Anticoagulation-What's New

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What's Old

- Warfarin still works—cheap, effective
  - "If it ain't broke, don't fix it"
  - Increased bleeding risk vs. DOACS
  - DOAC simplicity hard to beat
  - Reversal no longer a major issue (Praxbind etc.)

Recent New CHEST Guidelines

Outpatient management

- In patients with low risk PE, outpatient Rx or early D/C rather than hospitalization

Anticoagulant

- In patients with DVT of leg or PE (without cancer) DOAC's rather than warfarin

Recent New Chest Guidelines

Sub-Segmental PE and no proximal DVT

Anticoagulation for pts. at higher risk for recurrence: pts. hospitalized, reduced mobility, Cancer, unprovoked sub-segmental PE, low pulmonary reserve, or marked respiratory symptoms

No anticoagulation for pts.: at low risk of recurrence (eg. Recent surgery or transient risk factor)

Recent New CHEST Guidelines

Cancer Patients

DVT of the leg or PE: LMWH rather than DOAC

How long to treat

VTE (Proximal DVT or PE) 2° surgery: 3 months

VTE (Proximal DVT or PE) 2° non-surgical transient risk factor (estrogens, pregnancy, leg injury, flight > 8hrs.): 3 months

Recent New CHEST Guidelines

Unprovoked VTE (Proximal DVT or PE): long term

Distal DVT

If not severely symptomatic: No anticoagulation (followup US)

If severely symptomatic: 3 months

ASA

Unprovoked VTE pts. Who opt to stop anticoagulation: suggest ASA long term

BRIDGE Trial

- Randomized, double-blind, placebo controlled
- Atrial fib. Patients (1884)
- Bridging with LMWH NOT needed
  - At least for mild / moderate risk for systemic TE
    - Mean CHADS-2 score: 2.3 (only 13.8% > 4)

BRIDGE Trial

- Greater bleeding with bridging before and after the procedure than just stopping and re-starting warfarin (3.2% vs 1.3%)
- Risk of arterial TE was no different between both groups (0.3% vs 0.4%)
- Study only looked at a. fib pts.