Rapid Clinical Updates: Updates on Anticoagulation for Hospitalists

December 14, 2023

These are additional questions from the Q&A session following the presentation, answered by the speakers.

Q: What about aspirin for PAD or peripheral stents? If on DOAC, still stop aspirin?

A: Can stop asa after the "usual time that dual antiplatelet therapy would be done".

Q: How does the chronic CAD data translate to PAD patients?

A: It is an extrapolation per the guidance statement.

Q: How much hypercoagulability workup should we be doing inpatient for acute DVT/PE? What are indications to consult for hypercoag workup inpatient for acute DVT/PE?

A: Very little need to do inpatient.

Q: In cases of Unprovoked DVT or PE at what point does one need to think about testing for hypercoagulable state? Wait for second event? Or "never"?

A: I rarely do hypercoag work up and do extended treatment for unprovoked unless bleeding risk is high.

Q: Can we use apixiban in CKD-5, not on HD?

A: Not studied, exclusion in the trials was CrCl < 25, but observational data and small RCTs in atrial fibrillation showing relative safety.

Q: Can you go over dosing adjustments for eliquis in patients with ESKD?

A: Dose per FDA using 2 or 3 of the ABCs.

Q: For the ESRD study checking apixaban vs warfarin, was the dose of apixaban 5 mg BID or 2.5 mg BID? And could you comment on the reduced dosing - usually it's only for meeting 2 of 3 criteria, but one of those three criteria are mainly for CKD and not so much ESRD

A: Agree with dose adjustment just for 2 or 3 of 3 in atrial fib.

Q: What BMI would you consider a contraindication to a DOAC, as much of these conditions occur in the obese? BMI>40, 50, 60, 70?

A: No limit per ISTH guidance in VTE.

Q: For a patient with VTE having received a few days of heparin drip, when transitioning to Eliquis, how many days of loading dose of Eliquis, still 7 days or less days (considering days of heparin drip)?

A: I usually use all 7 days in the starter pack unless many days on heparin/LMWH or in advanced CKD.

Q: ESRD patients have a higher risk of stroke and higher risk of bleeding. Of the two, which poses the greater risk?

A: Shared decision on what is more feared outcome with patient.

Q: What is the recommended dose of apixaban for esrd patients - 2.5 or 5mg bid?

A: Dose per FDA using 2 or 3 of the ABCs

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Q: I don't think this study (the mechanical valve study you presented) is applicable yet in clinical settings. Need further studies before applying it.

A: Somewhat agree.

Q: For mechanical MV on warfarin presenting with a stroke, you still need to re-initiate warfarin at a later time which needs bridging. Although not in the immediate 3 days, would

you then re-initiate warfarin + bridging therapy 6-7 days later, perhaps along the lines of "severe stroke" categorization?

A: I would not bridge, would start soon after the stroke realizing full effect takes longer than DOAC.

Q: For a patient having hx of CAD and A Fib currently taking ASA and DOAC and the patient did not have an acute cardiovascular event over the past 12 months, should ASA be discontinued?

A: Agree with dose adjustment just for 2 or 3 of 3 in atrial fib.

Q: If the patient is being loaded with Plavix +/- ASA after stroke does that affect your decision to start a DOAC?

A: If atrial fib related stroke, then stroke like embolic and DAPT not the correct treatment.

Q: How do you approach cases where you need to hold someone's DOAC for AFib/VTE for an inpatient procedure but the date is not set in stone. When would you consider starting heparin bridging in these situations?

A: Virtually never a reason to bridge with DOAC, hold pre day 1 for low bleeding risk procedure and hold pre day 1 and 2 for high risk.

Q: I haven't ordered hypercoag w/u probably since DOACs came out. Do they muck up the test results akin to warfarin?

A: Cannot do lupus anticoagulant test while on warfarin or DOAC.

Q: To confirm what you are saying about unprovoked VTE, your practice is to switch to prophylactic dosing at 6 months?

A: Yes, for most patients but I don't with cancer associated VTE.

Q: Are you seeing cost as problematic with certain insurances, public/private?

A: Yes, but less commonly.

Q: What are your thoughts on not anticoagulating for below the knee DVT or asymptomatic incidentally found small PE?

A: Subsegmental PE I treat, new study in Annals within past year or so. Isolated calf DVT, options are serial ultrasound and treat if extends or treatment for 3 months.

Q: Although life expectancy is relatively low in patients with ESRF, add A-fib and it complicates matters. So, in these cases Left Atrial Appendage closure a good option.

A: Absolutely.