Deprescribing Guide: Anticoagulants & Antiplatelets

INTRODUCTION TO ANTICOAGULATION DEPRESCRIBING

Many patients are admitted to hospice services already prescribed an antiplatelet or anticoagulant medication, especially if they have cardiovascular disease or a history of blood clots due to cancer. A recent study reported the prevalence of antithrombotic therapy at the time of hospice enrollment at nearly 7% of patients, with about 57% of those patients on aspirin therapy and over 18% on multiple antithrombotic medications.[1]

Antiplatelet medications prevent blood clots by inhibiting platelet aggregation and are used to decrease the risk of death from cardiovascular events such as myocardial infarction (MI), ischemic stroke, angina, or peripheral arterial disease.[2] Aspirin is the original antiplatelet medication and is available over-the-counter (OTC), thus patients may choose to take aspirin without prescriber advice. Non-aspirin antiplatelet medications are also used off-label for secondary prevention of cardiovascular disease in patients with diabetes or aspirin allergy, and in some patients with atrial fibrillation to prevent thromboembolism.[2] Additionally, clopidogrel or prasugrel may be used in dual antiplatelet therapy (DAPT) in combination with aspirin for patients with acute coronary syndrome (ACS) or following stent placement.[2] Anticoagulant medications also prevent blood clots but instead of inhibiting platelets, they prevent blood coagulation by reducing the action of clotting factors directly or indirectly. Anticoagulants are also used to prevent clotting in patients with atrial fibrillation, thromboembolic disease, and artificial heart valves.[2]

ANTIPLATLET AND ANTICOAGULANT MEDICATIONS

Antiplatelet Medications					
Aspirin	Clopidogrel (Plavix®)	Ticagrelor (Brillinta®)	Prasugrel (Effient®)	Aspirin/dipyridamole (Aggrenox®)	
Anticoagulant Medications					
Warfarin (Coumadin®)	Enoxaparin (Lovenox®)	Rivaroxaban (Xarelto®)	Dabigatran (Pradaxa®)	Apixaban (Eliquis®)	Edoxaban (Savaysha®)

The decision to discontinue antiplatelet and/or anticoagulant medications should always be an individualized approach, weighing the risks vs. benefits, and the patient and family's goals of care. Discontinuing these medications is generally considered acceptable in any patient with a life-limiting illness, especially when adverse effects are possible.[3] The information below is based on literature review in the primary care and hospitalized patient population. There are no studies determining risk vs. benefit of aspirin, other anti-platelet therapies, or anticoagulants for patients in hospice or palliative care. Due to the likelihood of drug interactions, consulting with a pharmacist when adding or discontinuing any medication is recommended.

Consider deprescribing if any of the following factors present:	
Risk of bleeding	• Increased risk for major hemorrhage or bleeding complications present in patients on anticoagulation therapy with advanced age, CHF, CVD, hypertension, liver or renal disease, diabetes, history of or recent GI bleed, anemia, concomitant use of antiplatelets or NSAIDs.[6,8,11,12] • HAS-BLED score tool can be used to assist clinicians in identifying patients at high risk for bleeding.[7] • When bleeding does occur, lack of access to reversal agents other than vitamin K (phytonadione) can be difficult. Hospitalization is required for patients to use the reversal agents for dabigatran, apixaban, and rivaroxaban to manage bleeding.[2]
No longer indicated	• No palliative benefit identified • Antiplatelet or anticoagulant medications may have been started with time-limited intent after a procedure or event. • Benefits of multiple antiplatelet or anticoagulation combination therapy is generally limited to 3-12 months of therapy; likely no additional benefit to longer therapy, only increased risk of bleeding, especially in the hospice population.[4]
Risk of falls	• Hospice patients, young and old, have an increased risk of falling, and potential for internal or external bleeds. • Risk of an intracranial hemorrhage in a debilitated ambulatory patient who may fall is greater than the benefit in preventing a stroke.[5]

Pill burden/monitoring	• Antiplatelet and anticoagulant medications contribute to polypharmacy and pill burden. • Warfarin requires routine PT/INR testing. Patients may wish to avoid finger sticks or blood draws. If routine bloodwork or INR testing is refused by patient, discontinue warfarin.[5]
Goals of Care	• Continuing medications that are not relieving any symptoms (i.e. not palliative), may be outside the goals of care (exception may be treatment of DVT).
Contraindications	• **CrCl≤ 30**: dabigatran, edoxaban; **≤ 15**: rivaroxaban, apixaban • *Active or at risk* of clinically significant bleed (ex: secondary to fall) • Significantly reduced liver function • Most hospice patients meet at least one contraindications above

PATIENT & CAREGIVER DISCUSSION POINTS:

- Acknowledge that patient and family concern about medication changes, especially stopping medications, is a common response.
- Provide reassurance that all medication changes are made in consultation with the patient's doctors. The decision to stop antiplatelet and anticoagulant medications is always an individualized approach.
- Ask the patient and family questions to bring them into the shared decision-making process. Use open ended questions that lead into conversations about stopping medications. — "Do you know why you are taking this medication? Is it hard to take all these pills every day? Do you ever feel worse after taking this pill? Have you noticed your wife is eating less than she used to? Have you felt unsteady when walking lately? Are you worried about your mom falling? What are your goals now that your dad is on hospice?"
- Explain that as patients age or diseases progress, certain medications that were once helpful can become harmful. The hospice team's role is to enhance comfort and quality of life by providing effective and safe medications, treating physical and emotional symptoms, and minimizing adverse events. — "Dr. Smith would like to discuss stopping your loved one's warfarin. Since you shared that she is no longer eating much and has fallen a few times over the past month, he is concerned the medication is no longer safe for her to take. The risk of her developing a bleed in her brain or stomach is greater than the risk of her having a stroke over that same time frame.

- Remind the patient and family that the hospice team will regularly reassess the patient's condition and medications — If the patient has a relatively good prognosis, has a symptomatic DVT or is at high risk for thromboembolism, is still ambulatory, adherent to their prescribed medication regimen, and at low risk for bleeding, the patient may benefit from continued anticoagulation. Reassess at each visit, change in condition, or change in location of care to determine continued need for the medication. For some patients following ischemic stroke, MI, stents, or other cardiovascular event, the risk of a second event may outweigh the risk of a GI bleed, indicating that continuing the medication is reasonable.
- Sometimes changing to an alternative, potentially safer medication is an option to meet the patient and family halfway — For example, aspirin seems to be similar in effectiveness to clopidogrel for patients with a history of cardiovascular or stroke; for patients wanting to continue some antiplatelet therapy, a change to aspirin can be considered. DAPT does not have significant benefit over aspirin alone for secondary prevention of MI or stroke.[4]

HOW TO DEPRESCRIBE

- Once the decision has been made to discontinue antiplatelet or anticoagulant medications, they may be stopped without a taper.
- If family or patient is hesitant to discontinue, consider a trial discontinuation for a limited period of time (e.g., 2 weeks or 1 month) and offer to re-evaluate once that trial is completed. Often, the family or patient needs this time as an "adjustment period" to accept the possibility of discontinuation, understand the medication is not helping, and realize that continuation is not necessary.
- Remind the patient/family that you will continue to provide the highest level of care, focused on patient comfort and symptom management.

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