Management of Anticoagulants in Procedures That Can Cause Bleeding

Manejo de anticoagulantes en procedimientos que pueden producir una hemorragia

To the Editor,

Vivas et al.1 are to be congratulated on their article; reaching a consensus among 24 scientific societies is a notable achievement. We have read the article carefully, and while we agree with almost all its content, a review of the literature2–9 reveals some areas of concern. One major concern is the limited information on bridging therapy with low – molecular-weight heparin (LMWH). Aside from stipulating that heparin bridging should be restricted to diseases associated with a high thromboembolic risk, the consensus document barely discusses LMWH. For example, there is no mention of the appropriate LMWH dose for patients at high thromboembolic risk (equivalent to 1 mg/kg/12 h enoxaparin, or 1.5 mg/kg if a single dose is used2–9). Moreover, we were confused by the following sentences: “The last dose of LMWH should be administered 12 hours before the operation or procedure in the case of prophylactic doses and 24 hours in the case of therapeutic doses. Unfractionated heparin should be administered 4 to 6 hours in advance.” This implies the existence of distinct prophylactic and therapeutic doses; however, we were unable to find any other reference to prophylactic and therapeutic doses in the text. This generates doubts about what course of action should be adopted. Similarly, the article does not specify when postprocedure LMWH should be initiated or how long the treatment should be maintained.

A second major concern relates to which patients should be maintained on anticoagulation therapy. Table 1 Table 1 of the supplementary material lists the low-risk procedures that do not require suspension of anticoagulation, corresponding to the assignation “a” in Figure 2 Figure 2 of the main text. The problem is that this assignation applies to very few patients, thus giving the impression that some hospital specialties have been over cautious in emphasizing the remote risk of bleeding and a thromboembolic episode.

For example, the text specifically mentions pulmonary vein catheter ablation, but this is not reflected in the supplementary material, where this procedure is not considered. Another controversial omission is dental procedures, contrasting with the inclusion of dental extraction in other guideline documents on anticoagulant use,2,8,9 including the guidelines of the Spanish College of Dentists.10

Our final concern relates to ophthalmology. The article states that anticoagulation can be maintained during procedures performed under topical anaesthesia. However, the preceding section on surgery contraindicates anticoagulation during cataract surgery. Does this then refer only to cataract surgery not performed under topical anaesthesia? Other guidelines and manuals include a list of procedures requiring suspension of anticoagulation,2,7,9 and this consensus document would have been strengthened by the inclusion of such a practical list.

We would like once again to congratulate the authors on the completion of this consensus document, which we are sure will be consulted and followed by health care professionals in all specialties.

Enrique Martín-Rioobó,* Cristina Martín-Manero,* Paula Medina-Durán,* and Luis Angel Pérla-de Torres*±

*Instituto Maimónides de Investigación Biomédica de Córdoba (IMIBIC), Hospital Universitario Reina Sofía de Córdoba, Universidad de Córdoba, Córdoba, Spain
±Unidad de Gestión Clínica Ribera del Muelle, Servicio Andaluz de Salud, Puerto Real, Cádiz, Spain
#Unidad de Gestión Clínica Poniente, Servicio Andaluz de Salud, Córdoba, Spain
$Unidad Docente de Medicina Familiar y Comunitaria de Córdoba, Servicio Andaluz de Salud, Córdoba, Spain

*Corresponding author: E-mail address: luis.angel.perula@gmail.com (L.A. Pérla-de Torres).

Available online 17 July 2018

REFERENCES


© 2018 Sociedad Española de Cardiología. Published by Elsevier España, S.L.U. All rights reserved.