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Dimakakos, Evangelos; Gomatou, Georgia; Catalano, Mariella; Olinic, Dan-Mircea; Spyropoulos, Alex C.; Falanga, Anna

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Review

Thromboembolic Disease in Patients With Cancer and COVID-19: Risk Factors, Prevention and Practical Thromboprophylaxis Recommendations—State-of-the-Art

EVANGELOS DIMAKAKOS^{1*}, GEORGIA GOMATOU^{1*}, MARIELLA CATALANO², DAN-MIRCEA OLINIC³, ALEX C. SPYROPOULOS^{4,5}, ANNA FALANGA^{6,7}, ANTHONY MARAVEYAS⁸, AARON LIEW⁹, SAM SCHULMAN¹⁰, JILL BELCH¹¹, GRIGORIOS GEROTZIAFAS^{12,13}, PETER MARSCHANG¹⁴, BENILDE COSMI¹⁵, JONAS SPAAK¹⁶, KONSTANTINOS SYRIGOS¹ and CANCER-COVID-19 THROMBOSIS COLLABORATIVE GROUP, endorsed by VAS-European Independent Foundation in Angiology/Vascular Medicine, UEMS Vascular Medicine/Angiology and European Society of Vascular Medicine, and supported by the Balkan Working Group for Prevention and Treatment of Venous Thromboembolism and Hellenic Association of Lung Cancer

¹Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece;

²Research Center on Vascular Disease & Angiology Unit,

Department of Biomedical Science, L Sacco Hospital, University of Milan, Milan, Italy;

³Medical Clinic No. 1, "Iuliu Hatieganu" University of Medicine and Pharmacy, Cluj-Napoca, Romania;

⁴Feinstein Institutes for Medical Research and The Donald and Barbara Zucker School of Medicine at Hofstra/Northwell Hempstead, Hempstead, NY, U.S.A.;

⁵Department of Medicine Northwell Health at Lenox Hill Hospital, New York, NY, U.S.A.;

⁶University of Milan Bicocca, School of Medicine, Milan, Italy;

⁷Department of Immunohematology and Transfusion Medicine, Hospital Papa Giovanni XXIII, Bergamo, Italy;

⁸Queens Centre Oncology & Hematology Faculty of Health Sciences Hull York Medical School Cottingham, Hull, U.K.;

⁹School of Medicine, College of Medicine Nursing and Health Sciences, National University of Ireland Galway (NUIG), and Portiuncula University Hospital & Galway University Hospital, Saolta University Health Care Group, Galway, Ireland;

¹⁰Department of Medicine and Thrombosis and Atherosclerosis Research Institute, McMaster University, Hamilton, ON, Canada;

¹¹Institute of Cardiovascular Research, University of Dundee, Ninewells Hospital and Medical School, Dundee, U.K.;

¹²Sorbonne University, Institut National de la Santé et de la Recherche Médicale (INSERM), Unit 938, Research Group Cancer, Biology and Therapeutics, Centre de Recherche Saint-Antoine (CRSA), Institut Universitaire de Cancérologie, Paris, France;

¹³Thrombosis Center, Tenon-Saint Antoine, Hôpitaux Universitaires de l'Est Parisien, Assistance Publique Hôpitaux de Paris (APHP), Paris, France;

¹⁴Department of Internal Medicine, Central Hospital of Bolzano (SABES-ASDAA), Bolzano, Italy;

¹⁵Division of Angiology and Blood Coagulation, Department of Specialty, Diagnostics and Experimental Medicine, University of Bologna, IRCCS S.Orsola Malpighi Research Institute, Bologna, Italy;

¹⁶Department of Clinical Sciences, Danderyd University Hospital, Karolinska Institutet, Stockholm, Sweden

*These Authors contributed equally to this study.

Correspondence to: Georgia Gomatou, 3rd Department of Medicine, "Sotiria" General Hospital, Messogion Ave 152, Athens 11527, Greece. Tel: +30 2107763332, Fax: +30 2107778838, e-mail: georgiagom@med.uoa.gr

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Abstract. Cancer and COVID-19 are both well-established risk factors predisposing to thrombosis. Both disease entities are correlated with increased incidence of venous thrombotic events through multifaceted pathogenic mechanisms involving the interaction of cancer cells or SARS-CoV2 on the one hand and the coagulation system and endothelial cells on the other hand. Thromboprophylaxis is recommended for hospitalized patients with active cancer and high-risk outpatients with cancer receiving anticancer treatment. Universal thromboprophylaxis with a high prophylactic dose of low molecular weight heparins (LMWH) or therapeutic dose in select patients, is currently

indicated for hospitalized patients with COVID-19. Also, prophylactic anticoagulation is recommended for outpatients with COVID-19 at high risk for thrombosis or disease worsening. However, whether there is an additive risk of thrombosis when a patient with cancer is infected with SARS-CoV2 remains unclear. In the current review, we summarize and critically discuss the literature regarding the epidemiology of thrombotic events in patients with cancer and concomitant COVID-19, the thrombotic risk assessment, and the recommendations on thromboprophylaxis for this subgroup of patients. Current data do not support an additive thrombotic risk for patients with cancer and COVID-19. Of note, patients with cancer have less access to intensive care unit care, a setting associated with high thrombotic risk. Based on current evidence, patients with cancer and COVID-19 should be assessed with well-established risk assessment models for medically ill patients and receive thromboprophylaxis, preferentially with LMWH, according to existing recommendations. Prospective trials on well-characterized populations do not exist.

The coronavirus disease 2019 (COVID-19) pandemic, caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), is an ongoing global health crisis with catastrophic social and economic impact that has been unparalleled in the last 100 years (1). COVID-19 is a systemic disease that implicates activation of endothelial cell and blood hypercoagulability and its manifestations vary from asymptomatic to severe respiratory dysfunction and multi-organ failure (1). Early in the pandemic, it was observed that COVID-19 is associated with abnormal coagulation parameters coupled with the occurrence of both arterial and venous thromboembolic events, and also with potential bleeding manifestations in certain patients (2, 3). Regarding venous thromboembolic events (VTEs), many epidemiological studies report a high incidence in patients with COVID-19 (4-6), and, additionally, it has been demonstrated that early prophylactic anticoagulation is associated with improved clinical outcome and with some survival benefit (7-9). Therefore, it is recommended that hospitalized patients with COVID-19 and outpatients with COVID-19 at high risk of VTE or high risk of disease worsening receive prophylactic anticoagulation; the dose and duration of thromboprophylaxis though vary according to different guidelines (10). It should be noted that each patient carries an individual risk factor for thrombosis. The degree of COVID-19 severity together with the individual's physical condition and comorbidities determine the total risk of disease worsening and thrombosis (10).

Patients with cancer and COVID-19 are a particularly vulnerable subgroup since they might be immunocompromised due to anticancer therapy or cancer itself, or due to old age with other underlying comorbidities (11). It has been shown that 30-day all-cause mortality is high for patients with COVID-19 and cancer (11, 12) and these patients have an

increased case-fatality rate compared to patients without cancer (13). It is well-established that cancer carries an intrinsic risk for thrombosis, which is heterogeneous across different malignancies (14). Intriguingly, the similarities between cancer and COVID-19 regarding their pro-thrombotic effect have been highlighted (15); however, whether there is an additive effect in the risk of thromboembolic events when a patient with cancer is infected with SARS-CoV-2 remains unclear (16). Hence, there are no particular recommendations for prophylactic anticoagulation in patients with cancer and COVID-19 in inpatient or outpatient settings (10). Given the ongoing pandemic, it is helpful to identify any distinct characteristics and requirements of each subgroup of patients to deliver the appropriate antithrombotic treatment. In this context, the aim of this review was to summarize and critically discuss the current evidence on thrombotic risk and prophylactic anticoagulation strategies in patients with cancer and COVID-19.

COVID-19 and Thrombosis

Epidemiology. COVID-19 is associated with a pattern of hypercoagulability coupled with a high incidence of thrombotic phenomena (2). A large body of epidemiological studies has established a strong association between severe COVID-19 with an increased VTE risk, including pulmonary embolism (PE) and deep vein thrombosis (DVT) (17-21). In a meta-analysis of 102 studies with follow-up duration that ranged from 8 to 86 days, the overall prevalence rates of PE and DVT among patients with COVID-19 were 7.8% and 11.2%, respectively, with statistically significant higher prevalence in the series that systematically screened patients compared to series of symptomatic patients (22). The rate of patients receiving pharmacological thromboprophylaxis among the included studies of this meta-analysis ranged from 16% to 100% (22). The incidence of VTEs is associated with the severity of COVID-19, with the highest risk observed in critically ill patients in the intensive care unit (ICU) (19, 23). The manifestation of VTE is associated with about 2-fold increased mortality. Interestingly, *in situ* thrombosis in small pulmonary vessels (termed "pulmonary intravascular coagulation") seems relevant in COVID-19, as revealed from several autopsy studies of patients whose cause of death was COVID-19 (24). SARS-CoV-2 infection might also be associated with an increased prevalence of arterial thrombotic events such as ischemic stroke, systemic arterial embolism, mesenteric ischemia and limb ischemia, which occur in approximately 4% of critically ill COVID-19 patients (25). Hemorrhage may occur in patients with severe COVID-19, indicating a COVID-19-related endothelium damage effect though its incidence is significantly lower as compared to thrombosis, particularly regarding clinically relevant, major bleeding events (17, 26).

Pathogenesis. Several mechanisms have been proposed in order to explain the hypercoagulability of COVID-19. All of them can be assessed by applying the principles of Virchow's triad, *i.e.*, the three pillars for thrombogenesis: (a) blood stasis, (b) endothelial injury, and (c) hypercoagulability (27). Hospitalized and, especially, critically ill patients are in prolonged immobility, thus they exhibit blood stasis. It is well known that SARS-CoV-2 infects host cells *via* binding to angiotensin-converting enzyme-2 (ACE2) and facilitated by transmembrane protease serine type 2 (TMPRSS2) in S protein priming (28, 29). ACE2 is abundantly expressed in a variety of cells in different tissues, mainly in lung alveolar epithelial cells, cardiac myocytes, and vascular endothelium (30). Endothelial cells account for one-third of the overall cellular population of the lungs. The direct invasion of the virus leads to endothelial cell injury, which disrupts the antithrombotic functions of endothelial cells (31-33). Initial evidence of endothelial injury comes from the elevated von Willebrand factor (VWF) levels, a glycoprotein synthesized by megakaryocytes and endothelial cells, which initiates platelet adhesion as a response to endothelial damage (34, 35). Accumulating evidence have documented that endothelial cell activation is a constituent process upon SARS-CoV-2 infection and COVID-19 (36). Accordingly, biomarkers of endothelial cell activation, *e.g.*, soluble thrombomodulin, free tissue factor pathway inhibitor (TFPI) and tissue factor (TF) activity in plasma are prognostic risk factors for intubation and death (37). Biomarkers of hypercoagulability and particularly increased levels of D-Dimers are predictors of disease worsening and mortality (38). Finally, activated neutrophils and their ability to release extracellular chromatin and form neutrophils extracellular traps (NETs), induce thrombus formation and appear to be potentially implicated in COVID-19 thrombosis (39).

Thrombotic risk assessment. Patients with COVID-19 are considered as a high VTE risk population *per se*. However, individual thrombotic risk stratification is highly recommended, and is valuable in daily clinical practice in order to initiate prophylaxis interventions and monitor patients throughout the disease. In this context, already established and validated risk assessment models (RAMs) for acutely ill hospitalized medical patients, namely the Padua Prediction Score (PPS), the International Medical Prevention Registry on Venous Thromboembolism (IMPROVE-RAM), and the Geneva Risk Score (40), are currently utilized and recommended for patients with COVID-19 particularly at the outpatient setting (41, 42). Also, a modified version of IMPROVE incorporating D-dimers, the IMPROVE-DD model, has been externally validated in patients with COVID-19 (43, 44). The risk assessment of disease worsening is also important when managing patients with COVID-19. To this end, COMPASS-COVID-19 has been

developed in order to identify patients with COVID-19 at risk of clinical deterioration and remains to be externally validated (45).

Thromboprophylaxis recommendations. Given the high thrombotic risk in patients with COVID-19, thromboprophylaxis strategies were early initiated in hospitalized patients with COVID-19 and associated with a survival benefit (7, 8). Therefore, universal prophylactic thromboprophylaxis, chiefly with the use of low molecular weight heparin (LMWH), is currently recommended for hospitalized patients with COVID-19 in all national and international guidelines (10, 46, 47). Defining the optimal dose for high-risk inpatients with COVID-19, with the use of higher-than-usual prophylactic doses has been investigated (48). Evidence from randomized control trials (RCTs) now supports the use of therapeutic-dose LMWH in select ward (non-ICU) COVID-19 inpatients (49-51), which are endorsed by international antithrombotic guidelines (46, 47). Regarding outpatients, guidelines recommend non-pharmacological measures for all COVID-19 patients, such as adequate mobility and hydration, and pharmacological interventions in patients with high VTE and low bleeding risk as well as in patients at high risk of disease worsening (47). A recent 4-arm RCT in COVID-19 outpatients did not show benefit of the direct oral anticoagulant (DOAC) apixaban or aspirin, although the trial was underpowered, and the results of two other trials with LMWH and the DOAC rivaroxaban are pending (52, 53). It is suggested that post-discharge patients are prescribed prolonged thromboprophylaxis up to 45 days in the case of high VTE risk (10). A recent RCT investigating the use of thrombo-prophylaxis in the post-discharge setting showed that rivaroxaban 10 mg/day for 35 days improved clinical outcomes compared with no extended thromboprophylaxis (54).

Cancer-associated Thrombosis

Epidemiology. In 1865, French physician Armand Trousseau, after the irony of self-diagnosis, reported migratory thrombophlebitis as a complication of cancer, from which he died two years later, in 1867 (55). Since then, various studies have revealed the correlation between thrombosis and cancer. Thrombotic events that occur in the setting of malignancy are referred to as cancer-associated thrombosis (CAT). CAT constitutes the second leading cause of mortality among cancer patients (14).

The devastating thromboembolic events in malignancy can affect the venous and arterial systems. Venous thromboembolic events, including DVT and PE, are more common and well-studied thrombotic manifestations in cancer patients than arterial thrombotic events (ATE) (56). It is estimated that cancer patients have a 5-to-7-fold increased risk of developing VTE (57), and approximately 20% of all VTE cases are

attributed to malignancy (58). The estimated annual incidence of VTE in cancer patients is 0.5% compared with 0.1% in the general population and is associated with shortened survival (57, 59). Notably, unprovoked VTE can be the first manifestation of a previous undiagnosed tumor (60). Regarding ATE, a recent study with data derived from the Surveillance, Epidemiology and End Results (SEER) database demonstrated that cancer patients have a 2-fold increased risk for ATEs (61).

Pathogenesis. The aberrant hemostasis of malignancy has a complex pathogenesis and involves several interactions of tumor cells with the clotting system. Drivers of CAT pathogenesis are the production of procoagulant substances, increased systemic inflammation, and tumor-induced platelet aggregation.

Tissue factor (TF) is a key player of the hypercoagulable state of malignancy. TF is an integral glycoprotein with a high affinity for factor VII/VIIa and, under normal conditions, is separated from the blood by the vascular endothelium (62). In the case of vascular injury or induced expression by endothelial cells, TF becomes exposed to blood and binds FVII/FVIIa. The complex TF/FVIIa enables the initiation of thrombin generation *via* the proteolytic activation of factors IX and X (63). TF is highly expressed in many types of cancer (pancreatic adenocarcinoma, glioma, ovarian cancer), leading to the initiation of the extrinsic coagulation pathway (64). Fibrin clot formation also plays a role in tumor metastasis by protecting circulating cancer cells from shear stress and natural killer cell-mediated attack (64). Other factors derived from cancer cells and contributing to CAT pathogenesis include extracellular vesicles, which are small membrane-enclosed structures that may express TF and phosphatidylserine in their surface and carry procoagulant potential (65-67), and cancer procoagulant (CP), a cysteine protease that directly activates factor X (57). Inflammatory cytokines, such as tumor necrosis factor- α , interleukin-1, and vascular endothelial growth factor, induce the production of TF, decrease the expression of the anticoagulant thrombomodulin (57) and podoplanin, and promote the proliferation of megakaryocytes and formation of platelets (68-71). Also, it has been demonstrated that cancers, through a systemic effect, can induce an increase in peripheral blood neutrophils and promote the formation of NETs which are then released into the extracellular space (72). NETs show pro-coagulant/pro-thrombotic characteristics by serving as scaffolds for blood cells' aggregations or with interactions with other molecules (72).

Thrombotic risk assessment. Thrombotic risk is highly heterogeneous among patients with cancer, as cancer is a heterogeneous disease itself. Each cancer type carries a differential intrinsic risk for thrombosis. Pancreatic and gastric cancers are associated with the highest thrombotic risk, followed by lung, testicular, gynecologic, bladder and central nervous system cancers, which are also frequently

complicated with VTE (73). However, prostate cancer, breast cancer, and melanoma are less commonly associated with VTE (58). Advanced stage of cancer is associated with increased risk for VTE as compared to localized stage (14). The time since cancer diagnosis as well as the type of the anticancer treatment are major determinants of the risk of cancer associated thrombosis (74).

Apart from cancer-related risk factors, patient-related and therapy-related risk factors predisposing to CAT have been identified. More specifically, patient-related factors include age (≥ 65 years), female sex, black race, comorbid conditions (obesity, heart or respiratory disease, renal failure, acute infection, cardiovascular risk factors or disease), immobility, and previous history of VTE (75). Therapy-related factors include major surgery (76), central venous catheters (77), and differential risk associated with chemotherapy agents, where the highest risk is associated with cisplatin, L-asparaginase, thalidomide, lenalidomide and tamoxifen (78). An increased risk for ATE has been linked to the use of angiogenesis inhibitors (bevacizumab, aflibercept) and several anti-angiogenic tyrosine-kinase inhibitors (sorafenib, sunitinib, pazopanib) or bcr-abl tyrosine kinase inhibitors (nilotinib, ponatinib) (79).

Several biomarkers have been extensively investigated as potentially predictive of VTE risk. Complete blood count, being practical and ubiquitously available in clinical practice, has been widely studied to predict VTE. In prospective studies of cancer patients, both elevated leukocyte and platelet counts, and low hemoglobin levels were associated with increased risk of initial VTE. Other biomarkers include D-dimers, tissue factor, and novel markers such as NETs, procoagulant phospholipid dependent clotting time, and thrombin generation assay as well as genetic polymorphisms (80).

Risk stratification models based on clinical characteristics and biomarkers have been developed to assess VTE risk in cancer. The Khorana score is the most well-known and can be easily applied to patients with active cancer before the initiation of anticancer treatment (81). However, it has a low accuracy in the evaluation of the risk for VTE particularly in patients with cancer associated with moderate or low risk (*i.e.*, lung cancer, breast cancer, prostate cancer, gynecological and colon cancer as well as in lymphoma) and it is not applicable after anticancer treatment initiation (82). The COMPASS-CAT score has been independently validated and is accurate for the prediction of VTE in patients with breast, lung, colon or ovarian cancer (83). Other scoring systems, such as VIENNA CATS, PROTECT, and CONKO have been proposed for the evaluation of the risk of CAT in ambulatory patients receiving anticancer therapy (82-87).

Thromboprophylaxis recommendations. According to international guidelines, patients with active cancer should be offered pharmacological thromboprophylaxis in the case

of hospitalization or when they are undergoing cancer surgery. At the outpatient setting, cancer patients receiving anticancer therapy who are at high risk of VTE should receive pharmacological thromboprophylaxis. More specifically, it is suggested that the individual VTE risk of each patient should be assessed with relevant risk stratification models and administration of prophylactic anticoagulation should be considered in high-risk ambulatory patients (88). Parenteral anticoagulants are recommended as first line thromboprophylaxis. DOACs and particularly the specific direct inhibitors of factor Xa (apixaban, betrixaban, edoxaban and rivaroxaban) are becoming promising alternatives to LMWH in the prevention of CAT (89-91).

Thrombosis in Patients With Cancer and COVID-19

Despite the abundance of epidemiological studies on VTE risk in patients with COVID-19 and even though active cancer has been reported as an independent risk factor for symptomatic VTE in patients hospitalized due to COVID-19 (92), there is scarce data from cohorts designed to include specifically this particular subgroup of patients.

In one of the first studies on the incidence of thrombosis and bleeding events in patients with cancer who were hospitalized due to COVID-19, the cumulative incidence of thrombotic events was 18.2% at day 28 in the non-cancer cohort and 14.2% in the cancer cohort. The cumulative incidence of major bleedings at day 28 was 20.8% in the non-cancer group and 19.5% in the cancer cohort. Therefore, the results did not indicate any difference in thrombotic or bleeding risk for patients with cancer (93). Similarly, in a French cohort, it was demonstrated that patients with and without active cancer who were hospitalized due to COVID-19 shared similar outcomes in terms of death, admission in intensive care, or thrombosis/bleeding (94). More specifically, symptomatic DVT occurred in 1.6% of patients with active cancer compared to 1.0% of patients without cancer, and symptomatic PE was diagnosed in 3.2% *versus* 8.5%, respectively (94). No significant differences related to a cumulative incidence of thrombosis between cancer and non-cancer groups were detected (9.8% *vs.* 5.80%) in another study from Spain. Thus, the authors conclude that the thrombotic effect of COVID-19 is not as evident in patients with cancer and does not appear to add to the pro-thrombotic activity of cancer (95).

In another prospective study of patients with non-hematological malignancies and COVID-19, the cumulative incidence of VTE (both symptomatic and asymptomatic) on day 14 after admission was estimated at 10%, without new VTE events after hospital discharge and up to 90 days follow-up; however, the study did not include a control group (96). In another cohort of 90 patients with COVID-19 and active cancer diagnosis, 11 (12.2%) patients were found to have 13 new thromboembolic events within 30 days of

COVID-19 diagnosis: 8 (8.9%) arterial and 5 (5.6%) venous (97). In this study, other factors related to cancer, such as cancer type, presence of metastases, and administration of prior chemotherapy, did not correlate with an increased incidence of thromboembolic events (97).

Li *et al.* performed a large cohort study of hospitalized patients with cancer and COVID-19, and the incidence of VTE and ATE was 7.6% and 3.9%, respectively. The frequency of VTE, but not ATE, was higher in patients who had received recent anticancer therapy (98). Interestingly, a simplified risk assessment model for VTE was suggested in the same study and was named CoVID-TE. The parameters included were the following: 1) Cancer subtype high to very-high risk by original Khorana score +1 point, 2) VTE history +2, 3) ICU admission +2, 4) D-dimer elevation +1, 5) recent systemic anticancer Therapy +1, 6) and non-Hispanic ethnicity +1 (98). The RAM stratified the patients of the study into two cohorts (low-risk, 0–2 points, n=1423 *vs.* high-risk, 3+ points, n=1034), and VTE occurred in 4.1% low-risk and 11.3% high-risk patients. When the patients with anticoagulant use prior to COVID-19 diagnosis were excluded, the CoVID-TE RAM demonstrated similarly good discrimination for VTE prediction. However, CoVID-TE RAM has not been externally validated yet (98).

Discussion

Our literature review demonstrated that current data do not support a pro-thrombotic summative effect between cancer and COVID-19, contrary to what one would expect based on the thrombotic pathophysiology of both disease entities. It has been suggested that the overwhelming thrombo-inflammatory state of active COVID-19 may outweigh a more modest hypercoagulable state of active cancer (93). Another explanation might be that patients with cancer, who are generally at risk for severe COVID-19, might be already in a critical situation when the COVID-19 cytokine storm occurs, and therefore, they are likely to die without developing thrombosis (99). Of note, it should be taken into consideration that, mainly during the first pandemic waves, patients with cancer might not had equivalent access to ICU, a setting which is associated with increased risk of thrombosis (100). Interestingly, a recent study defining prognostic factors in patients with COVID-19 and thoracic malignancies did not identify coagulation-related factors as determinants of worse prognosis (101). Finally, it should be noted that the thrombotic and bleeding risks are heterogeneous across cancer sites, stages, or treatment and that the published cohorts, which in general include any cancer history, might not permit the estimation of the risk in a well-characterized population of patients with pro-thrombotic cancer types.

The European Society for Medical Oncology (ESMO) published, at the beginning of the pandemic, consensus

recommendations on the management of patients with cancer and COVID-19 and recommended the use of pharmacological prophylaxis using LMWH or DOACs. It is recommended that prophylaxis of thromboembolic events for patients with cancer should be continued according to existing guidelines (102).

In the absence of specific recommendations for patients with active cancer and COVID-19, first of all, risk assessment approaches may be applied as for non-cancer patients with COVID-19. It is of paramount importance that all guidelines for COVID-19 thromboprophylaxis emphasize the role of thrombotic and bleeding risk stratification before any therapeutic intervention occurs (10). In this context, patients, particularly at the outpatient setting should be assessed with RAMs developed for acutely ill medical patients and recommended for patients with COVID-19, such as the Padua Prediction Score, Geneva Risk Score, and IMPROVE-RAM or IMPROVE-DD. Importantly, all RAMs mentioned above include active cancer as a risk factor for thrombosis, therefore, stratifying the patient with active cancer and COVID-19 at a higher risk *per se*. The introduction of RAMs specific for patients with cancer and COVID-19, as the CoVID-TE could be of some interest as clinical decision support tool as soon as it will be externally validated (98). Considering the assessment of the bleeding risk, the majority of guidelines for COVID-19 thromboprophylaxis incorporate the identification of risk factors (such as low platelet count, history of bleeding events), rather than the usage of risk scoring systems (10). Additional assessment of risk for disease worsening should be applied with pertinent scores (45).

After VTE and disease worsening risk assessments and taking into consideration the existing guidelines for thromboprophylaxis for patients with COVID-19, but in the absence of randomized clinical trials for patients with both active cancer and COVID-19 at the time being, it is reasonable to suggest that these patients could be offered (a) universal high prophylactic-dose LMWH in the setting of hospitalization, with select patients offered therapeutic-dose if they exhibit low bleeding risk, normal renal function, and high risk features, such as a D-dimers $>2x$ upper limit of normal or with oxygen requirements of 2 liters/minute nasal cannula O₂ or greater, (b) a prophylactic dose of LMWH in outpatients and at post-discharge up to 45 days. Recently, rivaroxaban at 10mg QD was also associated with clinical benefit at the post-discharge setting; however, the population of the trial did not include patients with active cancer (54).

Evaluation of renal function, bleeding risk, weight, age and caution for potential occurrence of heparin-induced thrombocytopenia (HIT) should be underlined and are of major importance for the improvement of the benefit-risk ratio of thromboprophylaxis (10, 103). Regarding the use of DOACs, even though their prophylactic role for cancer-associated thrombosis is emerging, when it comes to guidelines for COVID-19, most recommendations advise switching to LMWH

when a patient is admitted to the hospital is already treated with DOACs (10). At the post-discharge setting though, which means that the patient undergoes the end of the course of COVID-19 infection, thromboprophylaxis with DOACs could be considered as for other patients with active cancer, with special attention to bleeding risk assessment and potential drug-drug interactions. Mechanical measures of thromboprophylaxis (*e.g.*, graduated compression stockings or intermittent pneumatic compression) are also recommended in case of high bleeding risk and contraindication to pharmacological thromboprophylaxis (10).

A proposed algorithm for thromboprophylaxis management of patients with active cancer and COVID-19 is presented in Figure 1.

Conclusion

In conclusion, both cancer and COVID-19 are associated with increased incidence of thromboembolic events; however, an additive thrombotic risk for patients with cancer and COVID-19 has not been proven so far. Therefore, general guidelines for thromboprophylaxis in patients with COVID-19 should be applied, taking into consideration the specialties of the population of patients with cancer regarding their comorbidities and physical condition. Risk stratification for thrombotic and bleeding risk is of utmost importance. The use of well-established RAMs for acutely ill medical inpatients is recommended, and the introduction and validation of novel risk assessment models are greatly anticipated. Finally, prospective and randomized clinical trials of well-characterized cancer populations are needed to determine optimal anticoagulation strategies. Periodically updated evidence-based clinical guidelines and algorithms are essential to improve the quality of clinical decisions and maximize the benefit for patients with cancer and COVID-19.

Conflicts of Interest

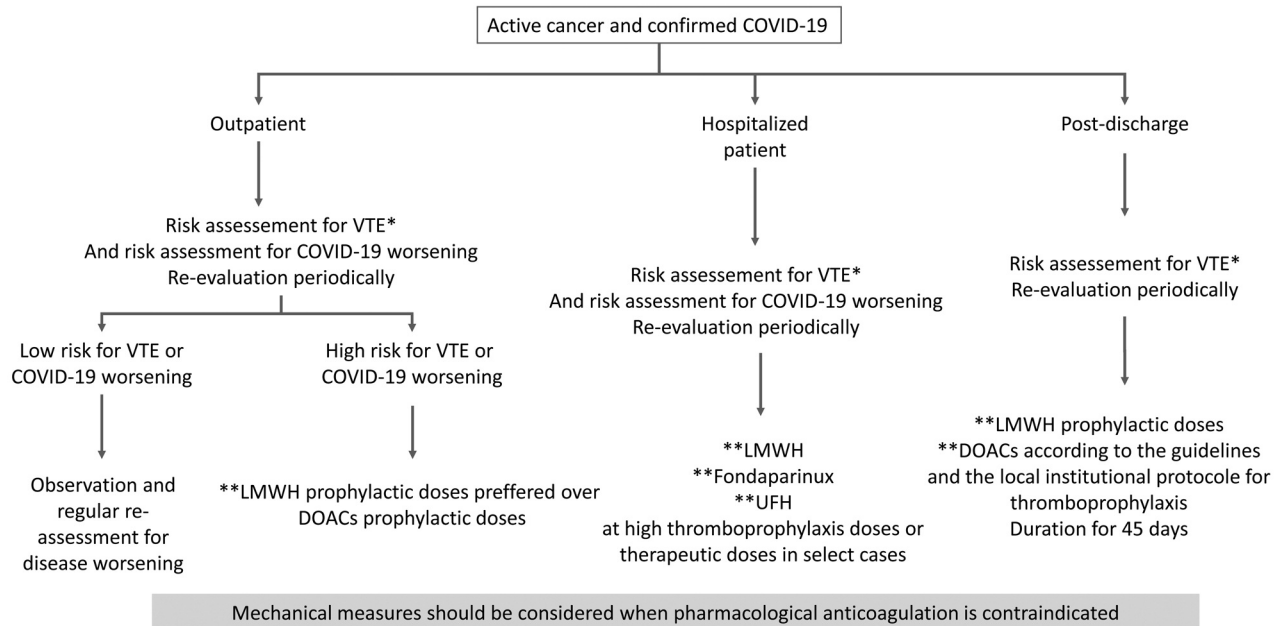
The Authors declare no conflicts of interest in relation to this study.

Authors' Contributions

E.D, G.G, M.C., D.O. A.S., A.F., A.M, L.A, S.S., J.B., G.G., P.M., B.C., J.S., K.S.: design of the study, literature review, writing of the original draft, figure preparation, revision, and final approval; Cancer-Covid-19 Thrombosis Collaborative Group: literature review, data collection and analysis, writing, revision, and final approval.

Cancer-Covid 19 Thrombosis Collaborative Group

The following investigators take authorship responsibility for the study results: Darko Antic, Clinic for Hematology, University Clinical Center Serbia, Belgrade, Serbia; Medical faculty, University of Belgrade, Belgrade, Serbia; Ales Blinc, Department of Vascular Diseases, Division of Internal Medicine, University Medical Centre, Ljubljana, Slovenia; Vinko Boc, Department of Vascular Diseases,



*Risk assessment based on the already-established RAMs for acutely ill patients

**After careful evaluation of bleeding risk, renal function, age and weight. Attention on potential occurrence of HIT.

Figure 1. Suggested algorithm for thromboprophylaxis management of patients with active cancer and COVID-19. VTE: Venous thromboembolism; RAM: risk assessment model; HIT: heparin-induced thrombocytopenia; LMWH: Low molecular weight heparins; DOACs: direct oral anticoagulants; UFH: unfractionated heparin.

Division of Internal Medicine, University Medical Centre, Ljubljana, Slovenia; Francesco Boccardo, Department of Surgical Sciences and Integrated Diagnostics (DISC), University of Genoa, Genoa, Italy; Department of Cardio-Thoracic-Vascular and Endovascular Surgery - Unit of Surgical Lymphology- IRCCS San Martino Polyclinic Hospital, Genoa, Italy; Marianne Brodmann, Division of Angiology, Department of Internal Medicine, Medical University, Graz, Austria; Patrick Carpentier, Centre de Recherche Universitaire de La Léchère Université Grenoble-Alpes, La Léchère, France; Denisa Celovska, Comenius University, Faculty of Medicine, 1st Department of Internal Medicine, Bratislava, Slovak Republic; Sergio De Marchi, Division of Angiology, Department of Medicine, University of Verona, Azienda Ospedaliera Universitaria Integrata Verona, Italy; Gabriel Dimitrov, Department of Cardiovascular Medicine, Cardiology-Angiology Division, L. Sacco Hospital, Milan, Italy; Katalin Farkas, Department of Angiology, Szent Imre University Teaching Hospital, Budapest, Hungary; Olga Fionik, Personalized Medicine Centre, Almazov National Medical Research Center, Saint Petersburg, Russian Federation; Eleni Fyta, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Ioannis Gkiozos, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Anders Gottsater, Department of Medicine, Lund University Malmö, Sweden; Paolo Gresele, Department of Medicine and Surgery, Division of Internal and Cardiovascular Medicine, University of Perugia, Italy; Amer Hamade, Vascular Medicine GHR Mulhouse Sud-Alsace Emile Muller Hospital, Mulhouse, France; Christian Heiss, Department of Clinical and Experimental Medicine, University

of Surrey, Guildford, UK; Surrey and Sussex Healthcare NHS Trust, East Surrey Hospital, Redhill, UK; Oguz Karahan, Medical School of Alaaddin Keykubat University Department of Cardiovascular Surgery, Alanya, Antalya, Turkey; Stamatis Karakatsanis, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Maryam Kavousi, Department of Epidemiology, Erasmus MC, University Medical Center Rotterdam, Rotterdam, the Netherlands; Anastasios Kollias, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Endre Kolossvary, Department of Angiology, St. Imre University Teaching Hospital, Budapest, Hungary; Elias Kotteas, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Matija Kozak, Department of Vascular Diseases, Division of Internal Medicine, University Medical Centre, Ljubljana, Slovenia; Abraham Kroon, Department of Internal Medicine, Maastricht University Medical Center, School for Cardiovascular Research (CARIM), Maastricht University, the Netherlands; Emre Kubat, Department of Cardiovascular Surgery, Gulhane Medical Faculty, Ankara, Turkey; Eleftheria Lefkou, Sorbonne Université, INSERM, UMR_S 938, Centre de recherche Saint-Antoine (CRSA), Research Group «Cancer, Biology and Therapeutics», Research Team «Cancer, Haemostasis, Angiogenesis», Paris, France; Perigenesis, Institute of Obstetric Haematology, Thessaloniki, Greece; Gianfranco Lessani, Vascular Medicine Unit, Internal Medicine Department, Città S'Angelo Private Hospital, Pescara, Italy; Chris Manu, General Medicine and Diabetes Foot Medicine, King's College Hospital, Diabetes Foot Clinic,

London, UK; Lucia Mazzolai, Heart and Vessel Department, Division of Angiology, Lausanne University Hospital (CHUV), Switzerland; Dragan Milic, University Clinical Centre Nis and Medical school University of Nis, Nis, Serbia; Jasminka Nancheva, Clinic for Orthopaedic Surgery, Medical Faculty University St. Cyril and Methodij, Skopje, Republic of North Macedonia; Kosmas Pantazopoulos, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Vasileios Patriarchas, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Evelina Pazvanska, Anesthesiology and Intensive Care Unit, Hospital "Zora", Sofia, Bulgaria; Zsolt Pecsvarady, Second Department of Internal Medicine (Vascular Center), Flor Ferenc Teaching Hospital, Budapest, Hungary; Sergio Pillon, UOSD Angiology, San Camillo-Forlanini Hospital, National Health Institute ISS, AO San Camillo Forlanini, Rome, Italy; Manilo Prior, Unit of Angiology, Department of Medicine, University of Verona, Cardiovascular and Thoracic Department, Verona University Hospital, Verona, Italy; Nikolaos Ptohis, Interventional Radiology, General Hospital of Athens G. Gennimatas, Athens, Greece; Isabelle Quere, Department of Vascular Medicine, Hôpital Saint Eloi, Montpellier, France; Marc Righini, Division of Angiology and Haemostasis, Department of Medicine, Geneva University Hospitals, Geneva, Switzerland; Karel Roztocil, Institute for Clinical and Experimental Medicine, Prague, Czech Republic; Gerit-Holger Scherthaner, Division of Angiology, Department of Medicine 2, Medical University of Vienna, Vienna, Austria; Oliver Schlager, Division of Angiology, Department of Medicine 2, Medical University of Vienna, Vienna, Austria; Aleksander Sieron, Faculty of Health Sciences, Jan Dlugosz University in Czestochowa, Czestochowa, Poland; Muriel Sprynger, Cardiology Department, CHU Sart Tilman, Liege, Belgium; Agata Stanek, Department and Clinic of Internal Medicine, Angiology and Physical Medicine, Faculty of Medical Sciences in Zabrze, Medical University of Silesia, Zabrze, Poland; Igor Stojkovski, Faculty of Medicine, Ss. Cyril and Methodius University, Skopje, Republic of North Macedonia; University Clinic of Radiotherapy and Oncology, Skopje, Republic of North Macedonia; Viera Stvrtinova, 1st Clinic of Internal Medicine, Faculty of Medicine, Comenius University, Bratislava, Slovak Republic; Dusan Suput, University of Ljubljana, Faculty of Medicine, Institute of Pathophysiology, Ljubljana, Slovenia; Nikolaos Syrigos, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Ioannis Trontzas, Third Department of Medicine, National and Kapodistrian University of Athens, School of Medicine, "Sotiria" General Hospital, Athens, Greece; Dragan Vasic, Department of Noninvasive Vascular Laboratory, Clinic of Vascular and Endovascular Surgery, University Clinical Centre of Serbia, Belgrade, Serbia; Adriana Visona, Angiology Unit, Azienda AULSS 2, Castelfranco Veneto (TV), Italy; Sokol Xhepa, University Hospital Center "Mother Theresa" of Tirana, Albania University of Medicine, Tirana, Albania.

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