Focus on the Practical Aspects of Oral Factor Xa Inhibition for Stroke Prevention in AF, Acute Treatment of VTE, and Secondary Prevention of Acute Coronary Syndrome (ACS)

Question # 1:
Do the pharmacological, clinical, compliance, and safety innovations associated with NOACs represent a new standard for “comprehensive and unified” treatment of patients with AF, VTE, and/or ACS?

Question # 2:
How do we overcome the barriers to making NOACs the new, evidence-based treatment paradigm for thrombosis management of AF, VTE, and ACS?

Question # 3:
Given new U.S. data confirming that TTR for warfarin is much less satisfactory than what we might have believed, is there now greater justification for switching more patients from VKA to a NOAC, across the spectrum of AV thrombotic continuum?
Question # 4: From a practical perspective, how effective do you believe we can “transfer and apply” the new innovative, NOAC-based strategies supported by clinical trials to the real world at the front lines of thrombosis care?

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Question # 5: Can you put the current landscape and need for NOAC-based anticoagulation for AF and VTE in perspective, based on recent real world results evaluating INRs and TTRs in patients on warfarin therapy?

Question # 6: What can we learn, from a practical clinical action perspective, from the landmark meta-analysis focused on the benefits of NOACs for stroke prevention in AF? What can you say about the safety of these agents?

Question # 7: What are the seminal developments in the emerging role of all-oral, factor Xa and direct thrombin inhibitor-based treatment of acute PE?

Question # 8: Based on the clinical trials evaluating the efficacy and safety of all-oral therapy with rivaroxaban for acute treatment of PE, which patient subgroups with VTE do you believe are the best candidates for this approach?

Question # 9: What new data is available that has helped to clarify some of the questions about bleeding risk associated with NOACs, and that has confirmed the superior net clinical benefits associated with these agents?

Question # 10: Please summarize the seminal advance and approval of an ultrasonic device that you investigated in the SEATTLE 2 Trial and that has been approved for treatment of massive PE?

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Question # 11: What is the pathobiological and historical rationale for evaluating anticoagulation agents, including NOACs, in the setting of ACS? And what did we learn from the ATLAS-ACS trial evaluating rivaroxaban?

Question # 12: Inasmuch as rivaroxaban is approved in Europe (but not the U.S.) for secondary prevention of ACS, based on the ATLAS-ACS trial, how should clinicians in Europe optimally select specific ACS patients in whom the net clinical benefit of triple therapy supports this strategy?

Question # 13: When considering rivaroxaban for secondary prevention of ACS, should we view patients with NSTEMI versus STEMI as more appropriate or more likely to derive benefits from adding this oral factor Xa inhibitor to DAP?

Question # 14: From a practical, bleeding risk perspective, why is it important to emphasize that the ATLAS-ACS trial and European approval of rivaroxaban for ACS is restricted to its role in combination with aspirin and clopidogrel, not other antiplatelet agents?

Question # 15: What is the role of genetic variants and platelet function testing in determining the need for adding a factor Xa inhibitor or selecting an alternative, PGY-12-inhibiting, antiplatelet agent?

Question # 16: Would an ACS patient treated with either aspirin plus ticagrelor or prasugrel, who has had a recurrent event, be considered an excellent candidate for triple therapy with aspirin, clopidogrel, and rivaroxaban? What other factors do you consider?

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Question # 17: How do you recommend we might align certain NOACs with specific patient profiles or clinical factors, to optimize the risk-benefit equation in any individual patient with AF?

Question # 18: What is your practical guidance for continued and concomitant use of a NOAC in a patient with AF who enters hospital for treatment of ACS and stent placement—and requires triple antithrombotic therapy?

Question # 19: From a practical perspective in an ACS patient, how do you decide between using aspirin plus a more potent antiplatelet agent (ticagrelor or prasugrel) versus aspirin and clopidogrel plus rivaroxaban, in the ATLAS-2 dose (2.5 mg PO BID) approved for ACS?
Question # 20: With overall mortality as well as large reductions in ICH confirmed for NOACs, is there now a greater, safety-based justification for switching more AF patients who are on warfarin—even those with acceptable INR control—to a NOAC and optimize net clinical benefit?

Question # 21: In AF patients undergoing cardioversion, how well anticoagulated should a patient be? And, is it safe to use a NOAC in this setting?

Question # 22: What surveillance and compliance strategies will likely optimize the risk-benefit ratio for NOAC use in the setting of AF?

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Question # 23: How has the recent approval of the oral anticoagulant, rivaroxaban, for secondary prevention of ACS changed the landscape of cardioprotection in ACS patients who previously were managed with dual antiplatelet therapy only?

Question # 24: Based on the results of the landmark ATLAS-ACS Trial, which patients in Europe, where the agent is approved for secondary prevention of ACS, represent the best candidates for rivaroxaban for secondary prevention of ACS? How do we select patients to optimize safety and efficacy of DAP plus rivaroxaban?

Question # 25: Can you give us a few profiles of patient types that you would consider to be ideal candidates for triple agent therapy with aspirin, clopidogrel, and rivaroxaban for secondary prevention of ACS?

Question # 26: From a practical perspective, how would you monitor an ACS patient whom you have committed to triple therapy with aspirin, clopidogrel, and rivaroxaban for secondary prevention of ACS? What would your vigilance strategy be?

Question # 27: What kind of bleeding signals or events in a post-ACS patient you have committed to aspirin, clopidogrel, and rivaroxaban would prompt you to discontinue one or more these agents?

Question # 28: Given the risk-benefit equation that is associated with the addition of rivaroxaban to DAP for secondary prevention of ACS, what percentage of ACS patients do you believe will likely be placed on this triple regimen?

Question # 29: How would you choose between dual antiplatelet therapy (prasugrel plus aspirin) versus triple therapy with aspirin, clopidogrel, and rivaroxaban?

Question # 30: How would you summarize the take-home message as it relates to the approval and availability in Europe to employ low-dose rivaroxaban for secondary prevention of ACS? How do we arrive at the optimal risk-benefit analysis?

Question # 31: From a practical, patient perspective how would you currently use low-dose rivaroxaban for secondary prevention of ACS? (French)

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Question # 32: What is the role of NOACs in VTE patients with cancer? Is there any data for rivaroxaban in this regard?

Question # 33: Since all four mega-trials evaluating NOACs for VTE treatment show non-inferiority compared to LWMH/warfarin, what is the rationale for using NOACs for treatment and secondary prevention of VTE?

Question # 34: With four NOACs demonstrating clinical efficacy and safety for acute treatment of VTE, how should the practitioner select among the available and approved agents for use in patients with PE or DVT?

Question # 35: What advice do you have for the practitioner who is concerned about the lack of a reversal agent for the NOACs?
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Question # 36:
What practical approaches do you advise for patients who require a surgical procedure while taking a NOAC? Do they require bridging? How do you manage these patients?

Question # 37:
What are the practical implications of using NOACs in place of LMWH/warfarin, and how do the trial designs evaluating NOACs for VTE differ from one another with respect to the results of an “all oral” strategy?

Question # 38:
Which co-morbidities—renal function, age, bleeding risk, drug interactions, and medication compliance—need to be assessed and followed most diligently to optimize dose titration and net clinical benefit of NOACs when used in the setting of VTE?

Question # 39:
When should the daily dose frequency of a NOAC play an important role in patients with AF or VTE who require long-term anticoagulation? When is once-daily dosing likely to be a significant advantage?

Question # 40:
From a practical perspective what are the specific methods—based on half-life, dosing, and timing—based on INR, for making the switch from a VKA to a NOAC safely and effectively?

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Question # 41:
In which populations of patients with AF can we appropriately and justifiably extend the safety—especially reduction of ICH—efficacy, and convenience aspects of NOAC-based treatment?

Question # 42:
What are the most important compliance-related issues we should be considering when prescribing NOACs?

Question # 43:
From a practical perspective, what is role of NOACs, such as rivaroxaban, AF patients with concomitant ACS or those with a stent insertion? And what studies are in progress to help refine our therapy for these patients?

How would you manage a 77-year-old patient on warfarin with poor INRs? What would be the rationale for switching this patient to a NOAC?

How would you approach a patient with AF who has a CHA2DS2-VASc of 3, and who comes to you for a dialogue about switching to a NOAC, even though they are “doing fine” on warfarin?

Professor Freek Verheugt, MD, PhD
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Question # 45:
What is the importance of the Garfield Global Registry for AF, in shaping our understanding of real world challenges and identifying areas for improvement in clinical care for cardiovascular disease and thrombotic disorders?

Question # 46:
From a practical perspective which AF patients should be switched from warfarin to a NOAC, and why are more clinicians choosing to preemptively switch AF patients from warfarin to a NOAC, even if their INRs are in good control?

Question # 47:
How often do you recommend renal function be checked on patients on NOACs? Do you check renal function on all patients, regardless of the NOAC that is being used?

Question # 48:
What are the advantages of using NOACs to enhance regimen adherence in patients with AF or VTE, and overcome the poor TTR results observed with warfarin?

Question # 49:
The ESC, EHRA, and U.S. guidelines for AF are converging. How do we improve compliance with AF guidelines that recommend preferential use of NOACs for AF?

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**Question # 50:**
Given the variable renal excretion among the NOACs, what practical recommendations do you make for initial assessment and subsequent monitoring of renal function? Are your recommendations the same for, let’s say, dabigatran versus rivaroxaban?

**Question # 51:**
While each of the NOACs has a recommended dose based on renal function, how would you choose among the specific NOACs if renal clearance is an important consideration for a particular patient?

**Question # 52:**
From a practical perspective which AF patients should be switched from warfarin to a NOAC, and what are the arguments for, and against, switching to NOACs, which are preferred by ESC guidelines?

**Question # 53:**
From a practical perspective what are the specific methods—based on half-life, dosing, and timing—based on INR, for making the switch from a VKA to a NOAC safely and effectively?

**Question # 54:**
Which co-morbidities—renal function, age, bleeding risk, drug interactions, and medication compliance—need to be assessed and followed most diligently to optimize dose titration and net clinical benefit of NOACs?

**Question # 55:**
Currently, rivaroxaban is the only approved once-daily NOAC. How important is this dosing schedule on medication compliance and medication adherence in the setting of AF? What do we know?

**Question # 56:**
How will anticoagulation services change and adapt to the era of NOAC-based prevention and treatment of AF and venous thromboembolism?

**Question # 57:**
As the lead author of the European Heart Rhythm Association Guidelines (EHRA), can you explain the rationale, development, format, and practical importance of this landmark document focused on stroke prevention in AF?

**Question # 58:**
From a practical, perspective which patients with AF should be switched from warfarin to a NOAC, and what are the arguments for, and against, switching to NOACs, which are preferred by ESC guidelines? Are we “under-switching”?

**Question # 59:**
With the increasing recognition of cryptogenic AF as a cause of stroke, should we approach patients with continuous AF differently from patients with paroxysmal AF?

**Question # 60:**
What is the role of biomarkers such as hs-BNP in helping us identify patients, let’s say, with a CHA2DS2-VASc score of 1, in whom long-term anticoagulation with a NOAC is being considered?

**Question # 61:**
Can you discuss what we currently know about the genetic risk factors for stroke and for sensitivity to NOAC- or warfarin-based anticoagulation?

**Question # 62:**
What is your position about patients who have a stent and are being managed with aspirin, clopidogrel, and oral anticoagulant? Are all three agents required, or can we consider using clopidogrel and an anticoagulant alone?

**Question # 63:**
How do we optimize adherence with NOACs, even though their simplified regimens offer many advantages over warfarin? What are the practical implications?

**Question # 64:**
What have we learned about the role and net clinical benefits of NOACs for stroke prevention in the elderly patient with AF?

**Question # 65:**
What is the role of NOACs in patients on hemodialysis?
Question # 66:
Based on the clinical trials evaluating the efficacy and safety of NOACs for acute treatment of PE, which patient subgroups with VTE do you believe are the best candidates for this approach?

Question # 67:
From a practical perspective, how do you recommend we use NOACs in the large population of VTE patients who are being managed with warfarin for long-term secondary prevention of VTE? Should we switch from warfarin to a NOAC?

Question # 68:
Based on the clinical trials programs—including EINSTEIN, AMPLIFY and others—showing safety and efficacy of NOACs for VTE treatment and prevention, how should we align specific NOACs with specific patients with VTE?

Question # 69:
Based on the clinical trials evaluating the efficacy and safety of NOACs for acute treatment of PE, which patient subgroups with VTE do you believe are the best candidates for an all-oral therapeutic strategy with rivaroxaban?

Question # 70:
Why are the safety, monitoring, and compliance issues associated with warfarin therapy shifting the risk-to-benefit equation toward NOAC use for VTE and AF as the treatment standard?

Question # 71:
From a practical, call-to-action perspective, how have the large VTE treatment trials—EINSTEIN, AMPLIFY, HOKUSAI and others—provided data that will prompt a shift toward NOACs as long-term foundation agents for VTE?

Question # 72:
How do you manage elderly and/or frail patients with VTE who would benefit from the use of NOACs for acute treatment of VTE and secondary prevention of VTE?

Question # 73:
How do we align specific NOACs with specific patient profiles and subgroups with acute PE or DVT?
Question # 82:
From a practical perspective, can you provide us with a roadmap for how to manage the spectrum of bleeding complications—from minor to significant—that might be encountered with NOAC-based anticoagulation?

Question # 83:
What is the pathophysiology of GI bleeding with NOACs and is there a role for proton pump inhibitors (PPIs) to decrease the risk of this complication?

Question # 84:
How should NOACs be managed in patients who may require elective or emergency surgery? When should these agents be stopped? When can they be continued or restarted?

Question # 85:
To what extent can the three available NOACs be monitored, and when is it advisable to do this?

Question # 86:
Can you give examples of patients who are taking an oral factor Xa inhibitor, and in whom you may wish to know a PT time?

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Question # 87:
What is the current status of antidotes/reversal agents for NOACs?

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Question # 88:
What consistencies as far as safety—i.e. reduction in ICH—support NOAC use for stroke prevention in AF, and what unique characteristics of these agents may help us select a specific NOAC for an individual patient?

Question # 89:
To what extent should the NOACs be used primarily for de novo patients with NVAF, and to what extent should patients on VKAs also be switched to NOACs to take advantage of the reduction in ICH?

Question # 90:
Is there a rationale for switching patients, especially elderly patients with high HAS-BLED scores and/or who may be at higher risk for ICH, from VKA to a NOAC?

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Question # 91:
What is driving the paradigm shift from VKA/LMWH to the NOACS for acute treatment of VTE?

Question # 92:
From a practical perspective how do we assign specific NOACs, including rivaroxaban, apixaban, and dabigatran, to specific patients with VTE? What factors drive your selection process?

Question # 93:
In the real world, when would you recommend a NOAC as the preferred strategy for long-term secondary prevention of VTE? Why?

Question # 94:
From a practical perspective, how do you recommend we use NOACs in the large population of VTE patients who are being managed with warfarin for long-term secondary prevention of VTE? Should we switch from warfarin to a NOAC?

Question # 95:
How should the emergency physician approach the AF or VTE patient who has had minor or major bleeding while taking a NOAC? Can you take us through the specific steps?

Question # 96:
Is there any data or clinical strategy that suggests how we might prevent bleeding complications in AF, VTE or ACS patients who are on a NOAC?

Question # 97:
To what extent should patients on VKA therapy be switched to NOACs to take advantage of the reduction in ICH?