START-Eventi *Walter Ageno (Varese)*
START-Laboratorio *Sophie Testa (Cremona)*
START-Antiplatelet *Rossella Marcucci (Firenze)*
FADOI-START-VTE-DOAC *Francesco Dentali (Varese), Nicola Mumoli (Livorno)*
START-Valvole *Daniela Poli (Firenze)*

12:00 **Lettura magistrale: Errori, contraddizioni e capovolgimenti nella scienza e nella medicina** *Sergio Coccheri (Bologna)*

12:30 **Simposio satellite: Le decisioni cliniche per la gestione dei pazienti dopo un tromboembolismo venoso ***
sponsorizzato da Alfa Wassermann
Moderatori: *Giuseppe M. Andreozzi (Padova), Marco Cattaneo (Milano), Giovanni Davi (Chieti), Anna Falanga (Bergamo)*

La storia naturale del tromboembolismo venoso dopo la fase acuta *Sabina Villalta (Treviso)*
Quali scelte possibili e quali criteri *Walter Ageno (Varese)*
Lo START-Post-VTE Registry: obiettivi e struttura *Gualtiero Palareti (Bologna)*

14:15 **Quale comunicazione per pazienti e professionisti in materia di anticoagulazione.**
Stato e prospettive del portale www.anticoagulazione.it
Gualtiero Palareti (Bologna), Silvia Malosio (Milano)

15:45 **Panoramica degli studi clinici in corso e prossimi con i NAO**
Giancarlo Agnelli (Perugia)

16:00 **Presentazione dello studio APIDULCIS**
Gualtiero Palareti (Bologna), Paolo Prandoni (Padova)

Manovre invasive e periodo perioperatorio nei pazienti anticoagulati

Bologna 1,2 Febbraio 2017

Vincenzo Toschi
SIMT e Centro Trombosi
ASST Santi Paolo e Carlo
Milano, Italy

Disclosure

Speaker fee: Aspen, Boehringer, Daichii Sankio, Bayer, Pfizer

The optimal peri-operative management of patients on chronic OAC is anchored on….

✓Risk stratification of patients and procedure-related risks for thrombosis and bleeding

✓Clinical consequences of thrombotic versus bleeding events

✓Discontinuation and reinitiation of OAC on appropriate pharmacokinetic parameters

✓ Whether an aggressive management strategy such as perioperative bridging therapy has advantages for the prevention of post-operative thrombotic complications at the cost of a possible increase in bleed risk

J Thromb Hemost 2016

Patient-related risk stratification for peri-operative thromboembolism

ACCP=American College of Chest Physicians; ATE=arterial thromboembolism; VTE=venous thromboembolism; AVR=aort replacement; TIA=transient ischemic attack

CHEST 2012; 141: e326S-50S

Stratificazione del rischio emorragico legato alla procedura

Alto rischio di sanguinamento(*)	Basso rischio di sanguinamento (^)	Minimo rischio di sanguinamento
Chirurgia maggiore con danno tissutale esteso	Artroscopia	Interventi dermatologici minori
Chirurgia dei tumori	Biopsia linfonodale o cutanea	Cataratta
Chirurgia ortopedica maggiore	Chirurgia di spalla, mano, piede	Procedure dentarie minori (estrazioni.....)
Plastica ricostruttiva	Angiografia coronarica	Impianto di PM o ICD
Chirurgia urologica o gastro-intestinale, inclusi polipi del colon	Biopsia endoscopica/ colonscopia con o senza biopsia	
Nefrectomia/biopsia renale	Colecistectomia per via laparoscopica	
Chirurgia SNC o in organi vascolarizzati	Broncoscopia con o senza biopsia	

*** Rischio a 2 gg di sanguinamento maggiore ≥ 2%; ^ rischio di sanguinamento maggiore a 2 gg < 2%**

Clinical consequences of thrombosis

- ✓ Mechanical heart valve thrombosis is fatal in 15% patients
- ✓ Embolic stroke results in death or major disability in 70% of patients
- ✓ VTE has a case-fatality rate of 8-10%

Ann Intern Med 2010; 152: 578-89

Note on Shaded Text: Throughout this guideline, shading is used within the summary of recommendations sections to indicate recommendations that are newly added or have been changed since the publication of Antithrombotic and Thrombolytic Therapy: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). Recommendations that remain unchanged are not shaded.

2012

DOI: 10.1378/chest.11-2298

Summary of Recommendations

Note on Shaded Text: Throughout this guideline, shading is used within the summary of recommendations sections to indicate recommendations that are newly added or have been changed since the publication of Antithrombotic and Thrombolytic Therapy: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). Recommendations that remain unchanged are not shaded.

e326S Perioperative Management of Antithrombotic Therapy

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2012

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2012

 Thrombolytic Therapy: American Colleg

* Corresponding author. A. John Camm, St George's University of London, Cranmer Terrace, London SW17 ORE, UK. Tel: +44 20 8725 3414, Fax: +44 20 87
Email: jcamm@sgul.ac.uk

† Other ESC entities having participated in the development of this document:
Associations: European Association of Echocardiography (EAE), European Association for Cardiovascular Prevention & Rehabilitation (EACPR), Heart Failure Associatic
Working Groups: Cardiovascular Surgery, Developmental Anatomy and Pathology, Cardiovascular Pharmacology and Drug Therapy, Thrombosis, Acute Cardiac Care
Heart Disease.
Councils: Cardiovascular Imaging, Cardiology Practice, Cardiovascular Primary Care.

Disclaimer. The ESC Guidelines represent the views of the ESC and were arrived at after careful consideration of the available evidence at the time they were writte
professionals are encouraged to take them fully into account when exercising their clinical judgement. The guidelines do not, however, override the individual responsibility
professionals to make appropriate decisions in the circumstances of the individual patients, in consultation with that patient, and where appropriate and necessary the
guardian or carer. It is also the health professional's responsibility to verify the rules and regulations applicable to drugs and devices at the time of prescription.

guardian or carer. It is also the health profess
Published on behalf of the European Society

should be weighed against the risk of str

Guida alla terapia antitrombotica Raccomandazioni

2016

I pazienti vengono distinti in due categoria di rischio

a) Pazienti a rischio di tromboembolismo elevato

- ✓ Protesi meccanica mitralica
- ✓ Protesi meccanica aortica non recente o associara a FA
- ✓ Protesi valvolare con pregresso TE arterioso o valvulopatia mitralica
- ✓ Precedente tromboembolismo cardiogeno o non spiegato
- ✓ Tromboembolismo venoso non recente (<3 mesi)

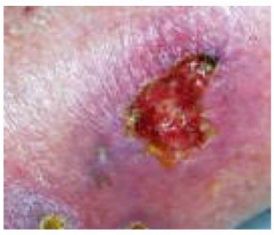
b) Pazienti a rischio di tromboembolismo basso mederato

- ✓ Tutti gli altri pazienti in terapia con AVK

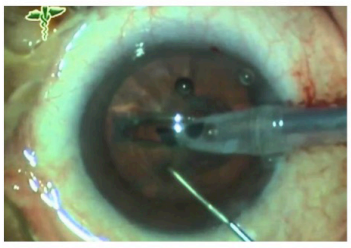
Two main questions

- ✓ Can OAC be safley continued for selected minor procedure or surgery?
- ✓ If a VKA needs to be temporarily interrupted, is heparin bridging necessary?

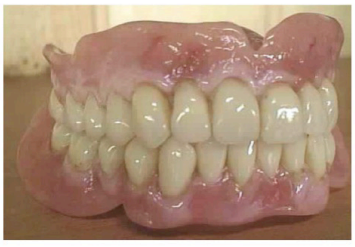
Can oral anticoagulants (VKA) be safely continued for selected procedures or surgeries?



Keep VKA + local hemostasis



Keep VKA



Keep VKA + local oral hemostasis

CHEST 2012; 141: e326S-50S

Guida alla terapia antitrombotica Raccomandazioni

2016

Interventi/procedure per i quali non è necessario sospendere il trattamento con AVK

- ✓Chirurgia cutanea
- ✓Cataratta con anestesia topica
- ✓Artrocentesi e iniezioni in tessuti molli e articolari
- ✓Punture e cateterismi di vene e arterie superficiali
- ✓Puntura sternale e biopsia osteo-midollare
- ✓Procedure cardiologiche: Eco transesofageo
- ✓Procedure odontoiatriche semplici: avulsioni dentarie e altre procedure

As compared with bridging therapy with
treatment at the time of pacemaker or IC
of clinically significant device-pocket hem
of Health Research and the Ministry of
BRUISE CONTROL ClinicalTrials.gov nur

height in meters.

‡ A patient could have more than one valve.

§ Data are for the 30 patients (15 patients in each treatment group) wh went testing for protein C or S deficiency or antiphospholipid antibod

¶ The $CHADS_2$ score is an index of the risk of stroke in patients with at lation. Scores range from 0 to 6, with higher scores indicating a great stroke.

2088

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The New Engl

clinicamente significativo della tasca

Bridging: stop warfarin -5gg; start LMWH/UFH -3gg e stop per 24 h

Bridging therapy and PM implantation: the BRUISE CONTROL trial

without interruption of warfarin therapy in patients requiring oral anticoagulation therapy. We found that this strategy is associated with a significantly lower rate of device-pocket hematoma, as compared with bridging therapy with heparin (3.5% vs. 16.0%). We also found that continued

tion that has been prop
"anticoagulant stress te
undergo surgery while
coagulation therapy, an
be detectable and appr
the wound is still open

(3.5% vs. 16.0%). We also found that continued the wound is still open.

2090 N ENGL J MED 368;22 NEJM.ORG MAY 30, 2013

The New England Journal of Medicine
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N Engl J Med 2013; 368: 2084-93

Bridging therapy and PM implantation: the BRUISE CONTROL-subgroup analysis

therapy is resumed postoperatively.[9]

Our results are consistent with observations on bridging therapy in other situations. Siegal et al.[22] recently conducted a meta-analysis of the safety and efficacy of periprocedural bridging therapy, which included more than 12,000 patients in 34 studies, with only one randomized trial. The comparison groups in these studies included mostly patients in whom oral anticoagulation therapy was discontinued without bridging, with smaller numbers of patients in whom oral anticoagulation therapy was continued during surgery. The authors concluded that bridging with heparin leads to a risk of overall bleeding that is 5 times as high, and a risk of major bleeding that is 3.6 times as high, as the respective risks associated with no bridging therapy. The risk of thromboembolic events did not differ significantly between the two treatment strategies.[22]

than 5%, for whom complete disc
anticoagulation therapy at the ti
might have been too risky. The f
trial are not directly relevant to p
lower risk of thromboembolic eve
it is possible that such patients n
any anticoagulation or bridging
the periprocedural period. Additi
large, randomized trials are ne
define the role of periprocedural
py with heparin.

Guidelines suggest that the c
warfarin at the time of minor de
logic, or ophthalmologic proced
ated with an acceptable risk of b
though not directly relevant, the
study are consistent with this rec
particularly since the bleeding ri
these other procedures, whereas
creased with pacemaker or ICD s

N Engl J Med 2013; 368: 2084-93

Albert Einstein College of Medicine, Montefiore Hospital, New York, NY (L.D.B.); Department of Biomedical Engineering, University of Texas, Austi
A.N.); Department of Cardiology, University of Foggia, Foggia, Italy (L.D.B., P.S.); Ospedale dell'Angelo, Mestre Venice, Italy (S.T., A.R.); Un
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the procedure (group 1, n=790) or to undergo the
with continuous warfarin (group 2, n=794; Figure

The baseline characteristics and risk factors we
anced between the 2 groups. In group 1, the avera
61±10 years; 76% were male; 29% had paroxysm
had persistent AF; 49% had long-standing persis
AF; the left atrial size was 44.8±7 mm; and the left
ejection fraction was 53±12%.

Patients in group 2 were 62±12 years of age;
male; 25% had paroxysmal AF; 24% had persister
had LSP AF; the left atrial size was 45.1±7 mm;
ventricular ejection fraction was 52±13%.

In group 1, 561 patients (71%) had a CHADS
compared with 588 (74%) in group 2 (P=0.17)

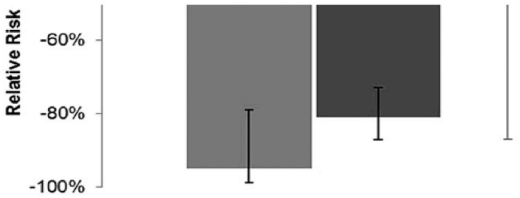
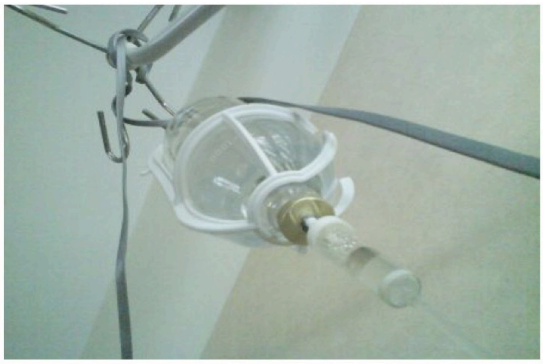


Figure 2. Incidence of periprocedural thromboembolic ever
bleeding complications were more frequent in the off-warfa
population (group 1). Patients on warfarin (group 2) had a 9
relative risk reduction in stroke/transient ischemic attack (TI
81% relative risk reduction in minor bleeding, and 50% rela
risk reduction in major bleeding compared with group 1. Err
represent 95% confidence interval of the relative risk reduct

Patients on warfarin = 794

"How to implement bridging therapy in patients who require it?



Received October 7, 2008; accepted April 10, 2009.
From the Clinical Cardiology, Thrombosis Center, Department of Cardiothoracic and Vascular Sciences, University of Padova School of Medici Padova (P.V., C.U., D.G., I.S.); Merate General Hospital, Lecco (E.N.); University Hospital, Bologna (G.G.); General Hospital, Vimercate (L.L.); Gene Hospital, Lecco (D.V.); General Hospital, Cremona (T.S.); General Hospital, Macerata (F.R.); University of Firenze, Firenze (P.D.); and Geriatric Clir Padova (N.G.), Italy.
The participating anticoagulation centers are listed in the Appendix.
Correspondence to Vittorio Pengo, MD, Clinical Cardiology, Thrombosis Center, Via Giustiniani 2, 35128 Padova, Italy. E-m vittorio.pengo@unipd.it

Circulation is available at http://circ.ahajournals.org DOI: 10.1161/CIRCULATIONAHA.108.823

1262 pz reclutati in 22 centri italiani; eparina a dose terapeutica nei pz ad alto rischio e a dose profilattica in quelli a rischio basso-moderato: 5 eventi TE (0.5%) e 15 emorragie maggiori (1.2%), nei pazienti ad alto rischio

interval of OAT discontinuation and resumption after the procedure, INR values throughout the perioperative and follow-up periods, type and dosage of LMWH used during the perioperative period, and adverse events with appropriate comments.

Outcomes and Follow-Up

The primary efficacy outcome was the incidence of thromboembolism from the OAT interruption (ie, 5 days before the procedure) to 30 days after the procedure. Thromboembolic events were defined as

ical data are exp
binomial 95% c
Fisher exact test
Exact logistic re
primary safety ou
software, version
Inc, Cary, NC).

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FEDERAZIONE CENTRI SORVEGLIANZA ANTICOAGULATI
F.C.S.A.

Guida alla terapia antitrombotica Raccomandazioni

2016

Bridging nei pazienti ad alto rischio

Usare dosi di EBPM ogni 12 ore sec. lo schema (enoxaparina):

- ✓ < 50 kg 2000 U x 2/die s.c.
- ✓ 50-69 kg 4000 U x 2/die s.c.
- ✓ 70-89 kg 6000 U x2/die s.c.
- ✓ 90-110 kg 8000 U x 2/die s.c.
- ✓ >110 kg 10000 U x 2/die s.c.

Bridging nei pazienti a rischio basso mederato

Usare dosi di EBPM profilattiche ogni 24 ore (enoxaparina):

- ✓ In tutti i pazienti 4000 U/die s.c.

Guida alla terapia antitrombotica Raccomandazioni

2016

Schema di *bridging*

Usare dosi di EBPM ogni 12 ore sec. lo schema (enoxaparina):

- ✓Giorno -5: sospensione AVK
- ✓Giorno - 4: inizio EBPM se il pz era in acenocumarolo
- ✓Giorno - 3: inizio EBPM se il paziente era in warfarin
- ✓Ultima somministrazione di EBPM almeno 12-24 ore prima dell'intervento
- ✓Controllo INR prima dell'intervento (intervento con INR>1.5)
- ✓Riprendere EBPM alla stessa dose la mattina successiva
- ✓Giorno + 1: riprendere AVK ad una dose >50% di quella abituale
- ✓Giorno + 2: proseguire con AVK ad una dose >50% di quella abituale
- ✓Giorno + 3 e successivi: proseguire con AVK alla dose abituale
- ✓Sospendere EBPM dopo due giorni con INR superiore a 2 (o a 2.5 per pazienti in *target* 3)

"Do we need to bridge?

P. Wilmot Cancer Center, University of Rochester, Rochester, NY (A.C.S.).

The online-only Data Supplement is available with this article at http://circ.ahajournals.org/lookup/suppl/doi:10.1161/CIRCULATIONAHA.112.105221/-/DC1.

Correspondence to Alex C. Spyropoulos, MD, FACP, FCCP, FRCPC, Associate Professor of Medicine, Division of Hematology/Oncology, Wilmot Cancer Center, University of Rochester Medical Center, 601 Elmwood Ave, Box 704, Rochester, NY 14642. Alex_Spyropoulos@URMC.Rochester.edu

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y in analyses of thromboembolic events, both arterial and venous, when assessed in patients who received bridging or no bridging and in full-dose versus prophylactic-risk, nonbridged patients.

Our findings are relevant to V require temporary discontinuation

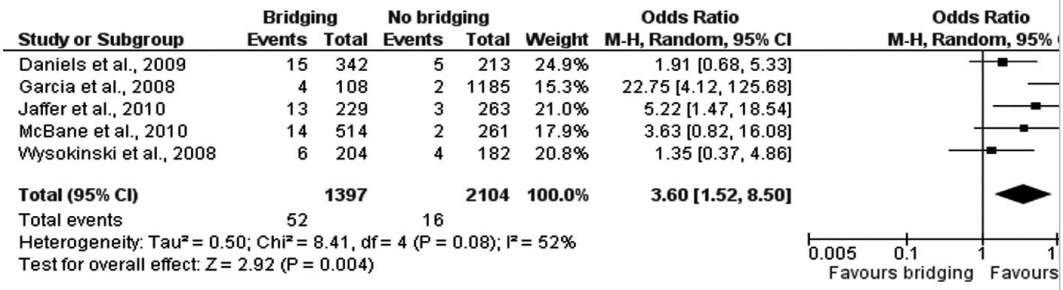

Figure 4. Forest plot of major bleeding events. M-H indicates Mantel-Haenszel; CI, confider

Research, Wynnewood, PA (P.R.K.); Department of Medicine, Stanford University School of Medicine, Palo Alto, CA (K.W.M.); Janssen Scientific A Raritan, NJ (P.C.); and New York University School of Medicine, Lenox Hill Hospital, New York, NY (J.A.).

*A complete list of the ORBIT-AF investigators can be found in the Acknowledgments.

Correspondence to Benjamin A. Steinberg, MD, MHS, Electrophysiology Section, Duke Clinical Research Institute, Duke University Medical C PO Box 17969, Durham, NC 27715. E-mail benjamin.steinberg@duke.edu

Circulation **is available at http://circ.ahajournals.org** **DOI: 10.1161/CIRCULATIONAHA.114.0**

P=0.004) and CHA_2DS_2-VASc (4.25 versus 4.0 scores were higher in bridged patients, there were ences in rates of $CHADS_2$ score ≥2 (78% versus 7(or CHA_2DS_2-VASc score ≥2 (94% versus 95%; P of additional antiplatelet therapy was similar for c single antiplatelet (39% versus 36%) and dual antip apy (3.0% versus 2.2%; P=0.2 across antiplatelet c

Among patients treated with warfarin who had follow-up international normalized ratio after the (n=1452), time to the achievement of the therapeutic international normalized ratio ≥2) after the procedu nificantly shorter for interruptions with bridging con those without bridging (median, 17 versus 23 days;

Dental work	1/166 (0.6)	0/16 (0)	0/166 (0)
Other	5/413 (1.2)	7/102 (6.9)	7/413 (1.7)

Excluding interruptions missing a date or those that occurred wi of a previous interruption. PCI indicates percutaneous coronary inte

*Includes stroke, systemic embolism, myocardial infarction, or ca hospitalization within 30 days of the procedure requiring interruptic

†Includes major bleeding or bleeding hospitalization within 30 procedure requiring interruption.

no-bridging group and 3.2% in the bridging group (relative risk, 0.4
0.20 to 0.78; P=0.005 for superiority).

CONCLUSIONS

In patients with atrial fibrillation who had warfarin treatment interrup
elective operation or other elective invasive procedure, forgoing bridgi
agulation was noninferior to perioperative bridging with low-molecu
heparin for the prevention of arterial thromboembolism and decreased
major bleeding. (Funded by the National Heart, Lung, and Blood Insti
National Institutes of Health; BRIDGE ClinicalTrials.gov number, NCT

N ENGL J MED 373;9 NEJM.ORG AUGUST 27, 2015

Figure 1. BRIDGE Study Design.

Screening visits occurred between 30 days and 5 days before the planned procedure, and randomization (R) occurred
procedure. Warfarin treatment was discontinued 5 days before the procedure, and administration of the study drug wa
before the procedure. It was recommended that the international normalized ratio (INR) be measured 1 day before the
INR was greater than 1.8, oral vitamin K (1.0 to 2.5 mg) was recommended; if the INR was 1.5 to 1.8, oral vitamin K w
the procedure or surgery was delayed up to 3 days, administration of the study drug was continued until 24 hours befc
Warfarin treatment was restarted on the evening of or the day after the procedure, and the study drug was restarted 1
a minor (or low-bleeding-risk) procedure and 48 to 72 hours after a major (or high-bleeding-risk) procedure. Administ
drug was continued after the procedure until the INR was 2.0 or higher on one occasion. The final patient follow-up occu
the procedure. LMWH denotes low-molecular-weight heparin.

PROCEDURES

Patients were randomly assigned to receive bridging anticoagulation therapy with dalteparin sodium (100 IU per kilogram of body weight administered subcutaneously twice daily) or to receive no bridging therapy (i.e., a matching subcutaneous placebo) from 3 days before the procedure until 24 hours before the procedure and then for 5 to 10 days after the procedure. Randomization was stratified according to study center either with the use of an interactive voice-response system with a toll-free telephone number and access codes or through the Internet. The study drugs were provided in identical vials.

The administration of study drug followed a standardized perioperative management protocol (Fig. 1). Warfarin treatment was stopped 5 days before the procedure, and administration of the study drug (dalteparin or matching placebo) was started 3 days before the procedure. The last preprocedure dose of dalteparin or placebo was given in the morning approximately 24 hours

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1884 pazienti con indicazione al VKA per FA arruolati e almeno un FR per stroke

Randomizzato, in doppio cieco. Dalteparina somministrata dal 3^ g prima dell'intervento ai 5-10 gg successivi

Primary ED: tromboembolismo arterioso e sanguinamenti maggiori (follow up a 30 gg)

N Engl J Med 2015; 373: 823-33

The Bridge trial: characteristics of the patients

† Race was self-reported. The patients for whom data were unknown are those who chose
‡ $CHADS_2$ is a score used to estimate the risk of stroke in patients with atrial fibrillation. T
point each is assigned for congestive heart failure, hypertension, age of 75 years or older
points are assigned for stroke or transient ischemic attack.

828 N ENGL J MED 373;9 NEJM.ORG AUGUST 27, 2015

N Engl J Med 2015; 373: 823-33

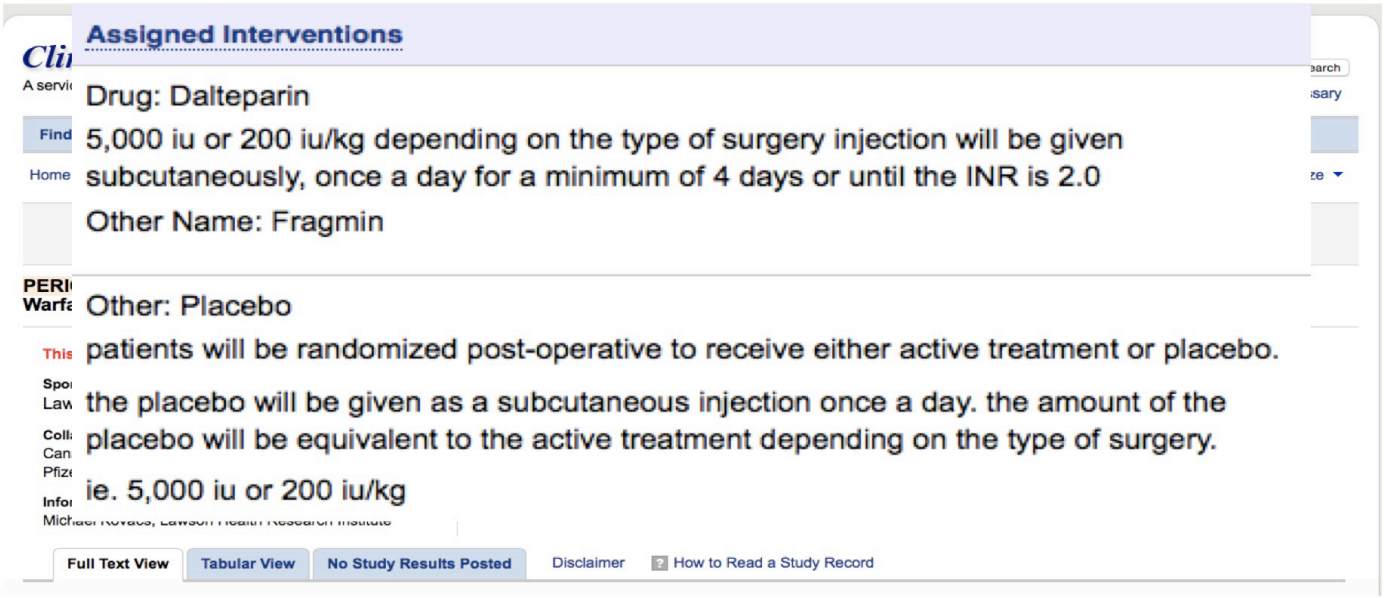
The Bridge trial: study outcomes

bridging. There was also less minor b
without bridging than there was with br
and there was no significant difference b
the groups with regard to myocardial infa
venous thromboembolism, or death. Ta
gether, these findings show that there i
clinical benefit in favor of a strategy of f
bridging, as compared with perioperative
ing with low-molecular-weight heparin.

The findings in our trial are consiste
those from nonrandomized comparisons
strategies. A meta-analysis of observation

* P value for non inferiority

N Engl J Med 2015; 373: 823-33



Pazienti con FA e almeno un fattore di rischio maggiore per stroke o portatori di protesi valvolari meccaniche. Primary EP = tromboembolismo maggiore; secondary EP = sanguinamento maggiore. Fine dell'arruolamento prevista per marzo 2017

ESC/ESA Guidelines on non-cardiac surgery: cardiovascular assessment and management ESC/ESA Guidelines on non-cardiac surgery: cardiovascular assessment and management 2014

Discontinuation of VKAs is hazardous:
-in pts with AF and CHA_2DS_2 VASc score ≥ 4
-In pts with mechanical prosthetic heart valves or newly inserted biological prosthetic heart valves
-In pts with mitral valvular repair (3 months)
-In pts with recent venous thromboembolism (3 months) or thrombophilia

For bridging there is better evidence for the efficacy and safety of LMWH (twice daily or once daily in low-risk patients). In patients with mechanical prosthetic heart valves UFH is preferred.

Stop VKAs 5 dd before the procedure/intervention; start heparin 3 dd before the procedure/intervention; stay on heparin until 24-12 h before the procedure

EXPERTS'OPINION

ADP	Adenosine diphosphate
AF	Atrial fibrillation
APA	Antiplatelet agents
APTT	Activated partial thromboplastin time
BSG	British Society of Gastroenterology
CrCl	Creatinine clearance
DAPT	Dual antiplatelet therapy
DES	Drug eluting stent
DOAC	Direct oral anticoagulant
eGFR	Estimated glomerular filtration rate
EMR	Endoscopic mucosal resection
EPBD	Endoscopic papillary balloon dilatation
ERCP	Endoscopic retrograde cholangio-pancreatography
ESD	Endoscopic submucosal dissection
ESGE	European Society of Gastrointestinal Endoscopy
EUS	Endoscopic ultrasound
IPB	Intraprocedural bleeding
LMWH	Low molecular weight heparin
MI	Myocardial infarction
MS	Mitral stenosis
N-STEMI	Non ST-elevation myocardial infarctio
NICE	National Institute for Health Care and Excellence
NOAC	Non-vitamin K oral anticoagulants
PAR-1	Protease-activated receptor 1
PCC	Prothrombin complex concentrate
PEG	Percutaneous endoscopic gastrostomy
PPB	Post polypectomy bleeding
PICO	Patients, Interventions, Controls, Outcomes
PPI	Proton pump inhibitor
PT	Prothrombin time
RCT	Randomised controlled trial
SEMS	Self-expanding metal stents

Veitch Andrew M et al. Endoscopy in patients… Endoscopy 2016; 48: 385–4(

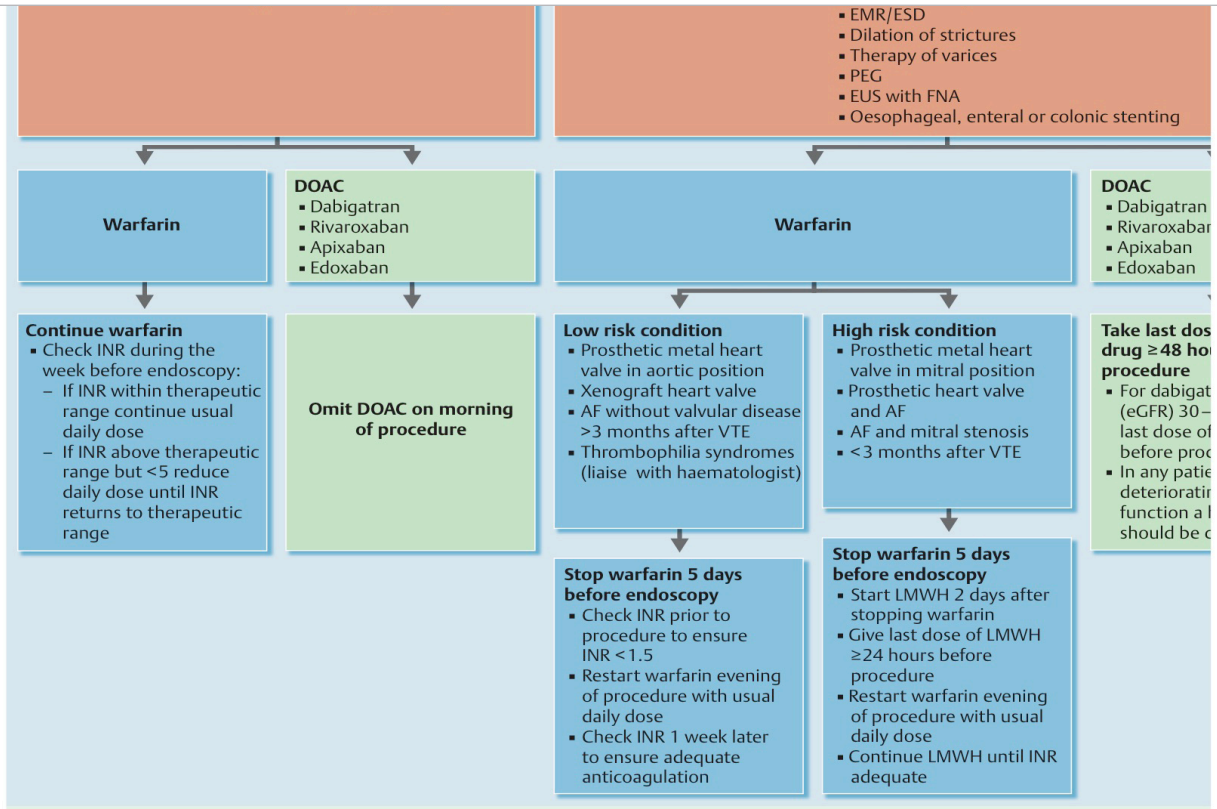


Fig. 2 Guidelines for the management of patients on warfarin or direct oral anticoagulants (DOAC) undergoing endoscopic procedures.

Veitch AM et al., Endoscopy 2016;48:385

Veitch Andrew M et al. Endoscopy in patients… Endoscopy 2(

Conclusioni

La definizione del rischio TE del paziente e del rischio emorragico legato all'intervento/procedura costituisce il primo passo per una corretta gestione peri-operatoria della terapia anticoagulante orale

Un basso rischio tromboembolico e interventi a minimo rischio emorragico non richiedono la sospensione dei VKA

Il bridging con "eparine" resta al momento indicato solo nei pazienti ad alto rischio TE (protesi valvolari, FA complicata da recente stroke o tromboembolismo o con $CHADS_2$ 5-6); va valutato in quelli a rischio intermedio

Se praticato, privilegiare l'uso di LMWH e scegliere la dose piena o quella profilattica in base al profilo di rischio emorragico della procedura