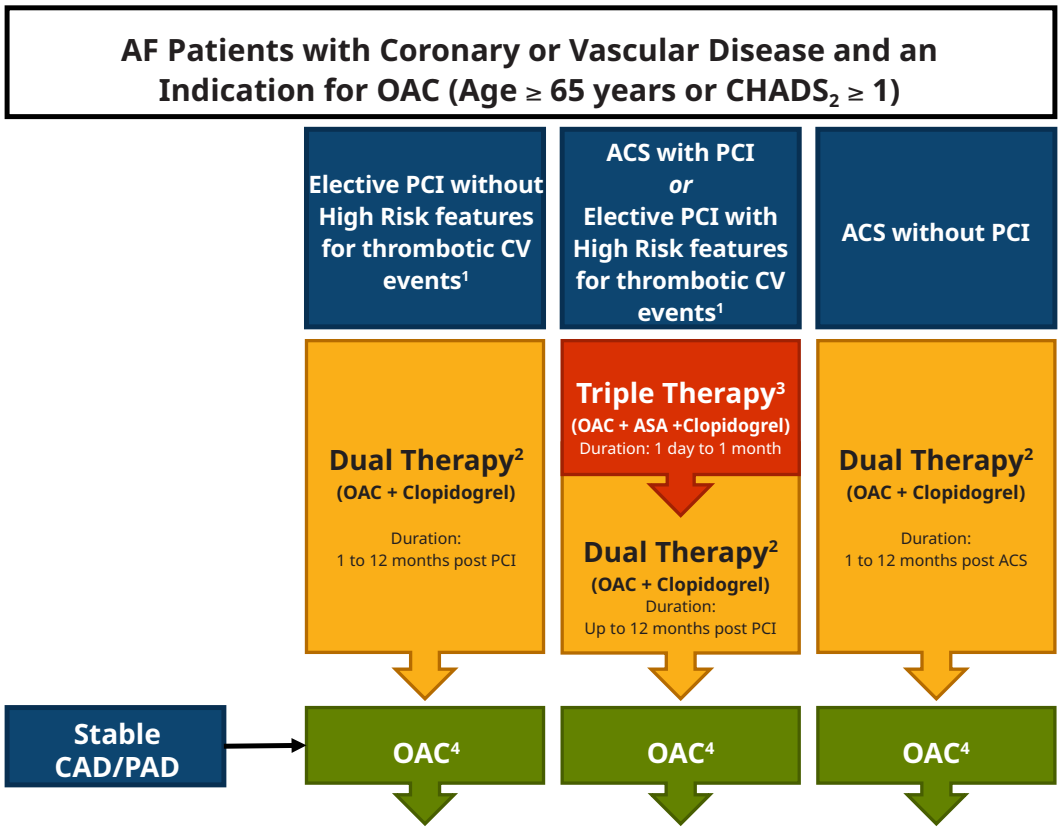
Appendix E: Management of Antithrombotic Therapy in Patients with AF And CAD/PAD (reproduced with permission from CCS 2020 guidelines)



1 PCI is considered high-risk based on clinical and angiographic features such as: diabetes mellitus, current smoker, chronic renal dysfunction (eGFR < 60 mL/min), prior ACS, multi-vessel disease, multiple stents implanted, complex bifurcation lesion, total stent length > 60 mm, prior stent thrombosis, chronic total occlusion intervention, or bioabsorbable vascular scaffold.

2 The OAC component evaluated as part of dual pathway therapy regimens include: warfarin daily, apixaban 5 mg BID (reduced to 2.5 mg if they met two or more of the following dose-reduction criteria: age > 80 years of age, weight < 60 kg, or Cr > 133 µmol per liter), dabigatran 110 mg or 150 mg PO BID, edoxaban 60 mg PO daily (30 mg in patients with CrCl 15–50 mL/min, bodyweight ≤ 60 kg, or concomitant use of specified potent P-glycoprotein inhibitors), rivaroxaban 15 mg PO daily (10 mg in patients with CrCl 30-50 mL/min). A DOAC is preferred over warfarin, however if warfarin is to be used the lower end of the recommended INR target range is preferred. All patients should receive a loading dose of ASA 160 mg at the time of PCI (if previously ASA naïve).

3 The OAC component evaluated as part of triple therapy regimens include: warfarin daily, rivaroxaban 2.5 mg PO BID, or apixaban 5 mg BID (reduced to 2.5 mg if they met two or more of the following dose-reduction criteria: age > 80 years of age, weight < 60 kg, or Cr > 133 µmol per liter). A DOAC is preferred over warfarin, however if warfarin is to be used the recommended INR target is 2.0-2.5. All patients should receive a loading dose of ASA 160 mg at the time of PCI (if previously ASA naïve). Thereafter, ASA may be discontinued as early as the day following PCI or it can be continued longer. The timing of when to discontinue ASA will depend on individual patient's ischemic and bleeding risk.

4 The dose of OAC beyond one year after PCI should be standard stroke prevention doses. A combination of an OAC and single antiplatelet therapy may be used only in highly-selected patients with high-risk features for ischemic coronary outcomes, and who are also at low risk of bleeding.