Initiation/Resumption of Anticoagulation after Ischemic Stroke

Consider the **risks** and **benefits**

Risk of recurrent ischemic stroke

Indication for AC:

- Mechanical valve: mitral position is higher risk than aortic
- AF: assess risk with CHADS-VASc Score

Severely enlarged left atrium on echo or presence of an intracardiac thrombus

Active systemic malignancy

Choice of anticoagulant:

- DOACs will result in therapeutic anticoagulation within hours of taking the first dose vs. warfarin which takes 3-5 days
- Timing outlined below is the time to therapeutic anticoagulation so needs to be adjusted based on warfarin vs. DOAC

Renal function needs to be considered & monitored if selecting a DOAC

Suggestion for timing of initiation/resumption of anticoagulation following ischemic stroke

Post-stroke day:

- **0-4**: Do not use AC unless there is a competing life-threatening indication (anterior wall STEMI, PE, intravascular or intracardiac thrombi). Discuss with neurology before initiation.
- **5-7**: High-risk for recurrent stroke, low risk for hemorrhagic transformation
- **7-10**: Intermediate risk for either recurrent stroke or for hemorrhagic transformation
- **11-14**: Low-risk for recurrent stroke, high risk for hemorrhagic transformation

- Antiplatelets should be stopped at the time of full anticoagulation unless there is a clear indication for their use.

Risk of hemorrhagic transformation of the ischemic stroke

HAS-BLED can be used if you are concerned about the risk of **SYSTEMIC** bleeding, but it is **NOT** useful at predicting the risk of hemorrhagic transformation of an ischemic stroke

Size of stroke: large strokes (> 60 mL) are at higher risk of hemorrhagic transformation than small strokes (<30 mL), but any size stroke can bleed and should not considered "safe" for OAC

Prior to initiation/resumption of AC:

Blood pressure MUST be controlled

The patient must be medically stable

There should be no procedures planned in the immediate future (PEG tube, pacemaker placement, etc.)

Fall risk should be assessed and addressed (PT, home health visit, avoid polypharmacy, correct orthopedic issues, address vision problems, provide walking assist devices, etc.

Counselling should be provided to avoid excess alcohol/other intoxication.
May chose **not** to initiate/resume anticoagulation in the setting of uncontrolled alcohol or drug use

Medications should be reviewed for polypharmacy, antiplatelets, NSAIDs, SSRIs and supplements and adjusted to reduce bleeding risks