Anticoagulation Roundtable
Challenging Cases for Anticoagulation
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.
• 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?
• 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?
• 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