**IS YOUR PATIENT ON A DOAC FOR NON-VALVULAR AF?**

**STOP and check – your patient might need a reduced dose if:**

**Poster created by Dr. Tehreem Muhammad Afzal. Endorsed by Cardiology Unit RVI**

**PLEASE NOTE: Patients with valvular heart disease or on concomitant anti-platelet therapy will require specialist input**

1. **Age is 80 years or more**
2. **Weight is less than 61 kg**
3. **Renal function is impaired**
4. **High bleeding risk**
5. **Concomitant use of other drugs (Dabigatran & Edoxaban)**

**Apixaban**

**Rivaroxaban**

**Dabigatran**

**Edoxaban**

**60mg OD**

**30 mg OD**

**if 1 out of 3:**

**1. Weight <61 kg**

**2. CrCl 15-50 ml/min**

**3. Concomitant ciclosporin, dronedarone,**

**erythromycin, ketoconazole**

**CrCl <15 ml/min**

**Usual Dose**

**150mg BD**

**20mg OD**

**5mg BD**

**110 mg BD**

**if 1 out of 4:**

**1. Age ≥ 80**

**2. CrCl 30-50 ml/min**

**3. Concomitant verapamil**

**4. High bleeding risk**

**CrCl <30 ml/min**

**CrCl <15 ml/min**

**CrCl <15 ml/min**

**2.5mg BD**

**if CrCl 15-29 ml/min**

**OR**

**if 2 out of 3:**

**1. Age ≥ 80**

**2. Weight <61 kg**

**3. Creatinine ≥ 133**

**Reduced Dose**

**Contra-indicated**

**15 mg OD**

**if CrCl 15-49 ml/min**

**Appropriate dosing of direct oral anticoagulants (DOACs) in patients with non- valvular atrial fibrillation**

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Direct oral anticoagulants (DOACs) are increasingly advocated as the primary anticoagulant to prevent stroke and systemic embolism in patients with atrial fibrillation. Studies have demonstrated that DOACs have reduced rates of stroke and bleeding complications compared to warfarin and do not require regular blood tests to assess their anticoagulant effect. However DOACS require dose adjustment according to patient’s age, weight, creatinine clearance and with concomitant use of certain medications.

We conducted a prospective audit over 4 weeks to assess whether dose of DOAC prescribed for non-valvular atrial fibrillation was correct in patients being admitted to Cardiology at the RVI. Twenty patients were identified. Only 17 had the correct dose prescribed. The remaining 3 patients were receiving an inappropriately reduced dose of apixaban (meeting only one criteria for dose reduction by way of age >80 years). All patients had been admitted on this regime from the community. This equates to only 85% of patients receiving an appropriate dose of DOAC. It is likely that lack of awareness about the specific dosing criteria for DOACs and fears of excess bleeding risk in the elderly led to inappropriate under-dosing.

Conclusion: Not all patients on DOACs are receiving the appropriate dose and it is important to increase awareness of this to prevent unnecessary thromboembolic complications. We have designed a poster to prompt prescribers to review DOAC doses and outlined the criteria for dose adjustment. We plan to use it on the wards and liaise with General Practice regarding its potential application in the community.