Rapid Recap Special Edition

Anticoagulation FORUM

ANTICOAGULATION Centers of Excellence

This Special Edition Rapid Recap aims to summarize key takeaway points from the newly published 2023 ACC/AHA/ACCP/HRS Guideline for the Diagnosis and Management of Atrial Fibrillation

Risk Stratification: While previous guidelines utilized the CHA_2DS_2-VASc score to determine if patients should receive anticoagulation for stroke prevention, the 2023 guidelines place an emphasis on annualized stroke risk and acknowledge other risk scores (ATRIA, GARFIELD-AF) may offer advantages in specific populations (i.e., renal disease) over CHA_2DS_2-VASc scoring. See the associated table for anticoagulation recommendations based on annualized stroke risk and how the risk scores compare. It should be noted CHA_2DS_2-VASc score remains the most validated scoring system.

Annualized Stroke Risk	CHA_2DS_2-VASc	ATRIA	GARFIELD-AF	Anticoagulation?
≥2%	≥ 2 in men ≥ 3 in women	7-15	≥1.60	Recommended
≥1% but <2%	1 in men 2 in women	6	0.9-1.59	Reasonable*

*Consider factors that might modify risk of stroke to help inform decision (i.e. AF burden, lifestyle risk factors, see Table 3 within the guidelines for a full list)

Anticoagulation Selection:

- DOACs are recommend over warfarin except in patients with atrial fibrillation (AF) who have a history of moderate-severe rheumatic mitral stenosis (although in other places, the guidelines omit the term rheumatic) or a mechanical heart valve. Non-evidence-based dose of DOACs should be avoided.

Anticoagulation Selection for those with CKD:

- CKD Stage 3: oral anticoagulation (OAC) **recommended** with DOACs preferred
- CKD Stage 4: OAC **reasonable** with warfarin or labeled doses of DOACs
- ESRD (CrCl <15 ml/min) or dialysis: "**might be reasonable**" to prescribe warfarin or an evidence-based dose of apixaban

NOT RECOMMENDED AND POTENTIALLY HARMFUL: aspirin either alone or in combination with clopidogrel

Device Detected Atrial High-Rate Episodes (AHRE)/Subclinical AF (SCAF): AHREs detected by cardiac implantable devices are associated with a lower risk of stroke than that of clinical AF therefore the threshold for initiating anticoagulation is higher as compared to clinical AF. It is suggested that both AHRE duration and CHA_2DS_2-VASc scoring should be used to aid decision making for anticoagulation.

AHRE Duration	Low stroke risk (CHA_2DS_2-VASc 0 in men, 1 in women)	Intermediate stroke risk (CHA_2DS_2-VASc 1 in men, 2 in women)	High stroke risk (CHA_2DS_2-VASc ≥2 in men, ≥3 in women)
<5 minutes	No anticoagulation	No anticoagulation	No anticoagulation Observe for burden, AF development
5min – 24hrs	No anticoagulation Observe for burden, AF development, periodically reassess patient stroke risk	Uncertain – awaiting data from ARTESIA and NOAH-AFNET trials*	Anticoagulation reasonable if CHA_2DS_2-VASc is ≥3 Use shared decision making that considers episode duration and patient risks *Awaiting data from ARTESIA and NOAH-AFNET trials to further inform decision
≥24hrs	No anticoagulation Consider data from COMMANDER HF, COMPASS		Anticoagulation reasonable. Use shared decision making that considers episode duration and patient risks

*Since publication of these guidelines, data from NOAH-AFNET and ARTESIA have been published. ARTESIA included patients with SCAF lasting ≥6min but <24hrs and were at least 55 years of age and required to meet one of the following: CHA_2DS_2-VASc score of ≥3, prior history of stroke, or age ≥75 years. ARTESIA showed stroke reduction with use of apixaban as compared to aspirin but at an increased risk of major bleeding. NOAH-AFNET included patients with SCAF lasting ≥6min and were at least 65 years of age with one additional risk factor for stroke (CHA_2DS_2-VASc score of ≥2). NOAH-AFNET showed edoxaban as compared to placebo did not significantly reduce the incidence of composite CV death, stroke, or systemic embolism and led to a higher incidence of composite of death or major bleeding.

Bleeding and Resumption of Oral Anticoagulation

Type of Bleed	Recommendations on Resumption
ICH	• 1 – 2 weeks: very high TE risk (>5% per year, i.e., rheumatic heart disease or a mechanical heart valve) • 4 – 8 weeks: all other patients, decision regarding if/when to resume requires careful risks vs benefit assessment • Spontaneous/nontraumatic ICH are associated with higher rates of recurrence and left atrial appendage (LAA) closure may be a reasonable alternative, although data for LAA closure is lacking in this specific patient population
Major GI bleeding	• Resumption of OAC "may be reasonable" after correction for reversible causes. Data has shown restarting OAC after GI bleeding is associated with lower risks of TE events and mortality but higher risks of recurrent GI bleeding. • Reassess long-term risks vs benefits with multidisciplinary team

Other Rapid Takeaways:

- After LAA exclusion/excision, OAC should be continued based on CHA_2DS_2-VASc scoring
- After catheter ablation, at least 3 months of OAC is recommended with longer durations determined by underlying risk (i.e., CHA_2DS_2-VASc scoring)
- After surgical ablation, 3 months of OAC is reasonable
- If cardioversion is deferred secondary to LAA thrombus, therapeutic OAC should be initiated for at least 3-6 weeks with repeat imaging before cardioversion
- Periprocedural bridging should not be administered for those on warfarin (except in those with recent stroke/TIA or mechanical heart valve)
- DOACs are preferred over VKA when antiplatelet therapy is indicated concomitantly after PCI
  - In most patients, triple therapy (OAC, aspirin, P2Y-12 inhibitor) should be limited to no more than 4 weeks after PCI
  - In patients with chronic CAD (>1 year after revascularization or CAD not requiring revascularization) without history of stent thrombosis, OAC monotherapy is recommended over OAC + concomitant antiplatelet therapy to reduce risk of major bleeding
- In patients with stable PAD, OAC monotherapy is reasonable over OAC + concomitant antiplatelet therapy

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