Intracranial hemorrhage and anticoagulation

- Venous thromboembolism prophylaxis in adults with acute traumatic brain injury: a systematic review
- Antithrombotic treatment of cervical artery dissection: A systematic review and meta-analysis
- APOE epsilon4 and Risk of Intracranial Hemorrhage in Patients With Atrial Fibrillation Taking Apixaban
- Effect of oral anticoagulant therapy on adverse outcomes in atrial fibrillation patients after intracranial haemorrhage
- The Concomitant Therapy of Direct Oral Anticoagulants with Amiodarone in Atrial Fibrillation: A Meta-analysis
- The Safety and Efficacy of Factor XIa Inhibitors for the Prevention of Stroke and Thromboembolism: A Systematic Review and Meta-Analysis of Randomized Controlled Trials
- Supratherapeutic warfarin and risk of intracranial hemorrhage in geriatric patients with blunt head trauma
- Prediction Model to Optimize Long-Term Antithrombotic Therapy Using Covert Vascular Brain Injury and Clinical Features

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A major disadvantage is the increased incidence of intracranial hemorrhages

Intracranial hemorrhage may be a particularly devastating complication of anticoagulant therapy. Very few accounts have reported data on the duration of anticoagulant discontinuation following intracranial hemorrhage or the intensity of anticoagulation during treatment for it, although we must adequately manage such a complication.

Intracerebral hemorrhage

see Anticoagulant Related Intracerebral Hemorrhage

Subdural hematoma

see Subdural hematoma and anticoagulant therapy.

Treatment

A number of therapies-including fresh frozen plasma (FFP), intravenous vitamin K, activated and inactivated prothrombin complex concentrates (PCCs), and recombinant activated factor VII (rFVIIa)-have been used alone or in combination to treat AAICH to reverse anticoagulation, help achieve hemodynamic stability, limit hematoma expansion, and prepare the patient for possible surgical intervention. However, there is a paucity of high-quality data to direct such therapy. The use of 3-factor PCC (activated and inactivated) and rFVIIa to treat AAICH constitutes off-label use of these therapies in the United States. However, in April 2013, the US Food and Drug Administration (FDA)

approved Kcentra.

Plasma is the only other product approved for this use in the United States.

Inconsistent recommendations, significant barriers (e.g., clinician-, therapy-, or logistics-based barriers), and a lack of approved treatment pathways in some institutions can be potential impediments to timely and evidence-based management of AAICH with available therapies. Patient assessment, therapy selection, whether to use a reversal or factor repletion agent alone or in combination with other agents, determination of site-of-care management, eligibility for neurosurgery, and potential hematoma evacuation are the responsibilities of the neurosurgeon, but ultimate success requires a multidisciplinary approach with consultation from the emergency department (ED) physician, pharmacist, hematologist, intensivist, neurologist, and, in some cases, the trauma surgeon [1].

Reversal

see Direct Oral Anticoagulant Reversal Agents.

Anticoagulation in traumatic brain injury

see Anticoagulation in traumatic brain injury

1)
Le Roux P, Pollack CV Jr, Milan M, Schaefer A. Race against the clock: Overcoming challenges in the management of anticoagulant-associated intracerebral hemorrhage. J Neurosurg. 2014 Aug;121 Suppl:1-20. doi: 10.3171/2014.8.paradigm. PubMed PMID: 25081496.

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