Decision pathway addresses bleeding in patients on oral anticoagulants

ACP Hospitalist Weekly Staff

The American College of Cardiology released guidance last week on managing major and nonmajor bleeding in any patient treated with direct-acting oral anticoagulants or vitamin K antagonists.

Bleeding is considered major if it is at a critical site, if there is hemodynamic instability, or if it is overt with a decrease in hemoglobin level of at least 2 g/dL or if two or more units of packed red blood cells are administered, the pathway said. If a patient taking anticoagulants presents with clinically relevant bleeding or if an urgent unplanned procedure is needed, anticoagulant activity must be measured, it noted. In patients with major bleeds, anticoagulants and antiplatelet agents should be discontinued, and airway and large-bore IV access should be secured. While reversal of oral anticoagulation is recommended in most patients if an agent is available, resuscitation and local hemostatic measures should not be delayed to obtain the agent, the pathway said. Local measures to control ongoing bleeding and/or hemodynamic instability, such as pressure and packing, should be combined with volume resuscitation, and aggressive volume resuscitation with IV isotonic crystalloids is also recommended.

For nonmajor bleeding, the pathway does not support routine reversal of oral anticoagulants, although temporary discontinuation is often advisable, the pathway said. Decisions about temporarily holding oral anticoagulants should be made according to individual patient characteristics, the nature of the bleeding, and anticoagulation intensity, the pathway advised. The patient and family should also be involved in the discussion, which should consider whether the anticoagulation is supratherapeutic or therapeutic, whether an invasive procedure is needed soon, whether the underlying bleeding risk has changed, whether additional diagnostic evaluation of the bleeding is warranted, whether baseline severe anemia is present, whether the patient has relevant medical comorbid conditions that require observation, and whether there is concern about slow bleeding from a critical site that requires repeated imaging, the pathway said.

The pathway noted that restarting oral anticoagulants after a bleeding event has net clinical benefit in most cases but that indications for such therapy should first be reassessed. Oral anticoagulants may no longer be indicated in patients who have nonvalvular atrial fibrillation with a CHA_2DS_2-VASc score of less than 2 in men or less than 3 in women, recovered acute stress cardiomyopathy, first-time provoked venous thromboembolism at least three months earlier, or bioprosthetic valve replacement without atrial fibrillation at least three months earlier. In addition, some indications for oral anticoagulants are temporary, the pathway noted, such as postsurgical prophylaxis. In patients with an ongoing indication for oral anticoagulants and a recent bleeding episode, the net clinical benefit of the therapy should be weighed against future bleeding risk, preferably in consultation with other clinicians as well as patients and family members, the pathway said.

The pathway, which offers additional recommendations on laboratory measurement, reversal and hemostatic strategies, and timing of anticoagulation reinitiation and includes several figures and algorithms to help guide care, was published by the *Journal of the American College of Cardiology* on July 14.