VDM Vascular Disease Management

INTERVIEW

Overcoming Barriers to Implementation of VOYAGER Results Into Everyday Practice

An Interview With R. Kevin Rogers, MD

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At the 2023 Amputation Prevention Symposium (AMP), R. Kevin Rogers, MD, MSc, RVPI, from the Division of Cardiology at the University of Colorado School of Medicine in Aurora, Colorado, presented a review of the findings from the VOYAGER-PAD Trial, which randomized patients with peripheral arterial disease (PAD) after surgical and lower extremity revascularization to rivaroxaban 2.5 mg twice daily plus aspirin or matching placebo plus aspirin. Dr. Rogers provided insights into the barriers that may be preventing clinicians from implementing the study findings into everyday practice.

Vascular Disease Management spoke with Dr. Rogers to discuss his presentation.

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Dr. Rogers, tell us about your presentation on overcoming barriers to implementation of VOYAGER results.

VOYAGER-PAD was a randomized trial including patients with symptomatic PAD who had undergone revascularization within the prior 10 days, and these patients were randomized to a low dose of rivaroxaban, 2.5 mg twice a day, which is much less than what we see for full anticoagulation, for example, an atrial fibrillation patient, vs placebo on a background of aspirin. It appeared in the VOYAGER-PAD trial that low-dose rivaroxaban did reduce major adverse limb events, particularly acute limb ischemia (ALI), over the 3-year course of the follow-up in the study.

The purpose of my presentation for this conference was, is this positive result being reflected in real practice? Are providers and clinicians really prescribing low-dose rivaroxaban to help prevent limb events in patients with PAD who have undergone lower extremity revascularization? It appears that for the most part, it's still being underutilized. We looked at our own experience in the University of Colorado in patients who had undergone lower extremity revascularization for PAD. The use of low-dose rivaroxaban was only around 16%, and the dominant antithrombotic strategy was dual antiplatelet therapy with aspirin and clopidogrel.

In our experience, 80% of the patients in our sample who had undergone lower extremity revascularization for PAD were getting dual antiplatelet therapy (DAPT), and only 16% were receiving low-dose rivaroxaban. But the data for DAPT really aren’t there. There hasn't been a trial that's shown that DAPT reduces limb events following lower extremity revascularization in PAD patients, yet we have data both from the VOYAGER-PAD trial and the COMPASS trial for PAD patients receiving lower dose rivaroxaban and aspirin, and the FDA has also given an approval for low-dose rivaroxaban for this indication.

What do you think are the specific barriers to using low-dose rivaroxaban?

The barrier to consider first would be bleeding, but there doesn't appear to be more bleeding. If you look at the data carefully, there just is not more bleeding for low-dose rivaroxaban, at least compared with DAPT, and even low-dose rivaroxaban and aspirin vs aspirin alone—there is a small increase in bleeding, but overall net clinical benefit. You're preventing more ALI events than you're causing bleeding events. So I don't think bleeding is the main obstacle. I think another obstacle that is often thought to be a barrier is cost.

Cost to the patient is a barrier, but with most insurance plans, patients are paying between zero and $47 per month for the drug. If they don't have an insurance plan or if that's still too much, there are options for pay coupons along with other options to afford the drug. So I don't think cost is the big barrier, especially if you look at overall medical cost to society. By reducing so many ALI events, we're actually saving money. It's cost saving to use rivaroxaban in symptomatic PAD patients who've undergone lower extremity revascularization.

This has been shown in multiple analyses. I think the main barrier is really clinician inertia. Providers are not prescribing this drug for whatever reason. We need to increase awareness, we need to make it easier for providers to understand the patient population for whom low-dose rivaroxaban is indicated, which would be symptomatic PAD patients who've undergone lower extremity revascularization, and we need to make it easier for providers to overcome any cost barriers in the minority of patients who cannot afford low-dose rivaroxaban.

What's the one takeaway that you want attendees to get from your presentation?

For providers who've performed a lower extremity revascularization procedure or who have a patient who's undergone lower extremity revascularization for PAD, please consider low-dose rivaroxaban. It decreases the subsequent ALI rate overall, it's cost-effective, and it behooves your patients to help them be able to take this medicine. Consider it and help them overcome any cost barriers that may remain. ■

