Matt's Guide to Anticoagulation Choices in AF

Patient confirmed to have Atrial Fibrillation on ECG recording.
All forms of Atrial Fibrillation (Paroxysmal, Persistent, Long Term Persistent & Permanent) require Stroke Risk Assessment

Is the patient less than 65 years old with no cardiovascular risk factors?
Such as diabetes, hypertension, PVD, IHD, LVSD,CCF

NO

Undertake a CHA_2DS_2VASc score to define low risk patients

SCORE 0

No thromboprophlaxis required
Aspirin only prescribed if required for previously diagnosed vascular disease

YES

SCORE >0

ANTICOAGULATION DECLINED

Discuss anticoagulation with the patient with AF, this should include attention to bleeding risk. Remember that published evidence suggests that patients are generally accepting of higher risk of bleeding than clinicians to prevent stroke

Can the patient take Warfarin therapy (no previous allergic response or side effects)?

YES

NO

Is the patient willing to trial Warfarin therapy?

NO

Consideration of a Novel Oral Anticoagulant (NOAC) should be made.

There are two currently licensed medication Dabigatran and Rivaroxaban.

Dose adjustments are required for Age, Renal Function and body mass

I suggest that the renal function and FBC is checked every 3 months

I would not suggest this form of medication in the frail or if poor compliance is an issue

These medications currently can not be monitored or reversed

YES

Initiate Warfarin therapy under the direction of an anticoagulation clinic with a target INR of 2.0-3.0 (tolerance up to INR 4.0)

After 3 months **consider** a switch to a NOAC if the INR >5, OR 2 consecutive INRs <1.8, OR frequent INR testing required

YES

NO

After 3 months is the Warfarin well controlled with an Individual Time in Therapeutic Range (iTTR) of >65%

NO

YES

Continue oral anticoagulation indefinitely with annual reassessment of FBC, U&E, LFTs, and consideration of iTTR and bleeding risk

Dr Matthew Fay