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

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

**CHA2DS2-VASc score = 0**
- Unlikely to benefit from anticoagulation

**CHA2DS2-VASc score ≥ 1**
- Discuss risks & benefits of anticoagulation. You may consider the use of a shared decision aid to help explain reduction in stroke risk & increased bleeding risk.
- Caution in prescribing anticoagulation if HAS-BLED >3
- Proceed if offering anticoagulation

Is creatinine clearance (CrCl) < 15 ml/min?
- eGFR can substitute CrCl but is less reliable in the elderly or at extremes of weight.

Offer DOAC: edoxaban / apixaban
- (see below)

**Offer warfarin**

**DIRECT ORAL ANTICOAGULANT DRUGS (DOAC).**

**EDOXABAN** (prescribing information – see SPC)
- Use first line. Dose:
  - 60mg once daily (no dosage adjustment for age)
  - 30mg once daily if weight* <61kg, CrCl <50ml/min or prescribed ciclosporin, dronedarone, erythromycin or ketocazole.

**APIXABAN** (prescribing information – see SPC)
- Second line use if intolerant to Edoxaban. 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

**FURTHER PRESCRIBING INFORMATION**

- Contra-indications: Warfarin and DOACs share many contra-indications, e.g. high bleeding risk, severe renal impairment and coagulation disorders.
- Monitoring: BNF recommends check renal/liver function before starting edoxaban and at least annually thereafter. No routine monitoring is recommended for apixaban 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.
- 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.

**CHA2DS2-VASc scoring**

<table>
<thead>
<tr>
<th>Congestive heart failure (inc LVD)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>1</td>
</tr>
<tr>
<td>Aged 75 or more</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</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>1</td>
</tr>
</tbody>
</table>

**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

**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 CHA2DS2-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 valvular AF.

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

Thromboprophylaxis for NVAF2.docx
Devised: P Currie Aug 2019