### APPROACH TO THROMBOPROPHYLAXIS FOR PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION (AF)

[Non-Valvular : Patients without prosthetic valve replacement and for whom there is no expectation of valvular surgery within one year]

#### Is CHA₂DS₂-VASc score* ≥ 2?
- **No**
  - Is eGFR below 30mL/min/m²?  
    - **Yes**
      - Warfarin (local consensus)
    - **No**
      - Suggest prescribe Apixaban or Rivaroxaban

#### Is CHA₂DS₂-VASc score* = 1
- **Yes**
  - Oral anticoagulation (OAC) preferred

#### If CHA₂DS₂-VASc score* = 0 no OAC

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**FURTHER PRESCRIBING INFORMATION**

**Contra-indications:** Many contraindications to Warfarin therapy will also apply to novel OACs, e.g. high bleeding risks, severe renal impairment and coagulation disorders.

**Renal function:** Monitor renal function before starting any novel OAC and at least annually.

**Non-compliance:** Non-compliance alone is not an indication for initiating a novel OAC; many causes of Warfarin non-compliance may also result in non-compliance with other OACs.

**Switching from Warfarin:** Stop Warfarin, start novel OAC when INR ≤ 2 (usually 3 to 5 days)

**INTERACTIONS**
- Do not prescribe with e.g. other anticoagulants, Azole antifungals, HIV PI drugs or Rifampicin.
- Caution advised with e.g. anti-platelets, NSAIDs and many anti-epileptic drugs.
- There are several other clinically important interactions with Warfarin and NOACs.

Please consult BNF – Appendix 1 (Anticoagulants) and relevant SPC.

### APIXABAN (prescribing information – see SPC)

- **Dose:** 5 mgs twice daily
- Reduce dose to 2.5mg twice daily in patients with at least two of the following characteristics
  - Age ≥ 80 years or body weight ≤ 60 kgs or Serum Creatinine > 133 mmol/L

### RIVAROXABAN (prescribing information – see SPC)

- **Dose:** 20 mgs once daily if eGFR ≥ 50mL/min/m²
  - Reduce dose to 15mg once daily if eGFR 30-49 ml/min/ m²
  - No dose reduction required for age

### VASc scoring

<table>
<thead>
<tr>
<th>Congestive heart failure (inc LVD)</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Aged 75 or more</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Stroke/TIA/thromboembolism</td>
<td>2</td>
</tr>
<tr>
<td>Vascular disease (prior to MI, PAD or aortic plaque)</td>
<td>1</td>
</tr>
<tr>
<td>Aged 65-74</td>
<td>1</td>
</tr>
<tr>
<td>Sex Category : female</td>
<td></td>
</tr>
<tr>
<td>Female and no other risk factors score 0</td>
<td></td>
</tr>
</tbody>
</table>

### *CHA₂DS₂–VASc scoring**

<table>
<thead>
<tr>
<th>Hypertension</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal renal and liver function (1 point each)</td>
<td>1 or 2</td>
</tr>
<tr>
<td>Stroke</td>
<td>1</td>
</tr>
<tr>
<td>Bleeding</td>
<td>1</td>
</tr>
<tr>
<td>Labile INRs</td>
<td>1</td>
</tr>
<tr>
<td>Elderly (e.g. age &gt;65 years)</td>
<td>1</td>
</tr>
<tr>
<td>Drugs or alcohol (1 point each)</td>
<td>1 or 2</td>
</tr>
</tbody>
</table>


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**HAS-BLED scoring**

*** Consider cardioversion in AF patients with structurally normal hearts. However, in asymptomatic patients over 65 years of age there is little justification in restoring sinus rhythm. Elective therapeutic anticoagulation is required for 4 weeks prior to DCC. Continue anticoagulation for at least 1 month after cardioversion. Patients with a high CHA₂DS₂–VASc score should remain on anticoagulation indefinitely even if sinus rhythm is restored.

**** In patients at extremes of weight (BMI<18.5 or >30) see BNF Advice – Prescribing in renal impairment – Patients at extremes of weight.

**NB.** Novel OACs should NOT be used in patients with prosthetic heart valves or valvular AF. Anti-platelet therapy should only be considered in patients who refuse, cannot tolerate or are unsuitable for OAC.