Perioperative Anticoagulation

Scope of the Problem

- >1 million people receiving warfarin in N.A.
- most are >65 years
- elderly 2-fold more likely to have surgery
- few prospective studies
- multiple "guidelines", none evidence-based
- arguments *against* and *in favour* of periop. "bridging anticoagulant therapy"

Recommendations of Consensus Groups

- ACCP
  - *full-dose* bridging anticoagulant therapy for "high-risk" patients (eg., recent stroke/TIA, mitral valve replacement, old valve type)
  - *low-dose* bridging anticoagulant therapy for "intermediate-risk" patients
  - no bridging anticoagulant therapy for "low-risk" patients (eg., AF+no previous stroke/TIA; VTE+no recent events)

- ACA/AHA
  - *full-dose* bridging anticoagulant therapy for "high-risk" patients
  - defined as: MVR+1 risk factor
    3 risk factors (AF, VTE LV dysf, mech valve)

Rationale Against Periop. Anticoagulation

- absolute risk of TE low
- risk of postop bleeding excessive

Rationale Favouring Periop. Anticoagulation

- clinical impact of TE
- ? rebound hypercoagulability after stopping warfarin and antiplatelet agents
- ? prothrombotic perioperative milieu

Assessment of Perioperative TE Risk

- condition/disease requiring anticoagulation
- additional TE risk factors
- clinical consequences of TE event

Assessment of Postoperative Bleeding Risk

- adequacy of postoperative hemostasis
- bleeding associated with surgery/procedure

Take-Home Messages

- no evidence-based guidelines
- approach based on TE and bleeding risk
- bridging therapy reasonable for “high-risk” patients, and should be considered for “intermediate-risk” patients
- avoid over-aggressive anticoagulation within first 24 hours after surgery

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