

**Supplementary Table 1**

## Demographics

Geographical region of employment ( <i>n</i> = 142)	% ( <i>n</i> )
Capital region of Denmark	28.9 (41)
Central Denmark region	21.8 (31)
North Denmark region	9.9 (14)
Region of Southern Denmark	32.4 (46)
Region Zealand	7.0 (10)
Position ( <i>n</i> = 142)	% ( <i>n</i> )
Chief physician	36.6 (52)
Senior registrar	23.9 (34)
Registrar	25.4 (36)
Intern/resident	14.1 (20)
Oncology subspecialty <sup>a</sup> ( <i>n</i> = 142)	% ( <i>n</i> )
Breast cancer	18.3 (26)
Lung cancer	19.0 (27)
Gastrointestinal cancer	19.0 (27)
Head-neck cancer	8.5 (12)
Urological	9.2 (13)
Unspecified, shifting between subspecialties	19.7 (28)
Cancer of unknown primary, palliation, sarcoma, gynecological cancer, neuroendocrine tumor, central nervous system tumor, and malignant melanoma	<4

<sup>a</sup>The response format was a free-text box, allowing participants to give an open answer.

## Treatment of venous thromboembolism in the oncology department

Are patients with DVT treated in the department? ( <i>n</i> = 142)	% ( <i>n</i> )
Yes	98.6 (140)
No	1.4 (2)
Are patients with pulmonary embolism treated in the department? ( <i>n</i> = 142)	% ( <i>n</i> )
Yes	62.7 (89)
Yes, but only if the patient is hemodynamically stable	35.9 (51)
No	1.4 (2)
Patients with pulmonary embolism who are not hemodynamically stable are treated in the: ( <i>n</i> = 51)	% ( <i>n</i> )
Medical department	0
Acute medical unit	9.8 (5)
Cardiology department	86.3(44)
Other (specify)	3.9 (2)

## Diagnosis

What is the most commonly used strategy to assess the clinical probability of DVT? ( <i>n</i> = 140) (Danish guidelines do not provide suggestions on diagnostic tools)	% ( <i>n</i> )
Wells' score	15.0 (21)
Other scoring system	0
Clinical assessment (no scoring system)	80.7 (113)
Don't know	4.3 (6)
What is the most commonly used strategy to assess the clinical probability of pulmonary embolism? ( <i>n</i> = 140) (Danish guidelines do not provide suggestions on diagnostic tools)	% ( <i>n</i> )
Wells' score	5.0 (7)
Geneva score	0
Other scoring system	0
Clinical assessment (no scoring system)	94.3 (132)
Don't know	0.7 (1)

## Anticoagulant treatment

First-line treatment in the department of patients with active cancer and cancer associated venous thrombosis: ( <i>n</i> = 140) (Guidelines recommend weight-based LMWH)	% ( <i>n</i> )
Vitamin K antagonist (warfarin)	0
Low-molecular-weight heparin (weight-based)	98.6 (138)
NOAC (Xarelto, Lixiana, Pradaxa, Eliquis)	0.7 (1)
Don't know	0.7 (1)
Second-line treatment in the department of patients with active cancer and cancer-associated venous thrombosis: ( <i>n</i> = 140) (Guidelines recommended VKA at the time)	% ( <i>n</i> )
Vitamin K-antagonist (warfarin)	12.1 (17)
Low-molecular-weight heparin (weight-based)	6.4 (9)
NOAC (Xarelto, Lixiana, Pradaxa, Eliquis)	36.4 (51)
Don't know	45.0 (63)
Specification of NOAC (second-line treatment): ( <i>n</i> = 36)	% ( <i>n</i> )
Xarelto	72.2 (26)
Lixiana	2.8 (1)
Pradaxa	11.1 (4)
Eliquis	13.9 (5)

Abbreviations: DVT, venous thromboembolism; LMWH, low-molecular-weight heparin; NOAC, novel oral anticoagulants; VKA, vitamin K antagonists.

## Treatment duration

Patients with active cancer and new-onset DVT are by default treated: (chose answer based on the common practice in the department; $n = 139$ ) (Guidelines recommend continued treatment in patients with active cancer. Treatment recommendations are irrespective of type of VTE (DVT/PE))	% (n)
3 months	3.6 (5)
6 months	36.0 (50)
12 months	2.2 (3)
As long as the patient have active cancer	58.3 (81)
Other, specify:	0
Patients with active cancer and new-onset pulmonary embolism are by default treated: (chose answer based on the common practice in the department) ( $n = 139$ ) (Guidelines recommend continued treatment in patients with active cancer)	% (n)
3 months	0
6 months	20.1 (28)
12 months	2.2 (3)
As long as the patient have active cancer	77.7 (108)
Other, specify:	0

Abbreviations: DVT, venous thromboembolism; PE, pulmonary embolism; VTE, venous thromboembolism.

## Increased bleeding risk

Our treatment choice in the department for patients with increased bleeding risk is: ( $n = 139$ ) (Guidelines recommend individual assessment)	% (n)
Vitamin K-antagonist (warfarin)	0
Low-molecular-weight heparin (weight-based)	40.3 (56)
NOAC (Xarelto, Lixiana, Pradaxa, Eliquis)	0
Individual assessment in terms of type and intensity of anticoagulant treatment	49.6 (69)
Don't know	10.1 (14)

Abbreviation: NOAC, novel oral anticoagulant.

## Recurrence while in anticoagulant treatment

Our treatment choice in the department if patients have a recurrent VTE while treated with LMWH: ( $n = 138$ ) [Guidelines recommend dose escalation of LMWH]	% (n)
Increases dosage of LMWH	70.3 (97)
Switches to Vitamin K antagonist (warfarin)	0.7 (1)
Switches to NOAC (Xarelto, Lixiana, Pradaxa, Eliquis)	2.2 (3)
Other, specify: <ul style="list-style-type: none"> <li>• Confers with center for thrombosis and hemostasis</li> <li>• Always confers with the thrombosis clinic/cardiologist</li> <li>• Asks the cardiologists/thrombosis center, who have specialized knowledge.</li> <li>• The hemostasis specialist on guard is contacted for advice.</li> <li>• Confer with center of thrombosis and hemostasis</li> <li>• Fortsæt med gængse dosering LMH efter vægt i terapeutisk dosering (continue LMWH without dose-adjustment)</li> <li>• Increase dosage to 125%</li> <li>• Increase dosage</li> <li>• Referral to the specialized department to determine cause. Additionally, switches to NOAC</li> <li>• Dividing current dose into two</li> <li>• Continuing current treatment</li> <li>• Treatment twice daily with LMWH</li> <li>• Seeks specialist advice</li> <li>• Dividing LMWH in two daily dosage, increase dosage of LMWH, and contacting the center of thrombosis and hemostasis</li> <li>• Dose is divided into two</li> </ul>	10.9 (15)
Don't know	15.9 (22)

Abbreviations: DVT, venous thromboembolism; LMWH, low-molecular-weight heparin; NOAC, novel oral anticoagulants; VTE, venous thromboembolism.

## Follow-Up

Follow-up after cancer associated thrombosis ( $n = 137$ ) (Not specified in the Danish guidelines)	% (n)
The patients are seen in the outpatient clinic at the oncology department for follow-up/control	44.5 (61)
The patient is referred to follow-up/control in a specialized thrombosis clinic/unit	34.3 (47)
Follow-up/control is handled by the general practitioner	13.9 (19)
Don't know	7.3 (10)

## Thromboprophylaxis

The question regards all patients in the department (including non-CT patients) All patients with active cancer, who are hospitalized and immobilized receives by default thromboprophylaxis (unless it is contraindicated)? ( <i>n</i> = 139) (Guidelines recommend prophylaxis unless contraindicated)	% ( <i>n</i> )
Yes	27.3 (38)
Yes, if the patient has evident risk factors for VTE (e.g., prior DVT or PE)	28.1 (39)
Only exceptionally	44.6 (62)

Abbreviations: CT, cancer-associated venous thrombosis; DVT, venous thromboembolism; PE, pulmonary embolism; VTE, venous thromboembolism.

## Cancer-associated venous thrombosis guideline

Does the department have a clinical practice guideline for cancer-associated venous thrombosis? ( <i>n</i> = 142)	% ( <i>n</i> )
Yes	52.1 (74)
No	11.3 (16)
Don't know	36.6 (52)