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LECTURE

When to anticoagulate and when to resume anticoagulation after stroke

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Abstract

Ischaemic strokes are attributed to a cardioembolic cause in approximately 20% of cases and atrial fibrillation (AF) is the most common cardioembolic source. AF is also associated with larger, more disabling and higher case fatality strokes which highlights the major importance of primary prevention with oral anticoagulants (OAC). Identifying patients with AF and other cardiovascular risk factors for starting these drugs is as important as evaluating their bleeding risk. CHA2DS2-VASc and HAS-BLED are two important tools, with the first helping deciding who to anticoagulate and the second serving as a guide to reduce modifiable bleeding risks (not to determine whether to offer anticoagulation or not).

If starting anticoagulation is becoming more common for primary prevention, the resumption of this therapy after ischaemic and haemorrhagic stroke is sometimes delayed or avoided. However, several studies have already shown that resumption is important to decrease stroke recurrence and all-cause mortality, outweighing the major concern - intracranial bleeding. Resuming OAC may be contraindicated in some cases, for example when a lobar haematoma is associated with cerebral amyloid angiopathy.

Still, the most difficult decision is not usually whether or not to start anticoagulation, but the ideal timing to do it. There are not enough data about this topic, although many observational studies have shown positive results with starting OAC between 36h to 90 days after the event.

In clinical practice, the timing often depends on the indication for anticoagulation and on the thrombotic risk associated with the disease. Decision must also take in consideration the size of the ischaemic lesion, the location and dimension of the intracranial hematoma and the adequate control of hypertension, which are the main risk factors for (re)bleeding.

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