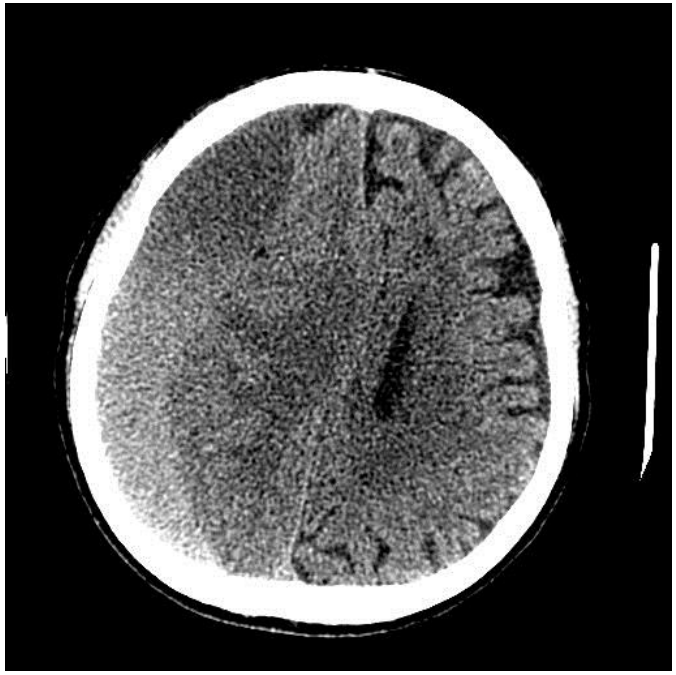
Anticoagulation Roundtable

Challenging Cases for Anticoagulation

Anticoagulation Initiative

Case 1

- 80 year old male with a history of apical hypertrophic cardiomyopathy, CKD stage IV, symptomatic PAF (not anticoagulated due to patient preference, CHADSVASC 5 – age, prior stroke, HTN) who presented with a large subdural hematoma after a mechanical fall from standing height requiring evacuation.



Case 1

- Postoperatively, he developed symptomatic AF with borderline hypotension despite rate control. A long term rhythm control strategy is preferred due to his symptoms.
- Prior antiarrhythmics:

  Disopyramide: worked well for rhythm control, however stopped secondary to anticholinergic side effects (urinary retention)

  Amiodarone: maintained on amiodarone for several years, however his most recent PFTs demonstrated a decrease in DLCO and therefore amiodarone was stopped.
- The patient is interested in pulmonary vein isolation

Questions for Case 1

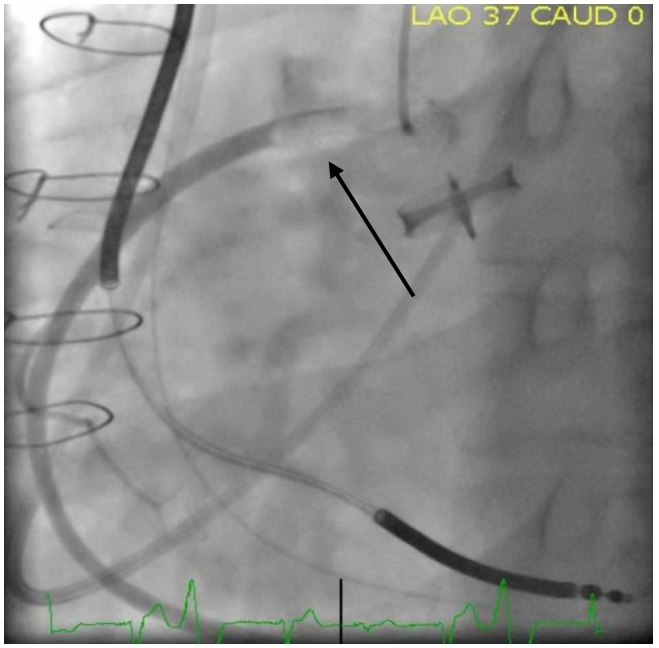
- When should anticoagulation be initiated after a subdural hematoma?
- What agent would be preferable?
- Would ablation ever be a substitute for anticoagulation therapy*?*
- How should patients be monitored for AF recurrence after ablation?

Take home points

- Using anticoagulation after a traumatic subdural hematoma is reasonably safe in most cases
- Anticoagulation must be used around the time of a PVI, and cessation of anticoagulation after a PVI will depend on the patient's stroke risk, patient preference, and any recurrence of AF

Case 2

- 47M with congenital aortic valve disease (3 prior valve surgeries, most recent: Hall tilting disc valve at age 25), NICM EF 38%, PAF presented with incontinence and gait disturbances, found to have NPH.
- Warfarin held, bridged with UFH
- UFH appropriately managed periprocedurally for 2 LPs and VP shunt placement
- Shortly after surgery, he had an embolic MI and CVA



Questions for Case 2

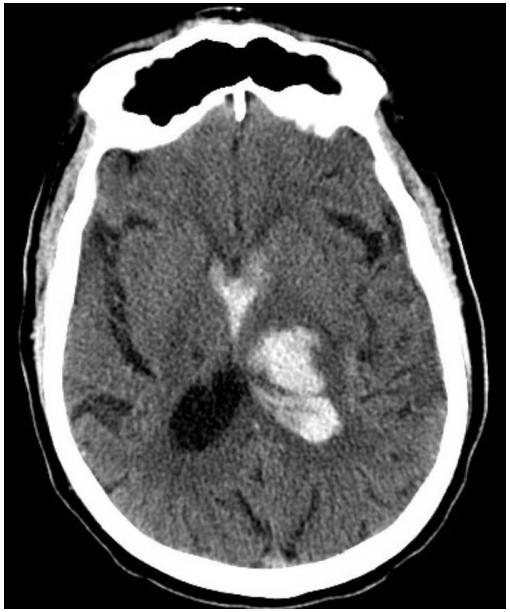
- When should anticoagulation be restarted in light of the embolic stroke?
- Add anti platelet therapy? – discussion of antiplatelet with anticoagulation
- Should the INR goal be higher? – single disc tilting valve
- How should future periprocedural anticoagulation be handled?

Take home points

- Patients with mechanical valves should be on both anticoagulation and aspirin (class I)
- Older generation valves (single tilting disc, ball and cage valves) have a higher thrombotic potential than bileaflet St. Jude valves

Case 3

- 68M with a history of persistent AF (CHADS 3, CHADSVASC 5: HTN, prior ischemic CVA, AAA) on rivaroxaban suffered a thalamic IPH with ventricular extension due to HTN (220/110 at presentation) 6 months ago. GFR > 60. No carotid disease. Discharged on ASA
- He now presents to discuss placement of a Watchman device.



Questions for Case 3

- When should anticoagulation be restarted after IPH?
- If Watchman is placed, which anticoagulant could be used? Is there a role for NOAC use with a Watchman?
- Should aspirin be continued?

Take home points

- Anticoagulation can be restarted in patients after certain types of ICH
- Watchman devices requires at least 6 weeks of warfarin therapy with aspirin after implantation, followed by DAPT for 6 months
- Watchman has not been compared to NOACs