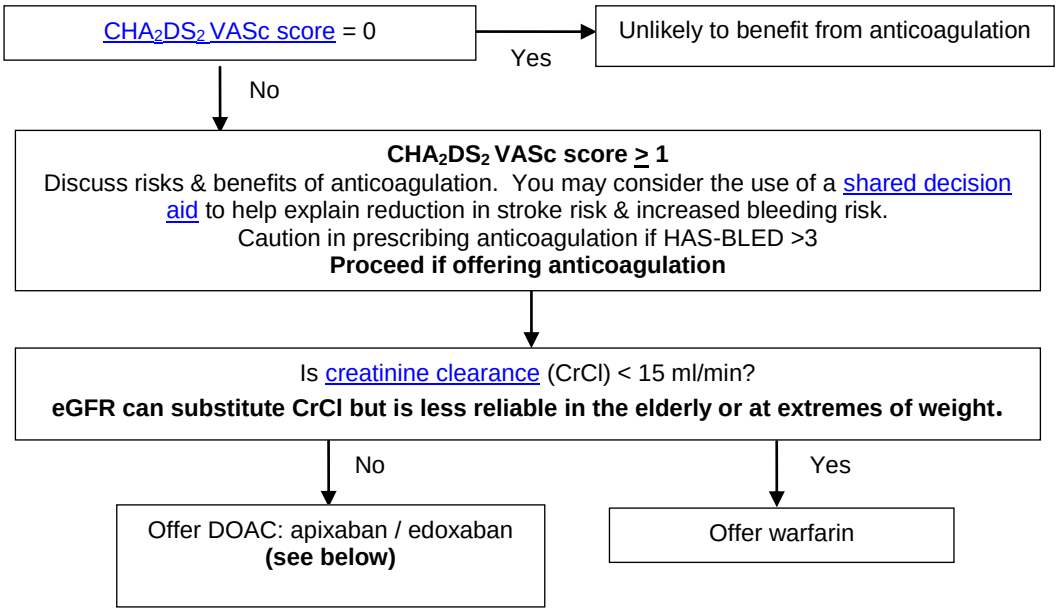
APPROACH TO THROMBOPROPHYLAXIS FOR PATIENTS WITH **NON-VALVULAR** ATRIAL FIBRILLATION (AF)

[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	**EDOXABAN (**prescribing information – see SPC) **Second line use if intolerant to apixaban or would require support with twice daily apixaban dosing. Dose:** • **60mg once daily** (no dosage adjustment for age) • **30mg once daily** if weight* <61kg, CrCl <50ml/min or prescribed ciclosporin, dronedarone, erythromycin or ketoconazole.

FURTHER PRESCRIBING INFORMATION

Contra-indications: Warfarin and DOACs share many contraindications, 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.
- 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_2DS_2–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 **C**ategory : female	1

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

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 CHA_2DS_2–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.