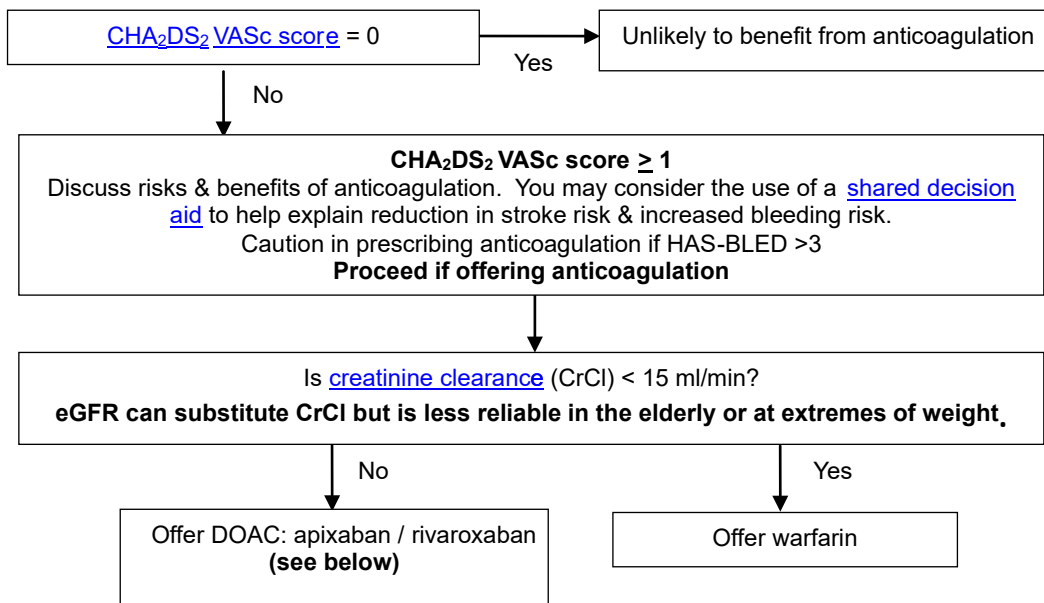


# APPROACH TO THROMBOPROPHYLAXIS FOR PATIENTS WITH **NON-VALVULAR** ATRIAL FIBRILLATION (AF)

[Non-Valvular: Patients without mechanical prosthetic valve replacement or moderate to severe mitral stenosis]



## DIRECT ORAL ANTICOAGULANT DRUGS (DOAC)

**APIXABAN** (prescribing information – see [SPC](#)) **Use first line. Dose:**

- **5mg twice daily**
- **2.5mg twice daily** in CrCl 15-29ml/min or in patients with two of the following characteristics: age ≥ 80 years, weight\* < 61kg or creatinine ≥ 133 µmol/L

**RIVAROXABAN** (prescribing information – see [SPC](#))

**Second line use if intolerant to apixaban or would require support with twice daily apixaban dosing. Dose:**

- **20mg once daily** (no dosage adjustment for age)
- **15mg once daily** if CrCl 15-50ml/min, Use with caution if CrCl 15-29ml/min.

## FURTHER PRESCRIBING INFORMATION

**Contra-indications:** Warfarin and DOACs share many contraindications, e.g. high bleeding risk, severe renal impairment and coagulation disorders.

**Monitoring:** No routine monitoring is recommended for apixaban, rivaroxaban or for warfarin (bar INR)

**If switching from warfarin:** Stop warfarin, start DOAC when INR ≤ 2 (usually 3 to 5 days)

**Antiphospholipid Syndrome:** DOACs should **NOT** be used in patients with the antiphospholipid syndrome

## IMPORTANT INTERACTIONS

- Do not prescribe with e.g. other anticoagulants, Azole antifungals, [HIV protease inhibitor drugs](#) or rifampicin. Caution advised with e.g. anti-platelets, NSAIDs and many anti-epileptic drugs.
- See SPS website articles: '[Understanding DOAC interactions](#)' and '[Managing interactions with DOACs](#)'. Please refer to SPC links for each drug above if required.

## ACUTE CORONARY SYNDROMES (ACS)

Patients with AF and ACS should receive a personalised treatment plan from cardiology.

## CHA<sub>2</sub>DS<sub>2</sub>-VASc scoring

|                                                      |   |
|------------------------------------------------------|---|
| Congestive heart failure (inc LVD)                   | 1 |
| Hypertension                                         | 1 |
| Aged 75 or more                                      | 2 |
| Diabetes                                             | 1 |
| Stroke/TIA/thromboembolism                           | 2 |
| Vascular disease (prior to MI, PAD or aortic plaque) | 1 |
| Aged 65-74                                           | 1 |
| Sex Category : female                                | 1 |

## HAS-BLED scoring

|                                                  |        |
|--------------------------------------------------|--------|
| Hypertension                                     | 1      |
| Abnormal renal and liver function (1 point each) | 1 or 2 |
| Stroke                                           | 1      |
| Bleeding                                         | 1      |
| Labile INRs                                      | 1      |
| Elderly (e.g. age >65 years)                     | 1      |
| Drugs or alcohol (1 point each)                  | 1 or 2 |

See [European Society of Cardiology Guidelines](#)

**[NB. Female & no other risk factors score 0]**

Consider cardioversion in AF patients with structurally normal hearts. However, in asymptomatic patients > 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 CHA<sub>2</sub>DS<sub>2</sub>-VASc score should be offered to remain on anticoagulation indefinitely even if sinus rhythm is restored.

## \*Actual Body Weight

DOACs should **NOT** be used in patients with mechanical prosthetic heart valves or severe valvular AF.

Anti-platelet therapy is not recommended for stroke prevention in atrial fibrillation.