

Editorial

The incidence and risk factors of venous thromboembolism in hospitalized cancer patients

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Cancer is a known risk factor for venous thromboembolism (VTE) in hospitalized patients.¹ Many risk assessment models include active malignancy as a factor in determining the need for thromboprophylaxis in the inpatient medical setting.²⁻⁵ For cancers requiring surgical treatment, the risk of inpatient VTE is also high and extends for 4-6 weeks postoperatively, particularly after abdominal or pelvic surgery.⁶ Due to the significant risk of VTE in cancer patients, thromboprophylaxis-whether medical or mechanical is recommended in the surgical setting.⁷⁻⁸ However, in medically ill patients, active cancer alone does not typically score high enough in risk assessment models to warrant thromboprophylaxis for all patients.²⁻⁵ Other factors, such as prolonged immobility and active infection, should also be considered.²⁻⁵ It is important to note that the studies shaping these guidelines were primarily conducted in Western populations. In contrast, clinical practices in Asian countries, including Thailand, may not follow the same approach due to the lower prevalence of thrombosis and lower awareness of thrombotic risks.

In this issue, Limpawittayakul, et al. explored the incidence of VTE in cancer patients admitted to the hospital for medical illness and surgical treatment. Additionally, they analyzed the risk factors for VTE in this subgroup of patients. The study demonstrated a high risk of VTE in this setting, with an overall incidence of 21.1%. The highest incidence of VTE was observed in patients undergoing surgical treatments, specifically

orthopedic and abdominal surgeries. Female sex, poor performance status according to the Eastern Cooperative Oncology Group and surgical treatment were identified as significant risk factors for VTE in the study.

Regarding the recent guidelines, thromboprophylaxis is recommended for medical cancer patients, particularly those with acute medical illness and immobility.⁷ For patients undergoing surgical treatment, thromboprophylaxis should be offered, with medical prophylaxis preferred over mechanical prophylaxis, except in those with a high bleeding risk. Additionally, patients undergoing high-risk surgeries may benefit from prophylactic anticoagulation for up to four weeks.⁷⁻⁸ This study has shown a significant rate of thrombotic events in Thai patients. These findings pave the way for further research to identify which patients, particularly in Asian populations, would benefit most from VTE prophylaxis while considering the balance of bleeding risks.

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