Management of Non-valvular Atrial Fibrillation

- Guidelines for anticoagulation apply to paroxysmal, persistent and permanent AF and atrial flutter. Do not use this guideline for patients with significant structural heart disease, congenital heart disease or cardiomyopathy.

- Do not offer aspirin or clopidogrel monotherapy solely for stroke prevention to patients with AF. Anticoagulation should be the treatment of choice to reduce the risk of strokes.

- Continue treatment for existing patients who are currently stabilised and well controlled on anticoagulation for stroke prevention.

- The majority of patients with AF should be offered rate control.

- In people with atrial fibrillation presenting acutely with suspected concomitant acute decompensated heart failure, seek senior specialist input on the use of beta-blockers and do not use calcium-channel blockers.

- Perform a 12-lead ECG in all patients, whether symptomatic or not, in whom AF is suspected because an irregular pulse has been detected.

- Do not routinely do an echo if the decision to initiate anticoagulation has already been made unless there is another indication (e.g. murmur or LVSD suspected).

- The GRASP-AF tool can be run on GP clinical systems and used to identify patients at risk of stroke.

- CHA₂DS₂-VASc score is the preferred tool for the assessment of stroke risk.

- Use ORBIT bleeding risk score in all AF patients to assess bleeding risk, if available on clinical systems. (Where ORBIT is not available, HAS-BLED may be used to assess bleeding risk). Modifiable factors that reduce risk should be addressed.

- Discuss the results of the assessments of stroke and bleeding risk with the person taking into account their specific characteristics, for example comorbidities, and their individual preferences.

- For most patients the benefit of anticoagulation outweighs the bleeding risk. Do not withhold anticoagulation solely because of a person's age or their risk of falls.

- For people with an increased risk of bleeding, the benefit of anticoagulation may not always outweigh the bleeding risk, and careful monitoring of bleeding risk is important.

- In most cases there is no immediate need for anticoagulation and clinicians should allow the patient some reflective time before a decision is made.

- Where a NOAC is considered to be the most appropriate anticoagulant, edoxaban is to be used 1st line for patients with NVAF unless there is a specific clinical reason not to do so.

- Doses should be selected with care when initiating treatment with a NOAC and should be reviewed on an annual basis.

- Poor compliance with warfarin does not equate to good compliance with a NOAC. NOACs have a relatively short half-life, so poor compliance will result in uncontrolled anticoagulation.
• Available ‘real world’ data suggest variable adherence to NOAC intake from 38% to 99% depending on the setting and definition. Patient education on the need for oral anticoagulation therapy and the importance of strict adherence is important (ref EHJ).

• Refer patients promptly at any stage if treatment fails to control the symptoms of AF and more specialised management is needed. NICE define promptly as within four weeks of failed treatment.

• Amiodarone is for initiation by the consultant or specialist only. Duration of treatment should be specified. Do not offer amiodarone for long-term rate control. Amiodarone should only be used as an interim therapy and should not usually be taken for longer than 12 months.

<table>
<thead>
<tr>
<th>Document Update</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>p.18 monitoring clarified</td>
<td>Feb 2022</td>
</tr>
<tr>
<td>Insert advice regarding using CrCl calculator embedded in GP clinical system</td>
<td>April 2022</td>
</tr>
<tr>
<td>p.17 Clarify advice on edoxaban for patients with high CrCl</td>
<td>May 2022</td>
</tr>
<tr>
<td>Update renal advice for edoxaban, link to PCCS resource</td>
<td>Feb 2023</td>
</tr>
<tr>
<td>MHRA drug safety on DOAC- reminder of dose adjustments in renal impairment</td>
<td>June 2023</td>
</tr>
<tr>
<td>Pg 8 &amp; 16: update advice regarding using the embedded calculator in SystmOne</td>
<td>Oct 2023</td>
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### 1. Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>ACS</td>
<td>Acute Coronary Syndrome</td>
</tr>
<tr>
<td>AF</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>ALP</td>
<td>Alkaline phosphatase</td>
</tr>
<tr>
<td>AST</td>
<td>Aspartate aminotransferase</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>Cr</td>
<td>Creatinine</td>
</tr>
<tr>
<td>CrCl</td>
<td>Creatinine Clearance</td>
</tr>
<tr>
<td>CYP3A4</td>
<td>Cytochrome P450, family 3, subfamily A, polypeptide 4</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>HF</td>
<td>Heart Failure</td>
</tr>
<tr>
<td>INR</td>
<td>International Normalised Ratio</td>
</tr>
<tr>
<td>LFT</td>
<td>Liver Function Test</td>
</tr>
<tr>
<td>LVSD</td>
<td>Left Ventricular Systolic Dysfunction</td>
</tr>
<tr>
<td>MI</td>
<td>Myocardial Infarction</td>
</tr>
<tr>
<td>NOAC</td>
<td>Non-vitamin K antagonist oral anticoagulants (apixaban, dabigatran, rivaroxaban, edoxaban)</td>
</tr>
<tr>
<td>NSAID</td>
<td>Non-Steroidal Anti-Inflammatory Drugs</td>
</tr>
<tr>
<td>PDA</td>
<td>Patient Decision Aid</td>
</tr>
<tr>
<td>SNRI</td>
<td>Serotonin and Norepinephrine Reuptake Inhibitor</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitor</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischaemic Attack</td>
</tr>
<tr>
<td>TTR</td>
<td>Time in Therapeutic Range</td>
</tr>
<tr>
<td>ULN</td>
<td>Upper Limit of Normal</td>
</tr>
</tbody>
</table>

### 2. Definitions

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute onset</td>
<td>Onset within the previous 48 hours</td>
</tr>
<tr>
<td>Atrial flutter</td>
<td>Abnormal heart rhythm that occurs in the atria of the heart. This condition is initially managed by secondary care. Atrial flutter and atrial fibrillation have similar goals, including rate control, prevention of recurrent episodes and prevention of thromboembolism. But the method of restoration of sinus rhythm the pharmacological management of atrial flutter and AF are very different, as atrial flutter responds better to electrical cardioversion, and antiarrhythmic drugs are only modestly effective. Patients with atrial flutter should be given antithrombotic therapy in the same manner as those with atrial fibrillation</td>
</tr>
<tr>
<td>Consider</td>
<td>Defined as an intervention which will do more good than harm for most patients and be cost effective, but other options may be similarly cost effective</td>
</tr>
<tr>
<td>Labile INR</td>
<td>Refers to unstable/high INRs or poor time in therapeutic range (e.g. TTR &lt;60% when using the HASBLED calculator)</td>
</tr>
<tr>
<td>Major bleed</td>
<td>NICE uses trials with different diagnostic criteria of major bleed e.g. haemoglobin of 2g/dL or more over 24h, transfusion of 2 units or more, bleeding that occurs in a critical site (including intracranial, intraspinal etc.) or bleeding that is fatal.</td>
</tr>
<tr>
<td>Offer</td>
<td>Defined as an intervention which will do more good than harm and be cost effective</td>
</tr>
<tr>
<td>Paroxysmal AF</td>
<td>AF which spontaneously terminates within 7 days, usually within 48 hours</td>
</tr>
<tr>
<td>Permanent AF</td>
<td>Persistent or long-standing persistent atrial fibrillation in which a decision has been made not to try to restore normal sinus rhythm by any means</td>
</tr>
<tr>
<td>Persistent AF</td>
<td>AF which persists for more than 7 days</td>
</tr>
<tr>
<td>Pill-in-the-pocket strategy</td>
<td>Defined as the person managing paroxysmal AF themselves by taking antiarrhythmic drugs only when an episode of AF starts.</td>
</tr>
<tr>
<td>Valvular AF</td>
<td>AF in the presence of mechanical prosthetic heart valve or moderate to severe rheumatic mitral valve disease.</td>
</tr>
<tr>
<td>Non-valvular AF</td>
<td>All other AFs are non-valvular</td>
</tr>
</tbody>
</table>

### NICE definition

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider</td>
<td>an intervention which will do more good than harm for most patients and be cost effective, but other options may be similarly cost effective</td>
</tr>
<tr>
<td>Offer</td>
<td>an intervention which will do more good than harm and be cost effective</td>
</tr>
</tbody>
</table>
3. Introduction

Atrial fibrillation (AF) affects about 1.2% of the population in the United Kingdom and accounts for about a sixth of all strokes. AF is the most common sustained cardiac arrhythmia and if left untreated AF is a significant risk for stroke and other morbidities. Men are more commonly affected than women and the prevalence increases steeply with age, from 0.5% of those aged 50–59 years to 10% of those over 80. The aim of treatment is to prevent complications, particularly stroke and alleviate symptoms.

4. Aim

The aim of this policy is to support prescribers in identifying and managing appropriate patients with AF for whom anticoagulation (with warfarin or a non-vitamin K antagonist oral anticoagulants (NOAC)) would be an effective and cost effective treatment for reducing stroke risk in non-valvular AF. Recommendations are based on NICE NG196¹.

5. Diagnosis and investigations

### Look for AF by OPPORTUNISTIC CASE FINDING

Take the pulse of those people presenting with any of the following:
- Breathlessness/dyspnoea
- Palpitations
- Syncope/dizziness
- Chest discomfort
- Stroke/transient ischaemic attack

Do not screen asymptomatic population for AF (evidence shows no benefit)

AF may also be detected as an incidental finding on clinical examination

### Irregular pulse detected: AF suspected: Do 12-lead ECG

Where paroxysmal AF suspected but undetected by 12-lead ECG, undertake a 24 hour ambulatory ECG if asymptomatic episodes are suspected or symptomatic episodes are less than 24 hours apart.

Use an ambulatory ECG monitor for a period appropriate to detect AF if symptomatic episodes are more than 24 hours apart

### ECG confirms AF or Flutter

<table>
<thead>
<tr>
<th>Personalised package of care</th>
<th>Rate or rhythm control</th>
<th>Stroke prevention/ bleeding risk assessment</th>
<th>Bloods? Echo? Referral?</th>
</tr>
</thead>
</table>
| Patients with AF should be offered a personalised package of care which should include:  
- Stroke awareness and measures to prevent stroke.  
- Rate control.  
- Assessment of symptoms for rhythm control.  
- Who to contact for advice if needed  
- Psychological support if needed.  
- Up-to-date and comprehensive education and information on:  
  o Cause, effects and possible complications of AF.  
  o Management of rate and rhythm control.  
  o Anticoagulation.  
  o Practical advice on anticoagulation.  
  o Support networks.  
| Rate control is the treatment of choice for the majority of patients. | Assess stroke risk using CHA₂DS₂-VASc  
and  
Assess bleeding risk using ORBIT bleeding risk score (or HAS-BLED if ORBIT unavailable) | Bloods: NICE do not recommend any specific blood tests. Most clinicians would check FBC, renal and thyroid function as a minimum. Consider lipid profile to assess CV risk.  
Echo: Do NOT routinely do echo. Do echo only if result will change management. Examples where echo is indicated include – left ventricular systolic dysfunction, mitral valve disease, or murmur, organise an echo if these are suspected.  
Referral to specialist: routine referral not needed. Refer promptly if treatment fails to control symptoms. (Prompt referral is defined as no longer than 4 weeks after the final failed treatment or no longer than 4 weeks if AF recurs after cardioversion and further specialist management is needed) |

$KardiaMobile$ (AliveCor) Heart Monitor is a pocket-sized ECG recorder which records rhythm and can identify paroxysmal AF. It may be a useful tool to investigate irregular pulse where a full ECG is not available immediately. However, it does not replace 12 lead or continuous ECG. See NICE MTG64.
6. Risk assessment for anticoagulation

Stoke and bleeding risk should be assessed in all patients with AF. Use CHA²DS²-VASc score to assess stroke risk and the ORBIT bleeding risk score (if available on clinical systems) or HAS-BLED to assess the risk of bleeding in patients who are starting or have started an anticoagulant.

The decision to stop anticoagulation should be made based on a reassessment of stroke and bleeding risk using CHA2DS2-VASc and ORBIT or HAS-BLED and following a discussion of the person's preferences. Do not stop anticoagulation solely because atrial fibrillation is no longer detectable.

<table>
<thead>
<tr>
<th>Use CHA²DS²-VASc to assess stroke risk</th>
<th>Use ORBIT or HAS-BLED to assess bleeding risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE recommend the use of CHA²DS²-VASc to assess the risk of stroke in people with:</td>
<td>Use the ORBIT bleeding risk score (if available on the clinical systems) to assess the risk of bleeding in people who are starting or have started anticoagulation. Offer modification and monitoring of the following risk factors:</td>
</tr>
<tr>
<td>• Symptomatic or asymptomatic paroxysmal, persistent or permanent atrial fibrillation</td>
<td>• Uncontrolled hypertension</td>
</tr>
<tr>
<td>• Atrial flutter</td>
<td>• Poor control of INR (“Labile INR“)</td>
</tr>
<tr>
<td>• A continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm (cardiologist decision or CHADSVASC≥2) or catheter ablation</td>
<td>• Concurrent medication, e.g. concomitant use of aspirin or other antiplatelets or a NSAID or SSRI.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORBIT bleeding risk score</th>
<th>ORBIT Score of ≥ 4 suggests high risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥75</td>
<td>Max. score = 7</td>
</tr>
<tr>
<td>Reduced Haemoglobin/Reduced Haematocrit/Anaemia</td>
<td></td>
</tr>
<tr>
<td>• Male: Hb &lt;13 mg/dL; Hct: &lt;40%</td>
<td></td>
</tr>
<tr>
<td>• Female: Hb &lt;12 mg/dL; Hct: &lt;30% Females or History of anaemia</td>
<td></td>
</tr>
<tr>
<td>Bleeding History</td>
<td>2</td>
</tr>
<tr>
<td>Insufficient renal function eGFR &lt;60mg/dL/1.73m²</td>
<td>1</td>
</tr>
<tr>
<td>Treatment with Anti-platelet agents</td>
<td>1</td>
</tr>
</tbody>
</table>

### CHA²DS²-VASc items

<table>
<thead>
<tr>
<th>Max. score = 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure or left ventricular dysfunction</td>
</tr>
<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Age ≥75</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Stroke or TIA</td>
</tr>
<tr>
<td>Vascular disease (prior MI, peripheral artery disease, aortic plaque)</td>
</tr>
<tr>
<td>Age 65-74</td>
</tr>
<tr>
<td>Sex category (female)</td>
</tr>
</tbody>
</table>

(See appendix 7 CHA2DS2-VASc score and stroke risk table)

### ORBIT bleeding risk score

<table>
<thead>
<tr>
<th>ORBIT Score</th>
<th>Risk group</th>
<th>Bleeds per 100 patient-years</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Low</td>
<td>2.4</td>
</tr>
<tr>
<td>3</td>
<td>Medium</td>
<td>4.7</td>
</tr>
<tr>
<td>4-7</td>
<td>High</td>
<td>8.1</td>
</tr>
</tbody>
</table>
Where ORBIT is not available, HAS-BLED may be used to assess bleeding risk

**HAS-BLED bleeding score**

<table>
<thead>
<tr>
<th>Score</th>
<th>Item</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hypertension (systolic BP &gt;160mmHg)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Abnormal liver function (hepatic derangement- bilirubin &gt;2 xULN and AST/ALP or ALP &gt; 3 xULN)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Abnormal renal function (serum Creatinine ≥200micromol/, Dialysis, transplant)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Bleeding tendency (previous bleeding history and/or predisposition to bleeding, e.g. anaemia)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Labile INR (Unstable/high INRs, Time in Therapeutic Range &lt; 60%)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Elderly (&gt;65yrs) e.g., age &gt; 65 years, frail condition</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Drugs (concomitant use of drugs such as antiplatelet agents, NSAID etc.)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Alcohol (alcohol abuse)</td>
<td></td>
</tr>
</tbody>
</table>

Max. score = 9 (score of ≥ 3 suggests high risk)

**CHA\textsubscript{2}DS\textsubscript{2}-VASc = 0 (Men)**
- **No ANTITHROMBOTICS**
- Reassess risks (stroke risk, bleeding risk) annually
- Do not offer aspirin (or any other drug) for stroke prevention to people aged under 65 years with no risk factors other than their sex

Review patients not taking any anticoagulants when they reach age of 65 or if they develop any of the following at any age:
- Diabetes
- HF
- Peripheral arterial disease
- Coronary heart disease
- Stroke, TIA or systemic thromboembolism

**CHA\textsubscript{2}DS\textsubscript{2}-VASc = 1 (Men)**
- Consider anticoagulation –NOAC
- Bearing in mind bleeding risk

Offer vitamin K antagonist if NOAC are contraindicated, not tolerated or not suitable
If anticoagulation not indicated offer **no antithrombotic treatment**

Discuss the options for anticoagulation with the patient, base the choice on their clinical features and preferences. Edoxaban is to be used 1st line for patients with NVAF unless there is a specific clinical reason not to do so

**CHADS\textsubscript{2}-VASc = 1 (Women)**

**CHA\textsubscript{2}DS\textsubscript{2}-VASc ≥ 2 (Men and women)**
- Offer anticoagulants - NOAC
- Taking bleeding risk into account

Offer vitamin K antagonist if NOAC are contraindicated, not tolerated or not suitable

Discuss the options for anticoagulation with the patient, base the choice on their clinical features and preferences. Edoxaban is to be used 1st line for patients with NVAF unless there is a specific clinical reason not to do so

Do not offer aspirin (or clopidogrel) monotherapy solely for stroke prevention to people with AF

**Annual review for all patients (see also appendix 1)**
- Re-assess stroke risk and bleeding risk (If on warfarin assess time in therapeutic range; If on a NOAC assess compliance)
7. Considering or offering an anticoagulant

NICE recommend when discussing the benefits and risks of anticoagulation, explain that:

- For most patients the benefit of anticoagulation outweighs the bleeding risk
- For people with an increased risk of bleeding the benefit of anticoagulation may not always outweigh the bleeding risk and careful monitoring of bleeding risk is important.
- Do not withhold anticoagulation solely because the person is at risk of having a fall
- Do not offer aspirin (or clopidogrel) monotherapy solely for stroke prevention to people with AF.
- If considering or offering anticoagulation, offer a NOAC. Edoxaban is to be used 1st line for patients with NVAF unless there is a specific clinical reason not to do so. Where a NOAC is contraindicated, not tolerated or not suitable in people with atrial fibrillation, offer a vitamin K antagonist. The clinician should discuss the options for anticoagulation with the patient and drug choice should take into account clinical features, preferences and bleeding risk.

8. Choice of anticoagulant

The choice of anticoagulant in AF should be made with the patient and is dependent upon clinical features and preferences. The risks and benefits of the treatment options should be presented to the patient in an easily understandable and unbiased manner.

The NOACs edoxaban, apixaban, dabigatran and rivaroxaban have not been directly compared in the same clinical trials, so it is not possible to say which one is better. They share some of the same advantages and disadvantages compared to warfarin, but because they work slightly differently, they also have some unique characteristics that make them better suited for different types of patients.

Where a NOAC is considered to be the most appropriate anticoagulant, the following order should be considered for patients with NVAF unless there is a specific clinical reason not to do so:

1. Edoxaban*
2. Rivaroxaban*
3. Apixaban* & Dabigatran

*subject to national procurement process

Detailed prescribing information for NOACs can be found in appendix 6

For adults with atrial fibrillation who are already taking a vitamin K antagonist and are stable, continue with their current medication and discuss the option of switching treatment at their next routine appointment, taking into account the person's time in therapeutic range.
Key points:

NOAC

✓ No requirement for INR monitoring.
✓ Provide immediate anticoagulant effect (time to peak effect ranges from 1-4 hours).
✓ Currently have known food interactions.
✓ Reduced risk of intracerebral bleeds versus warfarin (see p17 for further details)
X NOACs have shorter half-life and missed doses may result in more time without any anticoagulation and greater risk of thromboembolic complications.
X Adherence can be a challenge for patients managing anticoagulants
X Each NOAC has a higher acquisition cost than warfarin.
X Limited evidence on the reversal of the anticoagulant effects of the drugs.
X Renal function should be assessed and monitored using Cockcroft and Gault formula to calculate the CrCL, especially in patients with extreme BMI.
X In patients weight >120kg or BMI >40 kg/m² warfarin is locally recommended ahead of NOAC because there are limited clinical data available for patients at the extreme of weight. Consult with specialist if in doubt.
X Require baseline tests and on-going monitoring (see appendix 6)

For all patients being considered for treatment with NOACs use the Cockcroft and Gault formula to calculate the Creatinine Clearance (CrCl).

Cockcroft and Gault formula:

Estimated Creatinine Clearance (ml/min) = (140 – age) x Weight x Constant
Serum Creatinine
• Age (years)
• *Weight (Kg) (see p16-17 for further details of when to use IBW and ABW)
• Serum Creatinine (micromol/litre),
• Constant 1.23 for men; 1.04 for women

For practical purposes when calculating CrCl for NOAC dosing, many clinicians use the embedded calculator in the GP clinical system. If using the embedded calculator in SystmOne, ensure the creatine clearance using actual body weight is used. NB. It is very important to ensure that up-to-date weight & creatinine are used.

There are no published clinical trials that directly compare the NOACs against each other. See Detailed prescribing information in appendix 6.

When a decision has been made to prescribe an anticoagulant, certain patient factors may help guide treatment choice.

Those treated with NOACs should carry an anticoagulation card www.NOACforAF.eu

Warfarin (See local anticoagulation guidance for further information)

✓ vitamin K antagonist can be offered if NOACs are contraindicated, not tolerated or not suitable
✓ Reduced risk of GI bleed compared to NOAC – dabigatran, edoxaban and rivaroxaban.
✓ Patients with AF in the presence of mechanical prosthetic heart valve or moderate to severe rheumatic mitral valve disease should be treated only with warfarin not a NOAC.
✓ Clearance of warfarin is not affected by renal function.
✓ The benefits of NOACs over warfarin declines as the TTR on warfarin increases.
✓ Effective and familiar use of antidote with vitamin K should a severe bleed occur.
✓ INR gives clinicians a guide to patient compliance.
✓ Clinicians may choose to use warfarin in patients for whom the ability to readily and objectively monitor the extent of anticoagulation is paramount.
✓ For patients with poor adherence, the long time to onset and offset of action, maybe advantageous as the anticoagulant effect of warfarin will persist for days after the last dose.
X Warfarin - time to peak effect ranges from 3-5 days and a half-life averaging 40 hours.
X Warfarin is known to interact with certain foods e.g. cranberry, alcohol and other foods containing high amounts of vitamin K.
X Patients may have difficulty around complying with or accessing INR monitoring.

Reports of calciphylaxis, a very rare but serious condition causing vascular calcification and skin necrosis have been reported to the MHRA. The mortality rate is high. Patients should consult their doctor if they develop a painful skin rash. See MHRA, July 2016.
Anticoagulation control for existing patients on Warfarin

Exclude 1st 6 weeks of treatment

Calculate TTR over a maintenance period of at least 6 months (Use a validated method e.g. Rosendaal method for computer-assisted dosing)

Poor anticoagulation control
INRs
- TTR < 65%
- 2 INRs higher than 5 or 1 INR higher than 8 within past 6m
- 2 INRs less than 1.5 within the past 6m

Good anticoagulation control
Results TTR >65% and INRs normal

Check the following
- Cognitive function
- Compliance
- Drug interactions or co-morbidities
- Lifestyle factors including alcohol and diet
- Consider domiciliary monitoring arrangement for patients with reduced mobility
- Inconvenient or inappropriate monitoring arrangements – confirm suitability of arrangements for each patient

Continue treatment

Table 1: Conversion from Warfarin to:

<table>
<thead>
<tr>
<th>Edoxaban</th>
<th>Warfarin should be stopped. Monitor the INR and start edoxaban once the INR is ≤ 2.5.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rivaroxaban (for stroke prevention)</td>
<td>Warfarin should be stopped and treatment initiated when the INR is ≤3.0. When converting patients from warfarin, INR values will be falsely elevated after the intake of rivaroxaban. The INR is not valid to measure the anticoagulant activity of rivaroxaban, and therefore should not be used</td>
</tr>
<tr>
<td>Apixaban</td>
<td>Warfarin should be stopped. Monitor the INR and start apixaban once the INR is below 2.0</td>
</tr>
<tr>
<td>Dabigatran</td>
<td>Warfarin should be stopped and dabigatran started when INR is below 2.0 (usually 3-5 days after discontinuing warfarin for a patient with a stable INR 2.0-3.0)</td>
</tr>
</tbody>
</table>

Good anticoagulation control
Results TTR >65% and INRs normal

Check the following
- Cognitive function
- Compliance
- Drug interactions or co-morbidities
- Lifestyle factors including alcohol and diet
- Consider domiciliary monitoring arrangement for patients with reduced mobility
- Inconvenient or inappropriate monitoring arrangements – confirm suitability of arrangements for each patient

Continue treatment

Poor anticoagulation control
INRs
- TTR < 65%
- 2 INRs higher than 5 or 1 INR higher than 8 within past 6m
- 2 INRs less than 1.5 within the past 6m

Reassess anticoagulation

If poor anticoagulation control cannot be improved, evaluate the risks and benefits of alternative stroke prevention strategies and discuss these with the person.

Remember poor compliance with warfarin does not equate to good compliance with a NOAC. NOACs have relatively short half-life, so poor compliance will result in uncontrolled anticoagulation.

Consider NOACs
(See below)
<table>
<thead>
<tr>
<th>Considerations when choosing oral anticoagulation agent</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Once daily regime preferred? (consider concordance, reliant on carers/ nursing visits)</strong></td>
<td><strong>Preferred option:</strong> edoxaban (rivaroxaban is also taken once daily) or warfarin</td>
</tr>
<tr>
<td>Edoxaban</td>
<td>can be given as a single dose</td>
</tr>
<tr>
<td>Rivaroxaban</td>
<td>can be given as a single dose with food</td>
</tr>
<tr>
<td>Warfarin</td>
<td>although given as a single dose, it may be necessary to give several tablets dependant on dose</td>
</tr>
<tr>
<td><strong>Does the patient require medication in a compliance aid?</strong></td>
<td><strong>Preferred option:</strong> Edoxaban (rivaroxaban, apixaban or possibly warfarin are also choices)</td>
</tr>
<tr>
<td>Edoxaban</td>
<td>- no special storage requirement. Stable outside of original packaging for 3 months at 40°C and 75% relative humidity (personal communication with company)</td>
</tr>
<tr>
<td>Rivaroxaban</td>
<td>- no special storage requirement, can be used in compliance aid</td>
</tr>
<tr>
<td>Apixaban</td>
<td>- no special storage requirement, can be used in compliance aid</td>
</tr>
</tbody>
</table>
| Warfarin | - if risk assessment has been undertaken and a management plan is in place to manage dosage changes.  
*Note: Dabigatran is sensitive to moisture not suitable for compliance aid.* |
| **Does the patient have swallowing difficulties or a gastric tube?** | **Preferred option:** Edoxaban (rivaroxaban, apixaban are also choices) |
| Edoxaban | Swallowing difficulties:
*The tablets can be crushed and mixed with water or apple sauce for administration* |
| Enteral tubes | The tablets can be crushed and mixed with water for administration |
| Rivaroxaban | Swallowing difficulties:
*May be crushed and mixed with water or apple puree immediately prior to use and administered orally* |
| Gastric tube | *May be given through a nasogastric or PEG tube, after confirmation of the correct gastric placement of the tube. The crushed tablet should be administered in a small amount of water via a gastric tube after which it should be flushed with water.*  
*(Rivaroxaban should not be administered through feeding tubes which do not terminate in the stomach. For example this would include NJ, PEJ AND PEGJ tubes)* |
| Apixaban | Swallowing difficulties:
*Tablets can be crushed and dispersed in water, glucose 5%, apple juice, or apple puree.*  
*Take care to ensure the whole dose is administered.* |
| Enteral tubes | *Tablets can be crushed and dispersed in water or in glucose 5% for administration.*  
*Licensed for administration through nasogastric tubes. Take care to ensure the whole dose is administered, and flush well after each dose.*  
*Note: Dabigatran capsules must not be opened as it results in a substantial increase in drug bioavailability (+75%)* |
| **Is the patient likely to miss doses?** | **Preferred option:** Warfarin unless compliance aid helps (Edoxaban first choice, rivaroxaban and apixaban are suitable for compliance aids) |
| Warfarin | Patients with poor concordance may be at a greater risk of thromboembolic complications with NOACs as the shorter half-lives of these agents compared to warfarin will potentially result in more time without any degree of anticoagulation if a dose is missed |
| **Is the patient needle phobic?** | **Preferred option:** Warfarin
*Although there is no need for regular blood tests to monitor INR, people taking NOACs still require regular follow-up. When initiating treatment baseline tests need to be performed and patients monitored on a regular basis at least annually (see appendix 6) however less than with warfarin.*  
*Warfarin – requires frequent monitoring at least 3 monthly (note near patient testing only requires capillary blood)* |
| **Does the patient have BMI>40kg/m² or weight >120kg?** | **Preferred option:** Warfarin (local recommendation)  
*Consult with specialist if in doubt* |
9. Treatment of arrhythmia

a. Rate control strategies
Offer rate control as the first-line strategy to people with AF, except in people:
- whose AF has a reversible cause
- who have heart failure thought to be primarily caused by AF
- with new-onset AF
- with atrial flutter whose condition is considered suitable for ablation strategy to restore sinus rhythm
- for whom a rhythm control strategy would be more suitable based on clinical judgement

Key to algorithms
--- Secondary care responsibility
----------------- Primary care responsibility

Rate control strategies
(Preferred strategy for vast majority of patients)

Offer monotherapy with a **beta-blocker** (not sotalol) or a rate limiting **calcium channel blocker** as initial monotherapy to people with AF who need drug treatment as part of a rate control strategy. Base the choice of drug on the person's symptoms, heart rate, comorbidities and preferences when considering drug treatment.

Consider **digoxin** monotherapy for people with non-paroxysmal atrial fibrillation only if they are sedentary (do no or very little physical exercise) or other rate-limiting drug options are ruled out due to comorbidities or the person's preferences.

If monotherapy does not control symptoms and if continuing symptoms are thought to be due to poor ventricular rate control; consider combination therapy with any 2 of the following:
- a beta blocker
- diltiazem****
- digoxin

Refer if rate or symptoms still not controlled

---

*Beta-blockers licensed to treat AF: atenolol, acebutolol, metoprolol, nadolol, oxprenolol, propranolol. Locally bisoprolol is also routinely used for AF patients.
**Calcium channel blocker: diltiazem (unlicensed indication and need to obtain and document informed consent) or verapamil
***For people with atrial fibrillation and concomitant heart failure, follow the recommendations in NICE’s guideline on chronic heart failure.
****Unlicensed indication
b. **Rhythm control strategies**

Consider pharmacological and/or electrical rhythm control for people whose symptoms continue after heart rate has been controlled or if a rate control strategy was not successful.

**Rhythm control strategies**
(These will normally be initiated under the care of a cardiologist)

**Persistent AF**

After referral to secondary care, GP’s may be asked to prescribe amiodarone – see local guidance. Prescribing may need to continue for up to 12 months. Do not offer amiodarone for long-term rate control. Amiodarone should only be used as an interim therapy and should not usually be taken for longer than 12 months.

*Ensure communication of duration of treatment is provided to the GP*

GP to continue long term prescribing of amiodarone, see local guidance

**Paroxysmal AF**

Assess the need for drug therapy for long term rhythm control

Consider a standard beta blocker other than sotalol as first line initial treatment and continue long-term

Consultant may consider other drugs according to co-morbidities:
- Consider long term amiodarone (consultant initiation only) for people with left ventricular impairment or heart failure
- Do not offer class 1c antiarrhythmic drugs such as flecainide or propafenone to people with known ischaemic or structural heart disease
- Dronedarone in accordance with NICE TA197-AMBER follow local shared care

In patients with paroxysmal atrial fibrillation, a ‘pill-in-the-pocket’ strategy should be considered for those who:

- have no history of left ventricular dysfunction (confirmed through echo) or valvular or ischaemic heart disease and have a history of infrequent symptomatic episodes of paroxysmal atrial fibrillation and have a systolic blood pressure greater than 100 mmHg and a resting heart rate above 70 bpm and are able to understand how to, and when to take the medication

There is no definition of the frequency of paroxysmal AF. NICE do state:

“Therapy for paroxysmal AF should be tailored to the patient. For example, episodes of AF for 1 to 2 minutes once a year or for 10 hours twice a day are both paroxysmal AF, but their impact on the patient’s quality of life, if symptomatic, would be quite different. In patients with infrequent and brief paroxysms, the regular use of antiarrhythmic therapy may not be necessary (and is commonly not prescribed in current clinical practice). Such patients may be suitable for the pill-in-the-pocket approach. However, for infrequent but protracted and symptomatic paroxysmal AF, rapid cardioversion of each event and/or antiarrhythmic drug prophylaxis may be considered.”

From this they concluded “where people have infrequent paroxysms and few symptoms, or where symptoms are induced by known precipitants (such as alcohol, caffeine), a ‘no drug treatment’ strategy or a ‘pill-in-the-pocket’ strategy should be considered and discussed with the person.”
10. References


8. NICE TA 256. Rivaroxaban for the prevention of stroke and systemic embolism in people with atrial fibrillation. May 2012


11. Authors
Medicines Management, Clinical Effectiveness Team
In consultation with:
- Dr. Julia Baron, Dr. A McCance consultant cardiologist Royal Derby Hospital
- Dr. Justin Cooke, consultant cardiologist Chesterfield Royal hospital
Appendix 1: Review of patients with AF

Patients with AF are at an increased risk of stroke and should be encouraged to take anticoagulants. Discuss the risks Vs benefits at every opportunity with the patient, but not less than annually.

- For patients who are taking an anticoagulant, review the need for anticoagulation at least annually or more frequently if clinically relevant events occur affecting anticoagulation or bleeding risk.
- For patients who are not taking an anticoagulant, review stroke risk when they reach age of 65 or if they develop any of the following at any age – diabetes, HF, peripheral arterial disease, coronary heart disease, stroke, TIA or systemic thromboembolism.
- For patients who are not taking an anticoagulant because of bleeding risk or other factors, review stroke and bleeding risks at least annually and ensure all review and decisions are documented.

Appendix 2: Existing patients on treatment considered outside of current NICE guidelines

1. Existing patients on aspirin
   Aspirin monotherapy is not recommended solely for stroke prevention in people with AF. NICE concluded there was no clinical benefit of aspirin in reducing mortality and systemic emboli. There may be existing patients in primary care on aspirin monotherapy. At the next routine visit reassess the patient’s stroke and bleeding risk using the CHA2DS2-VASc and ORBIT bleeding risk scores or HAS-BLED and treat according to the guidance, to reduce the risk of stroke.

2. Existing patients on ‘no treatment’
   There will be existing patients (at low or high risk) who have chosen not to have any treatment or patients who are at low risk and so require no anti-thrombotic treatment. At the next annual review reassess these patients’ stroke and bleeding risk using the CHA2DS2-VASc and ORBIT bleeding risk scores or HAS-BLED and offer treatment again. Explore the patient’s views regarding anticoagulation and offer all therapeutic options.

3. Existing patients on dual antiplatelet therapy, solely for AF.
   NICE do not make a specific recommendation regarding dual antiplatelet solely to treat AF because they felt the potential number of patients was low. However dual therapy (with aspirin and clopidogrel) may be considered by a cardiologist in patients whom all anticoagulation is contra-indicated or not tolerated. Existing patient on dual antiplatelet solely for AF will need to be reviewed in light of the new guidance and offered anticoagulation if not done so previously.

Appendix 3: Consultant prescribing advice

1a. Patient with stable vascular disease with newly diagnosed atrial fibrillation
   Conclusive evidence of benefit for dual treatment for long term use is limited and is associated with an increased bleeding risk. The following advice is from local consultants:
   Patients with established CVD taking long term aspirin who develop AF requiring anticoagulation should usually have their aspirin stopped when INR reaches therapeutic levels.
   Do not prescribe the newer antiplatelets (ticagrelor and prasugrel) with warfarin or a NOAC in stable vascular disease.

1b. Stroke/TIA patient with newly diagnosed atrial fibrillation
   For patients taking a long term antiplatelet (usually clopidogrel) for stroke/TIA who then develop AF and require an oral anticoagulant, in most case the antiplatelet should be stopped. Stroke physicians may occasionally prescribe this combination for patients who have a further stroke despite therapeutic anticoagulation after carefully considering individual risks and benefits and that will be clearly communicated to primary care.

2. Triple therapy (dual antiplatelet and anticoagulant)
   Triple therapy combination will only be initiated under the advice of a cardiologist through a shared management plan. Example where triple therapy is indicated includes patient with AF undergoing coronary stent. GPs should not discontinue an antiplatelet without the agreement of a cardiologist.

3. Left atrial appendage devices
   In selected patients with a high stroke risk due to AF, unsuitable for anticoagulation left atrial appendage closure may be appropriate. Refer to cardiology.
Appendix 4: Antiplatelets and Anticoagulation

Antiplatelets maybe indicated in combination with anticoagulants, for other conditions associated with AF, such as myocardial infarction.

AF Patient with MI

Consider risk Vs. benefits

Offer clopidogrel with warfarin to people with a sensitivity to aspirin

Prescribe Aspirin+ warfarin

Prescribe warfarin and clopidogrel (follow consultant plan)

Consultant to consider addition of clopidogrel to treatment in people who have had an MI, who have undergone percutaneous coronary intervention (PCI) with bare-metal or drug-eluting stents and who otherwise need anticoagulation. Provide GP with clear management plan.

Limited evidence suggests that warfarin plus single antiplatelet therapy (warfarin plus clopidogrel) was more beneficial than triple therapy (warfarin plus clopidogrel and aspirin). Triple therapy increased the risk of all-cause mortality, ischaemic stroke and major bleeding and is not recommended

Do not routinely offer warfarin in combination with prasugrel or ticagrelor to people who need anticoagulation who have had an MI except on the advice of a consultant cardiologist.

Appendix 5: Antithrombotic therapy in AF patients presenting with ACS and/or undergoing PCI (This is a guide only and GPs should follow the advice of cardiologist)

In the event where a cardiologist considers a patient to require dual antiplatelet treatment with oral anticoagulation (OAC), this diagram represents the likely duration of treatment for triple therapy, dual therapy and OAC monotherapy. (European Heart Journal, 2021) 23, 1612–1676

Management of Atrial Fibrillation (AF)

Updated: February 2022  Review date: January 2025

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Appendix 6: Detailed prescribing information for NOACs
See also PCCS/PCPA/UKCPA guidance on prescribing anticoagulation in NVAF

<table>
<thead>
<tr>
<th>Edoxaban▼</th>
<th>Rivaroxaban▼</th>
<th>Apixaban▼</th>
<th>Dabigatran</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Licensed indication</strong></td>
<td>Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF) (^6,7,8,15) (with at least one additional risk factor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mechanism of action</strong></td>
<td>Direct &amp; reversible inhibitor of factor Xa</td>
<td>Direct factor Xa inhibitor</td>
<td>Direct inhibitor of factor Xa</td>
</tr>
<tr>
<td><strong>Standard Doses</strong></td>
<td>60mg once daily</td>
<td>20mg once daily</td>
<td>5mg twice daily</td>
</tr>
<tr>
<td>30mg once daily in</td>
<td>15mg once daily in</td>
<td>2.5mg twice daily in</td>
<td>110mg twice daily in</td>
</tr>
<tr>
<td>• CrCl 15-50ml/min</td>
<td>• CrCl 30-49 ml/min</td>
<td>• CrCl 15-29mL/min (use with caution)²</td>
<td>• Age ≥ 80 years or taking verapamil</td>
</tr>
<tr>
<td>• Body weight ≤60kg</td>
<td>• 2 or more of the following:</td>
<td>• Consider if:</td>
<td></td>
</tr>
<tr>
<td>• Concomitant P-glycoprotein inhibitors – ciclosporin, dronedarone, erythromycin, ketoconazole</td>
<td>o age &gt;80 yrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o body weight ≤60kg or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o serum Cr &gt;133micromol/l</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose reduction</td>
<td>Take with or without food</td>
<td>Take with food to increase absorption. Maybe crushed and put through NG tube if required (see p.10)</td>
<td>Take with or without food may be crushed and put through NG tube if required (see p.10)</td>
</tr>
<tr>
<td><strong>Administration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal impairment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(see additional advice above in Doses)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patients must have a baseline renal function test before initiating NOAC. Renal function can decline while on treatment hence monitor as suggested in the monitoring section below.

In practice eGFR and CrCL are not interchangeable; however for most drugs and for most patients (over 18 years) of average build and height, eGFR could provide some guidance. The SPC of each NOAC recommends that ‘Cockcroft and Gault’ formula is used for dosing and monitoring

**Cockcroft and Gault formula:** CrCL = \((140 - \text{Age}) \times \text{Weight} \times \text{Constant}\)

**Serum creatinine**

\[\text{Constant} = 1.23 \text{ (Men)}; 1.04 \text{ (Women)}\]

\(\text{Serum creatinine (in micromole/litre)}\)


For practical purposes when calculating CrCl for NOAC dosing, many clinicians use the embedded calculator in the GP clinical system. If using the embedded calculator in SystmOne, ensure the creatine clearance using actual body weight is used. NB. It is very important to ensure that up-to-date weight & creatinine are used. MHRA May 2023 Ensure all patients with renal impairment receive an appropriate DOAC dose and monitor renal function during treatment to ensure dose remains appropriate.
<table>
<thead>
<tr>
<th>Renal impairment (see additional advice above in Doses)</th>
<th>Edoxaban▼</th>
<th>Rivaroxaban▼</th>
<th>Apixaban▼</th>
<th>Dabigatran</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraindicated / Not recommended</strong></td>
<td>CrCl&lt;15ml/min</td>
<td>CrCl&lt;15ml/min</td>
<td>CrCl&lt;15ml/min</td>
<td>CrCl&lt;30ml/min</td>
</tr>
<tr>
<td><strong>Cautions See also individual SPCs</strong></td>
<td>CrCl&gt;95ml/min :- Consider alternative NOAC in line with SmPC* (e.g. rivaroxaban 20mg once daily), See UKCPA/PCCS/PCPA advice</td>
<td>CrCl&lt;30ml/min</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>notes</strong></td>
<td>During clinical development the Cockcroft-Gault formula was used to calculate CrCl.</td>
<td>The manufacturer’s advice to use actual bodyweight for all patients when calculating CrCl. (Actual body weight was used in the clinical trials)</td>
<td>The manufacturer’s advice to use actual bodyweight for all patients (Actual body weight was used in the clinical trials)</td>
<td>The manufacturer’s advice to use ideal bodyweight (IBW) in patients who are overweight and actual body weight should be used in underweight patients. The Devine formula can be used to calculate IBW (should only be used for patients over 5 feet in height): • For Male = 50kg + (2.3kg x height in inches over 5 feet) For Female = 45.5kg + (2.3kg x height in inches over 5 feet)</td>
</tr>
</tbody>
</table>

### Hepatic impairment

- Not recommended in severe hepatic impairment.
- Contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk.
- Use with caution as requires hepatic metabolism.
- Contraindicated in hepatic disease associated with coagulopathy and clinically relevant bleeding risk including cirrhotic patients with Child Pugh B & C
- Not recommended in severe hepatic impairment as requires hepatic metabolism.
- Contraindicated in hepatic disease associated with coagulopathy and clinically relevant bleeding risk
- Not recommended in patients with elevated liver enzymes >2 upper limit of normal.
- Contraindicated in patients with hepatic impairment or liver disease expected to impact on survival

### Contraindications (C/I) (list not exhaustive – refer to current SPC)

- Hypersensitivity
- Active bleeding
- Mechanical prosthetic heart valves
- Moderate to severe rheumatic mitral stenosis
- Pregnancy and breast feeding
- Uncontrolled severe hypertension (for edoxaban)
- Moderate to severe rheumatic mitral stenosis (for edoxaban)
- CrCL< 15ml/min (CrCl<30ml/min for dabigatran)

- Concomitant treatment with any other anticoagulant (except during switching -see below)
- A lesion or condition, if considered a significant risk factor for major bleeding
- Hepatic disease associated with coagulopathy and clinically relevant bleeding risk
- See also interactions section below.

NOACs are not recommended in patients with antiphospholipid syndrome, particularly high-risk patients (those who test positive for all 3 antiphospholipid tests — lupus anticoagulant, antcardiolipin antibodies, and anti-beta 2 glycoprotein I antibodies) see MHRA June 2019
### Interactions
*(list not exhaustive – refer to current SPC)*

- **Edoxaban▼**
  - Concomitant use with P-gp inhibitor (e.g., ciclosporin, dronedarone, erythromycin, or ketoconazole) **requires dose reduction to 30mg once daily.**
  - Use with caution when co-administered with P-gp inducers (e.g., phenytoin, carbamazepine, St. John's Wort or phenobarbital)
  - Avoid concomitant treatment with strong inhibitors of both CYP3A4 and P-gp e.g., ketoconazole, itraconazole, voriconazole or HIV protease inhibitors
  - Concomitant administration of a strong CYP3A4 inducers (e.g., rifampicin, phenytoin, carbamazepine, phenobarbital or St. John's Wort) should be avoided.
  - Concomitant use of rivaroxaban and dronedarone is not recommended

- **Rivaroxaban▼**
  - Avoid concomitant treatment with strong inhibitors of both CYP3A4 and P-gp e.g., ketoconazole, itraconazole, voriconazole or HIV protease inhibitors

- **Apixaban▼**
  - Avoid concomitant use with strong inhibitors of both CYP3A4 and P-gp e.g., ketoconazole, itraconazole, voriconazole or HIV protease inhibitors
  - Concomitant use with strong CYP3A4 inducers e.g., rifampicin, phenytoin, carbamazepine, phenobarbital or St. John’s Wort should be avoided

- **Dabigatran**
  - Concomitant use with P-gp inducers (e.g., rifampicin, St. Jon’s Wort, carbamazepine, or phenytoin) should be avoided.
  - SSRIs and SNRIs increased the risk of bleeding in RE-LY in all treatment groups
  - Concomitant treatment with systemic ketoconazole, cyclosporine, itraconazole, tacrolimus and dronedarone is contraindicated

Caution in patients treated concomitantly with NSAIDs (including acetylsalicylic acid) and anti-platelets as these typically increase the risk of bleeding (See SPC for further details)

### Monitoring

**Baseline monitoring:** clotting screening
- serum creatinine (for creatinine clearance) (Cockcroft and Gault is recommended for calculating creatinine clearance for DOACs)
- FBC
- liver function tests
- Body weight *(SPS – monitoring)*

**SPS suggests NOAC review appointment is carried out every 3 months (best practice) to assess:**
- Compliance and reinforce advice regarding the importance of a regular dosing schedule. (see 6-month non-persistence section below)
- Adverse effects or signs of bleeding or anaemia; Thromboembolic events (e.g. symptoms of stroke or breathlessness)
- Drug interactions & modifiable risk factors for bleeding e.g. uncontrolled hypertension; and check NOAC dosing

**Repeat renal and liver function tests and FBC at least annually, and more frequently if the patient has the following:**
- Renal impairment. Check renal function:
  - every 6 months if CrCl 30-60ml/min
  - every 3 months if CrCl 15-30ml/min (Dabigatran C/I in CrCl<30ml/min)
- Intercurrent acute illness that may impact on renal/hepatic function e.g. infections, acute heart failure. Repeat renal & liver functions tests as needed
  - *Patients need to be alerted that in such situations they should seek contact with their healthcare provider.*
  - check renal function every 6 months if patient has additional risk factors e.g., frail, multiple co-morbidities or age ≥75 years

**If renal function has declined review treatment, as NOAC may need to be stopped or a lower dose may be required- see renal section above**
<table>
<thead>
<tr>
<th></th>
<th>Edoxaban▼</th>
<th>Rivaroxaban▼</th>
<th>Apixaban▼</th>
<th>Dabigatran</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (≥80 yrs)</strong></td>
<td>No dose reduction is required</td>
<td>No dose reduction unless age related renal impairment</td>
<td>Consider dose reduction in ≥80yrs - 2.5mg twice daily only when patient also has either: body weight ≤60kg or serum Cr &gt;133micromole/l</td>
<td>Use reduced dose -110mg twice daily</td>
</tr>
<tr>
<td><strong>Pregnancy &amp; breastfeeding</strong></td>
<td>Contraindicated</td>
<td>Contraindicated</td>
<td>Not recommended</td>
<td>Not recommended</td>
</tr>
<tr>
<td><strong>Mechanical prosthetic heart valve</strong></td>
<td>Not studied – not recommended</td>
<td>Not studied – not recommended</td>
<td>Not studied – not recommended</td>
<td>Contraindicated</td>
</tr>
<tr>
<td><strong>Moderate to severe rheumatic mitral valve disease</strong></td>
<td>Not studied – not recommended</td>
<td>Not studied – not recommended</td>
<td>Not studied – not recommended</td>
<td>Not studied – not recommended</td>
</tr>
<tr>
<td><strong>Extremes of BMI</strong></td>
<td>Warfarin is locally recommended in patients with BMI ≥ 40 kg/m^2 or weight ≥120kg because there are limited clinical data available for NOAC for patients at extreme weight, and available pharmacokinetics/pharmacodynamics evidence suggests that decreased drug exposures, reduced peak concentrations and shorter half-lives occur with increased weight (concerns about underdosing). Consult with specialist if in doubt. Exposure of NOACs may vary by 20-30% at extremes of bodyweight (&lt;50 kg or &gt;100-120 kg). This may be problematic given the difficulties in monitoring the therapeutic effects. It is recommended that Cockcroft and Gault formula is used to calculate CrCL to adjust NOAC dosage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Poor adherence</strong></td>
<td>NOACs have shorter half-life therefore missed doses may result in more time without any anticoagulation and greater risk of thromboembolic complications. Once daily dosing (edoxaban &amp; rivaroxaban) may support concordance Warfarin – longer half-life and once a day dosing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Missed dose</strong></td>
<td>Missed dose should be taken immediately and then continued the following day with the once-daily intake as before. Do not double dose within the same day to make up for missed dose.</td>
<td>Missed dose should be taken immediately and then continued on the following day with once-a-day dosing. Do not double dose within the same day to make up for missed dose.</td>
<td>Missed dose should be taken immediately and then continued with twice a day as before. Do not double dose within the same day to make up for missed dose.</td>
<td>Missed dose may still be taken up to 6 hours prior to next scheduled dose. If within 6 hours of next dose, the missed dose should be omitted</td>
</tr>
<tr>
<td><strong>Requirement for compliance aid</strong></td>
<td>Shelf-life of 5 years and no special storage requirement. Stable outside of original packaging for 3 months at 40°C and 75% relative humidity (personal communication with company)</td>
<td>Shelf-life of 3 years and no special storage requirement – can be used in compliance aids</td>
<td>Shelf-life of 3 years and no special storage requirement – can be used in compliance aids</td>
<td>Not suitable for compliance aids</td>
</tr>
</tbody>
</table>
### Reversibility

<table>
<thead>
<tr>
<th><strong>Edoxaban</strong> ▼</th>
<th><strong>Rivaroxaban</strong> ▼</th>
<th><strong>Apixaban</strong> ▼</th>
<th><strong>Dabigatran</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemodialysis does not significantly contribute to edoxaban clearance. (SPC: 4-hour haemodialysis session reduced total edoxaban exposures by less than 9%)</td>
<td>A specific reversal agent (andexanet alfa), which antagonises the pharmacodynamics effect of rivaroxaban is available. However currently there is very limited clinical experience. Data suggest reversibility with prothrombin complex concentrate (PCC) has been successful; however currently there is very limited clinical experience. The use of activated charcoal to reduce absorption in case of rivaroxaban overdose may be considered</td>
<td>Haemodialysis is unlikely to clear apixaban and currently there is no antidote. Data suggest reversibility with prothrombin complex concentrate (PCC) has been successful; however currently there is very limited clinical experience. Administration of activated charcoal reduces apixaban exposure</td>
<td>For situations of life-threatening or uncontrolled bleeding, when rapid reversal of the anticoagulation effect of dabigatran is required, the specific reversal agent – idarucizumab (Praxbind)) is available. The SPC states haemodialysis will also clear dabigatran. Therefore, the use of idarucizumab or haemodialysis can be used in the case of uncontrolled bleeding associated with dabigatran therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Conversion from warfarin to NOAC</strong> (consult locally agreed pathways if available)</th>
<th><strong>Conversion from NOAC to warfarin/alternative NOAC</strong> (consult locally agreed pathways if available)</th>
<th><strong>Minor/ Nuisance Bleeding</strong>&lt;sup&gt;18&lt;/sup&gt;</th>
<th><strong>Before surgery</strong> (see SPC for details)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discontinue warfarin and start edoxaban when the INR is ≤ 2.5</td>
<td>NOACs have shorter half-life and converting a NOAC to an alternative NOAC should be theoretically uncomplicated. (see SPC for specific advice)</td>
<td>Nuisance bleeds can usually be managed by delaying intake or withholding the NOAC for a maximum of one dose. Minor bleedings may require more aggressive therapy with a focus aimed at treating the cause of the bleeding (e.g., PPI for gastric ulcers, antibiotics for UTI, etc.).</td>
<td>Edoxaban should be stopped as soon as possible and preferably at least 24 hours before the procedure. In deciding whether a procedure should be delayed until 24 hours after the last dose of edoxaban, the increased risk of bleeding should be weighed against the urgency of the intervention.</td>
</tr>
</tbody>
</table>

#### Conversion from warfarin to NOAC

Discontinue warfarin and start edoxaban when the INR is ≤ 2.5

#### Conversion from NOAC to warfarin/alternative NOAC

Because of the slow onset of action of warfarin, it may take 5–10 days before the INR is in the therapeutic range, with large individual variations. Therefore, the NOAC and warfarin should be administered concomitantly until the INR is in a range. As NOACs may have an impact on INR measurements, it is important that the INR is measured

- just before the next intake of the NOAC during concomitant administration and
- is re-measured early after stopping the NOAC to assure adequate anticoagulation.

It is also recommended to closely monitor INRs within the first month until stable values have been attained (i.e., three consecutive measurements within therapeutic range).

#### Minor/ Nuisance Bleeding

Nuisance bleeds can usually be managed by delaying intake or withholding the NOAC for a maximum of one dose. Minor bleedings may require more aggressive therapy with a focus aimed at treating the cause of the bleeding (e.g., PPI for gastric ulcers, antibiotics for UTI, etc.).

#### Before surgery

If the procedure cannot be delayed the increased risk of bleeding should be assessed against the urgency of the intervention.
<table>
<thead>
<tr>
<th>Efficacy for stroke prevention</th>
<th>Edoxaban▼</th>
<th>Rivaroxaban▼</th>
<th>Apixaban▼</th>
<th>Dabigatran</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-inferior to warfarin</td>
<td>Non-inferior to warfarin (ENGAGE AF-TIMI 48)&lt;sup&gt;16&lt;/sup&gt;</td>
<td>Non-inferior to warfarin (ROCKET-AF)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Superior to warfarin (ARISTOTLE)&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Slightly superior to warfarin with 150mg twice daily dose. Non-inferior to warfarin with 110mg twice daily dose (RE-LY)&lt;sup&gt;13&lt;/sup&gt;</td>
</tr>
<tr>
<td>Risk compared to warfarin</td>
<td>Major bleed</td>
<td>Reduced risk (ENGAGE AF-TIMI 48)&lt;sup&gt;16&lt;/sup&gt;</td>
<td>Similar risk (ROCKET-AF)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Reduced risk (ARISTOTLE)&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Intracranial bleed</td>
<td>Reduced risk (ENGAGE AF-TIMI 48)&lt;sup&gt;16&lt;/sup&gt;</td>
<td>Reduced risk (ROCKET-AF)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Reduced risk (ARISTOTLE)&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Major GI bleed</td>
<td>Increased risk with high dose edoxaban (60mg od)</td>
<td>Increased risk (ROCKET-AF)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Similar risk (ARISTOTLE)&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>dyspepsia/ upper GI side effects</td>
<td>Not reported</td>
<td>Similar risk of dyspepsia (ROCKET-AF)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Non-reported (ARISTOTLE)&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>MI</td>
<td>Reduced risk but not statistically significant</td>
<td>Reduced risk but trend did not reach statistical significance (ROCKET-AF)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Reduced risk (ARISTOTLE)&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mean time in therapeutic range</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-month non-persistence</td>
<td>No evidence</td>
<td>Evidence reinforces 3-monthly compliance check for NOACs</td>
<td>Evidence reinforces 3-monthly compliance check for NOACs</td>
<td>No evidence</td>
</tr>
</tbody>
</table>

Table adapted from and thanks to Greater Manchester Commissioning Support Unit Medicines Optimisation Team
Appendix 7: CHA2DS2-VASc score and stroke risk table

<table>
<thead>
<tr>
<th>CHA2DS2-VASc Score</th>
<th>n</th>
<th>Events per 100 patients/year</th>
<th>Ischaemic stroke</th>
<th>Stroke/TIA/ peripheral emboli</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>5343</td>
<td>0.2</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>6770</td>
<td>0.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>11,240</td>
<td>2.5</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>17,689</td>
<td>3.7</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>19,091</td>
<td>5.5</td>
<td>7.8</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>14,488</td>
<td>8.4</td>
<td>11.7</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>9577</td>
<td>11.4</td>
<td>15.9</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>4465</td>
<td>13.1</td>
<td>18.4</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>1559</td>
<td>12.6</td>
<td>17.9</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>268</td>
<td>14.4</td>
<td>20.3</td>
<td></td>
</tr>
</tbody>
</table>


Appendix 8: Resources for patients

- Atrial fibrillation: diagnosis and management, NICE Guideline NG196, updated 10/06/21, accessed 28/06/21, [https://www.nice.org.uk/guidance/ng196](https://www.nice.org.uk/guidance/ng196)
- British Heart Foundation: [https://www.bhf.org.uk/informationsupport/conditions/atrial-fibrillation](https://www.bhf.org.uk/informationsupport/conditions/atrial-fibrillation)