

ANTICOAGULATION FORUM

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INSIDE THIS ISSUE:

Letter to CMS.....	page 2
NCBAP Update.....	page 2
Case Vignette.....	page 3
Organizations Table.....	page 4
Updates from Literature.....	page 6

President's Column

David Garcia, MD

As you will see from reading this month's newsletter, the "world of anticoagulation" in late 2007 is anything but boring. I wish to highlight several things that may be of interest to you:

1) The Anticoagulation Forum has added its support to an effort aimed at increasing the number of patients who have access to self-testing machines. Below you will find a letter from the AC Forum to CMS (the administrative agency for Medicare) encouraging them to broaden the indications under which patient self-testing can be paid for.

2) The AC Forum Board of Directors met in Denver, Colorado on October 12. With outstanding leadership from Dr. Edith Nutescu, we performed a SWOT (strengths, weaknesses, opportunities, threats) analysis and have decided to hold a one-and-a-half day retreat in early 2008 to flesh out a long-term strategic plan for the organization. We also decided to improve the AC Forum website - please be on the lookout for a survey in which we will ask you how the website could be more useful. Finally, the Board of Directors continues to work on a "guidelines" paper that will provide consensus opinions and evidence pertinent to the management of chronically anticoagulated patients.

3) I'm pleased to inform you that our series "Anticoagulation Updates from the Literature" continues in this edition of the newsletter, thanks to our fearless editor (and Board member), Dr. Elaine Hylek.

4) I would like to offer heartfelt congratulations to the National Alliance for Thrombosis and Thrombophilia (NATT). Thanks to the hard work of its leadership, NATT has been awarded a large grant from the Centers for Disease Control. The funds from this CDC grant will support not only patients with thrombotic disorders but also the providers who oversee their care. A more detailed description of the grant proposal and NATT's future plans can be found elsewhere in this newsletter.

5) Three new anticoagulant agents have reached the late stage of drug development. Since one or more of these may be available within the next two to three years, I have asked Dr. Alex Spyropoulos write a short piece for our next newsletter that will help all of us to know which trial results we should watch for in the coming months.

I hope that you have a safe and happy holiday season! ■

NATT Update

Randolph Fenninger, NATT President

I am very pleased to report that the Centers for Disease Control and Prevention (CDC) has awarded the National Alliance for Thrombosis and Thrombophilia (NATT) a \$1.35 million two year cooperative agreement for patient and provider outreach and education. The award was announced in late September and is part of a larger CDC program on clotting and bleeding disorders.

This success followed months of hard work by NATT volunteers and Alan Brownstein, our executive director. After the application was submitted the entire NATT family was on pins and needles waiting to hear if CDC would approve the request and how much would be provided if approval was granted. We were delighted on both counts. Not only did CDC accept our proposals, the funding is generous enough to allow NATT to meet the objectives laid out in the application.

NATT will use its two grants to launch a national wake-up call to promote public and healthcare professional awareness of this serious medical condition that each year kills nearly 300,000 Americans. A national initiative called "Stop-The-Clot," will now be launched. The multi-tiered program, one of two receiving funding awards from the CDC, will focus its education and awareness efforts on such objectives as:

- Enhancement of NATT's successful patient seminars into a national Stop-The-Clot Forum series
- Establishment of a comprehensive consumer Clotting Information Resource Center

continued on page 3

To receive the "Anticoagulation Updates from the Literature" via email, please subscribe on our website at www.acforum.org. The "Anticoagulation Updates" provides short summaries of the latest published research and the clinical implications of this research.

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The National Certification Board for Anticoagulation Providers is pleased to announce that it has officially gained non-profit status as a 501(c)(6) organization. This achievement is a result of the diligent efforts of a committee of board members. One notable change in the certification process that accompanies this non-profit status is that the NCBAP can no longer waive the US license requirement for the Certified Anticoagulation Care Provider (CACP) credential. All individuals seeking certification or recertification must possess a current US license in medicine, nursing or pharmacy.

For those CACPs certified on or before December 31, 2002, please note that you must renew your certification prior to December 31, 2007. The application deadline has passed for the remaining paper exams this year, but several online exam dates remain. The schedule of online exam dates and detailed instructions regarding the online exam process are available on the NCBAP website (www.ncbap.org).

The first CACP exam offering of 2008 has been scheduled for February 2, 2008 in Albuquerque, NM. The application deadline for the Albuquerque exam is December 2, 2007. Watch the website for additional 2008 exam dates.

For more information about the CACP process or to download the Candidate Handbook and Application, visit our website: www.ncbap.org. Specific questions can be directed to info@ncbap.org

Letter to CMS Supporting Expanded Funding

Below is the text of a letter sent by the Anticoagulation Forum to the Centers for Medicare and Medicaid Services this past summer. It outlines the AC Forum's support for expanded CMS coverage of home monitoring devices. We expect a decision from CMS in early 2008.

Centers for Medicare and Medicaid Services
Department of Health and Human Services

COMMENT TO: Home Prothrombin Time (INR) Monitoring for Anticoagulation Management (NCD 190.11) Reconsideration Request

SUMMARY: I am writing in support of the Prothrombin-Time Self Testing Coalition's request that CMS expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin

without regard for the underlying condition that determines the need for warfarin.

Dear Ms. Spencer,

I wish to address this comment in support of the formal complete written request for reconsideration under the auspices of the Prothrombin-Time Self Testing Coalition. I am writing to offer my opinion about this request for reconsideration as both a practicing physician at the University of New Mexico Medical Center and as the President of the Anticoagulation Forum (AC Forum).

The AC Forum is a national network of anticoagulation providers with a membership of over 4,000 health care professionals. These providers represent over 1,350 anticoagulation clinics, which care

continued on page 5

Case Vignette

Treatment of Cancer-Associated Thrombosis

*Ann Wittkowsky, PharmD
Lynn Oertel, RN*

THE CALL: The hematology fellow calls your clinic to refer a new patient who has just been diagnosed with DVT, and to request a recommendation for antithrombotic therapy.

THE CASE: TJ is a 53 year old female with a 4 month history of peritoneal mesothelioma. She is currently receiving systemic chemotherapy, and is scheduled for surgical debulking with intra-abdominal hyperthermic chemotherapy in two months. In the last 48 hours, she developed symptoms consistent with left lower extremity DVT and a duplex ultrasound this morning confirmed this diagnosis.

THE PROBLEM: Several recent studies have confirmed that the use of LMWH for the first 3-6 months after VTE in patients with cancer decreases the rate of recurrent thrombosis, in comparison to traditional therapy with 5-7 days of heparin/LMWH followed by warfarin. Consensus guidelines from the American College of Chest Physicians (ACCP) and the National

Comprehensive Cancer Network (NCCN) recommend LMWH for the treatment of cancer-associated thrombosis.

THE SOLUTION: This patient should be started on a LMWH for a minimum of 6 months to treat cancer-associated thrombosis. A baseline hematocrit and platelet count are necessary, and a baseline serum creatinine and total body weight should be obtained to select the appropriate dose. The patient will require comprehensive education on the antithrombotic treatment plan and in addition will need to learn to perform a subcutaneous injection. If the patient is unable or unwilling to self-inject, a family member or a significant other can be taught. The patient should be taught to expect minor bruising at the site of injection, but to report more significant bruising as well as any bleeding complications. Platelet count should be monitored every 2-3 days for the first two weeks of therapy to assess the development of heparin-induced thrombocytopenia. Bleeding complications and recurrent thrombosis should be assessed on an ongoing basis.

Clinic personnel may need to petition her healthcare insurance provider to assure that this recommended therapy is covered financially. If so, copies of current guidelines should be included. ■

Buller HR et al. Chest 2004; 126 (suppl 3): 401-428 (ACCP Guidelines) www.nccn.org/professionals/physician_gls/default.asp (NCCN guidelines).

continued from page 1

NATT Update

- Collaboration with the national Hemophilia Treatment Centers, the Thrombosis and Hemostasis Centers, and the Anticoagulation Forum network for distribution of education materials
- And the development of a regional chapter infrastructure.

The CDC also awarded funding for a nurses and non-physician healthcare professionals' education project that will specifically address the areas of blood clot prevention, diagnosis, treatment and management. The healthcare professionals' education project is deemed an essential element in the fight against blood clots. The program will be delivered nationally through the utilization of evidence-based teaching methods in small group sessions led by trained faculty. The program's ultimate goal is to prevent secondary conditions in people with clotting disorders by improving their access to knowledgeable healthcare providers.

NATT will collaborate with many organizations in its development of a 12-region training program. Patients will be reached throughout the U.S. network of the 140-federally funded Hemophilia Treat-

ment Centers, the CDC Pilot Thrombophilia Centers and through participants of the Anticoagulation Forum.

The announcement has produced a flurry of activity including moving to new headquarters space to house incoming staff, organization of volunteer-staff working groups and setting up liaison with CDC. We look forward to this collaboration with CDC staff and the other organizations that will play a role in successful implementation of the agreement.

While this award directly benefits NATT and its programs, it is also tangible evidence that CDC recognizes the scope of the public health problem that blood clots represent. This is a major step in addressing the needs that CDC has identified and also acknowledges the important role that a consumer and patient based organization can play is helping to solve this major health care need.

For more information about NATT and how you can get involved, visit www.nattinfo.org. ■

Thrombosis Organizations and Interest Groups in the U.S. and Canada

Stephan Moll, MD, Chapel Hill, NC

A number of organizations, societies, coalitions, foundations, networks, consortia, and interest groups exist in the United States and Canada that take an interest in thrombosis – education of public, patients or health care providers, improvement of health care delivery, research, public policy and advocacy. To provide information as to which groups exist and to prevent confusion regarding their identity and the abbreviations used for their names, the following table is presented. Other organizations may exist. While there are clear differences between the goals of some of these groups, there is also much overlap in what they are trying to achieve. This should invite discussions about collaborations, partnerships, and marriages to optimize resources and avoid duplication of efforts. ■

Abbreviated Name	Full name	Website	Founded	Non-profit status? *	
A. HEALTH CARE PROVIDER DRIVEN ORGANIZATIONS					
AC Forum	Anticoagulation Forum	www.acforum.org	1991	yes	Anticoagulation clinic provider group, predominantly then by Dr. D. Garcia, Albuquerque, NM.
HTRS	Hemophilia and Thrombosis Research Society	www.htrs.org	1994	yes	Research organization consisting primarily of hematologists and researchers in research endeavors specific to bleeding and clotting disorders.
VDF	Vascular Disease Foundation	www.vdf.org	1998	yes	Mostly health care providers (predominantly, vascular surgeons) interested in education and improve awareness about vascular disease.
DVT Coalition	DVT Coalition	www.preventdvt.org	2003	no	Group of a variety of organizations and other stakeholders. Spokesperson, amongst others, Melanie Bloom.
VDC	Venous Disease Coalition	none yet	2006	Operates under 501c3 Status of VDF	Newly formed multidisciplinary group of mostly health care providers. Anticipated 2007 Surgeon General Office's "Call to Action" Steering committee: Dr. S. Vendantam, St. Louis; Dr. M. Walker, St. Helena, CA.
ATHN	American Thrombosis and Hemostasis Network	www.athn.net	2006	yes	Mostly hematologists and some non-MD health care providers interested in developing a national database for clinical outcomes research in collaboration with government agencies and non profit organizations in Lusher, Rochester Hills, MI.
NATF	North American Thrombosis Foundation	www.natfonline.org	2006	yes	Mission statement: www.natfonline.org/aboutus.html
INATE	Investigators Against Thromboembolism	www.inate.org	2001	no	Educational website with the mission to improve the education of health care researchers. U.S. core group: Dr. B. Davidson, New York.
ClotCare	ClotCare	www.clotcare.com	2000	no	Educational website for health care providers and patients. Founded by M. Walker, St. Helena, CA. Funded by unrestricted industry grants. Commercial ClotCare software developed by H. Bussey.
AVF	American Venous Forum	www.venous-info.com	1988	yes	Group of vascular surgeons. Forum dedicated to education and research on venous disorders. President: Dr. M. Dalsing, Indianapolis, IN.
TIGC	Thrombosis Interest Group of Canada	www.tigc.org	1991	yes	Group of Canadian health care providers interested in thrombosis. President: Dr. A. Roussin, Montréal, QC.
NCBAP	National Certification Board for Anticoagulation Providers		1998	yes	Multi-disciplinary group of anticoagulation providers interested in the CACP (Certified Anticoagulation Care Provider) certification program.
ACP	American College of Phlebology	www.ncbap.org	1985	yes	Educational organization interested in all aspects of venous disease and varicose vein disease diagnosis and treatment. President: Dr. S. Moll, Chapel Hill, NC.
B. PATIENT DRIVEN ORGANIZATIONS					
NATF	National Alliance for Thrombosis and Thrombophilia	www.phlebology.org	2003	yes	National thrombosis/thrombophilia patient advocacy organization. Chairman of Medical and Scientific Advisory Board: Dr. S. Moll, Chapel Hill, NC.
NHF	National Hemophilia Foundation	www.hemophilia.org	1948	yes	Focused on bleeding disorders since 1948. Recently merged with the American Hemophilia Society. Kessler, Washington, DC.
TAP	Thrombophilia Awareness Project	www.fvleiden.org/tap	2002	yes	Non-profit patient organization, headed by patient Dr. S. Moll, Chapel Hill, NC. fvleiden.org (Q/A section written by Dr. S. Moll, Chapel Hill, NC).

For more information on the Anticoagulation Forum, please visit our website at: www.acforum.org



Anticoagulation FORUM

Description

pharmacists and nurses, some MDs. Founded by and headed until Jan 2007 by Dr. J. Ansell, Boston, since

ologists. President: Dr. L. Valentino, Chicago, IL. Primary purpose is to facilitate basic science and clinical disorders.

surgeons), few patients. President: A. Drooz, Vienna, VA (vascular surgeon). Mission: to provide public cases. Previous focus was on arterial disease, recently also venous disease.

lders in DVT. Eleven people steering committee: www.preventdvt.org/mediaCenter/committeeMembers. Funded by Sanofi-Aventis.

h care providers, formed after a Surgeon General's DVT meeting May 2006. Main focus: to take the "ion" to practical application. Operates with some shared resources with the Vascular Disease Foundation. R. McLafferty, Springfield, IL; Dr. J. Weitz, Hamilton, ON; Dr. S. Goldhaber, Boston.

providers involved in hemophilia care, but also thrombosis care. Creation centers around an interest in analysis research. Mission also includes fostering of collaboration with patients, providers, suppliers, the thrombosis and hemostasis community. Chairpersons: Dr. Amy Shapiro, Indianapolis, IN; Dr. Jeanne

Founder and president: Dr. S. Goldhaber, Boston.

worldwide management of patients with venous thromboembolism. Moderated by thrombosis treaters/ k; Dr. F. Rickles, Washington, DC. Funded by an unrestricted educational grant from Sanofi-Aventis.

ents on optimal use of antithrombotic therapy. Started by pharmacist Dr. H. Bussey, San Antonio, TX and industry grants. This website is separate from www.clotcare.com/thesystem - a website offering the and M. Walker.

ation and exchange of information concerning basic and clinical research in venous and lymphatic

furthering education, research, and improved clinical management relating to thrombosis. Chairman:

that has established a national certification process in the US for anticoagulation providers, leading to credential. Headed by L. Oertel, RN, Boston, MA.

venous disease, but especially in researching and teaching the most innovative and up-to-date methods of ant: Dr. R. Min, New York.

ty group to improve awareness, prevention, diagnosis, treatment, and support relating to thrombosis tific Advisory Board: Dr. S. Moll, Chapel Hill, NC.

incorporated thrombosis into its mission. Chairman of Medical and Scientific Advisory Council: Dr. C.

Deborah Smith, Blue Lake, CA, focusing on patient education via the thrombophilia website www.thrombophilia.org (Chapel Hill, NC).

continued from page 2

Letter to CMS

for over 500,000 individuals on oral anticoagulation therapy; many are Medicare beneficiaries.

Currently, CMS provides coverage for home INR testing of patients with mechanical heart valves. I believe CMS should also cover the cost of such monitoring for patients who are anticoagulated with warfarin for conditions such as deep vein thrombosis (DVT), pulmonary embolism (PE), and atrial fibrillation.

A number of recent studies have clearly documented that patient home monitoring increases the benefits and reduces the harms of anticoagulant therapy:

1. Ansell J, et al. *International Journal of Cardiology*, 2004; 99:37-45
2. Fitzmaurice DA, et al. *British Medical Journal*, 2005; 331(7524): 1057
3. Heneghan C, et al. *The Lancet*, 2006; 367:404-11
4. Menendez-Jandula B, et al. *Annals of Internal Medicine*; 2005;142:1-1

Home monitoring offers patients many benefits, including: increased patient safety, increased "time in therapeutic range", improved quality of life, and reduced loss-of-work time.

Unfortunately, many patients do not currently have access to these benefits because CMS and other 3rd party payers do not provide reimbursement for home testing. I strongly support the Prothrombin-Time Self Testing Coalition's request for CMS to expand the population eligible for coverage of home PT/INR monitoring to patients on long-term warfarin.

Sincerely,

David Garcia, M.D.

Associate Professor, Internal Medicine

University of New Mexico

President, Anticoagulation Forum

(signed on behalf of the AC Forum Board of Directors)



Anticoagulation FORUM



Meta-analysis: Anticoagulant Prophylaxis to Prevent Symptomatic Venous Thromboembolism in Hospitalized Medical Patients

Francesco Dentali, MD; James D. Douketis, MD; Monica Gianni, MD; Wendy Lim, MD; and Mark A. Crowther, MD, MSc

Summary: The rate at which effective antithrombotic prophylaxis is provided to patients with acute medical illnesses is suboptimal. The explanation for sub optimal provision of prophylaxis is unknown. A potential explanation is the lack of evidence that such prophylaxis reduces clinically relevant endpoints. This systematic review assessed the effect of anticoagulant prophylaxis on clinically important outcomes in hospitalized medical patients. In total, 9 studies enrolling 19,958 patients were included. Patients who received anticoagulant prophylaxis had significant reductions in any PE (relative risk, 0.43 [CI, 0.26 to 0.71]; absolute risk reduction, 0.29%; NNTB, 345) and fatal PE (relative risk, 0.38 [CI, 0.21 to 0.69]; absolute risk reduction, 0.25%; NNTB, 400). This benefit was offset by a nonsignificant

increase in major bleeding (relative risk, 1.32 [CI, 0.73 to 2.37]) and there was no impact on all-cause mortality (relative risk, 0.97 [CI, 0.79 to 1.19]).

Clinical Implications: This study suggests that effective anti-thrombotic prophylaxis reduces the risk of clinically apparent venous thromboembolism in patients admitted with an acute medical illness. Ideally, this observation would be confirmed in a large prospective study however the size of the required study probably makes this impractical.

Annals of Internal Medicine 2007;146(4):278-288 ■

Comparison of Outcomes Among Patients Randomized to Warfarin Therapy According to Anticoagulation Control

White HD, Gruber M, Feyzi J, Kaatz S, Tse H-F, Husted S, Albers GW

Summary: This study is a pooled analysis of the 3,587 patients randomized to warfarin in the SPORTIF III and V trials (Stroke Prevention using an Oral Thrombin Inhibitor in atrial Fibrillation). The relationship between INR control and rates of death, bleeding, MI, or stroke was examined. Quality of anticoagulation control was defined as good (>75% time in the 2-3 range), moderate (60-75%), and poor (<60%). Compared to the good control group, the poor control group had higher rates of annual mortality, 4.20% vs 1.69%, major bleeding, 3.85% vs 1.58%, MI, 1.38% vs 0.62%, and

stroke 2.10% vs 1.07%.

Clinical Implications: Time in the 2-3 INR range is associated with decreased death, major hemorrhage, myocardial infarction, and stroke. Overall, approximately 1/3 of patients enrolled in the SPORTIF trials had INR values in the 2-3 range for more than 75% of the observation time.

Archives of Internal Medicine 2007;167:239-245. ■

The Influence of Patient Adherence on Anticoagulation Control with Warfarin. Results from the International Normalized Ratio Adherence and Genetics (IN-RANGE) Study

Kimmel SE, Chen Z, Price M, Parker CS, Metlay JP et al.

Summary: This study of 136 patients in 3 anticoagulation clinics used an electronic Medication Event Monitoring System over a mean of 32 weeks to record the date and time that the warfarin prescription bottle was opened by each patient. Under-adherence, as evaluated by lack of prescription bottle opening, was significantly associated with under-anticoagulation. Thirty-six percent of patients missed more than 20% of bottle openings, equivalent to 1-2 missed doses per week.

Clinical Implications: Poor adherence to anticoagulant therapy significantly influences the stability of anticoagulant control, and is common even in the anticoagulation clinic where adherence is stressed repeatedly throughout therapy.

Archives of Internal Medicine 2007; 167:229-35. ■

Combined Aspirin-Oral Anticoagulant Therapy Compared to Oral Anticoagulant Therapy Alone Among Patients at Risk for Cardiovascular Disease. A Meta-Analysis of Randomized Trials

Dentali F, Douketis JD, Lim W, Crowther M.

Summary: This meta-analysis evaluated the results of 10 clinical trials in which oral anticoagulant therapy was combined with aspirin and compared to oral anticoagulation alone. The 4,180 patients included were anticoagulated for mechanical heart valves, atrial fibrillation or coronary artery disease. Compared to oral anticoagulation alone, combined therapy was associated with a lower incidence of arterial thromboembolism (OR 0.66) but the benefits were limited to patients with mechanical valve replacement (OR 0.27). Combined

therapy did not benefit patients with atrial fibrillation (OR 0.99) or CAD (OR 0.69). Combined therapy did not influence all cause mortality, but increased the risk of major bleeding (OR 1.43).

Clinical Implications: Combining aspirin with oral anticoagulant therapy appears to benefit only patients with mechanical heart valves, and increases the risk of major bleeding.

Archives of Internal Medicine 2007; 167:117-124. ■

Factor IX Inhibitors as Novel Anticoagulants (Brief Review)

Howard EL, Becker KCD, Rusconi C, Becker RC

Summary: A contemporary review of factor IXa Biology in cell-based coagulation and evolving platform for pharmacologic inhibition. Factor IXa is a pivotal protease in coagulation. It is the only soluble coagulation protein that can diffuse from tissue factor-bearing cells to platelets, wherein complex formation with factor VIIIa leads to thrombin generation. Factor IXa inhibitors range from active site blocked antagonists to RNA aptamers (with complimentary antidotes that target binding exosites).

Clinical Implications: An ability to attenuate thrombin generation both on tissue factor-bearing cells and platelets, coupled with drug regulating systems that employ pharmacologically-inert antidotes, may foster safe and effective management of thrombotic disorders and use in prothrombotic extracorporeal circulatory devices.

Arteriosclerosis, Thrombosis and Vascular Biology 2007;27:722-727 ■

Vitamin K Supplementation Can Improve Stability of Anticoagulation for Patients with Unexplained Variability in Response to Warfarin

Elizabeth Sconce, Peter Avery, Hilary Wynne, Farhad Kamali

Summary: Some studies suggest that patients on warfarin with unexplained, unstable INRs have poor, or fluctuating levels of vitamin K intake, and that even small changes in diet may have large effects on the INR. Seventy unstable warfarin-treated patients were randomly assigned to receive 150 ug daily of oral vitamin K or placebo (double blind) for 6 months. Therapeutic control was measured in each group during the 6 months and compared between groups as well as with the degree of control in the preceding 6 months leading up to randomization. Vitamin K supplementation resulted in a significant reduction in the standard deviation of the INR compared to placebo ($p < 0.001$), and a significant increase in time in therapeutic range (59% to 87% in the treated group; a 28% improvement vs 63% to 78% in the placebo group; a 15% improvement;

$p < 0.01$). Anticoagulant control improved in 33/35 patients receiving vitamin K supplementation and only 24/33 placebo patients. Vitamin K supplementation also resulted in an increase in daily warfarin dose requirements of 16% compared to 1.5% in the placebo group.

Clinical Implications: Patients with unexplained instability of their INR control may benefit from a trial of a small daily dose of oral vitamin K (~150 ug/day). Such therapy may stabilize vitamin K levels of individuals who have poor reserves. One must monitor the INR closely during such an intervention because patients will likely need a boost in their warfarin dose to counter the increase in vitamin K intake.

Blood 2007; 109:2419-2433. ■

High Density Lipoprotein and the Risk of Recurrent Venous Thromboembolism

Eichlinger S, Pechneiniuk NM, Hron G et al.

Summary: The investigators studied 772 patients after a first spontaneous VTE (average f/u 48 months) and recorded the end point of recurrent VTE, which occurred in 100 patients. The relationship between plasma lipoprotein parameters and recurrence was evaluated. Patients with, as compared to those without VTE recurrence had lower levels of apolipoprotein AI (1.12 ± 0.22 versus 1.23 ± 0.27 , $p < 0.001$). There was strong trend for an association between recurrence and low levels of HDL particles and HDL cholesterol.

Clinical Implications: The relationship between venous and arterial thrombosis is recognized for several acquired thrombophilias; however, the interface of traditional risk factors for atherosclerosis, such as low HDL cholesterol and VTE has received less attention. The "link" may relate to HDLs effect on Activated Protein C, endothelial cell nitric oxide synthesis and vascular proinflammatory responses.

Circulation 2007;115:1609-1614. ■

Registry of Interactions between Oral Anticoagulants and Dietary Supplements

The ClotCare Registry of Interactions between Oral Anticoagulants and Dietary Supplements is now available online. At this time, anticoagulation clinicians are invited to begin using the registry to report observed interactions between warfarin and dietary or herbal supplements. The system will ask the reporting clinician to check responses to several questions in order to grade the strength of the data being reported. Development is currently underway to make this registry searchable so that cases reported may be reviewed by others. More information about this registry may be accessed at: <http://www.clotcare.com/clotcare/warfarinherbalregistry.aspx> ■

Conference Proceedings

The Journal of Thrombosis and Thrombolysis will again be publishing the Anticoagulation Forum's National Conference proceedings. This special issue will include the manuscripts from each conference speaker as well as the abstracts that were presented at the conference. We expect the Journal to be published in early 2008. To request a free copy of the journal, please email Liz Goldstein at info@acforum.org with your mailing address.

Save the Date

The AC Forum will be holding its 10th National Conference on Anticoagulant Therapy May 7-9, 2009. The Event will be held at the Manchester Grand Hyatt Hotel in San Diego, California.
We hope to see you there!

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