

Determining Need for Anticoagulation	<ul style="list-style-type: none"> The need to anticoagulate is primarily based on ischemic stroke risk CHA₂DS₂-VASc is the recommended ischemic stroke risk tool DOACs are now recommended over warfarin except in patients with mod-to severe mitral stenosis or a mechanical heart valve Anti-platelets alone are NOT recommended for stroke prevention. 	CHA₂DS₂-VASc Scoring Tool		CHA₂DS₂-VASc Score		Yearly Stroke Risk (%)					
		Condition		Points							
		Congestive heart failure		1		0		No treatment		With anticoagulant	
		Hypertension		1		0					
		Age > 75 years		2		1		1.3		0.5	
		Diabetes mellitus		1		2		2.2		0.8	
		Stroke/TIA or thromboembolism (prior)		2		3		3.2		1.1	
		Vascular disease (MI, PAD, or aortic plaque)		1		4		4.0		1.4	
		Age 65-74 years		1		5		6.7		2.3	
		Sex Category (Female)		1		6		9.8		3.4	
		Score		Stroke Risk		2019 AHA /ACC Recommendation		For additional information about anticoagulation in Atrial Fibrillation, visit www.anticoagulationtoolkit.org			
		≥3		High		Anticoagulate (men and women)					
		2		High/Interm.		Anticoagulate (men) Consider (women)					
		1		Interm./Low		Consider oral anticoagulant in men					
		0		Low		Reasonable to omit anticoagulation					

Anticoagulant Selection	Pros		Cons		Dosing (see package inserts for full info)		Contraindications/Precautions		Assessment/Monitoring			
	Warfarin (Coumadin®)		<ul style="list-style-type: none"> Inexpensive Can be monitored Can be reversed Less GI bleeding Once daily dosing 		<ul style="list-style-type: none"> Many food/drug interactions Frequent INRs and dose changes May require bridging around procedures More intracranial bleeds 		<ul style="list-style-type: none"> Initial: 5mg/day (consider 2.5mg if high bleed risk) Subsequent dosing based on INR with <u>target range of 2-3</u> 		<ul style="list-style-type: none"> Pregnancy (except mechanical heart valves) Concomitant use of antibiotics, antifungals, herbal products, and inhibitors/inducers of CYP2C9, 1A2, and/or 3A4. 		<ul style="list-style-type: none"> Baseline: INR and CBC INR 3-5 days after initiation and approx. 7 days after dose changes INRs can be gradually spaced out if stable 	
	DOACs		All		<ul style="list-style-type: none"> More expensive No accurate direct measurement and may not be available Reversal agents expensive and may not be available Rely heavily on renal elimination 		<ul style="list-style-type: none"> DOAC specific (see below) 		<ul style="list-style-type: none"> Mechanical heart valves Pregnancy/nursing Triple positive antiphospholipid syndrome BMI>40, or weight >120kg Bariatric surgery Use carefully in patients with renal impairment 		<ul style="list-style-type: none"> Renal function, liver function, and CBC before initiation and at least yearly Assess pt at week 1, 3, and 3 months from initiation 	
			Apixaban (Eliquis®)		<ul style="list-style-type: none"> Twice/daily dosing 		<ul style="list-style-type: none"> 5mg BID 2.5mg BID if two of: age≥80, wt≤60kg, SCr≥1.5 2.5mg BID if co-administered with strong dual inhibitors of CYP3A4 and P-gp 		<ul style="list-style-type: none"> Strong dual CYP3A4 and P-gp inhibitor and at least two of: age≥80, wt≤60kg, Cr≥1.5 Strong dual inducers of CYP3A4 and P-gp Severe hepatic impairment 		<ul style="list-style-type: none"> See DOAC info above In addition, regularly assess weight and age (may need dose adjustment) 	
			Dabigatran (Pradaxa®)		<ul style="list-style-type: none"> Relies most on renal clearance Twice/daily dosing Increased dyspepsia Must stay in original packaging More GI bleeding than warf. 		<ul style="list-style-type: none"> 150mg BID (if CrCl>30mL/min) 75mg BID (CrCl 15-30mL/min or CrCl 30-50 mL/min with dronedarone or ketoconazole) 		<ul style="list-style-type: none"> P-gp inducers (eg. rifampin) P-gp inhibitors if CrCl <30mL/min 		<ul style="list-style-type: none"> See DOAC info above Use Cockcroft-Gault with actual weight to calculate CrCl 	
			Edoxaban (Savaysa®)		<ul style="list-style-type: none"> Inferior stroke prevention in patients with CrCl >95 mL/min 		<ul style="list-style-type: none"> 60mg daily (CrCl >50 to ≤95mL/min) 30mg daily (CrCl 15-50 mL/min) 		<ul style="list-style-type: none"> CrCl >95 mL/min³ Rifampin Mod/severe hepatic impairment 		<ul style="list-style-type: none"> See DOAC info above Use Cockcroft-Gault with actual weight to calculate CrCl 	
		Rivaroxaban (Xarelto®)		<ul style="list-style-type: none"> Should be taken with largest meal of the day More GI bleeding compared to warfarin 		<ul style="list-style-type: none"> 20mg daily (CrCl >50 mL/min) 15mg daily (CrCl ≤50mL/min) 		<ul style="list-style-type: none"> Combined P-gp and strong CYP3A4 inhibitors or inducers Mod/severe hepatic impairment Combined P-gp and moderate CYP3A4 inhibitors if CrCl <80 		<ul style="list-style-type: none"> See DOAC info above Use Cockcroft-Gault with actual weight to calculate CrCl 		

Patient Education	Anticoagulation			Warfarin-specific			DOAC-specific		
	<ul style="list-style-type: none"> Watch for s/sx of bleeding (especially intracranial) Notify healthcare provider if any s/sx of bleeding but seek immediate medical care if serious bleeding Notify clinic before starting any new med (including OTC) or having proc. ASA/NSAIDs ↑ bldg. Avoid NSAIDs and only use ASA if clear indication. Avoid dangerous activities that could lead to injuries (use protective gear) Notify dentist or physician that you are on anticoagulant prior to procedure Don't stop without consulting healthcare provider Provide written materials covering the above topics 			<ul style="list-style-type: none"> Maintain stable Vitamin K intake (eg. green leafy vegetables, broccoli, brussel sprouts, green tea) Notify if illness or change in health status (may effect INR) Alcohol can increase INR Visit www.anticoagulationtoolkit.org for patient handouts 			<ul style="list-style-type: none"> Very important not to miss a dose (since short half life) Dabigatran must be kept in original packaging Rivaroxaban should be taken with largest meal of the day Visit www.anticoagulationtoolkit.org for patient handouts 		

Long-term Management	<ul style="list-style-type: none"> Follow-up: at each f/u, assess for compliance, s/sx of bleeding or thromboembolism, interacting medication, and reinforce patient education. Bleeding <ul style="list-style-type: none"> Nuisance: minor bleeding common (epistaxis, bleeding gums, etc.) Not reason to d/c anticoagulant. Teach how to prevent/manage. Major bleeds: In most cases, resuming anticoagulation after bleeding controlled is best (~14 days after GI, within 1 mo. for intracranial) Periprocedural: Most pts don't need to have anticoag. interrupted for low bleed risk proc. unless pt has high bleed risk.(see table below) See warfarin and DOAC-specific peri-procedural info if interruption necessary. 			<ul style="list-style-type: none"> Follow-up: <ul style="list-style-type: none"> INRs 3-5 days after re-starting or any changes that can effect INR (ex. med or diet change) and approx. 7 days after any dose changes INRs can gradually be spaced out to monthly Dose changes per a standardized protocol Periprocedural: If high-risk proc. or high-risk pt. (see table bottom left), stop 5 days before. DO NOT bridge unless CHA₂DS₂-VASc ≥7 or stroke <3 mos. If bridging, start LMWH (UFH if CrCl<30) 3 days before proc. and stop 24 hrs before proc. (at least 4 hrs if UFH). Restart warfarin within 24 hrs of proc. at previous dose. Restart LMWH or UFH 24 hrs after low-risk proc. or 48-72 hours after high-risk proc. Stop LMWH/UFH when INR is therapeutic Switching to DOAC: stop warfarin and start DOAC when INR<2 (apixaban, dabigatran), ≤2.5 (edoxaban), <3 (rivaroxaban) 			<ul style="list-style-type: none"> Follow-up: annually assess CBC, liver function, renal function (more frequently if renal insufficiency), weight, and age. Adjust dose per package insert dosing instructions (above), if necessary. Periprocedural: If DOAC is to be interrupted, most pts should stop one day before low risk procedures and 2 days before high risk procedures. For dabigatran pts with CrCl<50, stop 3 days before low risk procedures and 4 days before high risk procedures. Bridging is rarely needed. DOAC can be restarted 24 hours after low risk procedure and 48-72 hours after higher risk procedure. Switching to another DOAC: discontinue current DOAC and start new one at next scheduled dose. Switching to warfarin: see DOAC package insert for instructions. 		
	High risk pt. Eg. major bleed <3 mos, platelet abnormalities (including ASA use), hx of bleeding during prior bridging								
	Low risk proc. Eg. minor dental and dermatological, cataract/glaucoma, diagnostic endoscopies								
	High risk proc. Eg. major surgeries, procedures in highly vascularized organs (eg. kidneys), spinal procedures								

References

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- Drug package inserts
 - Warfarin: https://packageinserts.bms.com/pi/pi_coumadin.pdf
 - Apixaban: https://packageinserts.bms.com/pi/pi_eliquis.pdf
 - Dabigatran: <http://docs.boehringer-ingelheim.com/Prescribing%20Information/PIs/Pradaxa/Pradaxa.pdf>
 - Edoxaban: <http://dsi.com/prescribing-information-portlet/getPIContent?productName=Savaysa&inline=true>
 - Rivaroxaban: <https://www.xareltohcp.com/shared/product/xarelto/prescribing-information.pdf>

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