Irish College of General Practitioners

Direct oral anticoagulants in General Practice

Case Discussion

Contents

1. Deciding whether to use a DOAC in atrial fibrillation
2. Changing from warfarin to a DOAC and dose reduction of DOACs in atrial fibrillation
3. Patient needing skin surgery in the practice and use of antiplatelets for primary prevention

Use these cases in conjunction with the ICGP QRG on DOAC use in atrial fibrillation available at ICGP Clinical Hub on ICGP website

Case 1

- John is a 68 year old man with a history of hypertension, diabetes, mild-moderate aortic stenosis and osteoarthritis. He had recently come in for his diabetes check and the practice nurse had noted she couldn't record his blood pressure using the electronic BP monitor. She noted his pulse was irregular and his ECG shows atrial fibrillation at a rate of 88 bpm. He is asymptomatic.
- His current medications are
  - Ramipril 5mg OD
  - Metformin 500mg TDS
  - Atorvastatin 40mg OD
  - Ibuprofen 400mg TDS
  - Lansoprazole 30mg OD

Recent blood tests
Hb 14.2g/dL

Creatinine 98umol/l

Weight 90kg
Height 178cm

Would you consider anticoagulation, if so what needs to be considered before deciding on an anticoagulant, and which anticoagulant would you choose?

Case 1

- Use Keele University or ACC coag evaluator to calculate risks and benefits. Based on this his CHADS2Vasc is 2 and HAS BLED is 3
- Keele University have useful patient information sheets
- Modifiable factors here include stopping ibuprofen as increases risk of bleeding
- His aortic stenosis is not a contra indication to a DOAC. Valvular atrial fibrillation is defined as a prosthetic valve or mitral stenosis.
- Both American and European guidelines recommend a DOAC as first line therapy for anticoagulation although warfarin is a reasonable choice also.
- Before prescribing a DOAC it is important to consider
  - Indication for anticoagulation
  - Duration of anticoagulation
  - Type and dose of anticoagulation
  - Whether a proton pump inhibitor is needed
  - Baseline haemaglobin, renal and liver function
  - Patient anticoagulation card and education
  - Possible medication interactions
  - Timing of follow-up

At first follow up visit review

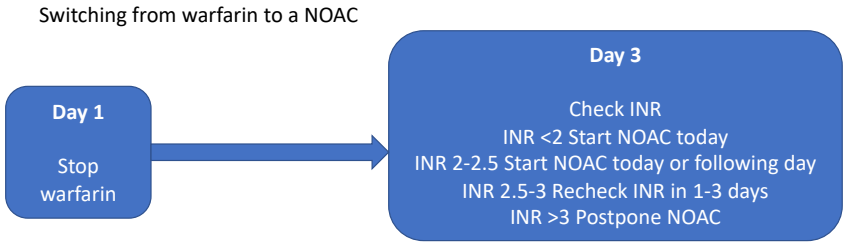
- If on correct dose
- Compliance
- Any events/bleeding/other side effects
- Blood results (if not done previously)
- Any interacting medications

Case 2

- Mary is a 82 year old woman who has a history of atrial fibrillation, hypertension and rheumatoid arthritis. She is taking warfarin, perindopril 5mg OD, methotrexate 15mg once weekly, folic acid 5mg once weekly. Her INRs have been labile ranging from 1.2 to 5.6. She has no history of bleeding. She comes into see you as she has heard there is a tablet she can take to thin her blood without having to have regular blood tests. Creatinine is 142umol/l. Weight 72kg
- What do you tell her?

Case 2

- Based on her history Mary does need anticoagulation
- A DOAC would be a reasonable choice. Her risk of stroke is high on warfarin due to labile INR leading to a low time in target range. It is important to consider the reasons for her labile INR. If adherence is an issue this needs to be addressed whether on warfarin or DOAC
- Based on the results her CHADS2Vasc is 4 her HASBLED is 4 and her creatinine clearance is 31 ml/min
- She should be considered for a reduced dose DOAC e.g. apixaban 2.5mg (as has creatinine >133umol/l and age >80 years). Alternatives are edoxaban 30mg (CrCl <50ml/min), rivoroxaban 15mg OD (CrCl <50ml/min), dabigatran 110mg BD (CrCl <50ml/min),
- Although she will not need blood tests to monitor the anticoagulant effect she will need regular blood tests to monitor her renal function, Hb and LFTs



Case 3

- John is a 76 year old man with a history of atrial fibrillation, diabetes, and depressive illness. He attends with a lesion on his left arm and you are suspicious it is a BCC. You wish to perform a punch biopsy. He is on rivoroxaban 20mg OD, aspirin 75mg OD, citalopram 20mg OD, metformin 500mg BD, atorvastatin 20mg OD
- What do you do?

Case 3

- You can proceed with the punch biopsy while he is on anticoagulation
- Procedures with minor bleeding risk are defined by the European Heart Rhythm Association as
  - Dental interventions
    - Extraction of 1-3 teeth
    - Paradontal surgery
    - Incision of abscess
  - Implant positioning
  - Cataract or glaucoma intervention
  - Endoscopy without biopsy of resection
  - Superficial surgery (e.g. abscess incision, small dermatological excisions)
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- For these procedures is recommended not to interrupt oral anticoagulation where bleeding is easily controllable. In general, these procedures can be performed 12–24 h after the last DOAC intake. It may be practical to have the intervention scheduled 18–24 h after the last DOAC intake, and then restart 6 h later (skipping one dose of dabigatran or apixaban or no dose of edoxaban or rivaroxaban) if concerned about bleeding. The patient may only leave the practice when the bleeding has completely stopped.
- He is on aspirin but has no history of cardiovascular event i.e. it is being used for primary prevention. In these circumstances it is recommended to consider stopping aspirin due to the increased risk of bleeding and lack of evidence of benefit
- In the event that he had ischaemic heart disease ordinarily he would only need antiplatelet therapy for 12 months following an acute event or stent insertion. Following this oral anticoagulant monotherapy is generally sufficient (see QRG for further details)