Signa Vitae
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Round Table Discussion V: Palliative Care

Thromboembolism in cancer patients. What should anaesthesiologists know

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Cancer patients are at high risk of thromboembolic complications (deep vein thrombosis, pulmonary embolism) which increase the morbidity and mortality rates. The thromboembolic risk is further increased perioperatively in cancer surgery, rendering its prevention and management a clinical challenge. International Societies and Experts' Panels have addressed this issue in an effort to fill in the existing gaps, since evidence is rather limited.

Thromboprophylaxis should be given to all patients undergoing cancer surgery. It should include pharmacological agents and should be initiated preoperatively and/or as soon as possible postoperatively. Mechanical prophylaxis alone is not recommended, and should be reserved only for cases where pharmacological thromboprophylaxis is contraindicated. Combined pharmacological/mechanical thromboprophylaxis should be used in high risk patients. The patient risk factors, co-morbidities, procedure type/duration and the surgical bleeding risk should be carefully assessed before deciding the scheme, drugs, dosing and timing of thromboprophylaxis. Low Molecular Weight Heparin (is the preferred agent), Unfractionated Heparin (if creatinine clearance <30 mL/min) and possibly Fondaparinux can be used for thromboprophylaxis. There is no consensus on the use of inferior vena cava filters; they are not recommended as a routine thromboprophylactic measure, but their placement could be considered in patients with pulmonary embolism or lower limb proximal deep vein thrombosis (especially during the first 2–4 weeks), if anticoagulants are contraindicated. The risk of intervention-related adverse effects/complications should be taken into account.

Postoperative pharmacological thromboprophylaxis should be maintained for at least 7–10 days. For high risk, major abdominal or pelvic surgery (laparotomy or laparoscopic), thromboprophylaxis should last longer (up to 4 weeks). Patients facing a high risk for both thrombosis and major bleeding should receive mechanical thromboprophylaxis first and pharmacological prophylaxis should be added as soon as possible. Early postoperative ambulation should be encouraged whenever possible.