# Considerations for Anticoagulation in NVAF for Primary Care 07.08.14

The EMSCN has produced the NVAF anticoagulation algorithm as an aid to clinicians to decide upon the most appropriate anticoagulation option for a patient **once the decision to anticoagulate has been made**.

The algorithm is being shared with CCGs and medicines management groups in the East Midlands as an aid to support the updating of local prescribing guidelines following publication of the NICE Guidelines for Atrial Fibrillation in June 2014.

Clinicians who view this algorithm should be aware that it is not a replacement of their local published guidelines.

**Table 1** (adapted from NICE: Patient Decision Aid – Atrial Fibrillation: medicines to help reduce your risk of a stroke – what are the options; June 2014?)

| **Patients should be encouraged to consider how important the following issues are to them and to discuss them with their GP prior to the initiation of an anticoagulant whether that be warfarin or a NOAC** |
|---|
| **1. What tablets or capsules I'd have to take and how often**<br><br>Warfarin dosing is variable whereas NOAC dosing is fixed. Warfarin is prescribed once daily whereas NOACs are either once daily (rivaroxaban) or twice daily (dabigatran or apixaban) |
| **2. The effect on my risk of having an AF-related ischaemic stroke**<br><br>Warfarin reduces the stroke risk in AF patients by approximately 65%. The NOACs have been shown to be at least as good as warfarin at reducing ischaemic stroke in AF patients and dabigatran 150mg bd has actually been shown to be better than warfarin at reducing ischaemic stroke in a large clinical trial. |
| **3. The effect on my risk of having major bleeding**<br><br>All anticoagulants significantly increase the risk of major bleeding. The NOACs in general cause no more major bleeding than warfarin and dabigatran 110mg and apixaban 5mg are both actually associated with less overall major bleeding when compared to warfarin. All NOACs are associated with significantly less bleeding within the brain compared to warfarin. Dabigatran 150mg and rivaroxaban 20mg are both associated with more gastrointestinal bleeding than warfarin. |
| **4. The need for regular blood tests**<br><br>Unlike with warfarin, the NOACs do not require anticoagulation monitoring. However, renal function, full blood count and liver function should be periodically assessed. |
| **5. What would happen if I forget to take a dose?**<br><br>It is potentially more dangerous if the odd dose of a NOAC is missed compared to missing the odd dose of warfarin as the NOACs have much shorter half lives (~ 12 hrs). |
| **6. The need to change what I eat or drink**<br><br>The NOACs have no known food or drink interactions (unlike warfarin- eg green leafy vegetables). The NOACs are also likely to be safer than warfarin in patients who have a high and variable alcohol intake |
| **7. Whether the medicine will interact with other medicines I take**<br><br>The NOACs have far fewer drug interactions compared to warfarin. Use of anti-inflammatory painkillers (eg ibuprofen) should be with caution with all anticoagulants. |
| **8. What would happen if the effects need to be reversed in an emergency**<br><br>Warfarin has a known antidote but it is not always possible to reverse its effects quickly. The NOACs do not have known antidotes but their effects wear off more quickly than warfarin and there are strategies that can be used to help reduce the anticoagulant effects |

NHS England East Midlands Strategic Clinical Networks

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Is the patient

1. Poorly controlled by warfarin (TTR < 65% (ignoring INR readings in first 6 weeks) or in the past 6/12: x2 INRs > 5 or x1 INR > 8 or x2 INRs < 1.5 ) despite good compliance?

2. Predicted to have interacting meds - e.g. brittle COPD patient likely to require multiple courses of Abx annually?

3. Known to have high alcohol intake?

4. Requiring a choice - eg commuters, needle phobics, difficulty with monitoring, difficulty in coping with variable dosing? *Refer to table 1 for patient considerations

**NOACs not recommended if adherence concerns**

NO → **Warfarin**

YES

Is the patient's creatinine clearance < 40?

Yes → **Warfarin**

NO

**Consider a NOAC**

**Contraindicated Drugs with NOACs:**

- Dronedarone
- "Azole" antifungals
- HIV protease inhibitors
- Rifampicin, St John's Wort and phenytoin

(Use lower dose of dabigatran (110mg bd) with verapamil)

**Considerations**

Clinical

Logistical issues

Require drug with most favourable ischaemic stroke prevention data vs warfarin or if previous ischaemic stroke (particularly if on warfarin):

→ **Dabigatran 150mg bd** (110mg bd if patient on verapamil or if > 80 or if CrCl 30-49ml/min)

HAS-BLED ≥ 3

→ **Dabigatran 110mg bd**

Previous ACS or recent GI bleed?

→ **Apixaban 5mg bd** (2.5mg bd if 2 or more of:
- > 80
- < 60kg
- creat > 133µmol/L)

Definitively needs dosette box prescribing?

→ **Apixaban 5mg bd** (2.5mg bd if 2 or more of:
- > 80
- < 60kg
- creat > 133µmol/L)

Pt can only cope with od prescribing and informed that other NOACs shown to be superior vs. warfarin at reducing all stroke events in RCTs whilst rivaroxaban shown to be only non-inferior to warfarin in its RCT

→ **Rivaroxaban 20mg od** (15mg od if CrCl 30-49ml/min)

**All NOACs: Switch to warfarin (if not contraindicated) if creatinine clearance < 30ml/min**