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Bridging anticoagulation: primum no nocere

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Background and Aim: Chronic oral anticoagulation(OAC) frequently requires interruption for various reasons and durations. The evidence to inform decisions making is limited, making current guidelines equivocal and imprecise. The aim of this work is to review the indications for both the need for OAC interruption and the practice of routine bridging when OAC interruption is indicated.

Methods: A search was conducted on MEDLINE, Guidelines Finder, The Cochrane Library, using the MeSH terms “bridging anticoagulation”. The researches were limited to the articles published in the last 5 years in English, Spanish and Portuguese.

Results: From the research resulted 3 systematic reviews articles. From their analysis, we conclude that: OAC should not be interrupted for procedures with low bleeding risk; patients at highest risk for thromboembolism(TE) without excessive bleeding risk should consider bridging, conversely, those at low risk for TE should not be bridged; intermediate-risk cases should be managed by individually considering patient and procedure-specific risks for bleeding and TE. Procedures amenable to uninterrupted therapeutic warfarin: endoscopy, biopsies, endovascular interventions, percutaneous coronary interventions, cardiac device implantation, cataract surgery, dermatologic surgery, dental extractions, minor noncardiac surgery. When bridging is deemed necessary, more conservative bridging strategies should be entertained, such as low-dose heparin, post-procedure-only heparin, delayed initiation of post procedure heparin and early transitioning off of heparin as the INR approaches 2.0, rather than after. Further studies are needed in bridging of novel oral anticoagulants.

Conclusions: Periprocedural anticoagulation management is a common clinical dilemma with limited evidence to guide our practices. Although bridging anticoagulation may be necessary for those patients at highest risk for TE, for most patients it produces excessive bleeding. Contemporary clinical practice continues to favor interruption of OAC and the use of bridging anticoagulation. Physicians should carefully reconsider the practice of routine bridging and whether periprocedural anticoagulation is even necessary.