Arizona Anticoagulation Forum Newsletter

For Members **September 2008**

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Upcoming Events

Patient Self Testing

Our next program will be sponsored by Roche Diagnostics. The topic will be focused on patient self testing.

As Medicare continues to expand its coverage of POC testing it is our responsibility to understand the coverage requirements and to learn the opportunities and challenges patient self testing offers.

The program date and speaker have not been confirmed, but Roche has committed to sponsoring this meeting. The program will likely be held in late October.

Invitations to this program will be coming out in the near future-be on the lookout!!

Meeting in Review

ACCP Guidelines 2008 Update

Chris Tankersley, PharmD provided an overview of the recent ACCP Guidelines.

- Key messages included:
  - Antithrombotic therapy for treatment of atrial fibrillation should focus on risk stratification based on $CHADS_2$ score.

Description	$CHADS_2$ Score	Recommen-dation
A. Fib. With h/o CVA/TIA	≥2	Warfarin Target INR 2.5: range 2.0-3.0
A. Fib +2 or more risk factors	2	Warfarin Target INR 2.5: range 2.0-3.0
A. Fib. +1 risk factor	1	ASA 75-325 mg or Warfarin Target INR 2.5: range 2.0-3.0
A. Fib with no other risk factors	0	ASA 75-325 mg

  - Treatment of acute DVT/PE with risk factors or unprovoked was changed from duration of 6-12 months to no less than 3 months, then re-evaluate patient. Also, fondaparinux was added to LMWH and UFH for initial treatment of acute DVT/PE.

- The updated guidelines provide an entire chapter on perioperative management of patients receiving warfarin, as well as antiplatelet therapy. Emphasis in the guidelines to risk stratify patients for bleeding versus embolism risk and bridging patients with LMWH appropriately based on their patient specific risk (indication for warfarin therapy, risk of bleeding due to the procedure, etc.).

FEATURE ARTICLE

Managing Antiplatelet Drugs Perioperatively

Patients taking antiplatelet medications, including aspirin, clopidogrel, NSAIDs, cilostazol and dipyridamole are at increased risk of bleeding due to surgery. The American College of Chest Physicians recently published guidelines to assist providers in managing these medications perioperatively. Patients requiring surgery within six weeks of placement of a bare metal coronary stent or within twelve months of placement of a drug-eluting stent, it is recommended that aspirin clopidogrel be continued. If at all possible, delay elective noncardiac procedures for six weeks post bare metal stent placement and twelve months post drug-eluting stent placement.

In patients requiring minor dental, minor dermatologic procedures or cataract surgery, aspirin can be continued. Clopidogrel can be discontinued at least five days (preferably 10 days) prior to the procedure in patients that are not at high cardiac risk. Patients that underwent a bare metal stent placement within the previous six weeks, and those that have had a drug-eluting stent placement within the past twelve months should continue clopidogrel.

In patients not at high risk of cardiac events that are undergoing a noncardiac procedure, it is recommended that aspirin, aspirin-containing medications and clopidogrel be stopped seven to ten days prior to surgery.
For patients at high risk of cardiac events undergoing noncardiac surgery or percutaneous coronary intervention (PCI), it is recommended that aspirin be continued and clopidogrel be discontinued five, or preferably, 10 days prior to surgery.

For patients requiring coronary bypass (CABG), it is recommended that antiplatelets be restarted 24 hours after surgery or the morning after surgery if hemostasis is achieved, assuming that it is held. If clopidogrel is stopped in patients undergoing PCI, it is suggested that patients be reloaded with a single 300mg to 600 mg dose. If aspirin is stopped prior to CABG, it is recommended that it be resumed 6-48 hours post procedure.

NSAIDs, including COX-2 inhibitors, have reversible antiplatelet effects. To ensure absence of antiplatelet effect, NSAIDs should be discontinued 5 half-lives before surgery. The chart below illustrates the length of time each NSAID should be held prior to surgery.

NSAID	Hold prior to surgery
Diclofenac Ibuprofen Indomethacin Ketoprofen	One day
Celecoxib Diflunisal Naproxen Sulindac	Two to three days
Meloxicam Nabumetone Piroxicam	Ten days

Cilostazol (Pletal) should be discontinued two to three days prior to surgery to ensure absence of effect during surgery. Dipyridamole should also be stopped two to three days prior to surgery, however in combination with aspirin (Aggrenox), it should be stopped seven to ten days before surgery due to the aspirin component.

Antiplatelet medications can be restarted 24 hours after surgery or the morning after surgery, if adequate hemostasis is achieved.
Since most published recommendations regarding perioperative management of antiplatelet therapy are based on expert opinion, it is important to consider each individual's risk of bleeding versus risks and consequences of thromboembolism when

making management decisions.
Chest 2008;133:299-39.

Upcoming Events / Opportunities

Advanced Preceptorship in the Management of Anticoagulation Therapy and Clinical Thrombosis

Albuquerque, New Mexico
November 7-8, 2008

This in-depth course was designed to meet the needs of physicians, nurses and pharmacists working in or setting up clinics to monitor and coordinate the care of patients on anticoagulation therapy. CE credits are provided for physicians, nurses and pharmacists. For more information, visit the website at www.lcfresearch.org.

SECAPS 2008-An Evidence-Based Approach to Antithrombotic Therapy

Nashville, TN
October 10-11, 2008

The goals of this program are to improve the care of patients receiving anticoagulation or Antithrombotic therapy. By facilitating patient-care/provider communication, providing up to date education concerning anticoagulation/anti-thrombotic issues, and enhancing the practice expertise of a multidisciplinary group of participants our goal can be reached. The target audience includes nurses, nurse practitioners, pharmacists, and other care providers. For more information, visit the course page at https://web.dii.utk.edu/pharmenroll/Entrance.aspx.

Southwest Symposium on Thrombosis and Hemostasis

Albuquerque, New Mexico
October 11, 2008

This symposium is intended for physicians, pharmacists, nurses and allied health professionals who provide care to patients on anticoagulants such as warfarin, low molecular weight heparin, aspirin and other anti-thrombotic agents. CME credit is available to physicians, pharmacists and nurses.

For additional information or a copy of the brochure visit the website at www.dvtnm.com.

The Anticoagulation Forum's 10th National Conference on Anticoagulant Therapy

San Diego, CA
(Manchester Grand Hyatt)
May 7-9, 2009
http://www.acforum.org

The Anticoagulation Forum's Conference provides unique opportunities to meet with colleagues from around the world with wide-ranging anticoagulation research interests and expertise in the diagnosis and treatment of thrombotic disorders.

Upcoming CACP Exam Dates

Date	Location
10/10/08	Nashville, TN
12/7/08	Orlando, FL

For more information regarding the exam and possible additional dates/locations visit the website at www.nabp.org