New Oral Anticoagulants (NOACs) have a new role on the scene of treatment of acute venous thromboembolism (VTE).

With a recent indication nod from the FDA in December 2013, Pradaxa (dabigatran) joins already approved Xarelto (rivaroxaban), as well as tried-and-true Coumadin (warfarin) in the arsenal to treat active VTE with an oral agent1.

However, the new question is, how does these medications stack up in patients with active malignancy?

In the EINSTEIN trial2, comparing rivaroxaban to warfarin, we see there is not statistical difference between the two in patients with active malignancy. Overall, 2.1% of patients taking rivaroxaban vs. 3% taking warfarin had recurrent VTE events. Table 1 demonstrates the subgroup analysis of patients with active cancer.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Patients who had an event</th>
<th>Patients who had an adverse bleeding event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rivaroxaban (n=118)</td>
<td>4 (3.4%)§</td>
<td>17 (14.4%)</td>
</tr>
<tr>
<td>Warfarin (n=89)</td>
<td>5 (5.6%)P=NS*</td>
<td>14 (15.9%)P=NS*</td>
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</tbody>
</table>

§Primary events were defined as: symptomatic, recurrent venous thromboembolism, defined as the composite of DVT or nonfatal or fatal pulmonary embolism

*NS: not significant

In conclusion, numerically fewer patients had recurrent VTE events on either rivaroxaban or dabigatran when compared to warfarin, though with no significant difference. However, we must note that both NCCN and ASCO recommend the use low molecular weight heparin for the treatment of VTE in patients with active malignancy, as there are better outcomes over warfarin4.

This poses the question, are these comparisons clinically relevant, if the comparator is not the currently accepted standard of care?