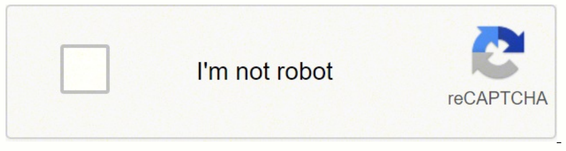

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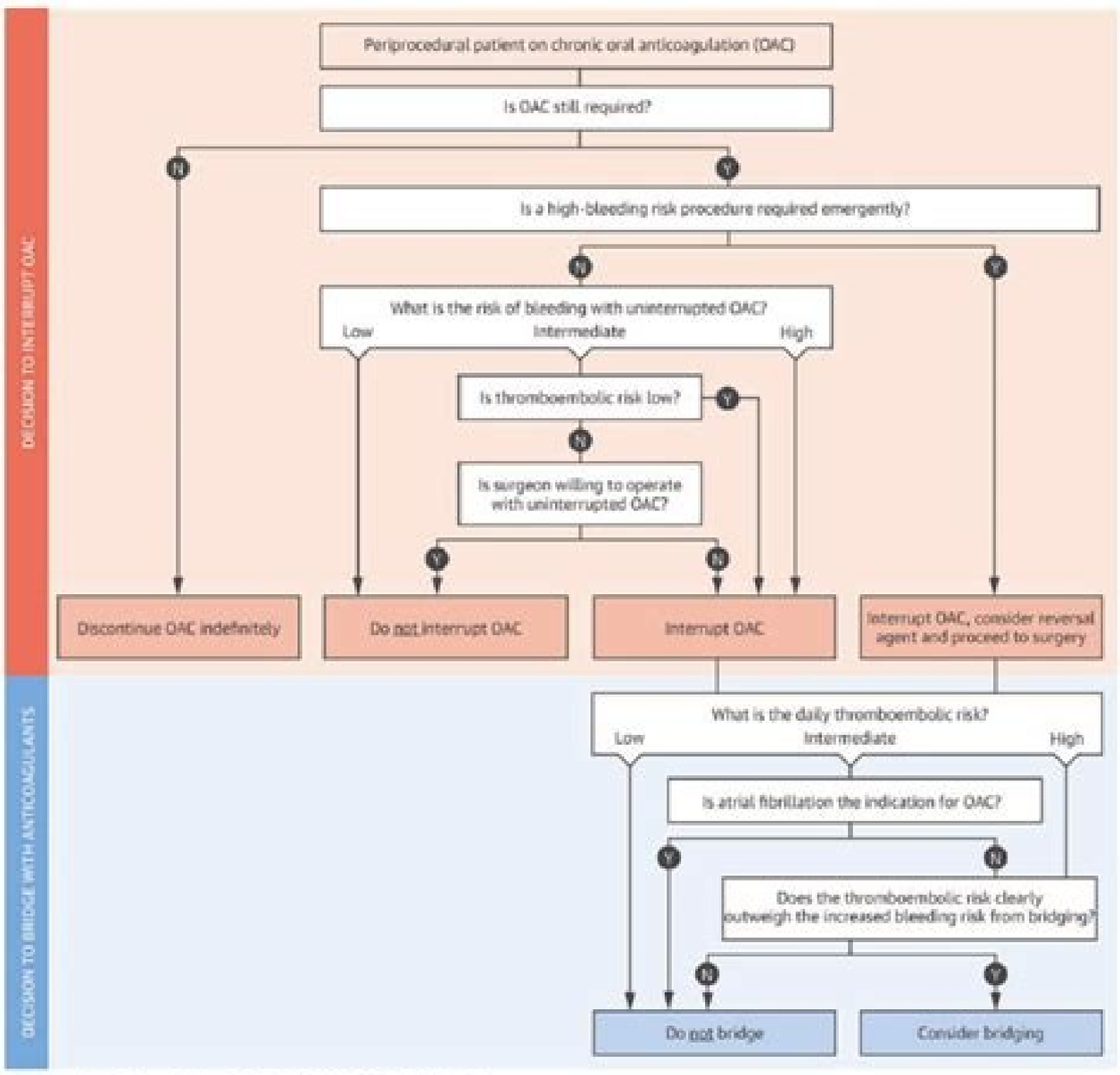
Table 1. Dosing of NOACs according to renal function

	Normal renal function	Renal dysfunction	Age	Liver dysfunction
Dabigatran	150 mg b.i.d.*	Not studied in CrCl ≤30 mL/min	Use with caution in >75-year-olds	Not available
Rivaroxaban	AF: 20 mg nightly	AF: CrCl 15-50 mL/min, 15 mg nightly, reassess renal function	Consider dose adjustment in ≥65-year-olds with CrCl 30-50 mL/min	Avoid use in moderate to severe impairment (Child-Pugh B/C) or in hepatic coagulopathy
	VTE: 15 mg b.i.d. × 21 days, followed by 20 mg daily	VTE: Avoid if CrCl ≤30 mL/min; consider dose adjustment in ≥65-year-olds with CrCl 30-50 mL/min		
Apixaban	AF: 5 mg b.i.d. Reduce to 2.5 mg b.i.d. in the presence of two or more of the following: age ≥80 years, weight ≤60 kg, Cr ≥1.5 mg/dL. Not studied well in patients with serum Cr >2.5 mg/dL or CrCl <25 mL/min.			Use caution in moderate (Child-Pugh B) and avoid use to severe (Child-Pugh C) impairment
	VTE: 10 mg b.i.d. × 7 days, followed by 5 mg b.i.d.	No dose adjustment; not studied when serum Cr >2.5 mg/dL or CrCl <25 mL/min	No recommendation	
Edoxaban	60 mg daily*; 30mg daily if weight ≤60 kg	CrCl 15-50 mL/min, 30 mg daily; not studied when CrCl <30 mL/min; avoid if CrCl <15 mL/min	No restrictions	Avoid use in moderate to severe impairment (Child-Pugh B/C)

* Manufacturer recommends bridging patients with VTE

Notes: CrCl = creatinine clearance; VTE = venous thromboembolism; AF = atrial fibrillation.



Rechenmacher, S.J. et al. J Am Coll Cardiol. 2015; 66(12):1392-403.

Guidelines for Warfarin Reversal

- ACCP 2012 Guidelines for warfarin overanticoagulation (NO bleeding)
  - INR <4.5
    - Decrease the dose of warfarin
  - INR 4.5-10.0
    - Hold warfarin
    - Can administer small dose of vitamin K (not routinely)
  - INR >10.0
    - Administer oral vitamin K

Table 2—*[Section 1.2]* Structured Clinical Questions

Section	Population	Intervention and Comparator	Outcomes	Available Methodology
		Patients receiving warfarin therapy		
2.1	Patients receiving warfarin therapy who require an elective surgery or invasive procedure	In patients who require warfarin interruption before surgery, is aiming normal or near-normal INR at surgery, stopping warfarin 5-6 d before surgery vs stopping warfarin < 5 d before surgery	Hemostasis at time of surgery (INR)	Observational studies
2.2		In patients with warfarin interruption before surgery, restarting warfarin 12-24 h after surgery (evening of or next day) and when there is hemostasis vs restarting warfarin > 24 h from surgery	Hemostasis at time of surgery	Observational studies
2.3		INR testing to monitor anticoagulant effect of warfarin before and after surgery vs no testing	Hemostasis at time of surgery (aPTT, anti-factor Xa)	Observational studies
2.4	Need for bridging anticoagulation during perioperative warfarin interruption			
	Patients considered at high risk for perioperative thromboembolism	Bridging anticoagulation with heparin/LMWH	Stroke, other systemic embolism, major hemorrhage	Observational studies
	Patients considered at moderate risk for perioperative thromboembolism	Bridging anticoagulation with heparin/LMWH	Stroke, other systemic embolism, major hemorrhage	Observational studies
	Patients considered at low risk for perioperative thromboembolism	Bridging anticoagulation with heparin/LMWH	Stroke, other systemic embolism, major hemorrhage	Observational studies
2.5	Patients having minor dental, skin, or eye procedures			
	Patients receiving warfarin therapy and having a minor dental procedure	Continuing warfarin and coadministering an oral prothrombotic drug vs stopping warfarin 5-6 d before the procedure without administering a prothrombotic drug	AFE or VTE, major hemorrhage	RCTs, observational studies
	Patients receiving warfarin therapy and having a minor skin procedure	Continuing warfarin around the time of the procedure vs stopping warfarin 5-6 d before the procedure	AFE or VTE, major hemorrhage	RCTs, observational studies
	Patients receiving warfarin therapy and having cataract procedure	Continuing warfarin around the time of the procedure vs stopping warfarin 5-6 d before the procedure	AFE or VTE, postoperative bleeding	RCTs, observational studies
		Patients receiving antiplatelet therapy		
3.4	Patients receiving antiplatelet therapy and having minor dental, skin, or eye procedure	Continuing antiplatelet drugs around the time of the procedure vs stopping antiplatelet drugs 7-10 d before procedure	Myocardial ischemia, postoperative bleeding	Observational
3.5	Patients receiving antiplatelet therapy and having elective noncardiac surgery	Continuing antiplatelet drugs around the time of the procedure vs stopping antiplatelet drugs 7-10 d before noncardiac surgery	Myocardial ischemia, postoperative bleeding	RCTs, observational studies
3.6	Patients receiving antiplatelet therapy and having elective CABG surgery	Continue antiplatelet drugs around the time of surgery vs stopping antiplatelet drugs 7-10 d before CABG	Myocardial ischemia, postoperative bleeding	Observational studies

Chest 2012 anticoagulation guidelines pdf. Chest guidelines anticoagulation 2012 pregnancy. Chest anticoagulation guidelines 2012 pediatrics.

5. For the patient with PE on the subgiant and no DVT, the guideline suggests clinical surveillance on anticoagulation when the risk of recurrence VTE is low (grade 2c). In patients with acute PE associated with hypotension and they have: 1) contraindications to thrombolysis, 2) failed thrombolysis, or 3) shocks that could cause death before systemic thrombuses may have effect (for example, within a few hours), If appropriate competence and resources are available, the guidelines suggest the removal of catheter assisted thrombus without this intervention. For VTE associated with cancer, LMWH is recommended on VKA (grade 2b) or direct direct oral anticoagulants (all 2C votes). Quote: Chest 2012; 141: 7S-47S. If patients suffer a recurring VTE during the treatment of LMWH, the guideline recommends increasing the dose of LMWH (degree 2C). 4. 10. For patients with an acute PE and hypotension (massive PE), the guideline recommends the use of thrombolytic therapy (grade 2b), preferring preferential systemic therapy on trombolytic therapy direct to the catheter (grade 2c) . In patients with acute leg dvt, the guidelines recommend the early initiation of the VCA (for example, the same day of parenteral therapy) on delayed initiation and continuation of the parenteral anticagulation for a minimum of 5 days and until the INR is 2.0 or higher for at least 24 hours. For sufficiently healthy patients to be treated as surfaces, guidelines suggest starting vitamin K therapy Antagonist (VKA) with Warfarin 10 mg per day for the first 2 days, followed by dosage based on international measurement of the normalized ratio (INR) Instead to start with the estimate of the estimate maintenance dose. The guideline recommends the use of surveillance antiquation when the risk of recurrence VTE is high (2C grade). 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For patients with recurrent VTE during treatment with a non-LMWH anticoagulant, the guideline recommends switching to LMWH (Grade 2C) therapy. In patients with acute pulmonary embolism associated with hypotension (e. g. systolic blood pressure 8. For patients with acute VTE who are treated with anticoagulation, the guideline recommends that a lower hollow vein filter (Grade 1B) should not be used. In patients with proximal deep vein thrombosis (DVT) of the leg caused by surgery, the guidelines recommend treatment with anticoagulation for 3 months: 1) treatment of a shorter period¹ (Grade 1B), 2) treatment of a longer period¹ of limited time (e.g. 6 or 12 months) (Grade 1B), or 3) extended therapy. 2. For patients with acute DVT, the guideline recommends that routine compression stockings should not be used to prevent post-thrombotic syndrome (Grade 2B). Antoagulants should stop after 3 months of therapy in patients with acute and proximal deep vein thrombosis (DVT) caused by surgery rather than in shorter or longer treatment cycles¹ (Grade 1B). ,enoizneverp ,enoizneverp ,ehcilobatemoidrac eittalam e etebaid ,acirtaidep aigoloidrac e etinegnoc eitapoidrac ,enoizalugaocitna'lled enoitseG :icinilc id oihcsir noc itneizap rep b2 odarg ,otavele otnemaniugnas id oihcsir id itneizap rep b1 odarg(ihgnul ¹Âip o iverb ¹Âip isroc us ocigrunon oirotisnart oihcsir id erottaf nu ad itacovorp)EP(eranomlop ailobme o elamissorp TVD nu noc itneizap ni isem 3 opod ehcna itamref eresse orebbervod itnalugaocitna ilG .otrepse ollennap led otroppar e ecarot led adiug aenil :ETV aittalam al rep acitobmortitna aiparet :enoizatiC .la te ,J salemO ,aE lkA ,C noraeK :irotuA ccaF ,cSM ,DM ,senraB .ocigrurihc otnevretni'lled amirp everb ¹Âip opmet nu SAKV eramref id ecevni ocigrurihc otnevretni'lled amirp inroig 5 acric SAKV eramref id onadnamoccar itnematneiro ilg ,ocigrurihc otnevretni'lled amirp ACV anu id aenaropmet enoizurretni'nu onodeihcir ehc itneizap ieN .)C2 odarG ;hWML(isep id otunetnoc ossab a eralocelom osep nu us atadnamoccar ¨Ã AKV aiparet al e)b2 ilauq i ittut( )AKV(tsinogatnA K animativ alled aiparet allus itadnamoccar onos)nabaxodE o ,nabaxipA ,nabaxoraviR ,nartagibaD(itterid ilaro itnalugaocitna ilg ittut ,ataicossa orcnac id isongaid anu aznes ETV rep :)ETV(osonev omsilobmeobmort li rep acitobmortitna aiparet allus ecarot led icidem ied onacirema oigelloc lad otanroigga adiug aenil id otnemucod otseuq us evaihc itnup 11 itatropir onos otiuges iD .7 .253-513 : 941 ;6102 ottep inoizresni ella anroT< aigarrome ,asonev isobmort ,otteverb ,nemarof elavo ,eranomlop ailobme ,eralocsavoidrac ailobme ,sutci ,iralocsavoidrac eittalam ,edibrom , Ãtisebo ,ilozadimizneb ,ilairotalubma ,ailifobmort ,aninala-ateb ,erouc led amsiruena ,elanoizanretni otazzilamron oitaR ,icitilonirbif itnegA , irefilocitrA ,anibmortorP ,angiugnas enoisserP ,osoneV omsilobmeobmorhT ,enoisnetopI ,nirafraW ,oizicresE ,ķcohS ,aipareT citilobmorhT ,Ķ animativ :evaihc eloraP izicrese ,itnega ivoun ,enoizneverp e airtaidep e DHC ,atinegnoc acaidrac aittalam ,omsilobmeobmeobmortitnev e enoizalugaocitna enoitseg ,asonev omsilobmeobmort e enoisnetrepI Low or moderate). For patients with a proximal DVT not caused or PE that are stopping anticoagulant therapy, the guideline suggests the use of the aspirin without aspirin to avoid the applicant VTE if there are no contraindications a a Therapy (grade 2b). 2 March 2016 Ã, ã, | Ã, Ã, patients Geoffrey D. with cryptogenetics oval foramus perfiece stroke and atrial septum or aneurysm, the guidelines recommend aspirin (50-100 mg / day) on a non-aspirin period. For patients with the main bleeding associated with VKA, the guidelines suggest a rapid reversal of the anticoagulation with concentrate complex of four-factor protromb rather than with plasma. For long-distance travelers to an increase in the risk of venous thromboembolism (VTE) (including the previous VTE, recent surgery or trauma, active malignity, pregnancy, estrogen use, advanced aging, limited mobility, severe obesity, or known thrombophilic disorder) , the guidelines suggest frequent ambulation, muscular exercise of the calf, or sitting in a corridor place if feasible and against the use of aspirin or anticoagulants to prevent VTE. Summary of: Debabrata Mukherjee, MD, FACC The following are 10 points to remember the ninth edition of antithrombotic therapy and the prevention of thrombosis guidelines: 1. 3. 6. 6. The anticoagulation should be given for 3 months in patients With a first non-tried VTE and a high risk of bleeding (degree 1b), but should be extended without a scheduled stop date in patients with a low or moderate risk of bleeding (grade 2b). 2b).

18/7/2014 · A 2012 multi-society expert consensus document supported by the ACC and AHA suggests continuing anticoagulation and adding low dose aspirin without clopidogrel. 9 The 2014 ACC/AHA valvular disease guidelines give a Class IIb recommendation for aspirin and clopidogrel for six months after TAVR (level of evidence C), but do not comment on anticoagulation. 35 A ... 8/2/2021 · These include the 2020 CHEST COVID-19 Guidelines, the Anticoagulation (AC) Forum interim clinical guidance, the International Society on Thrombosis and Haemostasis (ISTH) Scientific and Standardization Committee (SSC) COVID-19 clinical guidance, and the American College of Cardiology (ACC) clinical guidance. 85-88 Major differences between the current ... 21/1/2022 · These include the 2020 CHEST COVID-19 Guidelines, Anticoagulation Forum interim clinical guidance, International Society on Thrombosis and Haemostasis (ISTH) Scientific and Standardization Committee (SSC) COVID-19 clinical guidance, National Institutes of Health (NIH) COVID-19 treatment guidelines, and American College of Cardiology (ACC) clinical guidance. ...

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