New anticoagulants for prevention of CVA in patients with A. fib position statement

Background:

1) New anticoagulants, dabigatran (Pradax) and rivaroxaban (Xarelto), are being used more and more in James Bay for prevention of strokes in patients with non-valvular A. fib.
2) A significant concern is that there is no antidote in the case of major bleeding for these new medications.

Summary of new anticoagulants:

1) Higher dose dabigatran (150mg bid) seems to prevent CVA's better than warfarin. Rivaroxaban and lower dose dabigatran (110mg bid) is non-inferior to warfarin.
2) Warfarin, dabigatran and rivaroxaban all cause similar rates of major bleeding.
3) There is a higher rate of GI bleeding for patients on dabigatran and rivaroxaban compared to warfarin but lower rates of intracranial bleeding.
4) Bleeding in patients on dabigatran and rivaroxaban may be more problematic given that there is no antidote.
5) If someone on dabigatran or rivaroxaban bleeds in our region it is even more problematic as we have no timely access to G/C scopes, CT, neurosurgeons, etc.

**refer to INESSS document: “Fibrillation auriculaire chez l’adulte – Choix de l’anticoagulotherapie” for more detailed discussion

Conclusion:

Warfarin will continue to be first line for CVA prevention in patients with atrial fibrillation (non-valvular) however there is still a role for the newer anticoagulants in James Bay. The indications for starting dabigatran or rivaroxaban are

1) patients with very labile INRs and/or
2) where following their INR would be difficult (same criteria as for medicaments d’exception). This may be especially true in the case of patients who may spend a significant time in the bush and returning to the clinic regularly for INR checks poses a challenge.

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The risks and benefits of anticoagulation needs to be clearly explained to the patients. Patients on dabigatran or rivaroxaban should have their renal function monitored closely.

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