

# New VTE Guidelines Issued for Primary Care

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New venous thromboembolism guidelines aimed at primary care providers emphasize the need for swift diagnosis and initial treatment with low-molecular-weight heparin over the unfractionated formulation.

Issued jointly by the American College of Physicians and the American Academy of Family Physicians, the guidelines rep-

resent an acknowledgement that diagnosis of venous thromboembolism (VTE) is first and foremost a primary care challenge.

Risk factors for the condition, such as recent hospitalization, surgery, trauma, and immobilization, are well known, but early diagnosis—which is critical to a successful outcome—is difficult because thromboembolic events are often “clinically silent,” said Dr. B. Gail Macik, of the division of hematology and oncology at the University of Virginia, Charlottesville.

Advances in therapy are poised to reduce VTE-associated mortality, but they can only do so if they are well disseminated through the primary care ranks, which, historically, they have not been, Dr. Macik added.

In fact, most management guidelines to date have been geared toward patients with difficult or complicated disease in inpatient health care settings, such as intensive care units. In contrast, the new guidelines offer “clinically relevant screening and treatment

recommendations specifically for primary care physicians who are the most likely to have front-line contact with [undiagnosed] VTE,” she said. “As with most guidelines, these leave wiggle room for individual application, but the concise review and recommendation for care is very welcome,” said Dr. Macik, who was not involved in writing the recommendations.

The diagnostic and management guidelines, published separately, are based on findings of a comprehensive systematic literature review published in 2003 and recently updated by Dr. Jodi B. Segal and colleagues at the Johns Hopkins University Evidence-Based Practice Center in Baltimore (Ann. Intern. Med. 2007;146:211-22).

## Diagnosis

The importance of early diagnosis of VTE “cannot be overstressed,” wrote guideline coauthor Dr. Amir Qaseem, senior medical associate in the Clinical Programs and Quality of Care Division at the ACP.

To that end, diagnostic guidelines encourage using validated clinical prediction tools, such as the Wells prediction rule, to determine the probability of deep-vein thrombosis (DVT) and pulmonary embolism before performing more definitive testing (Ann. Fam. Med. 2007;5:57-62).

Because the Wells prediction rule performs better in younger patients without comorbidities or VTE history, “physicians should use their clinical judgment in cases where a patient is older or presents with comorbidities,” according to the guidelines.

Obtaining a high-sensitivity D-dimer assay is a reasonable option in appropriately selected patients with low pretest probability of DVT or pulmonary embolism, including younger patients without associated comorbidity or history of VTE and with short duration of symptoms. “In older patients, those with associated comorbidity, and long duration of symptoms, a D-dimer alone may not be sufficient to rule out VTE,” according to the authors.

Obtain an ultrasound in patients with intermediate to high pretest probability of DVT in the lower extremities. “Ultrasound is less sensitive in patients who have DVT limited to the calf, therefore a negative ultrasound does not rule out DVT in these patients,” the authors stressed. Additionally, “repeat ultrasound or venography may be required for patients who have suspected calf-vein DVT and a negative ultrasound,” as well as for those patients with suspected proximal DVT and an inadequate ultrasound.

Imaging is essential for patients with intermediate or high pretest probability of pulmonary embolism. Ventilation-perfusion, multidetector helical computed axial tomography, and pulmonary angiography are among the potential imaging options.

## Treatment and Prevention

Compared with unfractionated heparin, low-molecular-weight heparin (LMWH) is associated with a reduced risk of major bleeding and mortality in the treatment of DVT, and as such “should be used whenever possible for the initial inpatient treat-

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Brief Summary of Prescribing Information  
05-1114

### ROZEREM™

(ramelteon) Tablets

#### INDICATIONS AND USAGE

ROZEREM is indicated for the treatment of insomnia characterized by difficulty with sleep onset.

#### CONTRAINDICATIONS

ROZEREM is contraindicated in patients with a hypersensitivity to ramelteon or any components of the ROZEREM formulation.

#### WARNINGS

Since sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit after a reasonable period of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Worsening of insomnia, or the emergence of new cognitive or behavioral abnormalities, may be the result of an unrecognized underlying psychiatric or physical disorder and requires further evaluation of the patient. As with other hypnotics, exacerbation of insomnia and emergence of cognitive and behavioral abnormalities were seen with ROZEREM during the clinical development program.

ROZEREM should not be used by patients with severe hepatic impairment.

ROZEREM should not be used in combination with fluvoxamine (see PRECAUTIONS: Drug Interactions).

A variety of cognitive and behavior changes have been reported to occur in association with the use of hypnotics. In primarily depressed patients, worsening of depression, including suicidal ideation, has been reported in association with the use of hypnotics.

Patients should avoid engaging in hazardous activities that require concentration (such as operating a motor vehicle or heavy machinery) after taking ROZEREM.

After taking ROZEREM, patients should confine their activities to those necessary to prepare for bed.

#### PRECAUTIONS

##### General

ROZEREM has not been studied in subjects with severe sleep apnea or severe COPD and is not recommended for use in those populations.

Patients should be advised to exercise caution if they consume alcohol in combination with ROZEREM.

##### Use in Adolescents and Children

ROZEREM has been associated with an effect on reproductive hormones in adults, e.g. decreased testosterone levels and increased prolactin levels. It is not known what effect chronic or even chronic intermittent use of ROZEREM may have on the reproductive axis in developing humans (see Pediatric Use).

##### Information for Patients

Patients should be advised to take ROZEREM within 30 minutes prior to going to bed and should confine their activities to those necessary to prepare for bed.

Patients should be advised to avoid engaging in hazardous activities (such as operating a motor vehicle or heavy machinery) after taking ROZEREM.

Patients should be advised that they should not take ROZEREM with or immediately after a high fat meal.

Patients should be advised to consult their health care provider if they experience worsening of insomnia or any new behavioral signs or symptoms of concern.

Patients should consult their health care provider if they experience one of the following: cessation of menses or galactorrhea in females, decreased libido, or problems with fertility.

##### Laboratory Tests

No standard monitoring is required.

For patients presenting with unexplained amenorrhea, galactorrhea, decreased libido, or problems with fertility, assessment of prolactin levels and testosterone levels should be considered as appropriate.

##### Drug Interactions

ROZEREM has a highly variable inter-subject pharmacokinetic profile (approximately 100% coefficient of variation in  $C_{max}$  and AUC). As noted above, CYP1A2 is the major isozyme involved in the metabolism of ROZEREM; the CYP2C2 subfamily and CYP3A4 isozymes are also involved to a minor degree.

##### Effects of Other Drugs on ROZEREM Metabolism

**Fluvoxamine (strong CYP1A2 inhibitor):** When fluvoxamine 100 mg twice daily was administered for 3 days prior to single-dose co-administration of ROZEREM 16 mg and fluvoxamine, the  $AUC_{0-24}$  for ramelteon increased approximately 190-fold, and the  $C_{max}$  increased approximately 70-fold, compared to ROZEREM administered alone. ROZEREM should not be used in combination with fluvoxamine (see WARNINGS). Other less potent CYP1A2 inhibitors have not been adequately studied. ROZEREM should be administered with caution to patients taking less strong CYP1A2 inhibitors.

**Rifampin (strong CYP enzyme inducer):** Administration of rifampin 600 mg once daily for 11 days resulted in a mean decrease of approximately 80% (40% to 90%) in total exposure to ramelteon and metabolite M-II, (both  $AUC_{0-24}$  and  $C_{max}$ ) after a single 32 mg dose of ROZEREM. Efficacy may be reduced when ROZEREM is used in combination with strong CYP enzyme inducers such as rifampin.

**Ketoconazole (strong CYP3A4 inhibitor):** The  $AUC_{0-24}$  and  $C_{max}$  of ramelteon increased by approximately 84% and 36%, respectively, when a single 16 mg dose of ROZEREM was administered on the fourth day of ketoconazole 200 mg twice daily administration, compared to administration of ROZEREM alone. Similar increases were seen in M-II pharmacokinetic variables. ROZEREM should be administered with caution in subjects taking strong CYP3A4 inhibitors such as ketoconazole.

**Fluconazole (strong CYP2C9 inhibitor):** The total and peak systemic exposure ( $AUC_{0-24}$  and  $C_{max}$ ) of ramelteon after a single 16 mg dose of ROZEREM was increased by approximately 150% when administered with fluconazole. Similar increases were also seen in M-II exposure. ROZEREM should be administered with caution in subjects taking strong CYP2C9 inhibitors such as fluconazole.

Interaction studies of concomitant administration of ROZEREM with fluoxetine (CYP2D6 inhibitor), omeprazole (CYP1A2 inducer/CYP2C19 inhibitor), theophylline (CYP1A2 substrate), and dextromethorphan (CYP2D6 substrate) did not produce clinically meaningful changes in either peak or total exposures to ramelteon or the M-II metabolite.

##### Effects of ROZEREM on Metabolism of Other Drugs

Concomitant administration of ROZEREM with omeprazole (CYP2C19 substrate), dextromethorphan (CYP2D6 substrate), midazolam (CYP3A4 substrate), theophylline (CYP1A2 substrate), digoxin (p-glycoprotein substrate), and warfarin (CYP2C9 [S]/CYP1A2 [R] substrate) did not produce clinically meaningful changes in peak and total exposures to these drugs.

##### Effect of Alcohol on Rozerem

Alcohol: With single-dose, daytime co-administration of ROZEREM 32 mg and alcohol (0.6 g/kg), there was no clinically meaningful or statistically sig-

nificant effects on peak or total exposure to ROZEREM. However, an additive effect was seen on some measures of psychomotor performance (i.e., the Digit Symbol Substitution Test, the Psychomotor Vigilance Task Test, and a Visual Analog Scale of sedation) at some post-dose time points. No additive effect was seen on the Delayed Word Recognition Test. Because alcohol by itself impairs performance, and the intended effect of ROZEREM is to promote sleep, patients should be cautioned not to consume alcohol when using ROZEREM.

##### Drug/Laboratory Test Interactions

ROZEREM is known to interfere with commonly used clinical laboratory tests. In addition, *in vitro* data indicate that ramelteon does not cause false-positive results for benzodiazepines, opiates, barbiturates, cocaine, cannabinoids, or amphetamines in two standard urine drug screening methods *in vitro*.

##### Carcinogenesis, Mutagenesis, and Impairment of Fertility

**Carcinogenesis**  
In a two-year carcinogenicity study, B6C3F<sub>1</sub> mice were administered ramelteon at doses of 0, 30, 100, 300, or 1000 mg/kg/day by oral gavage. Male mice exhibited a dose-related increase in the incidence of hepatic tumors at dose levels  $\geq 100$  mg/kg/day including hepatic adenoma, hepatic carcinoma, and hepatoblastoma. Female mice developed a dose-related increase in the incidence of hepatic adenomas at dose levels  $\geq 300$  mg/kg/day and hepatic carcinoma at the 1000 mg/kg/day dose level. The no-effect level for hepatic tumors in male mice was 30 mg/kg/day (103-times and 3-times the therapeutic exposure to ramelteon and the active metabolite M-II, respectively, at the maximum recommended human dose [MRHD] based on an area-under-the-curve [AUC] comparison). The no-effect level for hepatic tumors in female mice was 100 mg/kg/day (827-times and 12-times the therapeutic exposure to ramelteon and M-II, respectively, at the MRHD based on AUC).

**In a two-year carcinogenicity study conducted in the Sprague-Dawley rat, male and female rats were administered ramelteon at doses of 0, 15, 50, 250 or 1000 mg/kg/day by oral gavage. Male rats exhibited a dose-related increase in the incidence of hepatic adenoma and benign Leydig cell tumors of the testis at dose levels  $\geq 250$  mg/kg/day and hepatic carcinoma at the 1000 mg/kg/day dose level. Female rats exhibited a dose-related increase in the incidence of hepatic adenoma at dose levels  $\geq 60$  mg/kg/day and hepatic carcinoma at the 1000 mg/kg/day dose level. The no-effect level for hepatic tumors and benign Leydig cell tumors in male rats was 60 mg/kg/day (1.429-times and 12-times the therapeutic exposure to ramelteon and M-II, respectively, at the MRHD based on AUC). The no-effect level for hepatic tumors in female rats was 15 mg/kg/day (472-times and 16-times the therapeutic exposure to ramelteon and M-II, respectively, at the MRHD based on AUC).**

The development of hepatic tumors in rodents following chronic treatment with non-genotoxic compounds may be secondary to microsomal enzyme induction, a mechanism for tumor generation not thought to occur in humans. Leydig cell tumor development following treatment with non-genotoxic compounds in rodents has been linked to reductions in circulating testosterone levels with compensatory increases in luteinizing hormone release, which is a known proliferative stimulus to Leydig cells in the rat testis. Rat Leydig cells are more sensitive to the stimulatory effects of luteinizing hormone than human Leydig cells. In mechanistic studies conducted in the rat, daily ramelteon administration at 250 and 1000 mg/kg/day for 4 weeks was associated with a reduction in plasma testosterone levels. In the same study, luteinizing hormone levels were elevated over a 24 hour period after the last ramelteon treatment; however, the durability of this luteinizing hormone finding and its support for the proposed mechanistic explanation was not clearly established.

Although the rodent tumors observed following ramelteon treatment occurred at plasma levels of ramelteon and M-II in excess of mean clinical plasma concentrations at the MRHD, the relevance of both rodent hepatic tumors and benign rat Leydig cell tumors to humans is not known.

##### Mutagenesis

Ramelteon was not genotoxic in the following: *in vitro* bacterial reverse mutation (Ames) assay; *in vitro* mammalian cell gene mutation assay using the mouse lymphoma TK<sup>+</sup> cell line; *in vivo/in vitro* unscheduled DNA synthesis assay in rat hepatocytes; and *in vivo* micronucleus assays conducted in mouse and rat. Ramelteon was positive in the chromosomal aberration assay in Chinese hamster lung cells in the presence of S9 metabolic activation. Separate studies indicated that the concentration of the M-II metabolite formed by the rat liver S9 fraction used in the *in vitro* genetic toxicology studies described above, exceeded the concentration of ramelteon; therefore, the genotoxic potential of the M-II metabolite was also assessed in these studies.

##### Impairment of Fertility

Ramelteon was administered to male and female Sprague-Dawley rats in an initial fertility and early embryonic development study at dose levels of 6, 60, or 600 mg/kg/day. No effects on male or female mating or fertility were observed with a ramelteon dose up to 600 mg/kg/day (786-times higher than the MRHD on a mg/m<sup>2</sup> basis). Irregular estrus cycles, reduction in the number of implants, and reduction in the number of live embryos were noted with dosing females at  $\geq 60$  mg/kg/day (79-times higher than the MRHD on a mg/m<sup>2</sup> basis). A reduction in the number of corpora lutea occurred at the 600 mg/kg/day dose level. Administration of ramelteon up to 600 mg/kg/day to male rats for 7 weeks had no effect on sperm quality and when the treated male rats were mated with untreated female rats there was no effect on implants or embryos. In a repeat of this study using oral administration of ramelteon at 20, 60 or 200 mg/kg/day for the same study duration, females demonstrated irregular estrus cycles with doses  $\geq 60$  mg/kg/day, but no effects were seen on implantation or embryo viability. The no-effect dose for fertility endpoints was 20 mg/kg/day in females (26-times the MRHD on a mg/m<sup>2</sup> basis) and 600 mg/kg/day in males (786-times higher than the MRHD on a mg/m<sup>2</sup> basis) when considering all studies.

##### Pregnancy: Pregnancy Category C

Ramelteon has been shown to be a developmental teratogen in the rat when given in doses 197 times higher than the maximum recommended human dose [MRHD] on a mg/m<sup>2</sup> basis. There are no adequate and well-controlled studies in pregnant women. Ramelteon should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

The effects of ramelteon on embryo-fetal development were assessed in both the rat and rabbit. Pregnant rats were administered ramelteon by oral gavage at doses of 0, 10, 40, 150, or 600 mg/kg/day during gestation days 6-17, which is the period of organogenesis in this species. Evidence of maternal toxicity and fetal teratogenicity was observed at doses greater than or equal to 150 mg/kg/day. Maternal toxicity was chiefly characterized by decreased body weight and, at 600 mg/kg/day, ataxia and decreased spontaneous movement. At maternally toxic doses (150 mg/kg/day or greater), the fetuses demonstrated visceral malformations consisting of diaphragmatic hernia and minor anatomical variations of the skeleton (irregularly shaped scapula). At 600 mg/kg/day, reductions in fetal body weights and malformations including cysts on the external genitalia were additionally observed. The no-effect level for teratogenicity in this study was 40 mg/kg/day (1,892-times and 45-times higher than the therapeutic exposure to ramelteon and the active metabolite M-II, respectively, at the MRHD based on an area-under-the-curve [AUC] comparison). Pregnant rabbits were administered ramelteon by oral gavage at doses of 0, 12, 60, or 300 mg/kg/day during gestation days 6-18, which is the period of organogenesis in this species. Although maternal toxicity was apparent with a ramelteon dose of 300 mg/kg/day, no evidence of fetal effects or teratogenicity was associated with any dose level. The no-effect level for teratogenicity was, therefore, 300 mg/kg/day (11,862-times and 99-times

higher than the therapeutic exposure to ramelteon and M-II, respectively, at the MRHD based on AUC).

The effects of ramelteon on pre- and post-natal development in the rat were studied by administration of ramelteon to the pregnant rat by oral gavage at doses of 0, 30, 100, or 300 mg/kg/day from day 6 of gestation through parturition to postnatal (lactation) day 21, at which time offspring were weaned. Maternal toxicity was noted at doses of 100 mg/kg/day or greater and consisted of reduced body weight gain and increased adrenal gland weight.

Reduced body weight during the post-weaning period was also noticed in the offspring of the groups given 100 mg/kg/day and higher. Offspring in the 300 mg/kg/day group demonstrated physical and developmental delays including delayed eruption of the lower incisors, a delayed acquisition of the righting reflex, and an alteration of emotional response. These delays are often observed in the presence of reduced offspring body weight but may still be indicative of developmental delay. An apparent decrease in the viability of offspring in the 300 mg/kg/day group was likely due to altered maternal behavior and function observed at this dose level. Offspring of the 300 mg/kg/day group also showed evidence of diaphragmatic hernia, a finding observed in the embryo-fetal development study previously described. There were no effects on the reproductive capacity of offspring and the resulting progeny were not different from those of vehicle-treated offspring. The no-effect level for pre- and postnatal development in this study was 30 mg/kg/day (39-times higher than the MRHD on a mg/m<sup>2</sup> basis).

##### Labor and Delivery

The potential effects of ROZEREM on the duration of labor and/or delivery, for either the mother or the fetus, have not been studied. ROZEREM has no established use in labor and delivery.

##### Nursing Mothers

Ramelteon is secreted into the milk of lactating rats. It is not known whether this drug is excreted in human milk. No clinical studies in nursing mothers have been performed. The use of ROZEREM in nursing mothers is not recommended.

##### Pediatric Use

Safety and effectiveness of ROZEREM in pediatric patients have not been established. Further study is needed prior to determining that this product may be used safely in pre-pubescent and pubescent patients.

##### Geriatric Use

A total of 654 subjects in double-blind, placebo-controlled, efficacy trials who received ROZEREM were at least 65 years of age; of these, 199 were 75 years of age or older. No overall differences in safety or efficacy were observed between elderly and younger adult subjects.

##### ADVERSE REACTIONS

**Overview**  
The data described in this section reflect exposure to ROZEREM in 4251 subjects, including 346 exposed for 6 months or longer, and 473 subjects for one year.

##### Adverse Reactions Resulting in Discontinuation of Treatment

Fifty percent of the 3594 individual subjects exposed to ROZEREM in clinical studies discontinued treatment owing to an adverse event, compared with 2% of the 1370 subjects receiving placebo. The most frequent adverse events leading to discontinuation in subjects receiving ROZEREM were somnolence (0.3%), dizziness (0.5%), nausea (0.3%), fatigue (0.3%), headache (0.3%), and insomnia (0.3%).

##### ROZEREM Most Commonly Observed Adverse Events in Phase 1-3 trials

The incidence of adverse events during the Phase 1 through 3 trials (% placebo, n=1370; % ramelteon [8 mg], n=1250) were: headache NOS (7%, 7%), somnolence (3%, 5%), fatigue (2%, 4%), dizziness (3%, 5%), nausea (2%, 3%), insomnia exacerbated (2%, 3%), upper respiratory tract infection NOS (2%, 3%), diarrhea NOS (2%, 2%), myalgia (1%, 2%), depression (1%, 2%), dyspepsia (1%, 2%), arthralgia (1%, 2%), influenza (0, 1%), blood cortisol decreased (0, 1%).

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in clinical trials of other drugs, and may not reflect the rates observed in practice. The adverse reaction information from clinical trials does, however, provide a basis for identifying the adverse events that appear to be related to drug use and for approximating rates.

##### DRUG ABUSE AND DEPENDENCE

ROZEREM is not a controlled substance.

##### Human Data: See the CLINICAL TRIALS section, Studies Pertinent to Safety Concerns for Sleep-Promoting Agents in the Complete Prescribing Information.

**Animal Data.** Ramelteon did not produce any signals from animal behavioral studies indicating that the drug produces rewarding effects. Monkeys did not self-administer ramelteon and the drug did not induce a conditioned place preference in rats. There was no generalization between ramelteon and midazolam. Ramelteon did not affect rotarod performance, an indicator of disruption of motor function, and it did not potentiate the ability of diazepam to interfere with rotarod performance.

Discontinuation of ramelteon in animals or in humans after chronic administration did not produce withdrawal signs. Ramelteon does not appear to produce physical dependence.

##### OVERDOSAGE

##### Signs and Symptoms

No cases of ROZEREM overdose have been reported during clinical development. ROZEREM was administered in single doses up to 160 mg in an abuse liability trial. No safety or tolerability concerns were seen.

##### Recommended Treatment

General symptomatic and supportive measures should be used, along with immediate gastric lavage where appropriate. Intravenous fluids should be administered as needed. As in all cases of drug overdose, respiration, pulse, blood pressure, and other appropriate vital signs should be monitored, and general supportive measures employed. Hemodialysis does not effectively reduce exposure to ROZEREM. Therefore, the use of dialysis in the treatment of overdose is not appropriate.

##### Poison Control Center

As with the management of all overdoses, the possibility of multiple drug ingestion should be considered. The physician may contact a poison control center for current information on the management of overdose.

##### Rx only

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**References:** 1. Rozerem package insert, Takeda Pharmaceuticals America, Inc. 2. Johnson MW, Suess PE, Griffiths RR. Ramelteon: a novel hypnotic lacking abuse liability and sedative side effects. Arch Gen Psychiatry. In press.

Continued from previous page

ment” of these patients, according to the treatment guidelines (Ann. Intern. Med. 2007;146:204-10).

Other recommendations regarding management include:

► **Home-based therapy.** Patients who have adequate support at home can receive LMWH treatment on an outpatient basis. Data on the risks among inpatients versus outpatients demonstrate only slight differences in the rates of recurrent VTE, major bleeding, and death. However, most studies relevant to this question “excluded patients with previous VTE, thrombophilic conditions, or significant comorbidity, pregnant patients, and patients unlikely to adhere to outpatient therapy,” the authors wrote. Also, several of the studies allowed for brief inpatient admissions for stabilization prior to randomization to outpatient treatment.

► **Compression stockings.** On the basis of evidence demonstrating a marked reduction in the incidence of postthrombotic syndrome among patients with DVT who wear compression stockings, the guidelines recommend the routine use of either over-the-counter or custom-fit stockings beginning 1 month after diagnosis of proximal DVT, and continuing for a minimum of 1 year. Of three randomized, controlled trials that studied the use of compression stockings, the two that enrolled patients within 1 month of developing proximal DVT showed a significant reduction in postthrombotic syndrome, while no such benefit was seen in the one trial that enrolled patients 1 year after the DVT event, the authors reported.

► **Pregnancy.** Anticoagulation management during pregnancy is particularly important, as the risk of VTE in pregnant women is five times greater than in non-pregnant women, the authors stated. However, the available data are insufficient to recommend specific therapies in pregnant women. The guideline recommends avoiding vitamin K antagonists because they can cross the placenta and have been associated with fetal bleeding and embryopathy at 6-12 weeks’ gestation. “Neither LMWH nor unfractionated heparin crosses the placenta, and neither is associated with embryopathy or fetal bleeding,” they wrote.

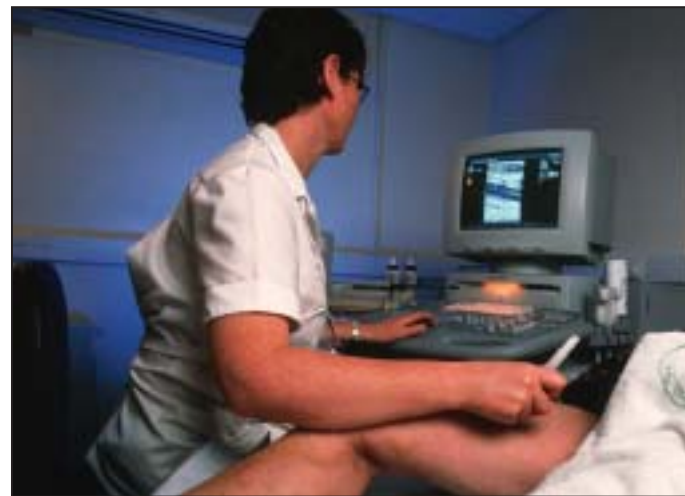
► **Secondary and idiopathic VTE.** For VTE secondary to transient risk factors, such as surgery, trauma, or immobilization, the available evidence indicates that patients may be well served with 3-6 months of oral anticoagulation therapy.

With respect to idiopathic VTE, available data suggest that extended-duration anticoagulation therapy is associated with a reduced relative risk of recurrence, although the optimal duration is not known as the length of therapy in the trials varied substantially, and the results reflect follow-up only to 4 years. Consequently, the guideline advises continuing anticoagulant therapy for more than 12 months for recurrent VTE.

► **Long-term treatment.** In comparing long-term treatment with LMWH versus vitamin K antagonists, the former is “safe and efficacious for the long-term treatment of VTE in selected patients, and may be preferable for patients with cancer,” as studies have linked LMWH to a survival advantage in this population. Specifically,

the data suggest that “LMWH may be a useful treatment for patients in whom INR [international normalized ratio] control is difficult.”

► **Pulmonary embolism.** Regarding pulmonary embolism treatment, “LMWH is at least as effective as unfractionated heparin,” according to a review of the available evidence; thus, either drug is appropriate for initial treatment, said Dr. Vincenza Snow, director of clinical programs and quality of care for the ACP. The authors did note, however, that additional trials are needed to more rigorously examine the efficacy of LMWH for pulmonary embolism. ■



© PHOTO RESEARCHERS, INC. Ultrasound should be performed in patients who are at intermediate to high risk of deep-vein thrombosis in the lower extremities.

## CALLING ALL ADOLESCENTS AND ADULTS



**A CALL TO ARMS**  
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Pertussis protection for both adolescents and adults 11 through 64 years of age

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### Safety Information

ADACEL vaccine is indicated for active booster immunization for the prevention of tetanus, diphtheria, and pertussis as a single dose in persons 11 through 64 years of age.

As with any vaccine, ADACEL vaccine may not protect 100% of vaccinated individuals. There are risks associated with all vaccines. The most common injection site adverse events include pain, erythema, and swelling. The most common systemic adverse events include headache, body ache, tiredness, and fever. ADACEL vaccine is contraindicated in persons with known systemic hypersensitivity to any component of the vaccine or a life-threatening reaction after previous administration of the vaccine or a vaccine containing the same substances. Because of uncertainty as to which component of the vaccine may be responsible, no further vaccination with the diphtheria, tetanus, or pertussis components found in ADACEL vaccine should be carried out. Because any intramuscular injection can cause injection site hematoma, ADACEL vaccine should not be given to persons with any bleeding disorder, such as hemophilia or thrombocytopenia, or to persons on anticoagulant therapy unless the potential benefits clearly outweigh the risk of administration. If the decision is made to administer ADACEL vaccine to such persons, it should be given with caution, with steps taken to avoid the risk of hematoma formation following injection.

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ADACEL vaccine is manufactured by Sanofi Pasteur Limited and distributed by Sanofi Pasteur Inc.

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Learn about pertussis disease and prevention at [www.ADACELVACCINE.com](http://www.ADACELVACCINE.com)

### References:

1. Centers for Disease Control and Prevention (CDC). Preventing tetanus, diphtheria, and pertussis among adults: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine: recommendations of the Advisory Committee on Immunization Practices (ACIP) and recommendation of ACIP, supported by the Healthcare Infection Control Practices Advisory Committee (HICPAC), for use of Tdap among health-care personnel. *MMWR*. 2006;55(RR-17):21-22. 2. CDC. Preventing tetanus, diphtheria, and pertussis among adolescents: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccines: recommendations of the ACIP. *MMWR*. 2006;55(RR-3):22.

\* Advisory Committee on Immunization Practices. † Tetanus, diphtheria, and acellular pertussis. ‡ 19-64 years of age. § 11-18 years of age.

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