

Practice patterns for extended venous thromboembolism chemoprophylaxis among urologic oncologists after radical cystectomy (PD60-06)

Christopher P Dall^{1,2}, Nathan Shaw^{1,2}, Jillian Egan^{1,2},
Filipe LF Carvalho^{1,2}, Ross E Krasnow², Lambros
Stamatakis²

¹ Department of Urology, MedStar Georgetown University Hospital, Washington, DC

² Department of Urology, MedStar Washington Hospital Center, Washington, DC

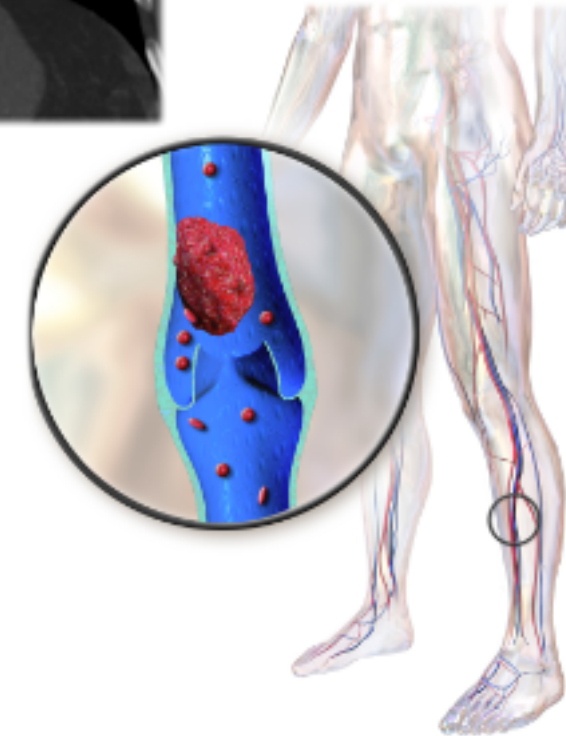
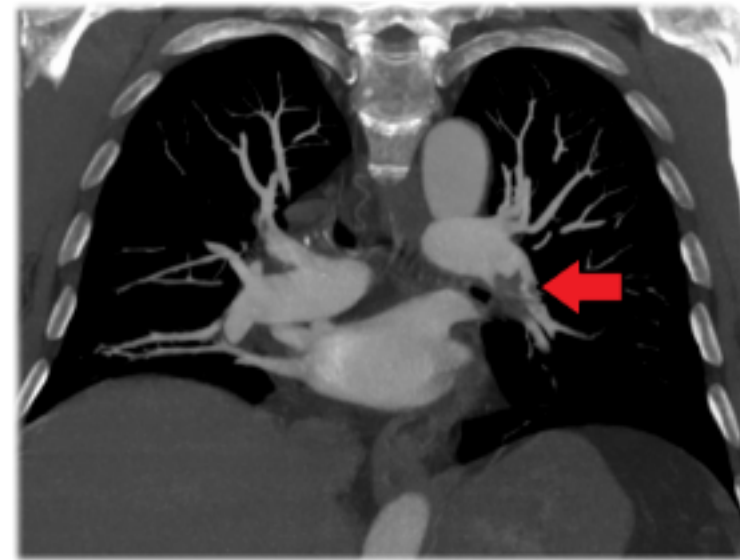


Disclosures

- None

Introduction

- Venous thromboembolism (VTE) occurs in up to 12% of patients after radical cystectomy (RC)¹
- Extended outpatient chemoprophylaxis (ECP) has been found to reduce perioperative morbidity and mortality associated with VTE²
- Little is known about the use of ECP following RC among urologic oncologists.



Aims

To determine urologic oncologists' practices with respect to DVT prophylaxis in both the inpatient and outpatient setting

and

to determine what barriers, if any, are seen with different forms of outpatient chemoprophylaxis

Methods



- Surveyed members of the SUO to determine practice patterns
- Questions on forms of inpatient and outpatient VTE prophylaxis used
 - Also assessed duration of use
- Asked providers to describe patient- or financial-specific barriers to anticoagulant use

Results – demographics of responders

- 121/878 (13.8%) responded
- 83% academic providers
- 65% performed ≥ 10 cystectomies annually
- 51% had practiced for ≥ 5 years

	N	%
Respondents	121/878	13.8
Practice patterns		
Academic	99	82.5
Private Practice	16	13.3
Other	5	4.2
# of years since fellowship		
<5	49	40.5
5-10	20	16.5
11-15	17	14.0
16-20	11	9.1
>20	14	11.6
Did not complete	10	8.3
Cystectomies per year		
0-10	42	34.7
11-25	33	27.3
26-50	29	24.0
51-75	12	10.0
>75	5	4.1

Results- Use of inpatient and outpatient chemoprophylaxis

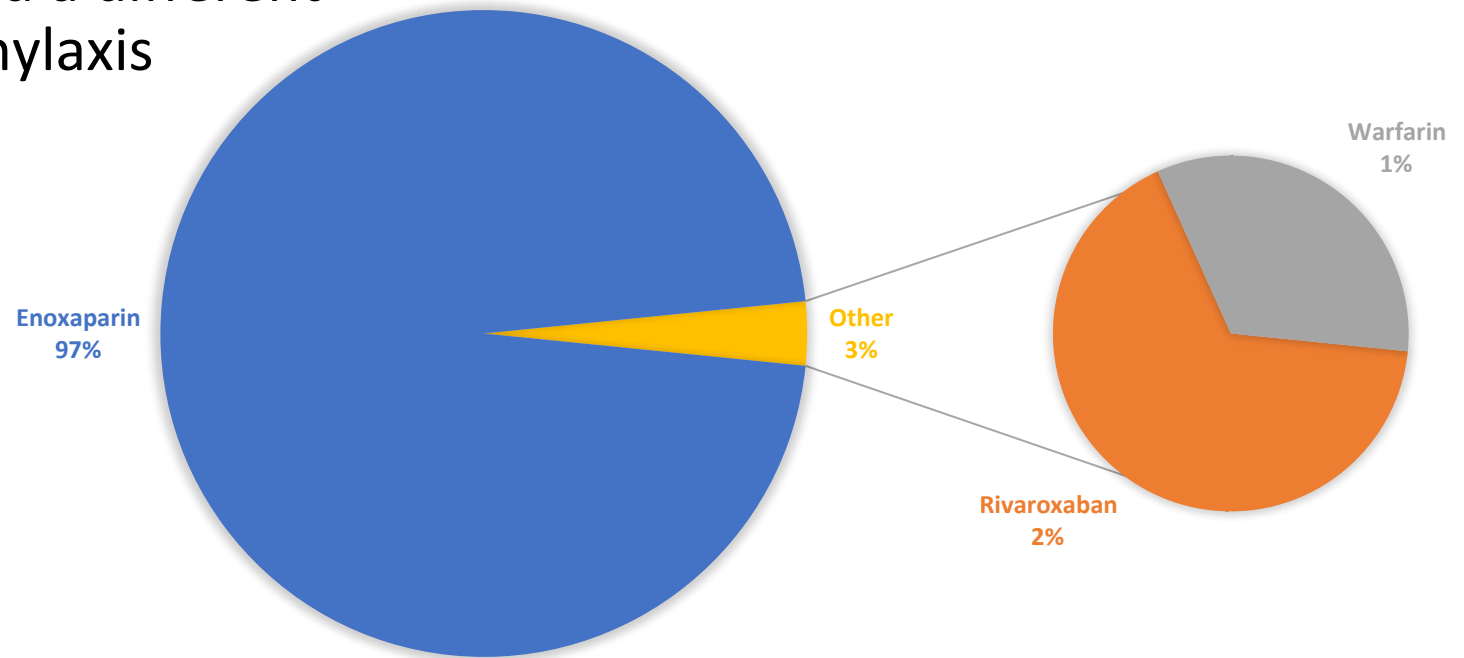
- Most responders used both inpatient and outpatient VTE chemoprophylaxis
 - 98% inpatient
 - 80% outpatient
- ECP was used for at least 3-4 weeks by 98% of study participants

	N	%
Use of inpatient VTE chemoprophylaxis		
Yes, with enoxaparin	72	61
Yes, with SQH	42	35.6
Yes, with DOAC	0	0
Yes, with warfarin	1	0.8
No	2	1.7
Use of outpatient VTE chemoprophylaxis		
Yes	94	80.3
No	23	19.7

Results-type of ECP used

Preference towards enoxaparin

- Only 3 providers used a different form of chemoprophylaxis

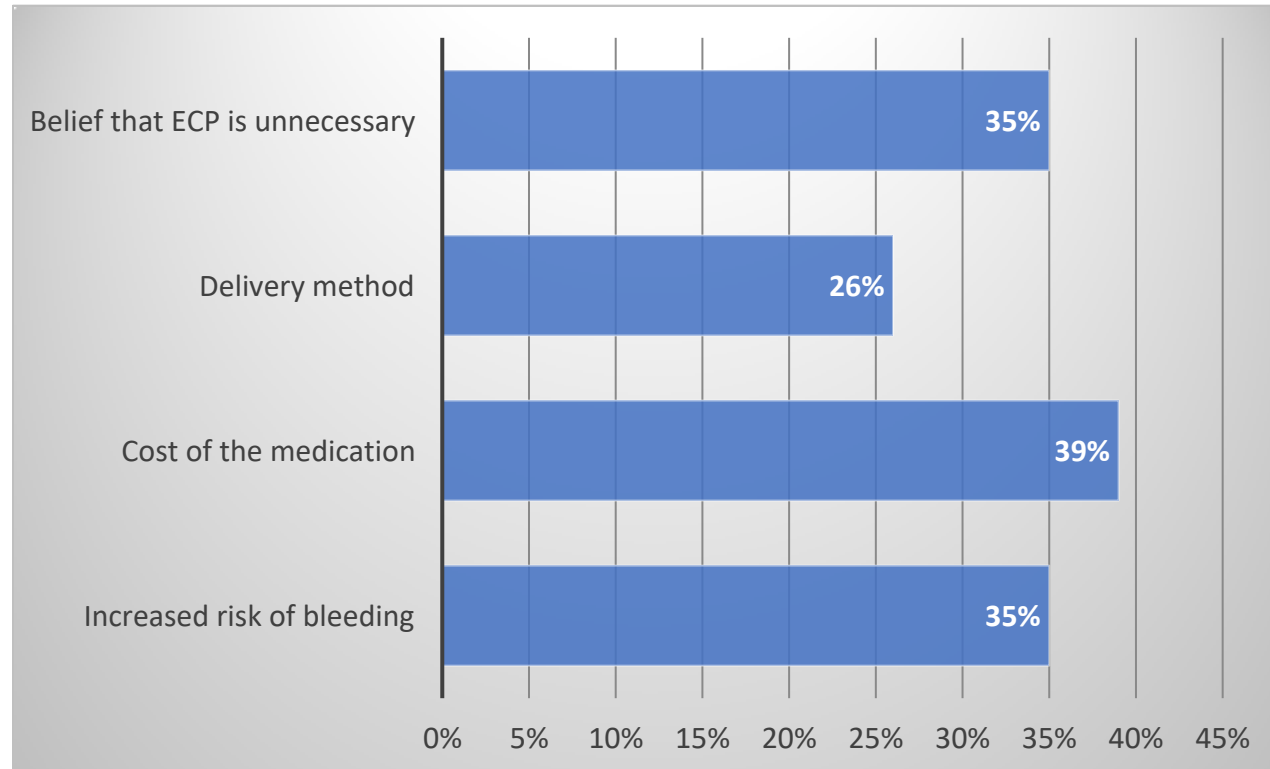


Results-barriers to enoxaparin

Barriers	N	%
Financial		
Lack of insurance coverage	31	37.8
Need for additional insurance authorization	36	43.9
Patient inability to afford the medication	42	51.2
Patient-specific		
Refusal to perform injections at home	15	17.9
Pain with injections	14	16.7
Poor compliance with injections	17	20.2
Side effects	4	4.8
Renal function	4	4.8

Please note providers could select multiple barriers, totals will not equal 100%

Results-reasons for not using ECP



Of the 19.7% of providers who did not use ECP, enoxaparin-specific barriers were cited by a significant number

Limitations

- Poor response rate
 - However, we do not know the percentage of SUO members perform cystectomies
- We did not assess patient adherence to enoxaparin in this study
- Only members of the SUO were queried, thus we cannot generalize to all urologists performing cystectomies

Discussion/Conclusions

- Despite the common use of enoxaparin as ECP, physicians noted significant barriers to its use
- Adherence rates to enoxaparin are low, but patients may have higher rates of compliance with oral forms of anticoagulation^{3,4}
- Use of oral anticoagulants has been associated with improved outcomes in other pelvic extirpative operations, namely in orthopedic populations, but remain understudied for urologic extirpative surgeries^{5,6}
- More research should be done to determine the optimal form of anticoagulation in the post-cystectomy population

References

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Thank you



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