

Case presentation

- 71-year-old asymptomatic male with a history of hypertension, type 2 diabetes mellitus, and atrial fibrillation; currently on treatment with lisinopril 40 mg QD, metformin 500 mg BID, warfarin 10 mg per week.
- BP 160/95, glycemia 110 mg/dL.
- He has a family history of stroke and GI bleed
- He has recently complained of epigastric discomfort after meals.

What would be the proper INR range for this patient?

- INR >1.7
- INR 2.5-3.5
- INR 2-3
- None of the above.

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INR >1.7

INR 2.5-3.5

INR 2-3

None of the above.

Guidelines.

- For patients without mechanical heart valves at high risk of stroke, chronic oral anticoagulant therapy with a vitamin K antagonist is recommended in a dose adjusted to achieve the target intensity international normalized ratio (INR) of 2.0 to 3.0, unless contraindicated.
- Factors associated with highest risk of stroke in patients with AF are prior thromboembolism (stroke, TIA, or systemic embolism) and rheumatic mitral stenosis (Level of Evidence: A).

Case continues:

You order a complete blood count, a metabolic panel and liver function tests. The results are within normal range.

INR history.

| DATE | INR | Warfarin mg |
|--|------------|---------------|
| 06.12.16 | 2.6 | 10 mg |
| 23.12.16 | 2.4 | 10 mg |
| 13.01.17 | 1.8 | 10 mg |
| 16.02.17 | 2.5 | 10 mg |
| 02.03.17 | 3.4 | 10 mg |
| 25.03.17 | 2.3 | 9.5 mg |
| A week before the consultation. | 2.1 | 9.5 mg |

You decide to switch from warfarin to a DOAC. According to current guidelines, how should this change be made in this patient?

- Wait until you have an INR > 2.5 with warfarin and then make the change.
- Suspend warfarin for one day and start DOAC the next day.
- Start DOAC the same day and stop warfarin in two months.
- Suspend warfarin for a week and then start DOAC.
- Start DOAC in combination with warfarin, then suppress warfarin in a week.

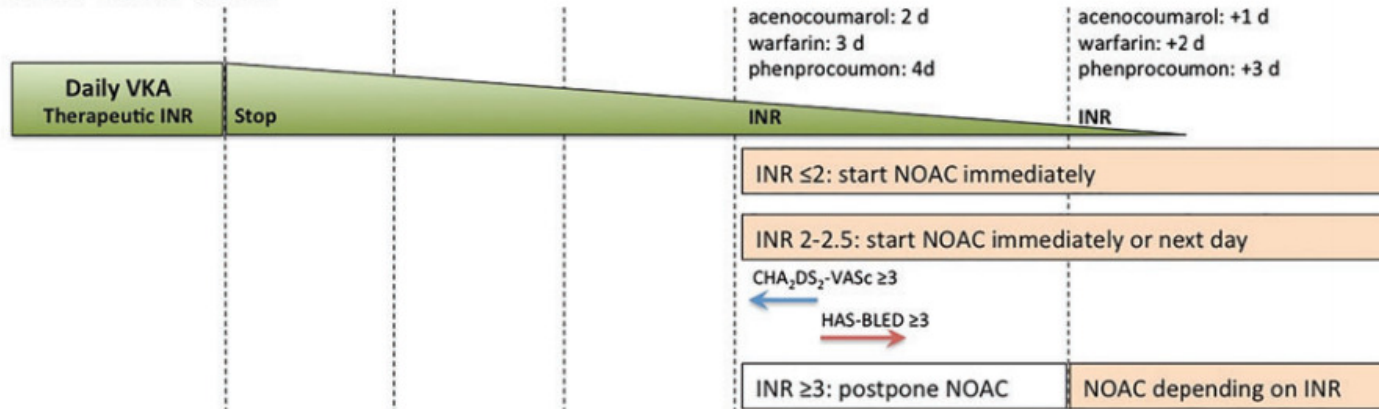
You decide to switch from warfarin to dabigatran. According to current guidelines, how should this change be made in this patient?

- Wait until you have an INR > 2.5 with warfarin and then make the change.
- Suspend warfarin for one day and start DOAC the next day.
- Start DOAC the same day and stop warfarin in two months.
- Suspend warfarin for a week and then start DOAC.
- Start DOAC in combination with warfarin, then suppress warfarin in a week.

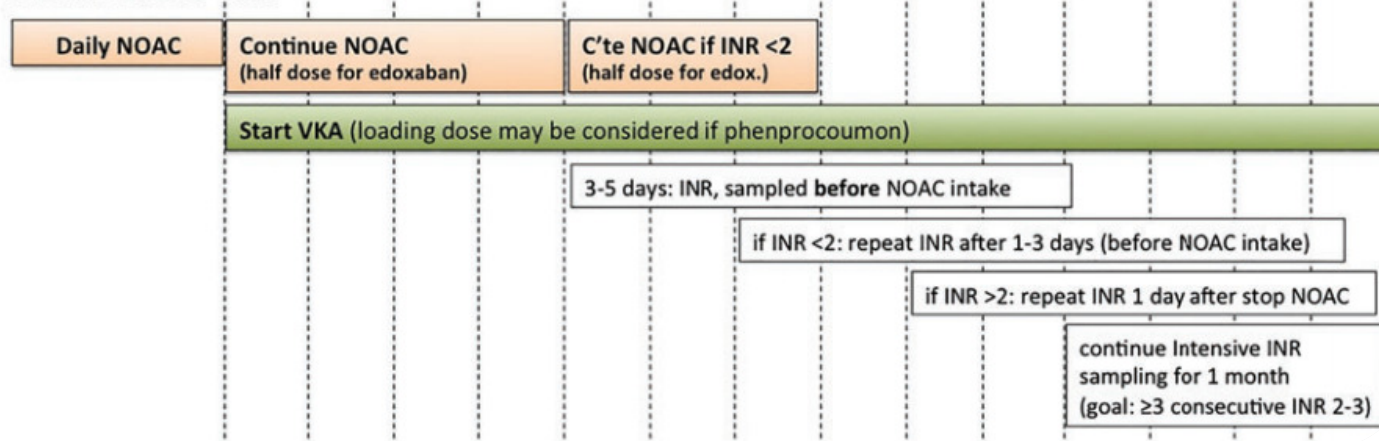
Guidelines.

- The focused update recommended dabigatran as a useful alternative to warfarin for the prevention of stroke and systemic thromboembolism in patients with paroxysmal to permanent AF and risk factors for stroke or systemic embolization who do not have a prosthetic heart valve or hemodynamically significant valve disease, severe renal failure (creatinine clearance <15 mL/min), or advanced liver disease (impaired baseline clotting function) (Class I, Level of Evidence: B).
- DOACs can be initiated once the INR is 2.0; if the INR is 2.0–2.5, DOACs should be initiated the next day.

From VKA to NOAC



From NOAC to VKA



Taking into consideration that he has recently complained of epigastric discomfort after meals and that he has a family history of GI bleed, which DOAC would you prefer?

- Dabigatran.
- Rivaroxaban.
- Apixaban.
- Edoxaban.
- Any, they are all the same.

Taking into consideration that he has recently complained of epigastric discomfort after meals and that he has a family history of GI bleed, which DOAC would you prefer?

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Taking into consideration that he has recently complained of epigastric discomfort after meals and that he has a family history of GI bleed, which DOAC would you prefer?

- Dabigatran. It is associated with dyspepsia in 10-30% of patients. Dyspepsia occurred in 348 patients (5.8%) in the warfarin group and in 707 patients (11.8%) and 688 patients (11.3%) in the 110-mg and 150-mg dabigatran groups, respectively (P<0.001 for both comparisons) in the RE-LY (NEJM 2009).
- Rivaroxaban. It is associated with a modest but statistically significant increase in GI bleeding (Larsen [BMJ](#). 2016).
- Apixaban.
- Edoxaban. It is not available in Mexico!
- Any, they are all the same. Definitely not!.