APPRAOCH 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]

1. **CHA2DS2-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 Female 1
   - Female and no other risk factors score 0

2. **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
   - Overall score: maximum 9

3. **Decision Tree**
   - **Is CHA2DS2-VASc score** ≥ 2?
     - Yes
     - Is eGFR below 30ml/min/m2? Yes No
     - Oral anticoagulation (OAC) preferred
     - Assess bleeding risk - HAS-BLED score** (see below) caution advised if ≥3
     - Do any of the following individual patient criteria apply:
       - Poor INR control, e.g. frequent dose changes required (6 visits to AC clinic / 6 months)
       - Allergy or major intolerance of coumarins
       - Difficulty monitoring INR, e.g. travel, difficult venepuncture
       - 1 month pre cardioversion ** (unlicensed indication) in patients not already established on Warfarin
     - **If CHA2DS2-VASc score** = 0 no OAC
     - **If CHA2DS2-VASc score** = 1
       - Is eGFR below 30ml/min/m2? Yes No
         - Prescribe WARFARIN (local consensus)
         - No specific dose reduction for age
       - Yes
         - **Prescribe EDOXABAN**

4. **FURTHER PRESCRIBING INFORMATION**
   - Contra-indications: Many contra-indications to Warfarin therapy will also apply to DOACs, e.g. high bleeding risks, severe renal impairment and coagulation disorders.
   - Renal function: Monitor renal function before starting any DOAC and at least annually.
   - Non-compliance: Non-compliance alone is not an indication for initiating a DOAC; many causes of Warfarin non-compliance may also result in non-compliance with other OACs.
   - Switching from Warfarin: Stop Warfarin, start DOAC when INR <2 (usually 3 to 5 days)

5. **INTERACTIONS**
   - Do not prescribe with other anticoagulants
   - Reduce edoxaban dose to 30mg once daily in combination with ciclosporin, dronedarone, erythromycin and ketoconazole
   - Apixaban is not recommended in combination with azole anti-fungals or HIV protease inhibitors
   - Caution advised when combining DOACs with, for e.g., anti-platelets (anti-platelet/OAC combination may be recommended on specialist advice), NSAIDs, rifampicin and several anti-epileptic drugs.
   - There are several other clinically important interactions with Warfarin and DOACs - see BNF

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**PLEASE REVIEW THE FOLLOWING GUIDELINES FOR COMPLETE INFORMATION**

**CHA2DS2-VASc**

**HAS-BLED**

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**Note**

* For patients at extremes of weight (BMI<18 or >40) see BNF section on Prescribing in Renal Impairment

**See**


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