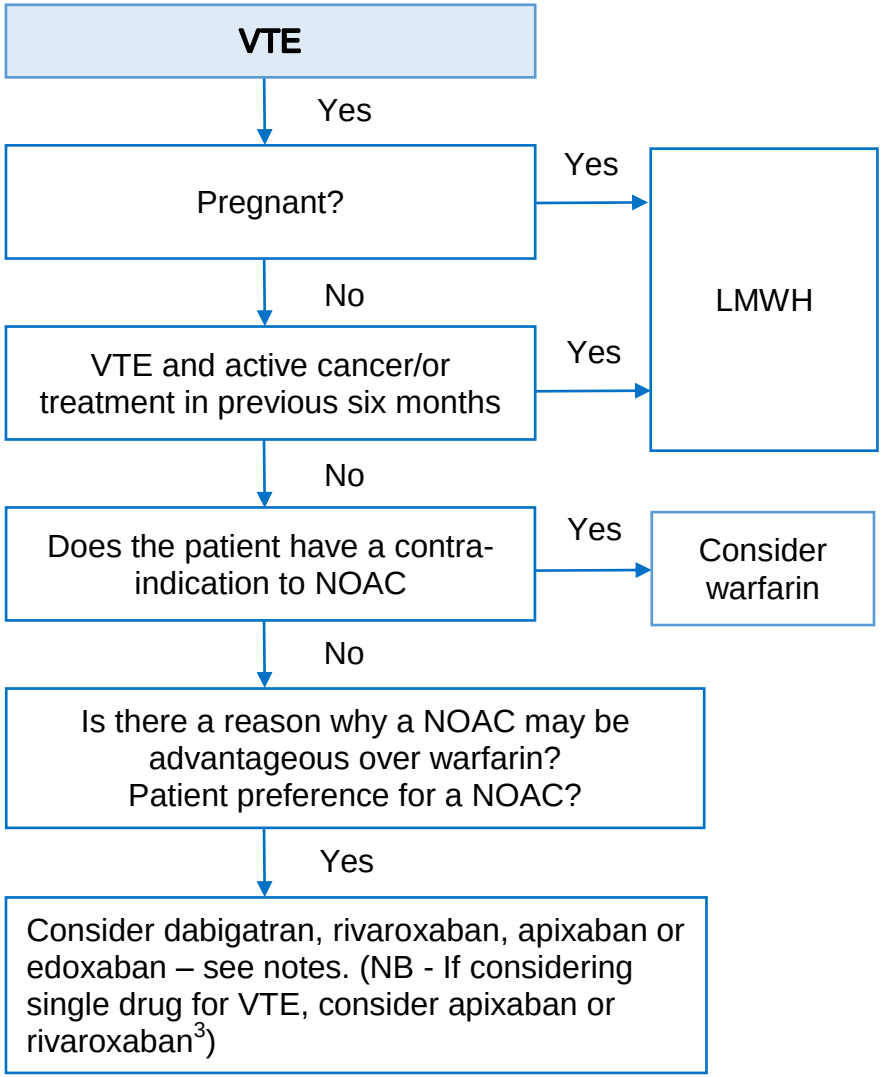
NHS Wiltshire Clinical Commissioning Group

Considerations for anticoagulation in Venous Thrombo-embolism (VTE)[1-3]



Short duration of therapy (at least three months) should be based on transient risk factors (e.g. recent surgery, trauma, immobilisation) and longer durations should be based on permanent risk factors or idiopathic DVT or PE.

Dabigatran - following treatment with parenteral anticoagulant for five days.

Discontinue the parenteral anticoagulant and start dabigatran 0-2 hours prior to the time that the next dose of the alternate therapy would be due, or at the time of discontinuation in case of continuous treatment (e.g. intravenous Unfractionated Heparin (UFH))

150mg bd or 110mg bd should be selected based on an individual assessment of the thromboembolic risk and the risk of bleeding for following:

- Age 75-80yrs
- CrCl 30-50ml/min
- Patients with gastritis, esophagitis or gastroesophageal reflux
- Other patients at increased risk of bleeding.

Antidote available

Rivaroxaban - For patients currently receiving a parenteral anticoagulant, discontinue the parenteral anticoagulant and start rivaroxaban 0 to 2 hours before the time that the next scheduled administration of the parenteral medicinal product (e.g. low molecular weight heparins) would be due or at the time of discontinuation of a continuously administered parenteral medicinal product (e.g. intravenous unfractionated heparin).

15mg twice daily for days 1-21 then 20mg daily.

Apixaban - Switching treatment from parenteral anticoagulants to apixaban(and vice versa) can be done at the next scheduled dose

Treatment: 10mg bd for the first 7 days followed by 5mg bd

Prevention of recurrent DVT and/or PE following completion of six months of treatment for DVT or PE: 2.5mg bd

- Consider if previous GI bleed or high GI bleeding risk
- Consider if CrCl 15-49ml/min

Edoxaban – following treatment with parenteral anticoagulant for at least 5 days. Discontinue subcutaneous anticoagulant and start edoxaban at the time of the next scheduled subcutaneous anticoagulant dose.

60mg daily following parenteral anticoagulant for at least five days.

Reduce dose to 30mg with one or more of following risk factors:

- Moderate to severe renal impairment, <=60kg,
- Concomitant use of P-glycoprotein inhibitors
- May be used with bioprosthetic heart valve after first three months

References

1. National Institute for Health and Care Excellence. Clinical Guideline 144 (CG 144). Venous thromboembolic diseases: diagnosis, management and thrombophilia testing. June 2012. Updated November 2015. Available at www.nice.org.uk/guidance/cg144 accessed 8/11/16
2. Scottish intercollegiate Guideline Network. Prevention and management of venous thromboembolism. December 2010. Available at http://www.sign.ac.uk/guidelines/fulltext/122/ accessed 17.10.16
3. Barnes GD, Kurtz B. Direct oral anticoagulants: unique properties and practical approaches to management. Heart 2016;**102:**1620-1626.
4. Summary of product Characteristics – Dabigatran, Rivaroxaban, Apixaban, Edoxaban