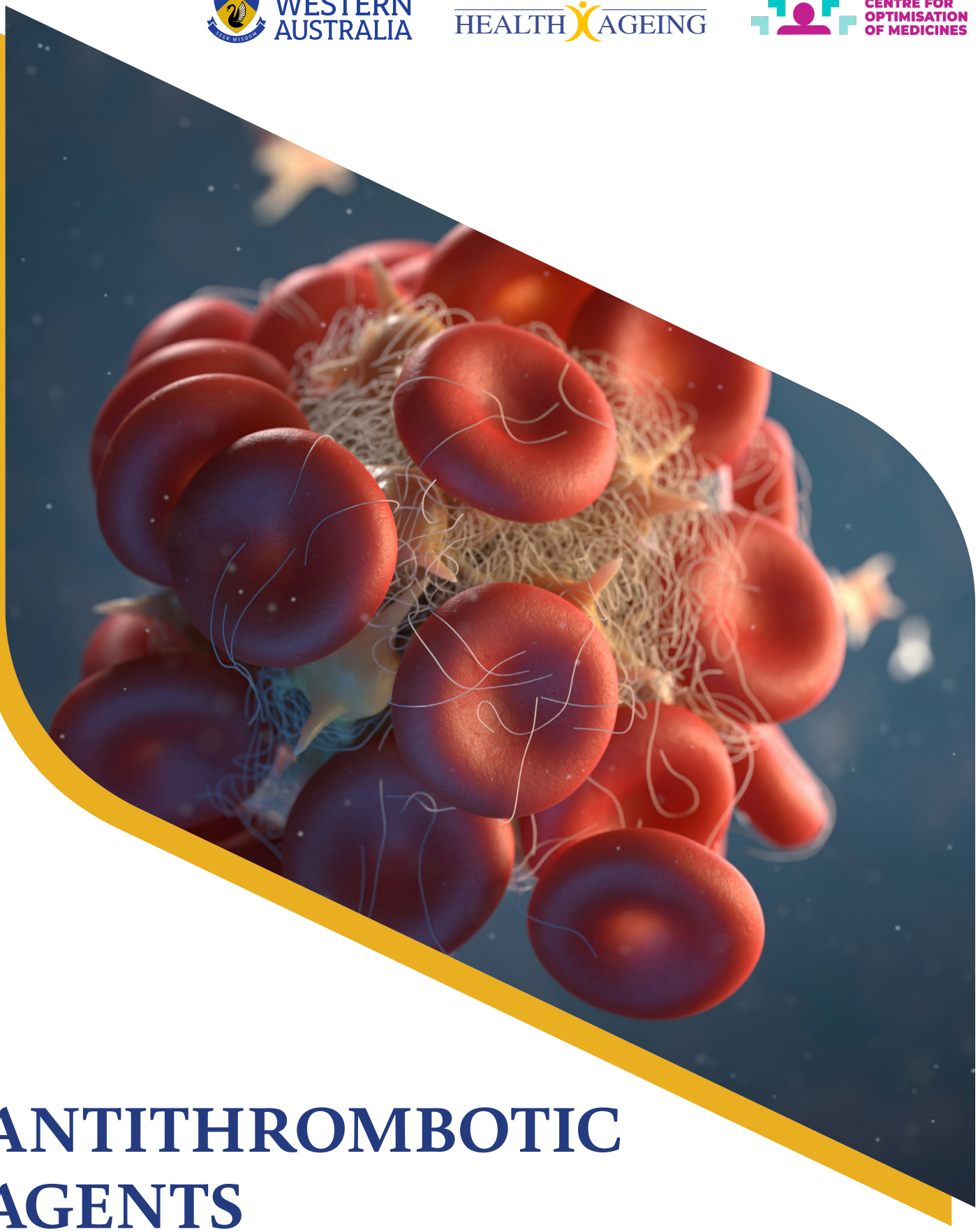
THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES



ANTITHROMBOTIC AGENTS

Deprescribing in older people: A clinical practice guideline

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ANTITHROMBOTIC AGENTS (ANTICOAGULANTS AND ANTIPLATELETS)

Anticoagulants

- Vitamin K antagonists: Warfarin*
- Heparins: Dalteparin, danaparoid, enoxaparin, heparin, nadroparin
- Direct thrombin inhibitors: Bivalirudin, dabigatran
- Direct factor Xa inhibitors: Apixaban*, rivaroxaban*
- Other antithrombotic agents: Fondaparinux

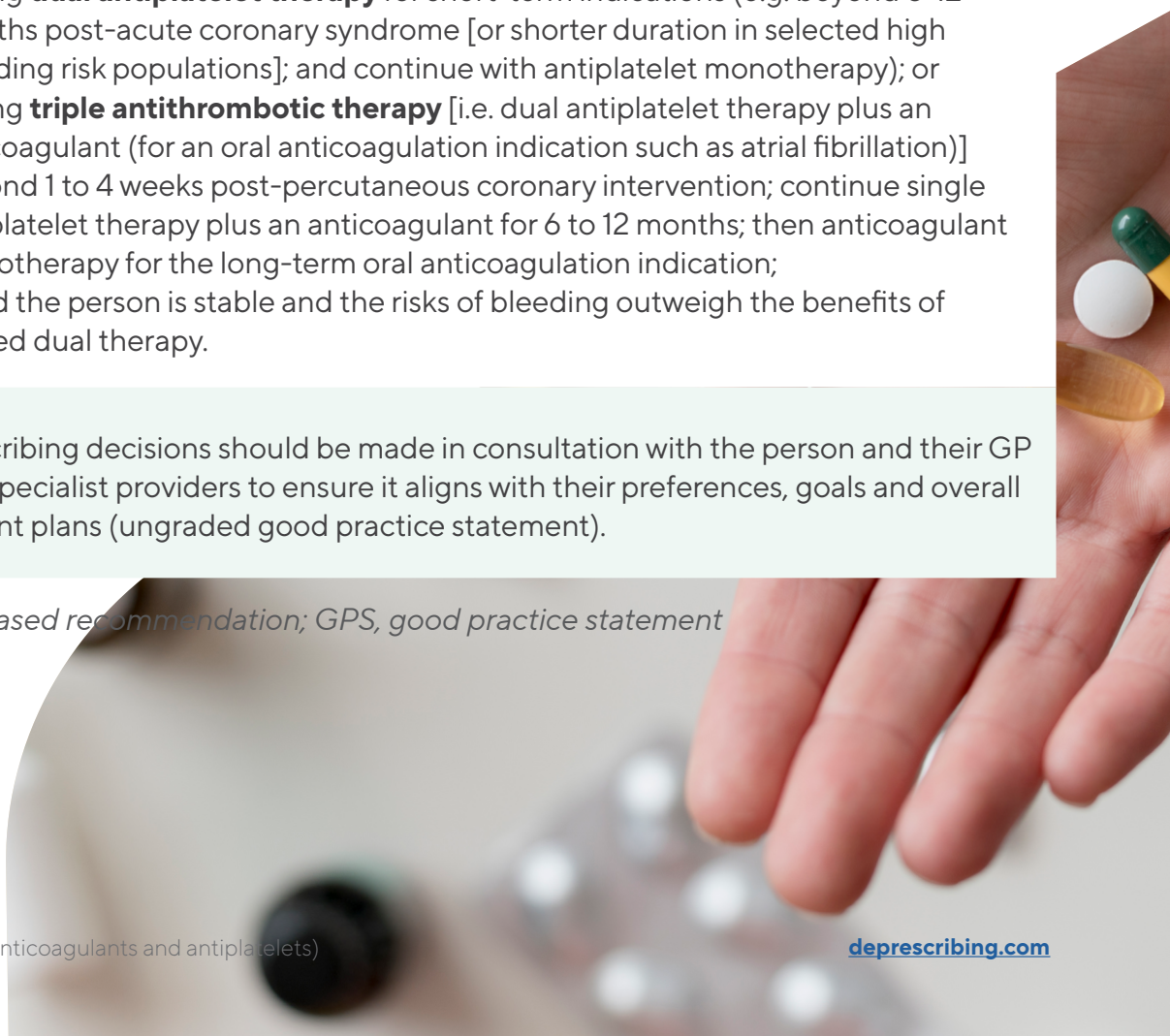
Antiplatelets

- Platelet aggregation inhibitors excluding heparin: Aspirin, clopidogrel*, ticagrelor, prasugrel, tirofiban, eptifibatide, dipyridamole
- Combination antiplatelets: Aspirin with clopidogrel or dipyridamole

*Common Pharmaceutical Benefits Scheme medicines

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	We suggest deprescribing be offered to older people taking **anticoagulants**: • For short-term indications (e.g. acute venous thromboembolism when anticoagulants have been taken for over 6-12 months in people without recurrent unprovoked venous thromboembolism or not at an increased risk of recurrence); or • When the risk of major/recurrent bleeding outweighs the benefit of prevention of ischaemic stroke or thromboembolism, following a shared informed decision-making process with the person and/or family/carers. We suggest deprescribing of **warfarin** be offered to older people with advanced chronic kidney disease (CKD IV-V/ESKD) as the risk of complications may outweigh the potential benefits of anticoagulation.
CBR	We suggest deprescribing of **antiplatelets** be offered to older people: • Taking **aspirin** for the primary prevention of cardiovascular events due to the progressive reduction in net benefit relative to increased risk of major bleeding in older people; • Taking **dual antiplatelet therapy** for short-term indications (e.g. beyond 6-12 months post-acute coronary syndrome [or shorter duration in selected high bleeding risk populations]; and continue with antiplatelet monotherapy); or • Taking **triple antithrombotic therapy** [i.e. dual antiplatelet therapy plus an anticoagulant (for an oral anticoagulation indication such as atrial fibrillation)] beyond 1 to 4 weeks post-percutaneous coronary intervention; continue single antiplatelet therapy plus an anticoagulant for 6 to 12 months; then anticoagulant monotherapy for the long-term oral anticoagulation indication; provided the person is stable and the risks of bleeding outweigh the benefits of continued dual therapy.
GPS	Deprescribing decisions should be made in consultation with the person and their GP and/or specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).

CBR, consensus-based recommendation; GPS, good practice statement



ONGOING TREATMENT

CBR We suggest continuing antithrombotics in robust older people with cardiovascular risk factors taking:

- **Anticoagulants** for the primary prevention of thromboembolic events due to atrial fibrillation or secondary prevention of cardiovascular events;
- **Extended anticoagulants** for the secondary prevention of venous thromboembolism following recurrent unprovoked proximal deep vein thrombosis or pulmonary embolism, or in people who have persisting provoking factors; or
- **Antiplatelets** for the secondary prevention of cardiovascular events (e.g. in people with coronary artery disease, peripheral artery disease or cerebrovascular disease);

provided there are no life-limiting diseases (where potential risks often outweigh potential benefits) or significant bleeding risk, and this aligns with the individual's goals and preferences, following informed consent.

GPS Healthcare providers should reassess an individual's cardiovascular and bleeding risk at least annually or more frequently, based on clinical indications or changes in health status, using a validated tool appropriate for the patient population (e.g. HAS-BLED for estimating major bleeding risk in people receiving anticoagulation for atrial fibrillation, and CHA2DS2-VASc for calculating stroke risk) (ungraded good practice statement).

HOW TO DEPRESCRIBE

CBR We suggest ceasing anticoagulants and/or antiplatelets, without the need for tapering.

CBR, consensus-based recommendation; GPS, good practice statement

MONITORING

CBR **Routine monitoring**

We suggest close monitoring of ongoing risk factors (e.g. risk of bleeding and cardiovascular events), at least monthly for the first six months after deprescribing, followed by monitoring every six months thereafter to maintain the therapeutic relationship while working on potentially modifiable cardiovascular risk factors through lifestyle optimisation. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

For **warfarin**, routine monitoring of the international normalised ratio (INR) when stopping is generally not required, especially if the INR is within the therapeutic range. However, closer monitoring (a few days after cessation) may be preferred if there are concurrent illnesses or medicine changes (including prescribed, over-the-counter medicines, complementary and alternative medicines). For people who need to restart warfarin therapy, closely monitoring the INR is essential to achieve the therapeutic range.

CBR We suggest advising people to present for medical attention in case of concerning symptoms (e.g. dyspnoea, chest pain, or painful and/or swollen calf suggestive of venous thromboembolism).

CBR, consensus-based recommendation; GPS, good practice statement

Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

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