Discussion

Dr Mark Onaitis *(La Jolla, Calif)*. Congratulations on this important article that highlights a high rate of VTE after P/D despite standard-of-care prophylaxis. This is important information, and I have 3 questions.

First, while acknowledging the bleeding risk, should we be doing more than the standard of care prophylaxis in terms of Lovenox (Sanofi-Aventis, Paris, France) or other things to prevent these DVTs?

Dr Michael T. Jaklitsch *(Boston, Mass)*. One alternative is to administer Lovenox at a more therapeutic rate. This particular protocol was developed about 10 to 12 years ago in the face of approximately a 4% fatal PE rate. The balance for malignant pleural mesothelioma in diseased pleurectomies leave an open, weeping, potentially bleeding source on the inside of the ribcage. That's why we have not gone to using Lovenox, but this is precisely the sort of data generation that would springboard us to then have a multispecialty discussion to see if there is a better way to do it.

Dr Onaitis. Second, do you use epidurals for these patients and did this affect the prophylaxis; you can't use Lovenox if you have an epidural in?

Dr Jaklitsch. Yes, that's true. We do use epidurals in the majority of these patients, and according to the recommendations by the anesthesiology professional societies, you can't have a dose of Lovenox and then get an epidural catheter.

Dr Onaitis. It seemed like a lot of the clots are due to the central line, and so have you changed management trying to avoid central lines in these patients?

Dr Jaklitsch. That was one of the more interesting aspects of the data that came out of this. I can't say that we have regimented against it, but obviously seeing that links of all the upper-extremity clots were from central lines, there are alternatives to central line placement.

Dr Benjamin D. Kozower *(St Louis, Mo)*. I think this is the third example I have seen where the more you screen the more you find. So your quality metrics don't look so good but yet you are delivering quality care. What are you going to do going forward?

Dr Jaklitsch. That's right. I think that we as a Society need to keep emphasizing to our public that screening for morbidity when it's grade 2 or grade 3 morbidity we believe prevents grade 4 and grade 5 morbidity. So the old method where the study was dinged by the morbidity rate, I think we have become more sophisticated to say lower-stage morbidity is worth searching for so you can prevent the grade 4s and grade 5s.

Unidentified Speaker. One clarification. I understand you found 30 VTEs, 33%, or 10 of them, were asymptomatic, and if I understand correctly, of those 10 that were asymptomatic, when you did anticoagulate them, none of them had a complication from the anticoagulation. Is that correct?

Dr Jaklitsch. That is correct.