
# 30-year mortality after venous thromboembolism: a population-based cohort study.

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Databases as Topic - statistics & numerical data
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Male
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Regression Analysis
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Risk factors
Survival Rate
Venous Thromboembolism - epidemiology - mortality

Abstract: Studies on long-term mortality after venous thromboembolism (VTE) are sparse.

Using Danish medical databases, we conducted a 30-year nationwide population-based cohort study of 128 223 patients with first-time VTE (1980-2011) and a comparison cohort of 640 760 people from the general population (without VTE) randomly matched by sex, year of birth, and calendar period. The mortality risks for patients with deep venous thrombosis (DVT) and pulmonary embolism (PE) were markedly higher than for the comparison cohort during the first year, especially within the first 30 days (3.0% and 31% versus 0.4%). Using Cox regression, we assessed mortality rate ratios (MRRs) with 95% confidence intervals (CIs). The overall 30-year MRR was 1.55 (95% CI, 1.53-1.57) for DVT and 2.77 (95% CI, 2.74-2.81) for PE. The 30-day MRR was 5.38 (95% CI, 5.00-5.80) for DVT and 80.87 (95% CI, 76.02-86.02) for PE. Over time, the 30-day MRR was consistently 5- to 6-fold increased for DVT, whereas it improved for PE from 138 (95% CI, 125-153) in 1980 to 1989 to 36.08 (95% CI, 32.65-39.87) in 2000 to 2011. The 1- to 10-year and 11- to 30-year MRRs remained 25% to 40% increased after both DVT and PE but were 3- to 5-fold increased after DVT and 6- to 11-fold increased after PE when VTE was considered the immediate cause of death.

Patients with VTE are at increased risk of dying, especially within the first year after diagnosis, but also during the entire 30 years of follow-up, with VTE as an important cause of death. Although 30-day mortality after DVT remained fairly constant over the last 3 decades, it improved markedly for PE.

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# Cholangitis and subsequent gastrointestinal cancer risk: a Danish population-based cohort study.

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Male
Middle Aged
Registries
Risk assessment
Risk factors



Abstract: While patients with gastrointestinal cancer are at increased risk of cholangitis, it is less clear whether cholangitis is also a marker for occult gastrointestinal cancer. If an undiagnosed cancer obstructs the bile duct system and causes cholangitis, the short-term risk of cancer will appear increased. However, an increased long-term risk of cancer may originate from chronic inflammatory processes. We assessed the risk of a gastrointestinal cancer diagnosis subsequent to a cholangitis diagnosis during a 17-year period in Denmark.

We conducted a nationwide population-based cohort study by linking Danish medical registries during 1994-2010. We quantified the excess risk of cancer in cholangitis patients using relative (standardised incidence ratio; SIR) and absolute (excess absolute risk per 1000 person-years at risk; EAR) risk calculations.

4333 patients with cholangitis (including 178 with primary sclerosing cholangitis) were followed for 17 222 person-years. During the follow-up period, 477 gastrointestinal cancers occurred versus 59 expected, corresponding to a SIR of 8.12 (95% CI 7.41 to 8.88). Risk was increased mainly for cancer in the small intestine (SIR 18.2; 95% CI 8.69 to 33.4), liver (SIR 16.3; 95% CI 11.6 to 22.2), gallbladder and biliary tract (SIR 70.9; 95% CI 59.0 to 84.4) and pancreas (SIR 31.7; 95% CI 27.8 to 36.0). During the first 6 months of follow-up, 314 patients were diagnosed with gastrointestinal cancer, corresponding to a SIR of 49.8 (95% CI 44.4 to 55.6) and an EAR of 175.

Cholangitis is a marker of occult gastrointestinal cancer.



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# Pericarditis as a Marker of Occult Cancer and a Prognostic Factor for Cancer Mortality.

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Follow-Up Studies
Humans
Middle Aged
Mortality - trends
Neoplasms - diagnosis - mortality
Pericarditis - diagnosis - mortality
Prognosis
Registries


Abstract: Pericarditis may be a serious complication of malignancy. Its significance as a first symptom of occult cancer and as a prognostic factor for cancer survival is unknown.

Using Danish medical databases, we conducted a nationwide cohort study of all patients with a first-time diagnosis of pericarditis during 1994 to 2013. We excluded patients with previous cancer and followed up the remaining patients for subsequent cancer diagnosis until November 30, 2013. We calculated risks and standardized incidence ratios of cancer for patients with pericarditis compared with the general population. We assessed whether pericarditis predicts cancer survival by the Kaplan-Meier method and Cox regression using a matched comparison cohort of cancer patients without pericarditis.

Among 13 759 patients with acute pericarditis, 1550 subsequently were diagnosed with cancer during follow-up. The overall cancer standardized incidence ratio was 1.5 (95% confidence interval [CI], 1.4-1.5), driven predominantly by increased rates of lung, kidney, and bladder cancer, lymphoma, leukemia, and unspecified metastatic cancer. The



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# Sarcoidosis and subsequent cancer risk: a Danish nationwide cohort study.



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Cohort Studies
Colonic Neoplasms - complications - diagnosis - epidemiology
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Immune System Diseases - complications - diagnosis - epidemiology
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Middle Aged
Neoplasms - complications - diagnosis - epidemiology
Registries
Risk factors
Sarcoidosis - complications - diagnosis - epidemiology
Tonsillar Neoplasms - complications - diagnosis - epidemiology
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# Survival after splanchnic vein thrombosis: A 20-year nationwide cohort study.

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Budd-Chiari Syndrome - complications - diagnosis - epidemiology - mortality

Cohort Studies

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Humans

Kaplan-Meier Estimate

Male

Middle Aged

Portal Vein - pathology

Prognosis

Proportional Hazards Models

Splanchnic Circulation

Survival Analysis

Venous Thrombosis - complications - diagnosis - epidemiology - mortality



Abstract: Splanchnic vein thrombosis (SVT) is a rare condition with a poorly understood prognosis.

We conducted a population-based cohort study (1994-2013), using data from Danish nationwide medical registries, to examine the short- and long-term prognosis of SVT. We identified 1915 incident cases of SVT and a matched comparison cohort of 18,267 persons without SVT (matched by cancer, cirrhosis, pancreatitis, alcohol-related disease, atrial fibrillation/flutter, venous thromboembolism, heart failure, and inflammatory bowel disease). We used the Kaplan-Meier method to calculate absolute risk of death. Using stratified Cox regression, we computed mortality rate ratios (MRRs) with 95% confidence intervals (CIs), comparing SVT patients with the comparison cohort.

We identified 1,500 (78%) patients with portal vein thrombosis, 204 (11%) with hepatic vein thrombosis, and 211 (11%) with mesenteric vein thrombosis. The mortality risks were markedly higher for SVT patients than for the comparison cohort during the first 5years of follow-up (30-day risk: 20.6% vs. 0.7%; 31-364-day risk: 21.7% vs. 4.7%; and 1-5-year risk: 25.4% vs. 17.7%). The corresponding MRRs were 40.7 (95% CI: 32.4-51.1), 7.4 (95% CI: 6.4-8.6), and 2.4 (95% CI: 2.1-2.8), respectively. The 30-day mortality was higher after mesenteric vein thrombosis than portal and hepatic vein thrombosis, whereas portal vein thrombosis had a stronger impact on mortality after 30days than hepatic and mesenteric vein thrombosis.

Splanchnic vein thrombosis has a poor short- and long-term prognosis that varies according to subtype of thrombosis. Reasons for the increased mortality in patients with SVT need further clarification.



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