WACARDIOLOGY

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PERI-PROCEDURAL MANAGEMENT OF ANTICOAGULATION IN NON VALVULAR AF – 2017 ACC CONSENSUS GUIDELINES

1) WHETHER TO INTERRUPT

- Those at low procedural risk of bleeding may be continued on anticoagulation especially if the patient is at high risk of thromboembolic events and is considered for bridging anticoagulation (data stronger for warfarin with limited data on NOACs).

2) WHEN TO INTERRUPT

- For Warfarin, the consensus is to stop 5 days prior to surgery and to check INR within 24 hours of surgery.
- For Anti-Xa inhibitors, withhold for 24 hours if there is a low bleeding risk; otherwise 48 hours to ensure adequate washout.
- For Direct thrombin inhibitors, withhold for 24-120 hours depending on the risk of bleeding and the Creatinine Clearance Calculator (CrCl).

3) WHETHER TO BRIDGE

- Bridge if the CHADsVasc score is >6 or those with a prior thrombo-embolic event including stroke unless the patient is at high risk for bleeding (eg previous major bleed, use of antiplatelet agent, or previous bleeding from bridging). Bridging is mainly for patients on Warfarin. NOACs rarely require bridging due to short half-life.

4) HOW TO BRIDGE

- Use Low Molecular Weight Heparin (LMWH) when INR <2 OR after omitting 2-3 doses of the OAC if the INR is not measured. Discontinue LMWH at least 24 hours prior to surgery or even 48 hours if there is impaired renal function. Dose reduction to 1mg/kg once a day for CrCl 15-30. Use unfractionated heparin (UFH) if there is severe kidney impairment.

5) WHEN TO RESTART ANTICOAGULATION

- Warfarin can be restarted in most situations within 24 hours. If the patient is at high risk for thromboembolic events, use parenteral UFH within 24 hours once haemostasis is achieved or 48-72 hours if there is a high risk of bleeding including operations where bleeding may lead to significant morbidity/mortality till INR therapeutic.
- For Darbigatran – Low risk bleed procedures, 75mg can be given the night of the procedure, with resumption of full dose the following morning. In high risk bleed procedures, full dose anticoagulation can be resumed 48-72 hours post-surgery.
- For Anti-Xa inhibitors, resume anticoagulation within 24 hours if there is a low risk of bleeding vs 48-72 hours if there is a high risk of bleeding. Bridging parenteral agents are usually not required for NOACs.

Ed.

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