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ANTICOAGULANT PRIMARY PROPHYLAXIS

PROPHYLACTIC ANTICOAGULATION DECISIONS IN HIGH-RISK PATIENTS RECEIVING CANCER DIRECTED THERAPY: ANALYSIS OF THE VERMONT METHOD

J. Barker[1], K. Libby[1], C. Holmes[2], K. Martin[2]

[1]University of Vermont Health System; [2]Department of Medicine, University of Vermont, Burlington, VT, USA

Introduction. Validated scoring tools, such as the Khorana risk score and Protecht score, identify patients starting cancer directed therapy with the highest VTE risk. Despite guideline recommendations for prophylactic anticoagulation for patients at high-risk of VTE, less than 5% of patients receive VTE education and guideline directed VTE prophylaxis. The *Vermont Model* is a clinical program dedicated to address VTE prevention in ambulatory cancer patients starting systemic therapy, including nurse-driven risk assessment for all patients, and referral to consult with a thrombosis specialist for anticoagulation discussion for high-risk patients. While the *Vermont Model* successfully improved rates of anticoagulation for high-risk patients, the reasons for which anticoagulation was not started in high-risk patients remains unclear.

Aim. We aimed to determine the proportion of high-risk patients started on prophylactic anticoagulation and reasons anticoagulation was not started.

Methods. In this retrospective observational study, we manually reviewed charts of high-risk patients, defined as either Khorana or Protecht Score of 3 or higher seen in the *Vermont Model* between 2018-2023. We categorized reasons that anticoagulation was not recommended into 8 distinct categories. We used descriptive statistics and logistic regression to test associations between no anticoagulation and clinical characteristics.

Results. Of 284 high risk patients, 144 (50.7%) were started on anticoagulation and 140 (49.1%) were not. Of the 140 patients not started on AC, 98 (72%) did not consult with a thrombosis specialists. Out of those 98, 31 (22.3%) had no referral to a thrombosis specialist, 23 (16.6%) were already on anticoagulation, and 20 (14.4%) clinically declined and either transitioned to hospice or died prior to consultation. Of the 42 out of 140 who consulted with thrombosis specialists and were not started on anticoagulation, 16 (39.0%%) had concomitant/interacting medications and 15 (36.6%) were deemed to have a high bleeding risk. Neither tumor type (p=0.09) nor type of treatment (0.56) were associated with starting anticoagulation.

Conclusions. When patients in the *Vermont Model* consulted with a thrombosis specialist, 78.7% started anticoagulation. Ensuring expedited access to discuss primary prophylaxis may increase anticoagulation for high-risk patients starting cancer directed therapy.