Appendix 1

1) What is your specialty?
   • Urology
   • General surgery
   • Gynecology
   • Thoracic surgery
   • Medical oncology
   • Thrombosis

2) How long have you been in practice?
   • < 10 years
   • 10-20 years
   • > 20 years

3) What best describes the hospital you work in?
   • Academic/Teaching-hospital
   • Community

4) What province do you practice in?
   • Ontario
   • Quebec
   • PEI
   • Newfoundland
   • British Columbia
   • Nova Scotia
   • New Brunswick
   • Alberta
   • Manitoba
   • Saskatchewan
   • The Territories

For patients receiving abdominopelvic surgery for cancer:

5) Do you routinely use/recommend mechanical VTE prophylaxis?
   • Yes
   • No

6) Which type?
   • Graded compression stockings (TEDs)
   • Pneumatic/sequential compression devices (SCDs)
7) When do you commonly start mechanical prophylaxis?
   - Before surgery
   - At the time of surgery (in the OR)
   - After surgery

For patients receiving abdominopelvic surgery for cancer:

8) Do you routinely use/recommend pharmacological (medical) prophylaxis?
   - Yes
   - No

9) When do you most commonly start/recommend starting pharmacological prophylaxis?
   - Before surgery
   - At the time of surgery (in the OR)
   - After surgery on the same day
   - Post-operative day #1
   - Other

10) After surgery, in hospital, what pharmacological prophylaxis do you most commonly use/recommend? (assuming the patient is eligible for all types – ex: no renal impairment)
    - Low molecular weight heparin (ex. enoxaparin)
    - Unfractionated heparin
    - Coumadin (ex. Warfarin)
    - DOAC (ex. rivaroxaban, dabigatran)
    - Aspirin

11) When do you most commonly stop pharmacological prophylaxis after surgery?
    - When the patient is ambulating regularly
    - When the patient is discharged from hospital
    - On a specific post-operative day (ex: specific number of days after surgery irrespective of inpatient or outpatient status)
    - Varies based on patient and procedure factors
    - Other, please specify

12) Do you ever recommend/prescribe VTE prophylaxis for patients after discharge from hospital (ie. extended duration)?
    - Yes
    - No
13) What type of VTE pharmacological prophylaxis do you most commonly use/recommend after discharge from hospital?
   - Low molecular weight heparin (ex. enoxaparin)
   - Unfractionated heparin
   - Coumadin (ex. Warfarin)
   - DOAC (ex. rivaroxaban, dabigatran)
   - Aspirin

14) What length of extended duration thromboprophylaxis do you typically use/recommend?
   - 1 week (7 days from date of surgery)
   - 2 weeks (14 days from date of surgery)
   - 3 weeks (21 days from date of surgery)
   - 4 weeks (28 days from date of surgery)
   - Other, please specify

15) Do you alter the VTE prophylaxis based on patient specific factors?
   - Yes
   - No

16) What patient factors alter the prophylaxis you order? (Choose all that apply):
   - Age
   - BMI
   - Renal function
   - Smoking
   - Recent chemotherapy
   - Patient history of VTE
   - Family history of VTE
   - Other, please specify

17) Do you alter the VTE prophylaxis based on surgery specific factors?
   - Yes
   - No

18) What surgery factors alter the prophylaxis you order? (Choose all that apply):
   - Type of operation (ex. organ removed, lymph node dissection performed)
   - Surgical approach (laparoscopic vs open)
   - Length of surgery (hours)
   - Patient position during the procedure (ex. lithotomy, supine)
   - Use of epidural anesthetic
   - Other, please specify
19) Do you use a guideline to help direct VTE prophylaxis?
   • Yes, I use the ACCP guidelines (CHEST 2012)
   • Yes, I use a surgical specialty guideline (ex. association guideline)
   • Yes, I use a thrombosis association guideline
   • No, I do not use a guideline
   • Other, please specify

20) Do you use a risk assessment tool to help direct VTE prophylaxis?
   • Yes, I use the Caprini risk assessment tool
   • Yes, I use the Rogers score
   • Yes, I use the NICE VTE guidelines
   • Yes, I use the Khorana score
   • No, I do not use a risk assessment score
   • Other, please specify

21) In what settings do you believe thromboprophylaxis increases the risk of bleeding?
   (Please check all that apply)
   • When given during neoadjuvant chemotherapy
   • When given intra-operatively (ex. heparin during OR)
   • When given in-hospital after surgery
   • When given after discharge from hospital (ex. extended duration prophylaxis)
   • Other, please specify

22) Do you consider a patient’s risk of bleeding before prescribing thromboprophylaxis?
   • Yes
   • No

23) Do you treat patients that receive systemic chemotherapy (ex. cisplatin) before or after surgery (neoadjuvant or adjuvant)?
   • Yes
   • No

For patients receiving chemotherapy before or after abdominopelvic surgery for cancer:

24) Do you believe chemotherapy changes the risk of VTE?
   • Yes
   • No

25) Do you prescribe pharmacological VTE prophylaxis to patients while on systemic chemotherapy before/after surgery?
   • Yes
   • No
26) If yes, what type of prophylaxis do you routinely prescribe?
- Low molecular weight heparin (ex. enoxaparin)
- Unfractionated heparin
- Coumadin (ex. Warfarin)
- DOAC (ex. rivaroxaban, dabigatran)
- Aspirin

27) If you do not prescribe thromboprophylaxis during chemotherapy, why not? (Choose all that apply):
- I do not believe chemotherapy impacts VTE risk sufficiently to warrant prophylaxis.
- I am concerned about the risk of bleeding with prophylaxis for patients on chemotherapy.
- Patients care is directed by another physician during chemotherapy.
- Cost, convenience barriers to prophylaxis.
- Other, please specify

Clinical vignettes:
28) A 75-year-old male patient is preparing to undergo a surgery to remove a cancerous tumour with an open approach. He is a smoker and has a BMI of 36. He also receives neoadjuvant chemotherapy. The risk of VTE from the time of initiating chemotherapy to 30 days post-operative is 10% and the risk of transfusion is 2% on chemotherapy and 35% after surgery based on the procedure he is receiving.

Please select all times in his care that you would prescribe/recommend thromboprophylaxis. (Choose all that apply):
- During neoadjuvant chemotherapy
- Intra-operatively (ex. heparin during the operation)
- Post-operatively while in-hospital
- Extended duration after hospital (ex. discharged home on prophylaxis)
- Other, please specify

29) A patient has a baseline risk of 10% of a VTE and 5% of major bleeding (embolization, re-operation, etc) during their treatment for a cancerous tumour. If a medication could decrease the risk of VTE to 5%, what absolute increase in bleeding would you allow to prescribe the prophylaxis?
- No increase risk of bleeding is acceptable
- 1% absolute increase, 20% relative increase (bleeding risk now 6%)
- 2.5% absolute increase, 50% relative increase (bleeding risk now 7.5%)
- 5% absolute increase, 100% relative increase (bleeding risk now 10%)
- Other, please specify
30) A given POST-OPERATIVE patient has a risk of VTE of 5% within 30 days of their surgery based on the patient and procedure variables. If a medication could decrease this rate when given for 28 days after surgery, what absolute change in the rate of VTE would you require to prescribe the medication, assuming the patient has a very low bleeding risk at the time of hospital discharge?

- A 2% decrease in VTE risk (patient’s risk now 3%)
- A 2.5% decrease in VTE risk (patient’s risk now 2.5%)
- A 3% decrease in VTE risk (patient’s risk now 2%)
- A 3.5% decrease in VTE risk (patient’s risk now 1.5%)
- Other, please specify

31) Would you participate in a clinical trial investigating? (Check all that apply):

- Timing of initiation of pharmacological thromboprophylaxis with surgery (intra-op versus post-op)
- Use of thromboprophylaxis with neoadjuvant or adjuvant chemotherapy
- Use of mechanical thromboprophylaxis
- Use of different pharmacological options for thromboprophylaxis
- None
- Other, please specify