Anticoagulanti dopo stroke

Dr. Marcello Naccarato

Clinica Neurologica Stroke Unit – Trieste

Direttore: Prof. Paolo Manganotti

Table I Selected indications and contraindications for non-vitamin K antagonist oral anticoagulant therapy in atrial fibrillation patients

Condition	Eligibility for NOAC therapy
Mechanical prosthetic valve	Contraindicated
Moderate to severe mitral stenosis (usually of rheumatic origin)	Contraindicated
Mild to moderate other native valvular disease (e.g., mild-moderate aortic stenosis or regurgitation, degenerative mitral regurgitation etc.)	Included in NOAC trials
Severe aortic stenosis	Limited data (excluded in RE-LY) Most will undergo intervention
Bioprosthetic valve (after > 3 months post operatively)	Not advised if for rheumatic mitral stenosis
	Acceptable if for degenerative mitral regurgitation or in the aortic position
Mitral valve repair (after > 3 months post operatively)	Some patients included in some NOAC trials
PTAV and TAVI	No prospective data yet May require combination with single or dual antiplatelet therapy
Hypertrophic cardiomyopathy	Few data, but patients may be eligible for NOACs

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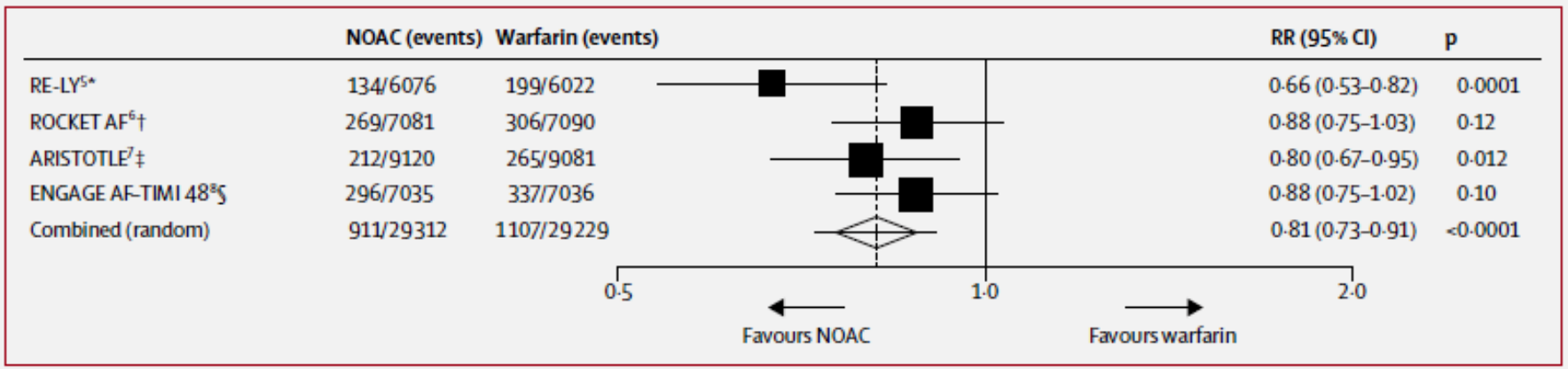

***Figure 1*: Stroke or systemic embolic events**

Data are n/N, unless otherwise indicated. Heterogeneity: I^2=47%; p=0·13. NOAC=new oral anticoagulant. RR=risk ratio. *Dabigatran 150 mg twice daily. †Rivaroxaban 20 mg once daily. ‡Apixaban 5 mg twice daily. §Edoxaban 60 mg once daily.

Lancet 2014; 383: 955–62

Table 5 Key safety results from phase III trials with novel oral anticoagulants compared with standard therapy

	RE-LY [21, 26, 27] (dabigatran)[a]		ROCKET AF [22, 30] (rivaroxaban)	ARISTOTLE [23] (apixaban)	ENGAGE AF [25] (edoxaban)	
	110 mg bid	150 mg bid			30 mg od	60 mg od
Major bleeding (%/year)	2.92 vs 3.61**	3.40 vs 3.61†	3.60 vs 3.40†	2.13 vs 3.09***	1.61 vs 3.43***	2.75 vs 3.43***
Major and NMCR bleeding (%/year)	N/A	N/A	14.90 vs 14.50†	4.07 vs 6.01***	7.97 vs 13.02***	11.10 vs 13.02***
Major GI bleeding (%/year)	1.15 vs 1.07†	1.56 vs 1.07***	2.00 vs 1.24***	0.76 vs 0.86†	0.82 vs 1.23***	1.51 vs 1.23*
Intracranial hemorrhage (%/year)	0.23 vs 0.76***	0.32 vs 0.76***	0.50 vs 0.70*	0.33 vs 0.80***	0.26 vs 0.85***	0.39 vs 0.85***
All-cause mortality (%/year)	3.75 vs 4.13†	3.64 vs 4.13†	4.50 vs 4.90†	3.52 vs 3.94*	3.80 vs 4.35**	3.99 vs 4.35†
Myocardial infarction (%/year)	0.82 vs 0.64†	0.81 vs 0.64†	0.91 vs 1.12†	0.53 vs 0.61†	0.89 vs 0.75†	0.70 vs 0.75†

bid twice daily, *GI* gastrointestinal, *N/A* not applicable, *NMCR* non-major clinically relevant, *od* once daily

† p = not significant; * $p < 0.05$; ** $p < 0.01$; *** $p \leq 0.001$

[a] Updated data (2010 and 2014) after identification of additional events post-publication (2009)

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Table 13 NOACs and approved/studied doses across indications

Stroke prevention in atrial fibrillation (SPAF)		
	Standard dose	**Comments/dose reduction**
Apixaban[30]	2 × 5 mg	2 × 2.5 mg if two out of three: weight ≤60 kg, age ≥80 years, serum creatinine ≥133 µmol/(1.5 mg/dL) [or if CrCl 15–29 mL/min]
Dabigatran[28]	2 × 150 mg / 2 × 110 mg	No pre-specified dose-reduction criteria[a]
Edoxaban[31]	1 × 60 mg	1 × 30 mg if: weight ≤60 kg, CrCl ≤50 mL/min, concomitant therapy with strong P-Gp inhibitor (see **chapter 5**)
Rivaroxaban[29]	1 × 20 mg	1 × 15 mg if CrCl ≤50 mL/min

[a]SmPC: 2 × 110 mg if age ≥80 years, concomitant verapamil, increased risk of GI bleeding.

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Neurol Sci (2014) 35:723–727
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ORIGINAL ARTICLE

Recommendations for the use of new oral anticoagulants (NOACs) after TIA or stroke caused by atrial fibrillation (AF), after a consensus conference among Italian neurologists (the Venice group)

Vito Toso

The questions that were answered by the consensus participants regarded two topics.

(A) What continuous prophylactic treatment should we recommend for patients with a stroke ascribed to AF, who were not previously on antithrombotic treatment, to prevent further strokes?

A1 Aspirin should not be used at any dose [6, 12].

A2 Aspirin should not be used in combination with clopidogrel [13].

A3 Always choose a NOAC.

1-A3 Because of the superiority of the three novel drugs versus warfarin in reducing cerebral hemorrhagic complications.

2-A3 Because of the non-inferiority of the three novel drugs as compared to warfarin in reducing ischemic stroke.

3-A3 Because of the superiority versus warfarin in reducing ischemic stroke, when the higher dose of dabigatran is administered.

4-A3 Because even after transient cerebral ischemia, the risk of a recurrence is considered to be high, independently of the ischemic score used—CHADS2 or CHA2DS2-VASc.

31/07/2015 Raccomandazione 12.5.4 (LLGG **Iso-spread**)

In caso di ictus ischemico o TIA attribuibile a FAnv in paziente che non assumeva terapia antitrombotica è indicato l'impiego di **anticoagulanti orali (NAO o AVK)**

31/07/2015 Raccomandazione 12.5.6 (LLGG **Iso-spread**)

In caso di ictus ischemico o TIA attribuibile a FAnv è **indicato** l'utilizzo dei **NAO** per la loro almeno uguale efficacia e per la loro maggiore sicurezza in confronto alla terapia con AVK.

Europace (2016) **18**, 1609–1678
doi:10.1093/europace/euw295

ESC GUIDELINES

2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

The Task Force for the management of atrial fibrillation of the European Society of Cardiology (ESC)

Recommendations for secondary stroke prevention

Recommendations	Class[a]	Level[b]	Ref[c]
Anticoagulation with heparin or LMWH immediately after an ischaemic stroke is not recommended in AF patients.	III (harm)	A	477
In patients who suffer a TIA or stroke while on anticoagulation, adherence to therapy should be assessed and optimized.	IIa	C	
In patients who suffer a moderate-to-severe ischaemic stroke while on anticoagulation, anticoagulation should be interrupted for 3–12 days based on a multidisciplinary assessment of acute stroke and bleeding risk.	IIa	C	
In AF patients who suffer a stroke, aspirin should be considered for prevention of secondary stroke until the initiation or resumption of oral anticoagulation.	IIa	B	485
Systemic thrombolysis with rtPA is not recommended if the INR is above 1.7 (or, for patients on dabigatran, if aPTT is outside normal range).	III (harm)	C	472, 474
NOACs are recommended in preference to VKAs or aspirin in AF patients with a previous stroke.	I	B	363, 482
After TIA or stroke, combination therapy of OAC and an antiplatelet is not recommended.	III (harm)	B	486
After intracranial haemorrhage, oral anticoagulation in patients with AF may be reinitiated after 4–8 weeks provided the cause of bleeding or the relevant risk factor has been treated or controlled.	IIb	B	483, 484, 487

31/07/2015 Raccomandazione 12.5.12 (LLGG **Iso-spread**)

In caso di ictus emorragico in pazienti trattati con **AVK** o **antiaggreganti per FAnv**, dopo aver valutato con attenzione la necessità della ripresa del trattamento anticoagulante mediante CHA2DS2-VASc, è **indicato scegliere un NAO** per il netto guadagno, in complicanze emorragiche intracraniche, sulla terapia con AVK