NHS
Bradford Districts
Clinical Commissioning Group

BRADFORD'S
HEALTHY HEARTS

Top Tips: AF management

- Use Warfarin monitoring calculations in Clinical Tools in S1
- Consider INR range of 2-3 or 2-4 in this tool
- Consider TTR in last 6 months as well as the tool's default 12 months. Seek reasons for anomalies seen (e.g. hospitalisation, antibiotics, new meds, poor adherence, variable alcohol intake etc.) and whether these are reversible or likely to continue to affect warfarin long term
- Can calculate Creatinine Clearance for NOACs with Renal Disease Calculations tool in Clinical Tools in S1

Dose adjustment of Rivaroxaban

- The recommended daily dose of Rivaroxaban is 20mg once daily, which is also the recommended maximum dose. Therapy should be long term unless the risk of bleeding outweighs the benefits of prevention of stroke and systemic embolism.

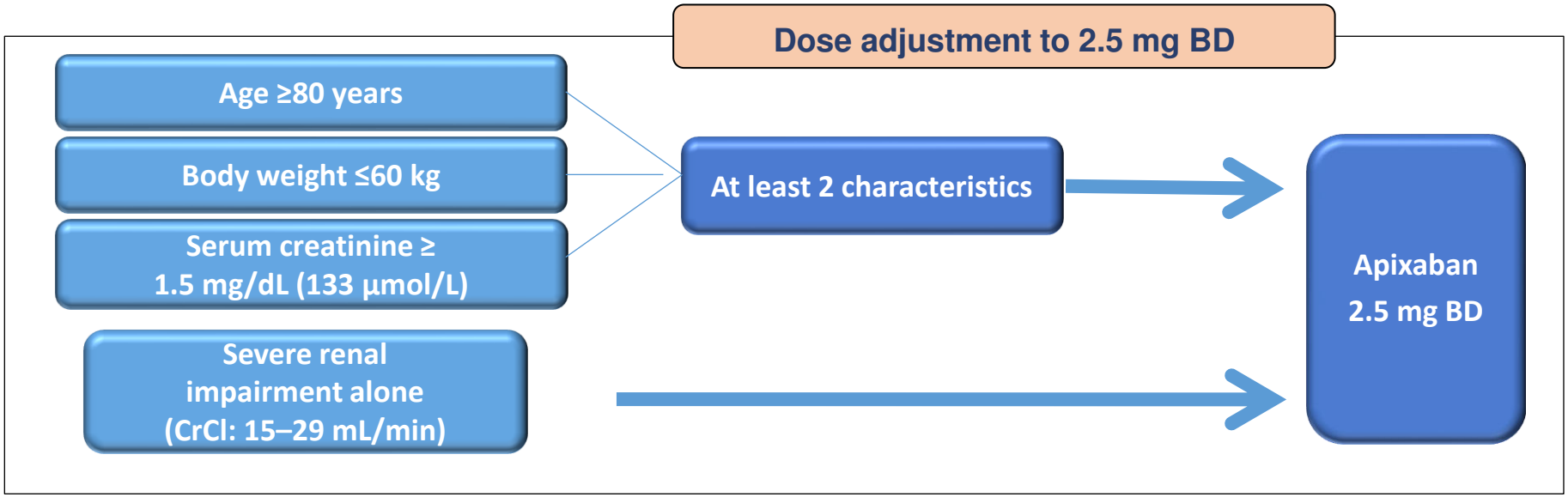
- Suggest check FBC U&E LFT clotting prior to therapy and then FBC U&E LFT at least yearly. U&E more often if age >75, frail or Creatinine Clearance <60:
  - 6 monthly if CrCl 30-60
  - 3 monthly if CrCl 15-30

- For the following the recommended reduced daily dose of rivaroxaban 15mg once daily applies:
  - Patients with moderate renal failure (creatinine clearance CrCL 30-49ml/min)
  - Patients with severe renal failure (CrCl 15-29 ml/min)

- Use is not recommended in patients with creatinine clearance < 15 ml/min

Dosing for apixaban of stroke in NVAF

The recommended dose of apixaban is 5 mg taken orally twice daily (BD)



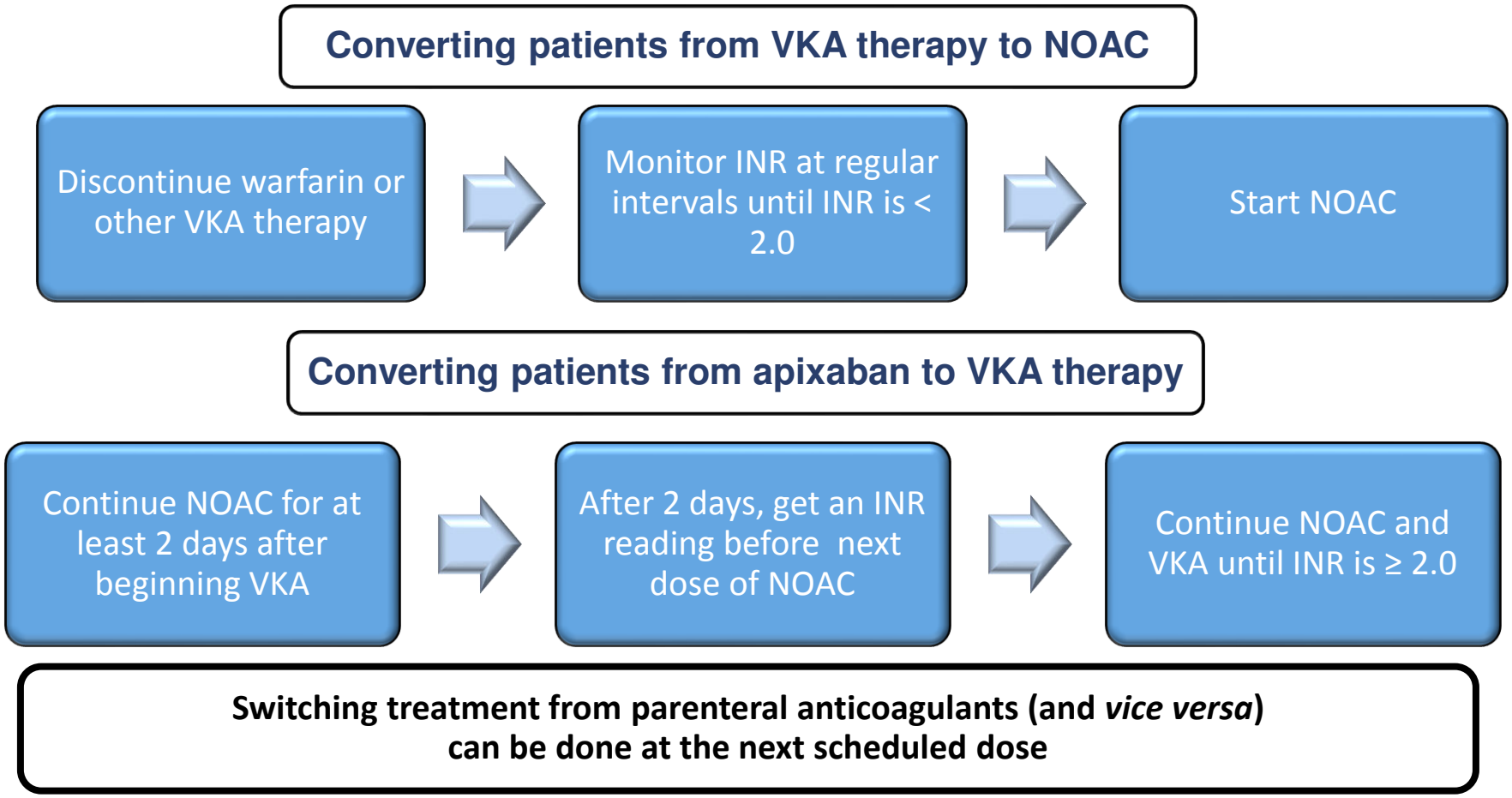
Apixaban SPC September 2013. Available at http://www.medicines.org.uk/EMC/medicine/27220/SPC/Eliquis+5+mg+film-coated+tablets/ Last accessed Oct 2013

Rivaroxaban dose

- Use Creatinine Clearance, NOT eGFR.
  CrCl calculator is in SystmOne (in Clinical Tools - Renal disease calculations)

- **CrCl 50 - 80 ml/min** - no dose adjustment is necessary in patients with mild renal impairment
  = 20mg od
- **CrCl 15 - 49 ml/min** - reduce the dose to 15mg once daily
- **CrCl < 15 ml/min** - use not recommended.

Suggestion in NVAF patients requiring switch from VKA to NOAC or NOAC to VKA



Note SPC for rivaroxaban uses INR of 3 as a cut off rather than 2 used above, but pragmatically, local haematology advice is to use INR 2 as a cut off for switching all NOACs

Advantages of NOACs

- Rivaroxaban was non-inferior to warfarin in reducing the rate of stroke, with a comparable rate of major bleeding in the ROCKET-AF trial
- Apixaban use resulted in modest reductions in the rates of stroke and major bleeding compared to warfarin in the ARISTOTLE trial
- All three NOACs reduced the risk of intracranial bleeding compared to warfarin in clinical trials
- No need for routine anticoagulant monitoring
- Dosing regimens are uncomplicated and a more stable level of anticoagulation is achieved with full concordance
- Fewer potential interactions with other medications, alcohol and diet

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Disadvantages of NOACs

- Newer agents than warfarin and much less real world experience than with warfarin
- No official antidote (but likely coming soon)
- Expensive drug cost (but very little “monitoring” costs)

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NOAC monitoring

- Baseline FBC U&E LFT clotting
- Review regularly
- FBC U&E LFT yearly
- U&E more often if reduced renal function:
  - Suggestion for apixaban (based on ESC): :
    - **CrCl 30 - 80 ml/min** – yearly U&E
    - **CrCl 15 - 29 ml/min** – 6 monthly U&E
    - **CrCl < 15 ml/min** - use not recommended.

  - Suggestion for Rivaroxaban (based on ESC):
    - **CrCl 50 - 80 ml/min** – yearly U&E
    - **CrCl 15 - 49 ml/min** – 6 monthly U&E
    - **CrCl < 15 ml/min** - use not recommended.

- Also check U&E if you suspect renal function may have significantly deteriorated (e.g. any cause for AKI – UTI with sepsis, dehydration with D&V etc)