

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.**

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Bleeding in critical site (examples below)	Hemodynamic instability (examples below)	Overt bleeding with either:
- Central nervous system bleeds (intracranial, spinal, intraocular) - Pericardial tamponade - Airway, including posterior epistaxis - Hemothorax - Intra-abdominal - Retroperitoneal - Intra-articular - Intra-muscular	- Elevated heart rate - Decrease in SBP >40 mm Hg - Mean arterial pressure (intra-arterial) <65 mm Hg - SBP <90 mm Hg - Orthostatic blood pressure changes - Urine output <0.5 mL/kg/hr	- 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 bleeds¹**

	Specialized Test	Drug Level Interpretation	General Test	Drug Level Interpretation
Dabigatran	dTT, ECT, ECA	<u>Normal</u> : not clinically relevant Results correlate with drug level	TT	<u>Normal</u> : not clinically relevant <u>Prolonged</u> : may/may not be clinically relevant
			aPTT	<u>Normal</u> : likely indicates lower drug level but can't exclude drug presence <u>Prolonged</u> : clinically relevant
Apixaban Betrixaban Edoxaban Rivaroxaban	Anti-Xa	<u>Absent activity</u> : not clinically relevant Results correlate with drug level (if calibrated for specific DOAC)	PT	<u>Normal</u> : does not exclude clinically relevant levels <u>Prolonged</u> : 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
- Provide local therapy/ manual compression - Assess for and manage comorbidities contributing to the bleed*	- Stop DOAC - Provide supportive care - 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	- Stop DOAC - Provide supportive care - 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	- Stop DOAC - Provide supportive care - Stop any antiplatelets - Consider surgical/procedural management	- 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
- Administer 5 g idarucizumab IV (two separate 2.5 g/50 mL vials) - If bleeding persists and there is laboratory evidence of persistent dabigatran effect after 12-24 hours, a second dose may be reasonable. - If idarucizumab not available, administer aPCC at 50 units/kg IV (refer to package insert 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	- Admin 4F-PCC 2,000 units IV (fixed dose) OR 25-50 units/kg IV, according to institutional protocol. - If 4F-PCC is not available, consider aPCC 50 units/kg IV (refer to prescribing information for max units) - Consider Activated charcoal (50 g) if ingested <2-4 hrs - Fresh-frozen plasma is not recommended - Andexxa is no longer available in the U.S. due to increased thrombotic risk.

PCC= prothrombin complex concentrate; 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: 2020 ACC Expert Consensus Decision Pathway on Management of Bleeding in Patients on Oral Anticoagulants. Am Coll Cardiol 2020;76:594-622. <https://doi.org/10.1016/j.jacc.2020.04.053>
- 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
- ⁴Cuker A, et al. Reversal of direct oral anticoagulants: Guidance from the Anticoagulation Forum. Am J Hematol. 2019;94:697–709. doi.org/10.1002/ajh.25475

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