μsesiones

Anticoagulación precoz en el ictus

en pacientes con FA no valvular

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If untreated, the risk of early recurrence of ischemic stroke in patients with AF is between 0.5% and 1.3% per day.

Guía ESO 2019

Recomendaciones

- Antiagregación durante las primeras 48 horas
- Iniciar anticoagulación **DOAC** (o AVK; evitando heparina)

NIHSS <8[1]	NIHSS 8-16	NIHSS >16
3-4 días	7 días	14 días

1. Volumen de infarto <1.5 cm

	Quality of evidence	Strength of recommendation
Medical treatment		
We do not recommend antiplatelet agents (single or dual), over no antiplatelet therapy.	Moderate	Weak
We recommend VKA therapy over no antithrombotic medication	Moderate	Strong
We recommend VKAs (INR 2-3) over antiplatelet therapy.	Moderate	Strong
We recommend NOACs over VKAs	High	Strong
We suggest NOACs over aspirin in patients who have failed or are unsuitable for VKA therapy.	Moderate	Weak
Timing and bridging of medical treatment		
We cannot make recommendations about the optimal time for initiating anticoagulation treatment in patients with acute ischemic stroke.	Low	Weak
Expert opinion: We suggest antiplatelet therapy in the first 48 h after ischemic stroke associated with AF. We consider it reasonable to start anticoagulant therapy at day 3 or 4 from the index stroke in patients with mild stroke and small infarcts (<1.5 cm) and at day 7 for moderate infarcts. For large infarcts, OACs might be best delayed for 14 days after the index stroke.		
We suggest that bridging therapy should be avoided prior to anticoagulation with VKAs or NOACs.	Low	Weak

Guía ESC 2018 (1-3-6-12)

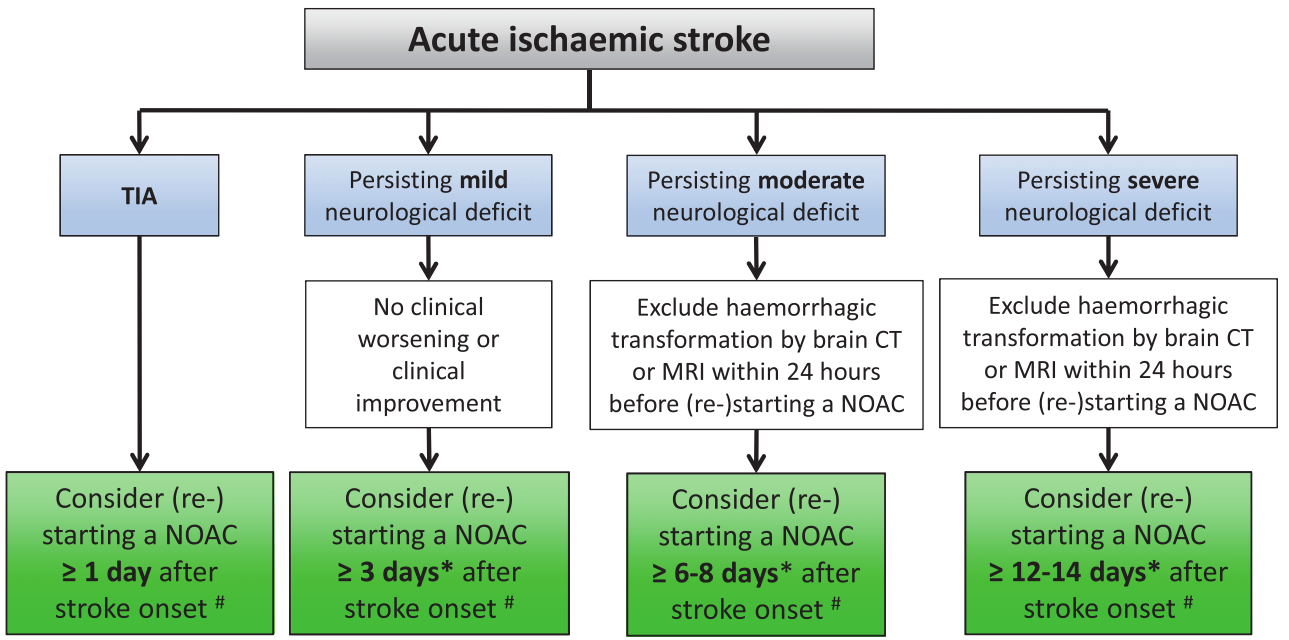
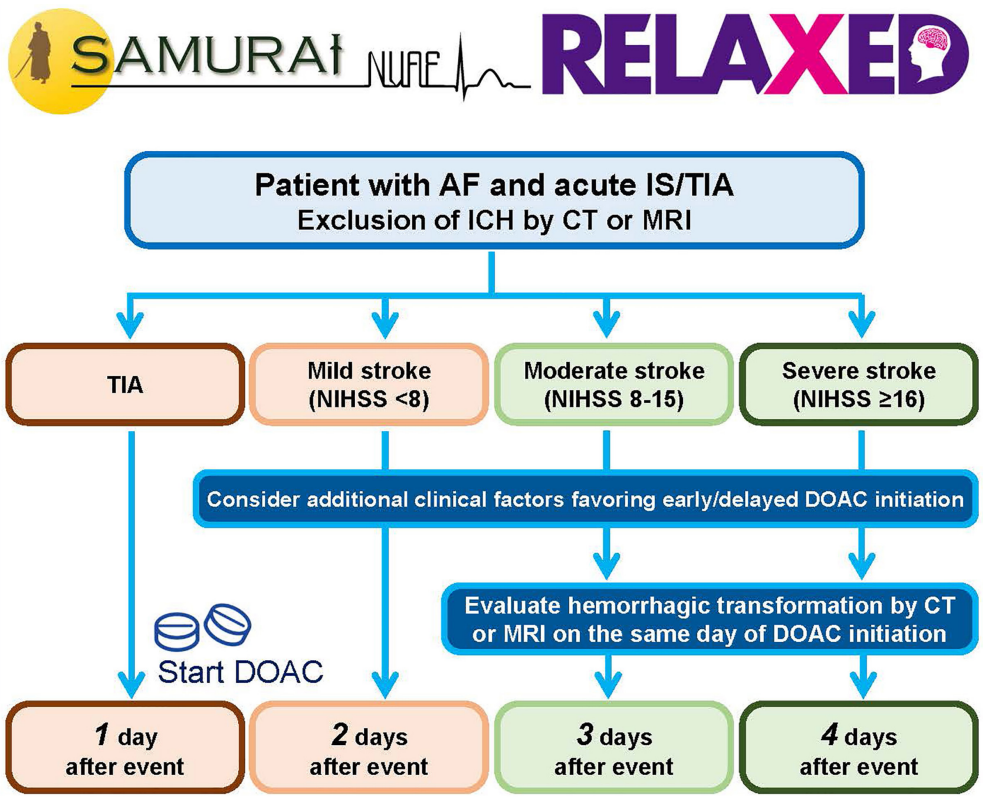


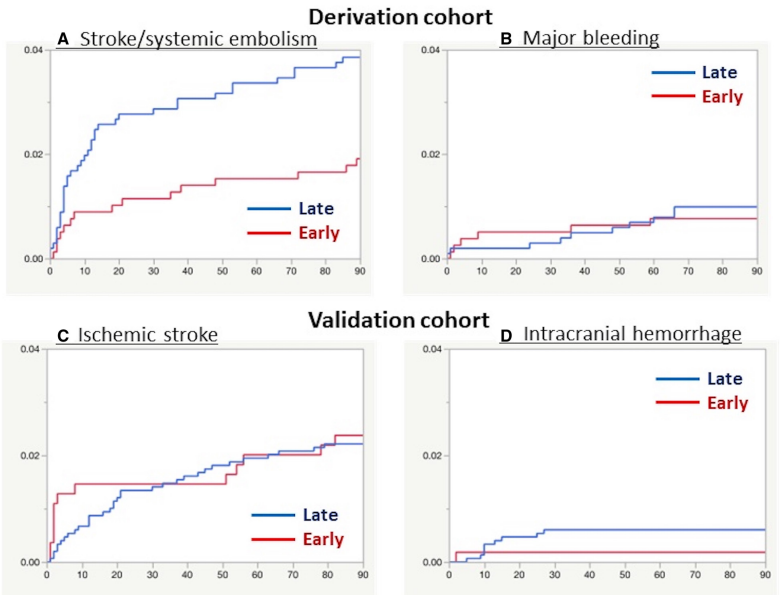
Figure 14 (Re-) initiation of anticoagulation after transient ischaemic attack/stroke. (Re-) start only in the absence of contraindications and if stroke size is not expected to substantially increase the risk of secondary haemorrhagic transformation. *Consider shorter delays to (re-) start a non-vitamin K antagonist oral anticoagulant if there is a very high risk of stroke recurrence (e.g. left atrial appendage thrombus) and no haemorrhagic transformation on follow-up brain imaging (using computed tomography or magnetic resonance imaging). Consider longer delays to (re-)start a non-vitamin K antagonist oral anticoagulant according to the recommendations made in the European Society of Cardiology Atrial Fibrillation Guidelines 2016. #Without proven evidence; consider inclusion of patient in an ongoing trial.

1-2-3-4 😬



Development and validation of the practical "1-2-3-4-day" rule for starting direct oral anticoagulants after ischemic stroke/TIA with atrial fibrillation

- Japón (2 observacionales) + validación con registro Europeo
- **Mediana** de inicio de DOAC para los cuatro grupos de ictus; definen *inicio precoz* como un día menos:
  - **Japón**: 2-3-4-5
  - *Inicio precoz*: 1-2-3-4
  - **Europa**: 2-5-8-8



> **Menor riesgo de ictus… en Japón**
>
> - **HR 0,5** [95% CI 0,27 - 0,89]
> - mismo riesgo de hemorragias graves

> **⚠ ¡Ojo!**
>
> - Estudio no aleatorizado
> - Más fibrinolisis / trombectomía en el grupo precoz
>   - neuroimagen en 24 horas del ictus
> - Ictus graves excluidos
> - Mayor efecto del **rivaroxaban** en japoneses

Todo el mundo pasa de las guías

AIT	NIH <8	NIH 8-16	NIH >16
2 días	3-4 días	7 días	14 días
2 (1-3)	5 (2-10)	8 (4-14)	8 (4-14)

Mediana y rango intercuartílico

The NEW ENGLAND JOURNAL of MEDICINE

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Early versus Later Anticoagulation for Stroke with Atrial Fibrillation

U. Fischer, M. Koga, D. Strbian, M. Branca, S. Abend, S. Trelle, M. Paciaroni, G. Thomalla, P. Michel,

Tipo de ictus	Menor	Moderado	Mayor
Precoz	<48 horas	<48 horas	6-7 días
Tardío	3-4 días	6-7 días	12-14 días

¿Un ictus moderado?

Menor

- ≤1,5 cm

Moderado

- Una rama de ACM o ACA

Mayor

- ACM, ACA o ACP completa
- ≥2 ramas de ACM
- ≥2 territorios
- ≥1,5 cm en cerebelo o tronco

JAMA Neurology | Original Investigation

Early vs Late Anticoagulation in Minor, Moderate, and Major Ischemic Stroke With Atrial Fibrillation

Post Hoc Analysis of the ELAN Randomized Clinical Trial

RESULTS A total of 1962 of the original 2013 participants (909 [46.3%] female; median [IQR] age, 77 [70-84] years) were included. The primary outcome occurred in 10 of 371 participants (2.7%) with early DOAC initiation vs 11 of 364 (3.0%) with late DOAC initiation among those with minor stroke (odds ratio [OR], 0.89; 95% CI, 0.38-2.10); in 11 of 388 (2.8%) with early DOAC initiation vs 14 of 392 (3.6%) with late DOAC initiation among those with moderate stroke (OR, 0.80; 95% CI, 0.35-1.74); and in 8 of 219 (3.7%) with early DOAC initiation vs 16 of 228 (7.0%) with late DOAC initiation among those with major stroke (OR, 0.52; 95% CI, 0.21-1.18). The 95% CI for the estimated risk difference of the primary outcome in early anticoagulation was −2.78% to 2.12% for minor stroke, −3.23% to 1.76% for moderate stroke, and −7.49% to 0.81% for major stroke. There was no significant treatment interaction for the primary outcome. For infarct size, interrater reliability was moderate (κ = 0.675; 95% CI, 0.647-0.702) for local vs core laboratory raters and strong (κ = 0.875; 95% CI, 0.855-0.894) between core laboratory raters.

CONCLUSIONS AND RELEVANCE The treatment effect of early DOAC initiation did not differ in people with minor, moderate, or major stroke assessed by brain imaging. Early treatment was not associated with a higher rate of adverse events, especially symptomatic intracranial hemorrhage, for any infarct size, including major stroke.

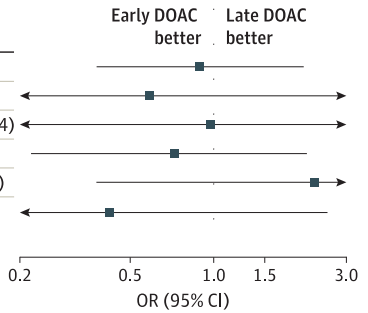
TRIAL REGISTRATION ClinicalTrials.gov Identifier: NCT03148457

JAMA Neurol. 2024;81(7):693-702. doi:10.1001/jamaneurol.2024.1450
Published online May 28, 2024.

Figure 2. Unadjusted Odds Ratios (ORs) of the Primary Composite Outcome and Secondary Outcomes at 30 Days

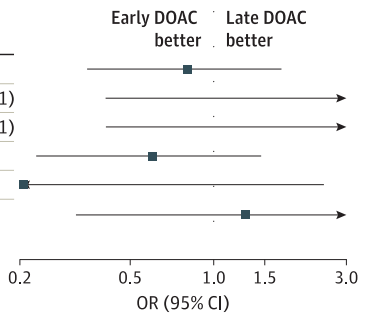
A Minor stroke

Outcome	Early DOAC (n = 371) No. of events, %	Late DOAC (n = 364) No. of events, %	OR (95% CI)
Composite primary outcome at 30 d	10 (2.7)	11 (3.0)	0.89 (0.38-2.10)
Major extracranial bleeding	1 (0.3)	2 (0.5)	0.59 (0.05-4.43)
Symptomatic intracranial hemorrhage	0 (0)	0 (0)	0.98 (0.01-181.14)
Recurrent ischemic stroke	5 (1.3)	7 (1.9)	0.72 (0.22-2.16)
Systemic embolism	3 (0.8)	1 (0.3)	2.30 (0.38-23.83)
Vascular death	1 (0.3)	3 (0.8)	0.42 (0.04-2.56)



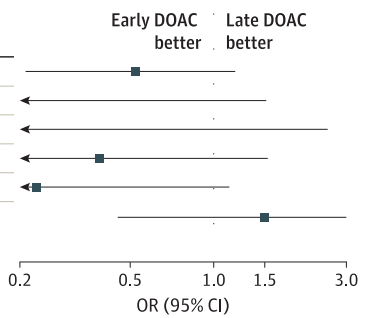
B Moderate stroke

Outcome	Early DOAC (n = 388) No. of events, %	Late DOAC (n = 392) No. of events, %	OR (95% CI)
Composite primary outcome at 30 d	11 (2.8)	14 (3.6)	0.80 (0.35-1.74)
Major extracranial bleeding	2 (0.5)	0 (0)	5.08 (0.41-701.21)
Symptomatic intracranial hemorrhage	2 (0.5)	0 (0)	5.08 (0.41-701.21)
Recurrent ischemic stroke	7 (1.8)	12 (3.1)	0.60 (0.23-1.47)
Systemic embolism	0 (0)	2 (0.5)	0.20 (0.00-2.48)
Vascular death	4 (1.0)	3 (0.8)	1.30 (0.32-5.86)

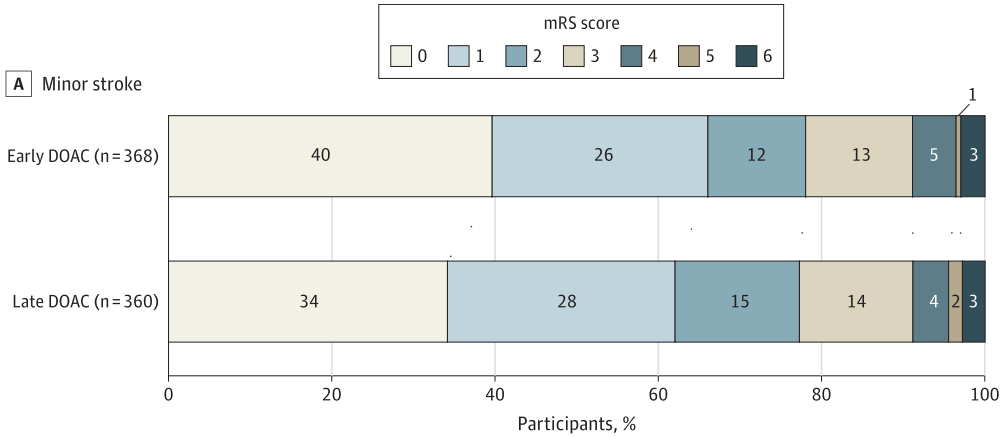


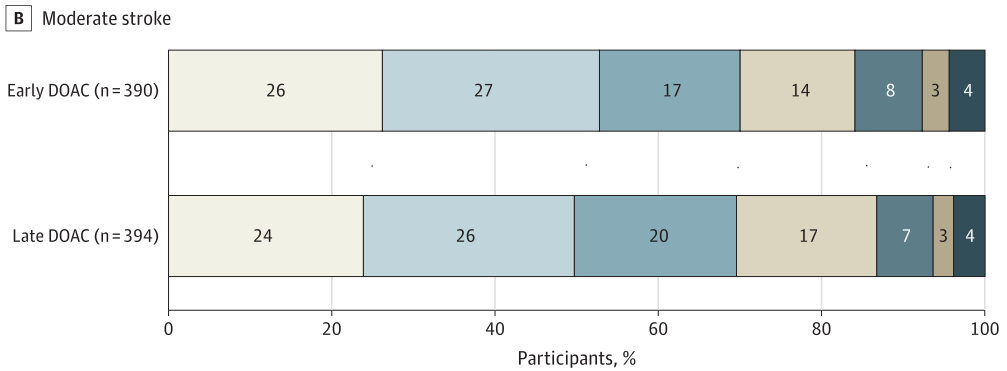
C Major stroke

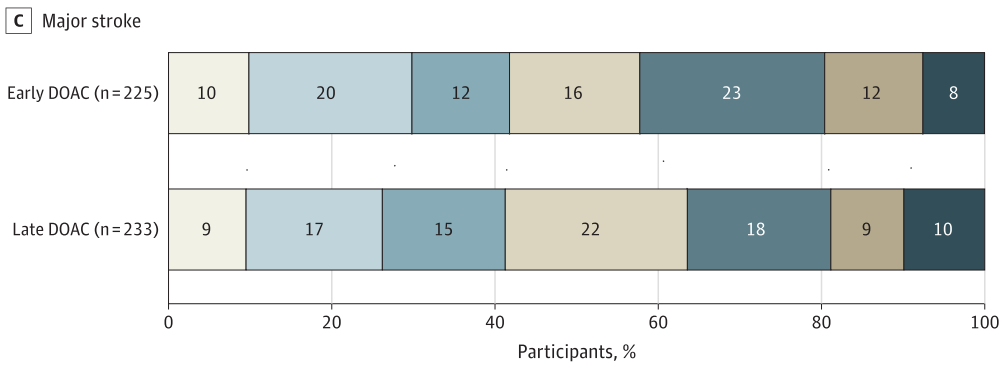
Outcome	Early DOAC (n = 219) No. of events, %	Late DOAC (n = 228) No. of events, %	OR (95% CI)
Composite primary outcome at 30 d	8 (3.7)	16 (7.0)	0.52 (0.21-1.18)
Major extracranial bleeding	0 (0.0)	3 (1.3)	0.15 (0.00-1.53)
Symptomatic intracranial hemorrhage	0 (0.0)	2 (0.9)	0.21 (0.00-2.56)
Recurrent ischemic stroke	2 (0.9)	6 (2.6)	0.39 (0.07-1.56)
Systemic embolism	1 (0.5)	6 (2.6)	0.23 (0.02-1.13)
Vascular death	6 (2.7)	4 (1.8)	1.52 (0.45-5.55)



The incidences of the primary and secondary outcomes at 30 days were comparable for all infarct size groups, including minor (A), moderate (B), and major (C) stroke. DOAC indicates direct oral anticoagulant.







In all infarct size groups, including minor (A), moderate (B), and major (C) stroke, the mRS score distribution at 90 days was similar between early and late direct oral anticoagulant (DOAC) initiation. For mRS score shifts between early and late DOAC initiation, the odds ratio was 0.86 (95% CI, 0.65-1.13) for minor stroke, 0.92 (95% CI, 0.69-1.22) for moderate stroke, and 1.04 (95% CI, 0.69-1.56) for major stroke.

Recomendaciones

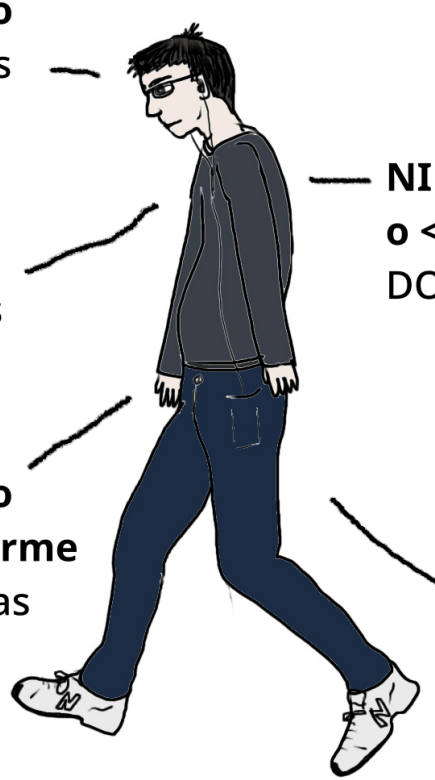
Ictus o AIT asociado a FA no valvular tras comprobar que no hay hemorragia…

Las guias del 2019

AIT o infarto
AAS 48 horas

NIHSS 8-16
DOAC 7 días

NIHSS >16 o infarto enorme
DOAC 14 días



NIHSS <8 o <1,5 cm
DOAC 3-4 días

Infarto grande
DOAC 7 días

Me acabo de leer un artículo

AIT
DOAC <24 horas

Infarto pequeño o grande
DOAC <48 horas

Infarto enorme
DOAC 7 días

Recomendaciones

- En AIT se podría anticoagular en 24 horas con imagen
- En infartos pequeños o medianos parece seguro ≤48 horas
- En infartos mayores es posible a la semana
- Las guías contemplan dos semanas en infartos grandes
- La evidencia actualmente no apoya ninguna actitud[1]

1. pero parece favorecer tiempos más cortos

Muchas gracias

Podéis encontrar estas diapositivas en

cerebro.neocities.org

Referencias

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