## Questions and Answers from the SEL DOAC Educational Webinars, November 2020

Take home message: "*If your patient has anything to lose by having an ischaemic AF-related stroke, please anticoagulate effectively*"

| QUESTION | ANSWER |
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| **Renal function monitoring:** | |
| **1) You said we should use actual body weight, but what about overweight patients? How do we calculate adjusted Body weight? Do you have a preferred website to use?** | If weight >120kg, in secondary care they use adjusted body weight to calculate creatinine clearance (CrCl).<br>For primary care, use the MD-calc app or website: www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation<br>Calculate CrCl using actual body weight, for weights 50kg-120kg. Ignore height if between these weights.<br>When using MDCALC, if you add the height for a patient over 120kg, the adjusted body weight will automatically be calculated to determine an accurate renal function.<br>See guidance: calculating renal function when monitoring DOACs |
| **2) Should patients with creatinine clearance >95ml/min be referred to secondary care?** | Currently, edoxaban is the only DOAC agent with a caution in high renal clearances in the SPC: https://www.medicines.org.uk/emc/product/6905/smpc. On referral to secondary care, anticoagulation clinics are able to check levels to determine if the DOAC is providing effective anticoagulation or if the agent may require switching. If patients are tolerating edoxaban well, it is effective and adherence is good, then switching agent may not be the safest option. |
| **Liver function monitoring:** | |
| **3) Which liver function tests (LFTs) are required?** | For DOACs, don't worry too much about an isolated mildly raised GGT if the other LFTs are normal: discuss reducing alcohol intake. AST, ALP and bilirubin are the most important liver function tests to review with DOAC therapy. |
| **Anticoagulation and antiplatelets:** | |
| **4) If a patient was on aspirin after ischaemia but now has been initiated on rivaroxaban. Can aspirin be stopped?** | Aspirin should be reviewed to reduce bleeding risk. If the patient has not experienced a cardiac event (MI/PCI/ischaemia) within the last year then it may be possible to stop aspirin. Ideally, review antiplatelets with cardiology or anticoagulation team support. |
| **5) How should triple therapy be reviewed?** | Patients taking dual antiplatelet therapy following a cardiac event should have a duration plan, especially if prescribed with anticoagulation. Advice and guidance (cardiology/haematology) may be useful if durations are not clear. |

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| **6) When conducting SMRs- some pts are on both clopidogrel and aspirin- which one is superior with less risk? As some cardiologists are suggesting clopidogrel indefinitely and stopping aspirin, as historically we stopped clopidogrel after a year?** | Local cardiovascular protocols may vary: ESC guidance states a preference for aspirin long term but new NICE guidance for ACS published 18/11/20 states clopidogrel long term if stented and aspirin long term for medical management in combination with anticoagulation: https://www.nice.org.uk/guidance/ng185<br>For patients prescribed antiplatelet and anticoagulation long term consider PPI protection. |
| **7) How long can a patient take a combination of edoxaban and aspirin for?** | No maximum time but aim is to stop antiplatelets as soon as it is safe to do so considering CVD risk, length of time since cardiac event and bleeding risk. This should be reviewed each year as part of the DOAC review. |
| **8) Use of PPI prophylaxis with antiplatelets, anti-coagulants in at risk patients is good practice but there is no national guidance on dosage. What is the preferred PPI for patients who are on DOAC but cannot modify the risk of GI bleed?** | For PPI prophylaxis: first line in SEL is omeprazole 20mg daily. But PPI choice may depend on potential interactions with other medications, if a blister pack is required, and if the patient has swallowing difficulties eg. lansoprazole is prescribed in combination with clopidogrel and in patients with swallowing difficulties. |
| **DOAC Interactions:** | |
| **9) Are there any herbal remedies that are known to interact with DOACs?** | In particular: St John's wort, garlic capsules (antiplatelet effects) and turmeric.<br>Fish oils would have to be taken in very large quantities to affect anticoagulation- often prescribed to treat hyperlipidaemia.<br>UKMI link: https://www.sps.nhs.uk/articles/is-it-safe-to-take-herbal-medicines-with-non-vitamin-k-antagonist-oral-anticoagulants-noacs/ |
| **10) Should SSRI antidepressants be reviewed with DOAC therapy?** | SSRI medication may contribute to the bleeding risk for patients taking anticoagulation and should be reviewed if possible with the patient along with any other modifiable bleeding risk factors. For many patients, it may not be possible to stop antidepressants and, if the patient is high bleeding risk, then PPI prophylaxis should be considered. |
| **DOAC patient pathway queries:** | |
| **11) For hospitals outside of SEL e.g. Darent valley, is there a standard initiation quantity for DOAC e.g. 1 month/3 months before we** | Current variations in practice across London and Surrey, please check with the discharging hospital medicines information department for queries. |

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| **can take over in primary care?** | |
| **12) I recently referred a patient to be anticoagulated after an AF diagnosis at UHL. Her appointment was 4 months in the future. One of our of doctors has initiated anticoagulation in primary care as this wait seemed a long time in the future! Has anyone else experienced such long delays?** | Waiting times for AC clinic can be up to 12 weeks currently, the aim is to see new patients within 2 weeks of an NVAF diagnosis. With the new DOAC pathways, AC clinics will be focussing on high risk and new initiations with the aim of reducing waiting times. |
| **13) Just to confirm: a specific transfer of DOAC prescribing form is no longer needed - a detailed clinic letter or discharge summary replaces this. 1 month supply of DOAC from secondary care for AF, 3 month supply of DOAC from secondary care for VTE?** | Yes this is the new DOAC pathway from 1st October in SEL |
| **14) Can primary care adjust DOAC dosing or should these patients be referred to secondary care?** | If you are ever unsure please ask anticoagulation clinics for advice: For NVAF patients please follow the SPC: www.medicines.org.uk/emc for each DOAC and refer to the SEL DOAC initiation/monitoring guidance for dosing regimes. For VTE patients, please refer to the initiating AC clinic for support with dosing. |
| **15) Is first initiation of DOAC always advised to be done by secondary care? Or Can GP's initiate and pharmacists review in low risk pts?** | At the moment this varies across SEL and is being reviewed. We are supporting DOAC review by GPs and pharmacists at this stage. |
| **16) Is Edoxaban first line for NVAF in SEL?** | Yes, cost-effective once daily dosing: see choice of anticoagulation for stroke prevention in NVAF<br>In addition, Edoxaban is the only DOAC with a dose reduction purely for low body weight (drop to 30mg OD when under 60kg) - useful for low body weight patients who have normal renal function.<br>Edoxaban contains no lactose - useful if lactose intolerant. |
| **17) We need to code Transfer of Care on EMIS. What to do if DOAC was initiated long time ago when procedures were different, no letter available?** | AC clinics will no longer be chasing historic TOC forms from the end of December as the clinical information is not current |
| **18) Please, it would be useful if you put in** | For DOAC patients, AC clinics will be focusing on high risk patients- criteria in DOAC pathway for NVAF, |

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| **summary how to choose who to refer for Doac or warfarin as this is what anticoag have put to GPs to assess?** | some patients may not be suitable for a switch from warfarin to DOAC- see Safe DOAC to warfarin switching guidance |
| **DOAC guidance queries:** | |
| **19) Where can I find the DOAC guidance?** | Currently on the Lambeth APC website but will be transferring to the new SEL CCG IMOC website. All documents can be accessed currently via: SEL APC CVD guidelines |
| **20) Is the DOAC initiation/monitoring template in Emis? or a stand alone document?** | It is currently a document but could be adapted for Emis. See DOAC initiation/monitoring guidance |
| **21) The link to the switching for warfarin to DOAC document on APC website in FAQ not working - just to check - Does this advocate GPs can switch from warfarin in non complex pts without referral back to anticoag clinic if they and pt are happy to do so (thinking about those who are currently managed in community clinics)?** | It really depends on the locally commissioned service and the experience and confidence of the GP to switch.<br>Link: Safe DOAC to warfarin switching guidance |
| **Paroxysmal AF and cardioversion:** | |
| **22) Should patients with paroxysmal AF have anticoagulation reviewed? What about cardioversion? I have a patient when cardiology said stop as patient DC verted, and then follow up letter says lifelong DOAC** | Apart from ablation, once in AF, always in AF…<br>Patients with pAF have a similar risk of stroke to permanent AF and it is important to check the CHADVasc score with the ECG and anticoagulate accordingly.<br>For cardioversions, patients are usually anticoagulated for 4 weeks around the procedure but following this, patients with a CHADVasc score of 0 do not require long term anticoagulation- this is usually determined by the cardiologist at review. |
| **Management of bleeding adverse effects:** | |
| **23) Any advice on nose bleeds, guidance suggest if frequent or bleeding for more than 10 minutes then seek help, in this case do pts continue with DOAC and referred to anticoagulant clinic? Or should they stop DOAC and then referral to clinic?** | Stop DOAC temporarily and refer to ENT. See FAQs for DOACs document |
| **24) What level of bruising is alarming?** | Unusual for anticoagulants to cause widespread spontaneous bruising. More often happens when antiplatelet therapy is co-prescribed. |