

DOAC Bleeding Management (v1 1/2/2019)

Determine Bleed Severity

- Determining bleed severity is a key step in making treatment decisions.
- Bleeds can be classified into major and non-major based on several clinical factors.
- **If one or more of the following factors apply, the bleed should be considered major.**

Bleeding in critical site (examples below)	Hemodynamic instability (examples below)	Overt bleeding with either:
<ul style="list-style-type: none"> • Central nervous system bleeds (intracranial, spinal, intraocular) • Pericardial tamponade • Airway, including posterior epistaxis • Hemothorax 	<ul style="list-style-type: none"> • Intra-abdominal • Retroperitoneal • Intra-articular • Intra-muscular 	<ul style="list-style-type: none"> • Elevated heart rate • Decrease in SBP >40 mm Hg • Mean arterial pressure (intra-arterial) <65 mm Hg
	<ul style="list-style-type: none"> • SBP <90 mm Hg • Orthostatic blood pressure changes • Urine output <0.5 mL/kg/hr 	<ul style="list-style-type: none"> • Hemoglobin drop of ≥2 g/dL or • Administration of ≥2 U of packed RBCs

Assess for Clinically Relevant Drug Levels

- If last dose taken at least 24 hr ago in patients with normal renal function, drug levels probably not clinically relevant.¹
- If patient taking dabigatran, a TT can be used to rule out clinically relevant drug levels. Specialized tests can quantify drug levels.
- If apixaban, edoxaban, rivaroxaban, or betrixaban, anti-Xa is the preferred test and can be used to rule out relevant drug levels or quantify levels.
- **Don't wait for results before administering reversal agents in life-threatening bleeds!**

	Specialized Test	Drug Level Interpretation	General Test	Drug Level Interpretation
Dabigatran	dTT, ECT, ECA	Normal: not clinically relevant Results correlate with drug level	TT	Normal: not clinically relevant Prolonged: may/may not be clinically relevant
			aPTT	Normal: likely indicates lower drug level but can't exclude drug presence Prolonged: clinically relevant
Apixaban Betrixaban Edoxaban Rivaroxaban	Anti-Xa	Absent activity: not clinically relevant Results correlate with drug level (if calibrated for specific DOAC)	PT	Normal: does not exclude clinically relevant levels Prolonged: clinically relevant levels

Anti-Xa= anti-factor Xa; aPTT= activated partial thromboplastin time; dTT= dilute thrombin time; ECA= ecarin chromogenic assay; ECT= ecarin clotting time; PT= prothrombin time; TT= thrombin time

Manage Bleeding

All bleeds	Major Bleeds		Minor Bleeds	
	Critical site or life threatening	NOT critical site or life threatening	More serious minor bleeds†	Less serious minor bleeds
<ul style="list-style-type: none"> • Provide local therapy/ manual compression • Assess for and manage comorbidities contributing to the bleed* 	<ul style="list-style-type: none"> • Stop DOAC • Provide supportive care <ul style="list-style-type: none"> • Secure airway and large-bore IV access • Aggressive volume resuscitation (NS or LR) • Correct hypothermia and acidosis • Early involvement of other services (eg. surgery) • RBC transfusions to achieve Hgb ≥7 g/dL (≥8 g/dL if pt has CAD) • Platelet transfusion to achieve counts >50 x 10⁹/L • Cryoprecipitate transfusion to maintain fibrinogen >100 mg/dL • Stop any antiplatelets • Consider surgical/procedural management • Administer reversal agent 	<ul style="list-style-type: none"> • Stop DOAC • Provide supportive care <ul style="list-style-type: none"> • Secure airway and large-bore IV access • Aggressive volume resuscitation (NS or LR) • Correct hypothermia and acidosis • Early involvement of other services (eg. surgery) • RBC transfusions to achieve Hgb ≥7 g/dL (≥8 g/dL if pt has CAD) • Platelet transfusion to achieve counts >50 x 10⁹/L • Cryoprecipitate transfusion to maintain fibrinogen >100 mg/dL • Stop any antiplatelets • Consider surgical/procedural management • Administer reversal agent if above not effective 	<ul style="list-style-type: none"> • Stop DOAC • Provide supportive care • Stop any antiplatelets • Consider surgical/procedural management 	<ul style="list-style-type: none"> • Consider continuing DOAC if appropriate indication • Assess risk/benefits of stopping any antiplatelets • Verify that DOAC dosing is correct and patient taking as directed

*eg. renal dysfunction, liver disease, thrombocytopenia

† Patient requires hospitalization, transfusion, or procedural intervention

DOAC Reversal

Dabigatran	Apixaban, Betrixaban, Edoxaban, Rivaroxaban
<ul style="list-style-type: none"> • Administer 5 g idarucizumab IV (two separate 2.5 g/50 mL vials) <ul style="list-style-type: none"> • If bleeding persists and there is laboratory evidence of persistent dabigatran effect after 12-24 hours, a second dose may be reasonable. • If idarucizumab is not available, administer 4F-PCC or aPCC 50 units/kg IV (refer to prescribing information for max units) • Activated charcoal (50 g) can be considered if ingested within 2-4 hours • Hemodialysis could be considered if drug level is high, especially in patients with poor renal function. • Fresh-frozen plasma is not recommended for DOAC reversal 	<ul style="list-style-type: none"> • Admin. ANDEXXA per package insert (Apix/Riva only) • If ANDEXXA not avail. Admin 4F-PCC 50 units/kg IV • If 4F-PCC is not available, consider aPCC 50 units/kg IV (refer to prescribing information for max units) • Activated charcoal (50 g) can be considered if ingested within 2-4 hours • Fresh-frozen plasma is not recommended for DOAC reversal

4F-PCC= four-factor prothrombin complex; aPCC= activated prothrombin complex concentrate

Restart DOAC

- Most patients benefit from restarting anticoagulation after bleeds, but make sure there is still a valid indication.
 - eg. CHA₂DS₂-VASc is ≥ 1 (in AF), length of treatment hasn't been reached (for VTE treatment or post-op prophylaxis).
- Base plan on the balance between bleeding and thromboembolic risks and discussions with other appropriate practitioners (eg. surgeons), the patient, and caregivers.
- Timing of restart: Delay restart if bleeding occurred in a critical site or if patient has a high risk for re-bleeding. Patients with GI bleed should typically wait at least 7-14 days. Patients with intracranial hemorrhage (and no mechanical valve) should wait at least 4 weeks.² In patients with moderate to high risk of recurrent VTE without high risk of recurrent bleeding, ASH suggests resuming anticoagulation within 90 days rather than discontinuation.³
- Make sure dose is correct based on age, renal function, weight, and indication and address any reversible risk factors such as interacting medications or unnecessary antiplatelet therapy.

References

- Unless otherwise referenced, document adapted from: 2017 ACC Expert Consensus Decision Pathway on Management of Bleeding in Patients on Oral Anticoagulants. JACC, Volume 70, Issue 24, 19 December 2017, Pages 3042-3067, ISSN 0735-1097, <https://doi.org/10.1016/j.jacc.2017.09.1085>
- ¹Levy JH, Ageno W, Chan NC, Crowther M, Verhamme P, Weitz J. When and how to use antidotes for the reversal of direct oral anticoagulants: guidance from the SSC of the ISTH. J Thromb Haemost. 2016 Mar;14(3):623-7. doi: 10.1111/jth.13227. Epub 2016 Feb 17.
- ²Hemphill, et al. 2015 AHA/ASA Guidelines for the Management of Spontaneous Intracerebral Hemorrhage. Stroke. 2015;46:000-000. DOI: 10.1161/STR.0000000000000069
- ³Witt WM, et al. American Society of Hematology 2018 guidelines for management of venous thromboembolism: optimal management of anticoagulation therapy. DOI 10.1182/bloodadvances.2018024893

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