C Richards (CR)	Acting Clinical Nurse Manager for General Surgery
Dr A Slade	Consultant Cardiologist
Ms J Trudgeon	Tissue Viability Nurse Specialist
Dr Iain Murray	Consultant Gastro-enterologist

Recipient of minutes

Dr D Browne (DB)	Medical Director (Governance)
I Nicholls	Medication Safety Lead Pharmacists

List of proposed corrections/addition/revisions/issues as circulated for the 1st August meeting.

Page	Addition/revision	Ref or action
5 glossary	EMC and SPC	
6	Renal Appendix 1 *correction*	
8	Licensed drug indications and local use Apixaban and rivaroxaban	Update and NICE approvals
10	Apixaban and drugs interactions	
11	specific assessment of drug level of NOAC in malabsorption, or questions of ompliance	
16/17	Action for <u>initial</u> assessment on admission Re-order of re-assessment recommendation	
19 27/31	Extremes of weight:Obesity Advice re "200u/kg and split the dose and give bd And >150kg do a 4 hour peak anti-Xa and cap if very high *For patients with renal impairment Issue remains re therapeutic in VTE/IHD	?audit
30	Need for/v of LMWH in cancer by 6/12 Who how? Care Pathway in development DVT clinic/Oncology	
44	Vit K 1-3 mg *correction*	
50	Consider Tranexamic Acid (1g i.v.) - Reordered algorithim	
62	provided renal function is adequate (creatinine clearance < 30 ml/min in which case substitute enoxaparin as per appendix 1,	
64	NOAC and surgery	
71	Peri-operative bridging with enoxaparin in CRF *it may be reasonable to limit the total daily dose to 150mg (as = standard dose for a 100kg and so otherwise end up with more than would give with standard dose dalteparin? Cf in STEMI enoxaparin dose is 1mg/kg bd max single dose 150mg but in over 75 0.75mg/kg bd max single 75mg – highest tabled weight is 150kg* Should we include a table for pre-filled dalterparin syringe dose?	
81	EHRA guidance ref	