



Emergency Care Perspective of Anticoagulation in the Era of New Oral Anticoagulants



- Outpatient treatment of low-risk venous thromboembolism (Acad Emerg Med. 2015;22(7):788-95)
 - Risk stratify all (Hestia or sPESI)
 - Cannot have a heparin requirement
 - Low complications (0/450 with ICH), high satisfaction, lower cost (Acad Emerg Med. 2015;22(7):796-802)
 - Main barrier is follow-up (Patient Prefer Adherence. 2016;10:561-9)



- **Atrial fibrillation** (Crit Pathw Cardiol. 2014;13(2):43-8)
 - Can do with warfarin, but why?
 - CHA2VASC2 and HASBLED
 - Need follow-up



- N=95 bleeds
 - Parenchymal/IVH (60%)
 - Subdural (24%)
 - Subarachnoid (7%)
 - Multiple (9%)



Head Bleeds 2015

Reason	Warfarin	Dabigatran	Apix or Riva
Atrial Fibrillation	40	6	15
VTE	10	0	1
Valve or device	11	0	0
LVAD	8	0	1
Fear	2	0	0



Striking fact

- 16 with anti 10a
- Number with elevated anti-10a level



Striking fact

- 16 with anti 10a
- Number with elevated anti-10a level
 - 4/16



Another Striking fact

- The word “reversal” for warfarin is a stretch

of Kcentra for hemostatic efficacy (a secondary objective) was not met.

Table 12: Rating of Hemostatic Efficacy in Subjects with Acute Major Bleeding

Rating	No. (%) of subjects [95% CI]		Difference Kcentra – Plasma (%) [95% CI]*
	Kcentra (N = 98)	Plasma (N = 104)	
“Effective” hemostasis	71 (72.4%) [62.3; 82.6]	68 (65.4%) [54.9; 75.8]	(7.1%) [-5.8; 19.9]

* Kcentra non-inferior to plasma if lower limit of 95% CI > -10%; Kcentra superior to plasma if lower limit of 95% CI > 0.

CI = confidence interval; N = number of subjects

Results of a post-hoc analysis of hemostatic efficacy stratified by actual dose of Kcentra or plasma administered in the acute major bleeding RCT are presented in Table 13.



- NOAC prescriptions on the rise in emergency care
- Fear of bleeding is more about fear than bleeding
 - Early data suggest a low rate of need for correction in setting of head bleeds