South East Essex NHS
Primary Care Trust

Southend University Hospital NHS
NHS Foundation Trust

GUIDELINES FOR CONSIDERING NOVEL ANTI-COAGULANTS IN ATRIAL FIBRILLATION – Revised MARCH 2013

The majority of patients with atrial fibrillation should receive anticoagulation with warfarin or a novel anti-coagulant (NOAC) after appropriate risk stratification. Aspirin should rarely be used, the efficacy of stroke prevention with aspirin is weak, with a potential for harm as the risk of major bleeding (and ICH) with aspirin is not significantly different to that of OAC, especially in the elderly. For the few patients who refuse any form of OAC, the recommended treatment is antiplatelet therapy (as dual aspirin–clopidogrel combination therapy or, less effectively aspirin monotherapy).

EXCLUSIONS

1. Patients with pre-existing severe valvular heart disease (via echocardiogram) or those with mechanical heart valves.
2. Contraindications to anticoagulation.

GUIDELINES

Indications for considering NOACs instead of Warfarin are as follows. South East Essex AF Group recommends Dabigatran as a first line treatment in any of the following circumstances:-

1. Patients with a previous history of stroke or TIA.
2. INR out of range for more than 35% of the time (compliance issues to be excluded as a reason for poor INR control).
3. Allergy to Warfarin or severe adverse reaction warfarin (and phenindione/ cenocoumarol are contra-indicated).
4. Contraindication to warfarin that ***does not*** apply to NOACs.

If you have any concerns relating to the above guidance or your patient is not suitable for dabigatran but may be suitable for other NOACS, please contact the acute Stroke/Cardiology team for advice.

CAUTIONS

1. Do not consider switching if the patient has had a coronary stent within the previous 12 months or a mechanical valve, please discuss with acute cardiology team directly.
2. Please ensure the patient is ***strictly compliant with twelve hourly dose***. Missing a dose will put the patient at a higher risk of thromboembolism due to short half-life of Dabigatran.
3. There is no direct antidote available for Dabigatran, due to the half-life a serious bleed is unlikely.

   (Please discuss points 2 & 3 above with the patient)
4. Dabigatran is contraindicated with Creatinine clearance of < 30, this should also be considered with all other NOACS and discussed with an acute care consultant.
5. Usual maintenance dose of 150mg, 110mg bd dose is only indicated in patients > 80 yrs, taking Verapamil, frail elderly or other high risk factors.

SWITCHING FROM WARFARIN AND ANTIPLATELETS

IF ON ASPIRIN OR CLOPIDOGREL:

Discontinue antiplatelet for 24 hours and initiate Dabigatran.

IF ON WARFARIN:

Discontinue warfarin; Replace with Dabigatran once the patient's INR is below 2.0 (The time this takes will vary from patient to patient). There is no need to give interim doses of low molecular weight heparin

Refer to 'Primary Care – Switch from Warfarin to Dabigatran' guidelines. *Further information BNF or NICE guideline*

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