Analysis of Prethrombotic States in Patients with Malignant Tumors

Lin Cui¹, You-Hong Sun¹, Jue Chen², Lu Wang¹, Jian-Jun Liu¹, Xiang-Rong Zhou¹, Jie Ding¹, Xing-Xiang Liu¹, Xin-En Huang³*

Abstract

Background: This study aimed to investigate the incidence and risk factors for a prethrombotic state in patients with malignant tumors. Materials and Methods: Plasma d-dimer (D-D) in patients with malignant tumors was measured. Abnormal rates of D-D and possible risk factors like gender, age, type of tumor, and staging of tumor were analyzed. Results: Of 1,453 patients, 629 demonstrated plasma D-D abnormality (43.3%). The D-D abnormal rate of male patients (n=851, 43.5%) was not statistically significantly different from that for female patients (n=602, 43.0%) (p>0.05). D-D abnormal rate increased with age and was statistically significant among different age groups (p<0.05). Regarding staging of tumor, D-D abnormal rate in patients with phase I was 2.0%, 6.2% in phase II, 47.6% in phase III and 83.1% in phase IV, with statistically significant differences between phase II and III, as well as phase III and IV (p<0.01). Conclusions: A prethrombotic state was closely related to malignancy of tumors. The risk factors for a prethrombotic state include age and tumor stage.

Keywords: Prethrombotic state - malignant tumor - risk factors

RESEARCH ARTICLE

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Materials and Methods

General information

The total sample included 1453 patients (aged from 26-91 years) with malignant tumor, 851 male accounted for 58.6% while 602 female accounted for 41.4% and the median age was 61.1 years old. All patients were diagnosed between January 2012 and December 2013. Among them, 2 patients in age group 20-, 47 in 30-, 221 in 40-, 344 in 50-, 511 in 60-, 235 in 70-, 92 in 80- and 1 in 90-. For tumor stage, 50 patients were staged phase I, 406 phase II (635 phase III and 362 phase IV. General characteristics were described in Table1.

Methods

Following a fasting period of 8-10h, 3mL venous blood samples were extracted from the patients and into tubes containing 1/10 volume anticoagulant Sodium Citrate Solution (0.109mo/L). The samples were centrifuged at 3000*g for 10min. The plasma samples were then separated and maintained at -20°C within 2h after blood samples collection. D-D levels were measured with the assistance of a Sysmex CA7000 automated blood coagulation analyzer and related reagents within 4h after blood samples collection.
Statistic analysis

Data analysis was performed using SPSS19.0 software. T-test was used on intra-group comparison and ANOVA analysis was performed for comparison between groups. \( P<0.05 \) was considered to indicate a statistically significance of difference.

Results

Abnormal rate of D-D

Abnormality of D-D was found in 629 patients with a proportion of 43.29% (629/1453). Details were presented in Table 2.

D-D and Gender

The abnormality of D-D was compared between male and female. Among 851 male, 370 samples (43.5%) showed abnormality and 259 in 602 (43.02%) female samples were abnormal, no statistically significant difference was detected between gender (\( x^2 = 0.030, P>0.05 \)).

D-D and Age

As shows in Table 3, D-D abnormal rate increase with age gradually and the correlations among groups are distinct (\( F=2.224, P=0.038 \)).

D-D and Tumor Stage

As Table 4 shows, regarding staging of tumor, except phase I (D-D abnormal rate=2.0%) and phase II
Table 5. Analysis on Different Tumor Types and D-D

| Tumor types         | p value | Tumor types         | p value | Tumor types         | p value |
|---------------------|---------|---------------------|---------|---------------------|---------|
| Cervical cancer with | Colon cancer 0 | Ovarian cancer with | Esophageal carcinoma 0 | NSCLC with | Cardiac carcinoma 0 |
| Ovarian cancer      | 0.019   | Gastric cancer      | 0.13    | NHL with            | 0.002   |
| PCa                 | 0.001   | Rectal carcinoma    | 0.028   | NSCLC              | 0.002   |
| Esophageal carcinoma| 0.243   | SCLC                | 0.863   | PCa                | 0.393   |
| Breast cancer       | 1       | NHL                 | 0.845   | Pancreatic cancer  | 0.71    |
| Gastric cancer      | 0.845   | PHC                 | 0.95    | Rectal carcinoma  | 0.834   |
| Rectal carcinoma    | 0.032   | SCLC                | 0.863   | NHL                | 0.021   |
| NHL                 | 0.006   | NSCLC               | 0.863   | PHC                | 0.012   |
| PHC                 | 0.001   | Cardiac carcinoma   | 0.95    | SCLC               | 0.863   |
| SCLC                | 0.123   | Cervical cancer     | 0       | NSCLC              | 0.002   |
| NSCLC               | 0.921   | Colon cancer        | 0       | NHL                | 0.998   |
| Cardiac carcinoma   | 0.324   | Ovarian cancer      | 0       | PHC                | 0.024   |
| Cervical cancer     | 0.002   | Rectal carcinoma    | 0       | SCLC               | 0.975   |
| Breast cancer       | 1       | NHL                 | 0.998   | NSCLC              | 0.462   |
| Gastric cancer      | 0.56    | NHL                 | 0       | Cardiac carcinoma  | 1       |
| Rectal carcinoma    | 0.14    | PHC                 | 0       | Cervical cancer    | 0       |
| NHL                 | 0       | SCLC                | 0.054   | Colon cancer       | 0.054   |
| PHC                 | 0       | NSCLC               | 0.95    | Ovarian cancer     | 0.95    |
| SCLC                | 0.012   | Cardiac carcinoma   | 1       | Esophageal carcinoma | 0.522 |
| NSCLC               | 0       | Cervical cancer     | 0       | Breast cancer      | 0.267   |
| Cardiac carcinoma   | 0       | Colon cancer        | 0.706   | Gastric cancer     | 0.23    |
| Cervical cancer     | 0       | Ovarian cancer      | 0       |                   |         |
| Colon cancer        | 0.706   | PCa                 | 0.352   |                   |         |
| Ovarian cancer      | 0       | Esophageal carcinoma| 0       |                   |         |
| PCa                 | 0.352   |                     |         |                   |         |
| Esophageal carcinoma| 0       |                     |         |                   |         |
This study demonstrated that the incidence of prethrombotic state was variable in different types of tumors. The incidence rate of malignant tumor complicated by prethrombotic state is not clear. López suggested that about 50% cancer patients displayed laboratory indicators of coagulation system (López JA et al., 2009). According to Spyropoulos et al, 90% malignant tumor patients with metastasis presented abnormal coagulation state, 4%~30% patients had deep venous thrombosis (DVT) within 6~12 months of cancer diagnosis, 10%~25% patients were diagnosed malignant tumor within 3~5 years of idiopathic DVT and more than 75% among them were confirmed within 1 year.

Prethrombotic state exists in many diseases (Ouyang et al., 1999; Chen et al., 2012; 2014; Huang et al., 2012; Wang et al., 2012; Tan et al., 2014). The tumor types in our data covered all kinds of common solid tumors. Of all 1453 patients, 629 revealed plasma d-dimer abnormality (43.29%). Subgroup analysis based on gender showed that D-D abnormal rate for male patients was 43.5%, and for female was 43.02%, which implied that there is no statistically significant difference between gender. However, D-D abnormal rate increase with age increase, which was validated with Zeng’s report (Zeng et al., 2012; Isiaia, 2011). Several possible reasons are as follows. Coagulation and fibrinolytic system was relatively stable in younger than in elderly patients. Incidence of chronic diseases increased and chronic hypoxia, inflammation, vascular degenerative change complicated by tumor with advancing age (Sud et al., 2009; Douma RA et al., 2010; Jaffrelot et al., 2012; Wei et al., 2012).

Our current study indicated that the incidence of prethrombotic state varied with tumor stage. The incidence rate of prethrombotic state raised with the increasing stage of tumor and our data showed that D-D abnormal rate in phaseI is 2.0%, 6.2% in phaseII, 47.6% in phaseIII and up to 83.1% in phaseIV with significant differences. Thus, advanced tumors are risk factors for prethrombotic state and patients of terminal malignant tumors are more susceptible to have prethrombotic state. (López et al., 2009; Sud et al., 2009).

It is generally known that prethrombotic state is closely related to thrombotic events and the incidence is as high as 4%~20%, which is the second leading cause of death of malignant tumor patients. Yan and others summarized clinical manifestations, risk factors and treatment of 40 patients with high coagulation state or thrombosis so as to find that the starting-time of thrombosis of 77.5% patients was in 2 months after high coagulation state happened. Analysis of clinic data of 20 cases of malignant tumor complicated by DVT pointed out that the total media survival time was 6.3 months, the media survival time of patients whose D-D levels were twice above normal was 4.5 months and twice below normal was 7.3 months. Therefore, early diagnose and intervention of malignant tumor complicated by prethrombotic state to prevent thrombosis should be taken in clinical practice as DVT negatively impact on life quality and threaten the lives of cancer patients.

As the number of tumor patients steadily grow, it’s important to judge prethrombotic state early. Partially, that has to do with thrombosis events, prethrombotic state has a close ties to metastasis on the flip side. Prethrombotic state is not only the pathological manifestation that tumor leads to, but also the key factor of tumor etiology and independent risk factor for prognosis of tumor. By the clinical study of Hu et al. on blood coagulation state of 180 malignant tumor patients, D-D level of tumor inchoate group is 4.5 months and twice below normal was 7.3 months. Therefore, early diagnose and intervention of malignant tumor complicated by prethrombotic state to prevent thrombosis should be taken in clinical practice as DVT negatively impact on life quality and threaten the lives of cancer patients.

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tumor and the D-D levels of patients elevated by degrees which indicated that blood coagulative and fibrinolytic activity strengthened with the increasing of tumor staging and tumor burden thus trapped body in a vicious circle, which resulted thrombosis and tumor progression ultimately. After comparative analysis between the plasma D-D level of 0–4 weeks and 4–8 weeks before the end of 72 malignant patients who were impending death, Zhang et al. found that the D-D level of 0–4 weeks significantly higher than 4–8 weeks before their last days (p=0.002), which suggested that plasma D-D level showed increasing direction following disease progression in terminal phase of malignancies, from which they concluded that malignant progression in connection with the activation of coagulative and fibrinolytic system.

As a consequence, prethrombotic state predicts the invasion, metastasis and other malignant biological behavior indirectly. The increasing degree of it may often provide the clue of disease progression and poor prognosis. Detecting prethrombotic state promptly and primary or secondary prophylactic anticoagulation therapy specifically could reduce thrombotic events, improve quality of life and prolong survival period. Meanwhile, there are certain practical signification for anti-metastasis and improving clinical effects of anti-tumor.

Currently, several international large scale clinical trials support the validity of anticoagulation therapy. It has been shown by the MEDENOX trail that anticoagulation therapy significantly reduced the risk of DVT (Relative Risk=0.37 (p<0.001). In the meantime, PREVENT trail saw the obvious drop of incidence of DVT in anticoagulation therapy group compared with placebo group. 2.77%:4.96%, p=0.0015, Relative Risk reduced45% (ARR=2.19). In ARTEMIS trail, the incidence rate of DVT in medicine group and control group were 5.6% and 10.5% respectively. OR=49.5% (p=0.029). These 3 clinical trails consisted of 5000 cases in total. Although these data only contained 5%~15% malignant patients to allow us to discuss more concrete data, prophylatic anticoagulant therapy significantly reduced the incidence and risk of DVT, from the trails results.

A clinical trail aimed at patients with solid tumor during advanced stage who ruled out thrombosis was implemented in 2004, which randomly divided 385 cases into Low molecular weight heparin group (LMWH) and placebo group, 2 groups. After 12-week-treatment, 2 and half-quantity therapeutic dose of LMWH for 2-week and half-quantity of LMWH for 4-week as maintenance therapy. Clinical follow up of these cases revealed that mortality of 12-month and 24-month were 12% and 10% respectively, while overall survival prolonged from 6.6 months to 8 months. With regard of median survival, comparing with 9.4 years of placebo group, it was 15.4 years in LMWH group (Kakkar et al., 2004). So, NCCN and ASCO recommend anticoagulant therapy for cancer hospitalized patients without contraindication.

We conclude that the prethrombotic state of malignant patients closely related to their prognosis and basic life quality because the rising plasma D-D level correlates with tumor invasion, progression and poor prognosis. Therefore, growing recommend of D-D quantitative measurement as indicator to evaluate prethrombotic state and prognosis of malignant patients. Pay close attention on the change of prethrombotic state of malignant patients to detect thrombosis as early as possible, which is of great importance to improve life quality and prognosis of advanced malignant patients.

In conclusion, the activation of coagulation is associated with tumor growth, angiogenesis and metastasis. In turn, tumor further stimulate the activation of the coagulation process. In its incubation period, malignant tumor may cause hypercoagulable state or share some common mechanism with thrombosis. If this assumption is correct, anticoagulant drugs can interfere not only malignant transformation of cells, but also tumor development (Bobek V, 2012). In clinical practice, discovering the prethrombotic state complicated by malignant tumor and giving anticoagulation therapy in time which could improve blood hypercoagulable, reduce thrombotic events, improve the quality of life and prolong survival time of patients and prevent tumor invasion and metastasis may have important implications. This may be another vital aspect of treating tumors (Ma et al., 2007; Imberti et al., 2009).

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