

cardioversion

Prevalence of Left Atrial Thrombus Detection by Transesophageal Echocardiography

A Comparison of Continuous Non-Vitamin K Antagonist
Oral Anticoagulant Versus Warfarin Therapy in Patients
Undergoing Catheter Ablation for Atrial Fibrillation

4,4%

AF \geq 4 weeks of therapy NOACs



Emboic Events in Patients With Atrial Fibrillation and Effective Anticoagulation: Value of Transesophageal Echocardiography to Guide Direct-Current Cardioversion

Final Results of the Ludwigshafen Observational Cardioversion Study

7,7%

AF and effective anticoagulation



Principal efficacy outcome



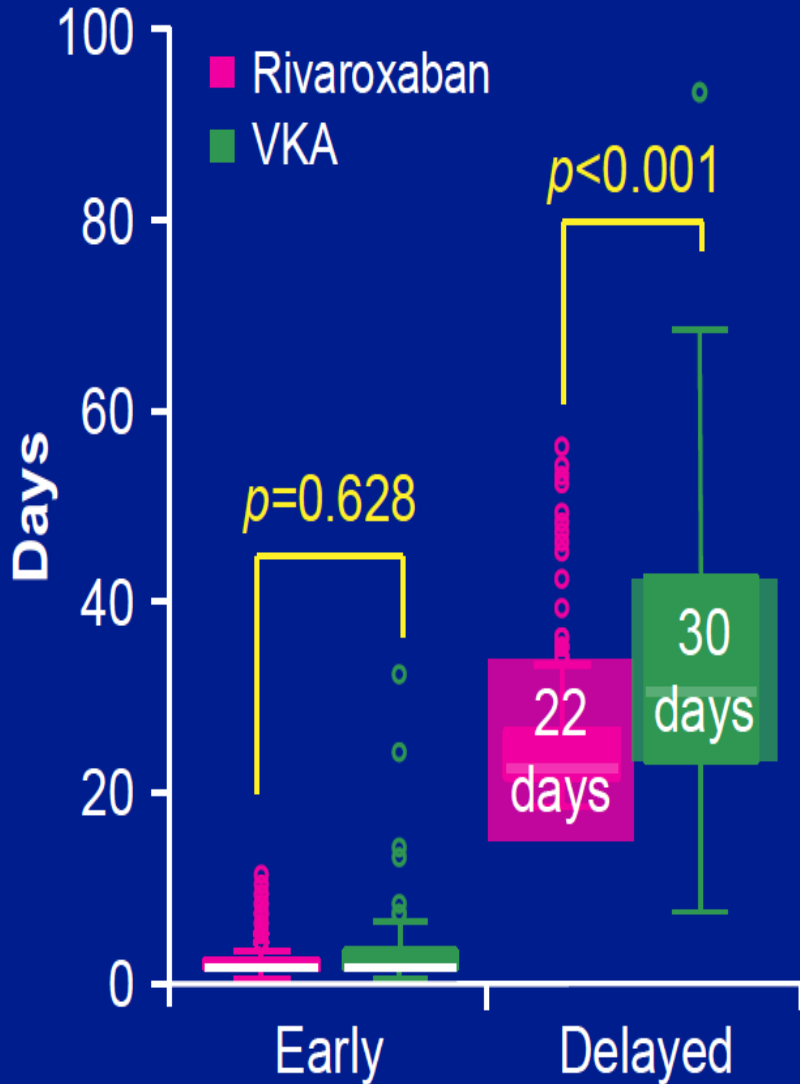
	Rivaroxaban (N=978)		VKA (N=492)		Risk ratio (95% CI)
	%	n*	%	n*	
Primary efficacy outcome	0.51	5	1.02	5	0.50 (0.15–1.73)
Stroke	0.20	2	0.41	2	
Haemorrhagic stroke	0.20	2		0	
Ischaemic stroke		0	0.41	2	
TIA		0		0	
Non-CNS SE		0	0.20	1	
MI	0.10	1	0.20	1	
Cardiovascular death	0.41	4	0.41	2	

Principal safety outcome

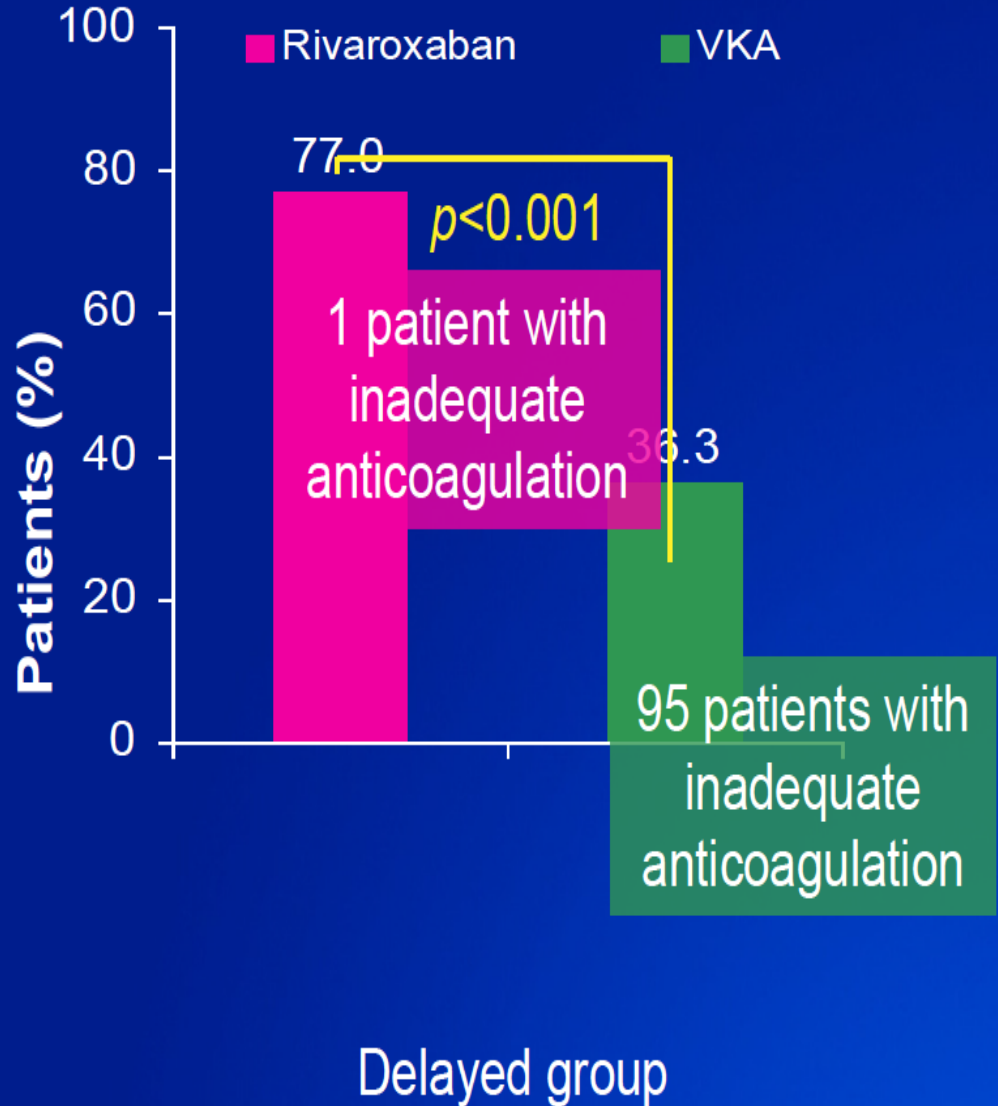


	Rivaroxaban (N=988)		VKA (N=499)		Risk ratio (95% CI)
	%	n*	%	n*	
Major bleeding	0.61	6	0.80	4	0.76 (0.21–2.67)
Fatal	0.1	1	0.4	2	
Critical-site bleeding	0.2	2	0.6	3	
Intracranial haemorrhage	0.2	2	0.2	1	
Hb decrease ≥ 2 g/dl	0.4	4	0.2	1	
Transfusion of ≥ 2 units of packed RBCs or whole blood	0.3	3	0.2	1	

Median time to cardioversion

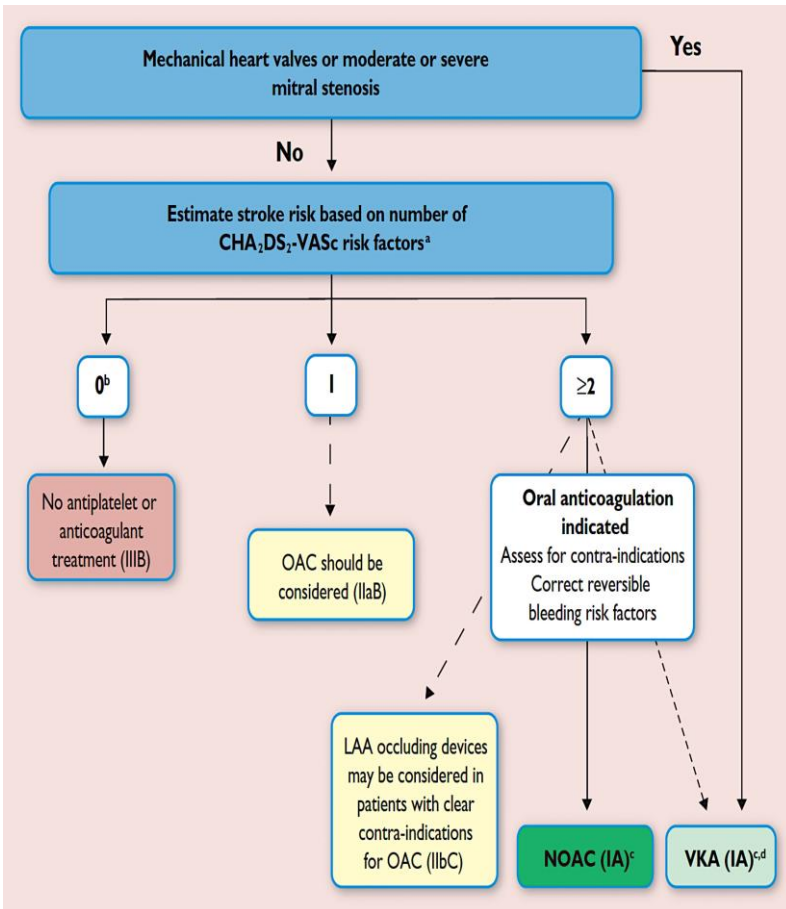


Patients cardioverted as scheduled*



TRT

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



Recommendations

Vitamin K antagonist therapy (INR 2.0–3.0 or higher) is recommended for stroke prevention in AF patients with moderate-to-severe mitral stenosis or mechanical heart valves.

When oral anticoagulation is initiated in a patient with AF who is eligible for a NOAC (apixaban, dabigatran, edoxaban, or rivaroxaban), a NOAC is recommended in preference to a Vitamin K antagonist.

Class ^a	Level ^b
I	B
I	A

practical guide NOAC

Last intake of drug before elective surgical intervention

Dabigatran

Apixaban–Edoxaban–Rivaroxaban

No important bleeding risk and/or adequate local haemostasis possible: perform at trough level (i.e. ≥ 12 or 24 h after last intake)

Low risk

High risk

Low risk

High risk

CrCl ≥ 80 mL/min	≥ 24 h	≥ 48 h	≥ 24 h	≥ 48 h
CrCl 50–80 mL/min	≥ 36 h	≥ 72 h	≥ 24 h	≥ 48 h
CrCl 30–50 mL/min ^a	≥ 48 h	≥ 96 h	≥ 24 h	≥ 48 h
CrCl 15–30 mL/min ^a	Not indicated	Not indicated	≥ 36 h	≥ 48 h
CrCl < 15 mL/min	No official indication for use			

There is no need for pre-operative bridging with LMWH/UFH

Bleeding while using a NOAC

- Inquire about last NOAC intake
- Blood sample to determine creatinine (clearance), hemoglobin and WBC
- Inquire lab on possibility for rapid coagulation assessment

Mild bleeding

- Delay or discontinue next dose
- Reconsider concomitant medication

Moderate severe bleeding

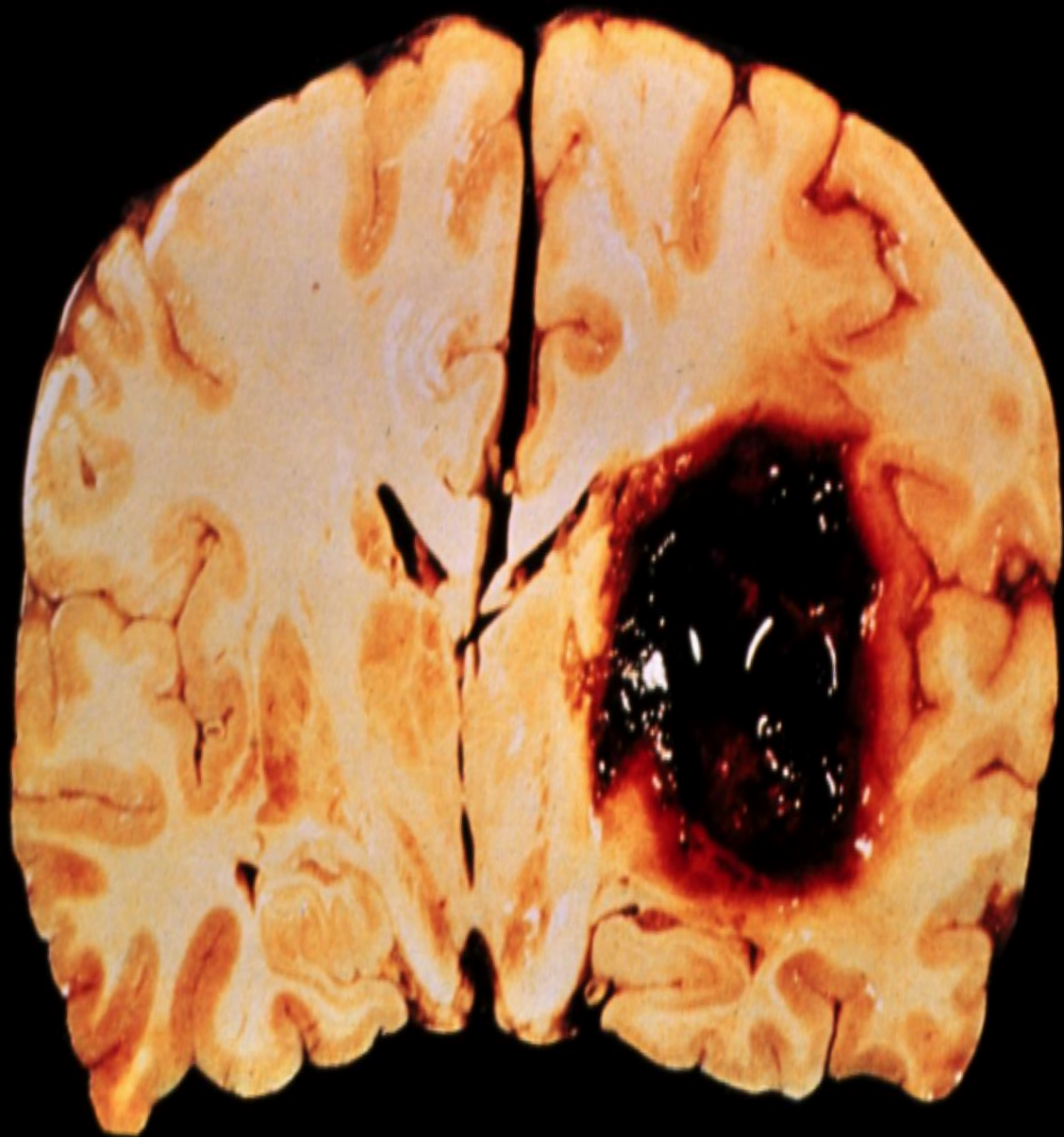
- Supportive measures :
- mechanical compression
 - endoscopic hemostasis if gastro-intestinal bleed
 - surgical hemostasis
 - fluid replacement (colloids if needed)
 - RBC substitution if needed
 - fresh frozen plasma (as plasma expander)
 - platelet substitution (if platelet count $\leq 60 \times 10^9/L$)
- For dabigatran:
- maintain adequate diuresis
 - consider hemodialysis
 - consider idarucizumab 5g IV (approval pending)
 - (charcoal haemoperfusion?)

Life-threatening bleeding

- For dabigatran-treated patients: idarucizumab 5g IV
- Otherwise, consider:
- PCC (e.g. Beriplex[®], CoFact[®]) 50 U/kg; +25 U/kg if indicated
 - aPCC (Feiba[®]) 50 U/kg; max 200 U/kg/day
 - ((rFVIIa (NovoSeven[®]) 90 $\mu\text{g/kg}$ no data about additional benefit))







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gracias por vuestra atención

