Clinical Practice Guideline for
Anticoagulation Management of Atrial Fibrillation

This guideline is to inform practitioners of the Standard of Care for evaluation and treatment of patients with atrial fibrillation, and is not intended to replace a practitioner’s judgment.

Atrial fibrillation is the most common form of arrhythmia. Atrial fibrillation increases the risk of stroke by five times in people 65 years and older. Risk varies depending upon the patient’s CHADS2 VASc score. Treatment of atrial fibrillation with anticoagulant therapy is known to reduce the incidence of CVA. Fifteen percent (15%) of CVA’s have cardiac origin. Two-thirds of these are due to atrial fibrillation.

The benefits of anticoagulant therapy are well-documented in studies. Coumadin is the preferred medication. Aspirin is better than placebo. Surveys show coumadin is underutilized in patients with atrial fibrillation. Use Aspirin in low-risk patients or those who refuse to take coumadin. Other Factor xa inhibitor anticoagulant agents (i.e., Pradaxa®/Xarelto®) for use in place of coumadin must meet strict prior authorization guidelines.

Patients with any high-risk factor or more than one moderate-risk factor should be prescribed an anticoagulant. High risk factors include prior stroke, transient ischemic attack or systemic embolus, and rheumatic mitral stenosis. Moderate risk factors include age > 75 years and diabetes mellitus. Patients who have paroxysmal atrial fibr, reoccurrences of atrial fibrillation or those who have been in atrial fibrillation longer than 48 hours prior to conversion to a sinus rhythm should be anticogulated for 3 weeks on direct oral anticoagulants or therapeutic on warfarin for 3 consecutive weeks, and reevaluated by their practitioner. Strong consideration should be given to prescribing indefinite anticoagulation particularly in high risk patients.

There are contraindications regarding prescribing anticoagulation. Contraindications include:

- Uncorrected major bleeding disorder- thrombocytopenia, haemophilias, liver failure, renal failure
- Uncontrolled severe hypertension-systolic greater than 200mmHg or diastolic greater than 120 mmHg
- Potential bleeding lesions-active peptic ulcer, esophageal varices, aneurysm, proliferative retinopathy, recent organ biopsy, recent trauma or surgery to the head, orbit or spine, recent stroke, confirmed intracranial or intraspinal bleed
- Uncooperative/unreliable patient
- Repeated falls or unstable gait
- Concomitant use of NSAIDS-increased risk of GI bleed-relative-try to stop NSAIDS
- Protein C deficiency- risk of skin necrosis on initiation of treatment, so caution needed

Contraindications to anticoagulants should be documented and readily visible in the patient’s medical record.
Antithrombotic Therapy for Patients with Atrial Fibrillation

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Recommended Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk factors</td>
<td>Aspirin, 81-325 mg daily</td>
</tr>
<tr>
<td>1 moderate-risk factor</td>
<td>Aspirin, 81-325 mg daily, or warfarin (INR 2.0-3.0, target 2.5)</td>
</tr>
<tr>
<td>Any high-risk factor or &gt;1 moderate-risk factor</td>
<td>Warfarin (INR 2.0-3.0, target 2.5)*</td>
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</tbody>
</table>

Less Validated or Weaker Risk Factors

<table>
<thead>
<tr>
<th>Moderate-Risk Factors</th>
<th>High-Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female gender</td>
<td>Age ≥ 75 years</td>
</tr>
<tr>
<td>Age 65-74 years</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>Heart failure</td>
</tr>
<tr>
<td>Thyrotoxicosis</td>
<td>LV ejection fraction ≤35%, diabetes mellitus</td>
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<tr>
<td></td>
<td>Previous stroke, TIA, or embolism</td>
</tr>
<tr>
<td></td>
<td>Mitral stenosis</td>
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<td></td>
<td>Prosthetic heart valve*</td>
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</tbody>
</table>

*If mechanical valve, target INR >2.5.
INR= international normalized ratio; LV = left ventricular; TIA= transient ischemic attack

*More detailed information, including the CHADS2-VASc risk scoring system, can be found in the Clinical Practice Guideline #10 – Anticoagulation Management.

Recommended Treatment Plan for Patients Age 65 or Older or Under 65 with Structural Heart Disease

1. Appropriate use of coumadin (warfarin) in patients with atrial fibrillation who do not have contraindications to coumadin. If placed on coumadin, INR level 2-3. Patients with INR levels outside 2-3, should have dosage adjustments. If the practitioner does not adjust dosages when the INR is not within the recommended range, there should be documentation in the patient’s medical record regarding the reason adjustment was not performed.
2. Increase education of patient’s regarding coumadin (warfarin) therapy and increase appropriate monitoring.
3. Encourage the use of diagnostic tests with echocardiography/trans-esophageal echocardiogram in patients with new onset atrial fibrillation.
4. Encourage the use of thyroid studies and consider secondary causes (ie caffeine, alcohol etc.) in patients with new-onset atrial fibrillation.

References


Original: 10/99
Reviewed: 10/00
Reviewed: 09/01
Revised: 10/02
Revised: 11/03
Reviewed: 06/04
Revised: 01/05
Revised: 01/06
Reviewed: 06/07
Revised: 08/08
Reviewed: 10/09
Reviewed: 12/10
Revised: 12/11
Revised: 12/12
Revised: 10/14
Revised: 08/16
Revised: 01/18