

Strategies for Assessing & Managing DOAC-Related Bleeding






COMPANION GUIDE

Restarting Anticoagulation Following DOAC Reversal






Patient Case

- 78-year-old male admitted to the ER after a mechanical fall with a head injury and a Glasgow Coma Score (GCS) of 13
- Medical history includes Afib, hypertension, chronic kidney disease, osteoarthritis, and macular degeneration
- Medications include apixaban, perindopril, meloxicam, and bisoprolol
- A CT scan shows a subdural hematoma of 12 mm

Acute DOAC Bleeding: Key Questions

-  How severe is the bleed?
-  Have supportive measures and interventions been initiated?
-  What DOAC has been taken and when?
-  Is DOAC present in “significant” quantities?
-  Is there a role for reversal?

When to Consider Reversing Anticoagulation

				
Severe or life threatening bleeding	Critical organ bleeding	Ongoing bleeding (despite measures to control)	Bleeding with expected long delay for hemostasis	Urgent surgery (cannot be done safely)

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- Based on his severe bleeding and possible presence of a significant quantity of apixaban, he was treated with andexanet alfa
- The patient's hematoma showed no sign of expansion on a repeat CT scan and enoxaparin was initiated for VTE prophylaxis
- At post-admission day 5, neurology team wants to know if/when apixaban should be restarted
- Although multiple studies have addressed this issue¹⁻⁷, definitive randomized, adequately powered studies are lacking

Curveball

- Would you restart DOAC if this patient had a spontaneous lobar hemorrhage rather than a subdural hematoma?
 - There is no evidence-based, optimal treatment for this clinical scenario
 - Requires individualized decision involving patient/caregiver, a multidisciplinary team, and understanding risk of rebleeding and potential modifiable risk factors

AHA/ASA Guidelines for Anticoagulation Restart⁸

In patients with NVAf and spontaneous ICH, the resumption of anticoagulation to prevent thromboembolic events and reduce all-cause mortality *may be considered based on weighing benefit and risk*

In patients with AF and spontaneous ICH in whom the decision is made to restart anticoagulation, *initiation ≈7 to 8 weeks after ICH may be considered after weighing specific patient characteristics*

In patients with AF and spontaneous ICH deemed ineligible for anticoagulation, *left atrial appendage closure may be considered* to reduce the risk of thromboembolic events

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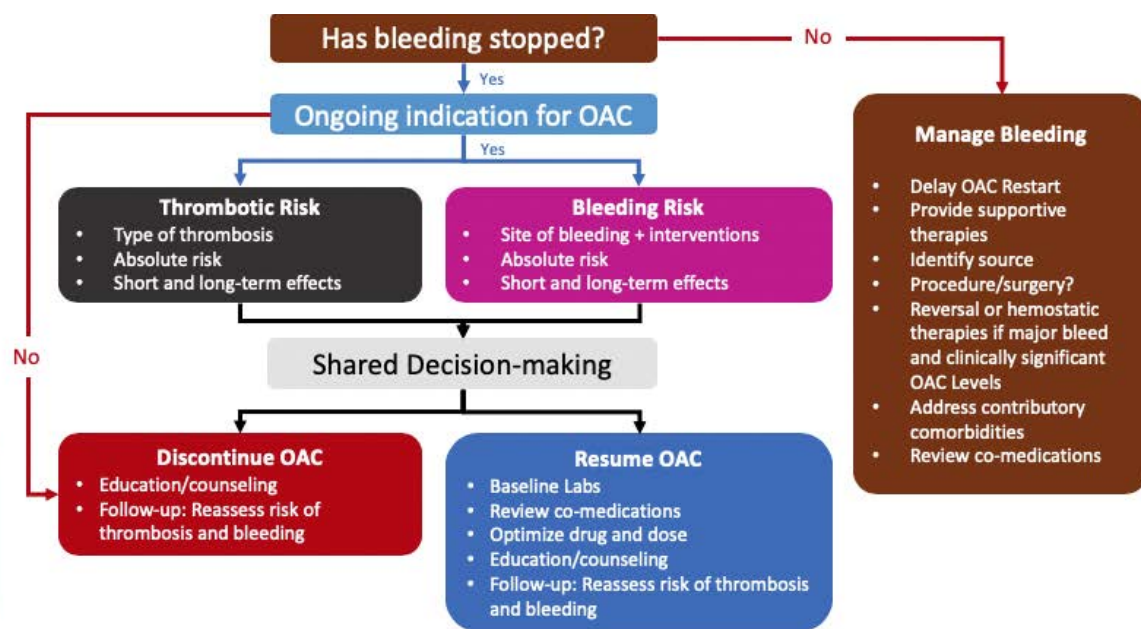
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Approach to Anticoagulation After Bleeding⁹

One Size Does Not Fit All.

ACC's ManageAnticoag App:

<https://www.acc.org/tools-and-practice-support/mobile-resources/features/manageanticoag>



References

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