Initiating a DOAC in Patients with Atrial Fibrillation / Flutter (AF)

Patients to consider

- Newly identified patients with AF or previous diagnosis not on an OAC
- Patients on VKAs with consistently low TTR < 70%, it is recommended to switch to DOACs unless contraindicated

Determine risk of stroke using <u>CHA2DS2-VASc</u> score and bleeding risk

- Patients with a CHA2DS2-VASc =1 in men or 2 in women should be <u>considered</u> for an oral anticoagulant (OAC)
- Patients with a CHA2DS2-VASc score >2 in men and >3 in women: It is recommended that these patients should be prescribed an OAC
- Assess bleeding risk using <u>HAS-BLED</u> score or <u>ORBIT</u> score and address modifiable risk factors for anticoagulation in all AF patients e.g. BP control, use of NSAIDs, alcohol intake, obesity

Assess if suitable for oral anticoagulation

• Consider contraindications, concomitant medicines (e.g. aspirin, SSRIs, NSAIDs, bisphosphonates), alcohol and drug abuse.

Does the patient have a contraindication to a DOAC?

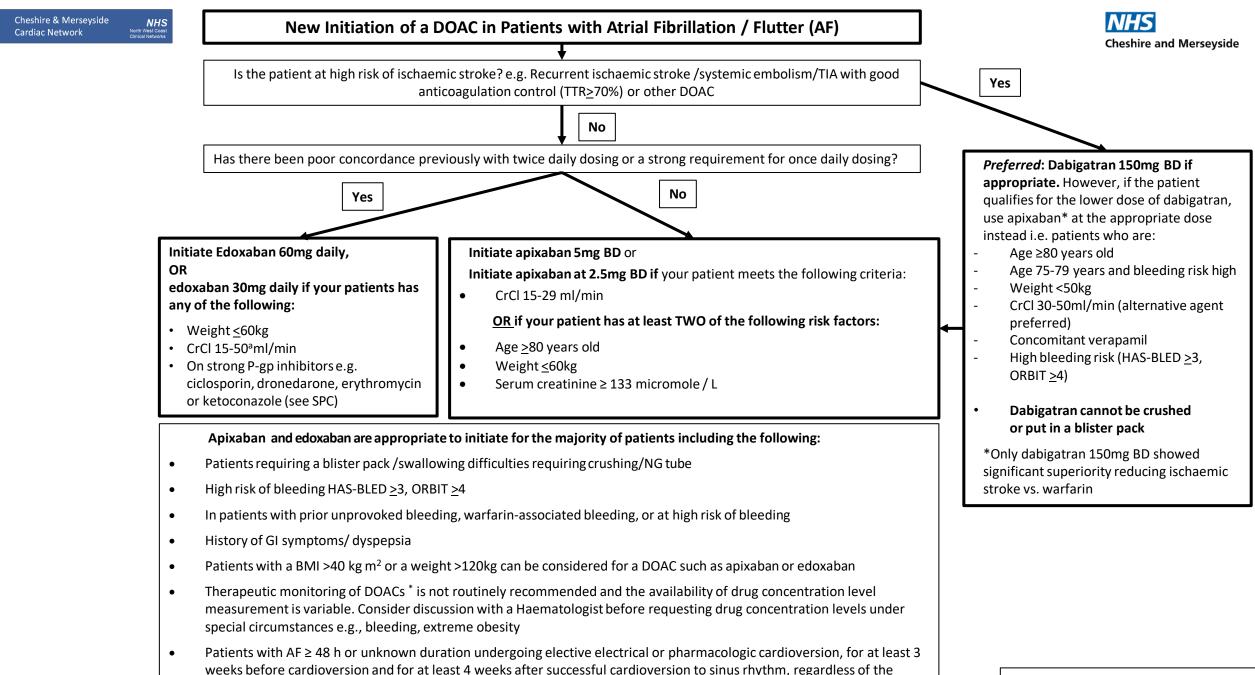
- With a prosthetic mechanical valve
- With moderate to severe mitral stenosis

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- With antiphospholipid antibody syndrome (APLS)
- Who are pregnant, breastfeeding or planning a pregnancy
- With severe renal impairment Creatinine Clearance (CrCl) < 15ml/min (apixaban, edoxaban and rivaroxaban). If CrCl 15-30 mL/min use apixaban, edoxaban and rivaroxaban with caution. Do not prescribe dabigatran if CrCl<30 ml/min.
- Requirement for triple therapy (dual antiplatelet therapy plus OAC) or those requiring a higher INR than the standard INR range of 2.0 3.0, without appropriate discussion with an anticoagulant specialist or cardiologist
- With active malignancy/ chemotherapy (unless advised by a specialist)
- Prescribed interacting drugs check SPCs for full list e.g. HIV antiretrovirals and hepatitis antivirals check with HIV drug interactions website at https://www.hiv-druginteractions.org/ and some antiepileptics – phenytoin, carbamazepine, phenobarbitone or rifampicin are likely to reduce DOAC levels so should be discussed with an anticoagulation specialist
- If the patient has a lesion or condition considered a significant risk for major bleeding, including current or recent gastrointestinal ulceration, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities seek specialist advice.
- There is no data to suggest lack of DOAC efficacy in patients with active CA but consider specialist advice before initiation
- There are little data on DOACs for patients with venous thrombosis at unusual sites (e.g. portal vein thrombosis) discuss with an anticoagulation specialist

If YES to any of the above, consider warfarin if clinically appropriate and discuss with specialist if required

If the answer if NO to all of the above, continue down the flowchart



baseline risk of stroke

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