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1 **Perioperative Bridging of Vitamin K Antagonist Treatment in Patients**
2 **with Atrial Fibrillation: Only a Very Small Group of Patients Benefits**

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20 Groningen, University Medical Center, Groningen, The Netherlands

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1 **Structured Abstract and Keywords**

2 **Aims:** Bridging anticoagulation in atrial fibrillation patients who need to interrupt vitamin K
3 antagonists for procedures is a clinical dilemma. Currently, guidelines recommend clinicians to take
4 the stroke and bleeding risk into consideration, but no clear thresholds are advised. To aid clinical
5 decision making, we aimed to develop a model in which periprocedural bridging therapy is compared
6 to withholding anticoagulation in atrial fibrillation patients, for several bleeding and stroke risk
7 groups.

8 **Methods:** A model was developed to simulate both a bridge and a non-bridge cohort, using simulated
9 INR values for patients on warfarin, acenocoumarol and phenprocoumon. For both clinical strategies,
10 stroke and bleeding risks were included and outcomes were stratified by CHA₂DS₂-VASc or CHADS₂
11 and HAS-BLED groups. Quality-adjusted life expectancy was the main outcome considered.

12 **Results:** Our analyses show bridging to only be beneficial for patients with HAS-BLED scores equal
13 or lower to 2 and with CHA₂DS₂-VASc scores of 6 or higher. For patients using acenocoumarol
14 bridging may be beneficial starting at a CHA₂DS₂-VASc score of 7. Post-procedural time to
15 therapeutic INR has a significant influence on the results: no significant benefit of bridging was found
16 for patients reaching therapeutic INR values within 5 days.

17 **Conclusion:** When deciding whether to bridge anticoagulation, clinicians should consider the
18 patient's individual stroke and bleeding risk, while also considering the patient's post-procedural INR
19 management. In practice, only a small subset of patients is expected to benefit from bridging
20 anticoagulation treatment.

21 **Keywords:** Bridging, periprocedural management, anticoagulation, vitamin K antagonists, modelling

22

1 **Condensed abstract**

2 We developed a model in which periprocedural bridging therapy is compared to withholding
3 anticoagulation in atrial fibrillation patients, for several bleeding and stroke risk groups. Our analyses
4 show that bridging may only be beneficial for a small subset of patients, with a low bleeding risk and
5 high stroke risk.

1 **What's new?**

- 2 · The Bridge trial by Douketis et al. concluded that bridging warfarin periprocedurally with
3 dalteparin was not beneficial. However, there has been much debate regarding the potential
4 advantages for specific patient groups, not included in the beforementioned trial, and
5 guidelines still advice the use of bridging anticoagulation for these groups.
- 6 · We build a model that shows that for most atrial fibrillation patients, bridging anticoagulation
7 is not likely to be beneficial, although small subgroups can be determined where bridging
8 anticoagulation may yield better life expectancy outcomes.
- 9 · Optimal INR management, where therapeutic values are reached within five days, will
10 improve life expectancy more than any benefit bridging of anticoagulants may have.

11

1 Introduction

2 Anticoagulant treatment reduces the risk of stroke in patients diagnosed with atrial fibrillation (AF).¹
3 As they increase the risk of bleeding, anticoagulants have to be interrupted prior to a procedure if the
4 risk of bleeding is considered high.² Oral vitamin K antagonists (VKAs) are discontinued around five
5 days prior to planned surgery; if the stroke risk is expected to be high, low-molecular-weight heparins
6 (LMWHs) or unfractionated heparin can be administered to bridge this short “unprotected” period,
7 referred to as bridging anticoagulation.² However, perioperative bridging is known to significantly
8 increase the bleeding risk, enhancing discussion on the appropriateness of bridging.³ Notably, the
9 recent BRIDGE trial (Perioperative Bridging Anticoagulation in Patients with Atrial Fibrillation) by
10 Douketis et al. showed no added value of bridging therapy in AF patients.³ However, the BRIDGE
11 trial included patients with a low average stroke risk (average CHADS₂ score of 2.3 and 2.4, for the
12 nonbridging and bridging arms, respectively) and might therefore have limited clinical validity.³

13 According to current guidelines, VKAs need to be interrupted if the procedural bleed risk or the
14 patient bleed risk is increased and perioperative bridging anticoagulation should be considered if the
15 annualized thrombotic risk is 5% or higher.² These recommendations are mainly based on expert
16 opinion: there is no clear clinical evidence to substantiate these claims.² The CHA₂DS₂-VASc and
17 CHADS₂ scores can be used to determine the stroke risk. Bleeding risk mainly depends on the type of
18 procedure, though bleeding risk will also vary per patient as expressed in their individual HAS-BLED
19 score.^{2,4,5} A previous modelling study showed that perioperative anticoagulation is superior to non-
20 bridging if a patient’s annual stroke rate exceeds 5.6% or there is a less than 2.0% increase in bleeding
21 risk caused by heparin.⁶ More recently, outcomes of bridging vs. non-bridging were simulated in a
22 Monte Carlo simulation model and it was concluded that patients at highest risk of ischemic
23 complications will benefit from bridging anticoagulation.⁷

24 We aimed to develop a model that compares perioperative VKA bridging to withholding
25 anticoagulation for different stroke and bleeding risk subgroups considering different VKAs and
26 procedures, resulting in straightforward clinical outcomes that can be used in medical decision
27 making.

1 **Methods**

2 **Model design**

3 A Markov model (figure 1) was developed to compare a bridge and a non-bridge cohort. The model
4 starts with 1,000 patients with two main stages being defined:

- 5 · Pre-procedural stage: five-day period before the procedure, since warfarin is usually
6 interrupted four to six days prior to the procedure.² Stroke and bleeding rates were based on
7 AF population parameters.
- 8 · Post-procedural stage: the 30-day follow-up period after the procedure, which is an often-used
9 period for both bleeding and stroke in clinical studies.³ Stroke risk was based on either the
10 CHADS₂ or CHA₂DS₂-VASc population parameters, bleeding rates were derived from the
11 BRIDGE trial.³⁻⁵

12 In line with the above, patients can undergo three events in the model:

- 13 · Procedure: a surgical procedure, with intraprocedural events not being specifically included in
14 the model, as the 24-hour period around the procedure is assumed to have the same
15 probabilities for specific events and complications as the pre-procedural period. All patients
16 without a pre-procedural stroke or bleeding underwent surgery.
- 17 · Stroke: an ischemic stroke, stratified in mild (modified Rankin Scale 0-3), severe (4-5) and
18 fatal (6). Stroke survivors entered the post-stroke state.
- 19 · Major bleeding: as defined by the International Society on Thrombosis and Haemostasis and
20 as used in the BRIDGE trial, including fatal bleeding.^{3,8} Patients surviving a bleeding event
21 entered the post-bleeding state.

22 The model was build using R and several packages (see Supplementary table S1, for a complete list).⁹

23 Transition probabilities

24 Supplementary tables S2-S7 list all parameters that were used as model input. The stroke risk for both
25 cohorts was simulated using international normalized ratio (INR) values and the odds ratios for stroke

1 as reported in a trial, using a method previously described.⁷ We assumed non-bridging patients
2 gradually moved from an INR value of 2.5 to 1.0 pre-operatively and back to 2.5 post-operatively,
3 using a normal logarithmic function. For the bridging cohort, a LMWH was administered during this
4 period, up to 24h prior to the procedure; post-operatively LMWH administration started 24h after the
5 procedure and was assumed discontinued when the INR reached 2.5. In the 48h-period around the
6 procedure, the INR was assumed to be 1.0, thus increasing the stroke risk.

7 The post-procedural period to reach an INR of 2.5 was assumed to vary between 5 and 15 days. Post-
8 procedurally, the stroke risk was tripled as compared to the pre-procedural probabilities, based on the
9 stroke rates of the BRIDGE trial.^{3,10} Since this parameter estimate was uncertain and not stratified for
10 the CHADS₂ or CHA₂DS₂-VASc subgroups, a wide beta-PERT distribution was applied in the
11 probabilistic analysis. Regarding the bleeding risk, the bleeding rate reported in the BRIDGE study
12 was used for the non-bridge cohort and the corresponding relative risk was applied to the bridge
13 group.³ Low and high bleeding rates were differentiated using data from Omran et al., assuming the
14 populations to be comparable.^{3,11} We considered patients with a HAS-BLED score of 0-2 to have a
15 low bleeding risk and a score of 3 or higher to have a high risk.¹¹

16 **Health outcomes and utilities**

17 The clinical outcomes we looked at, stroke (mild and severe) and bleeding events, are not of an equal
18 magnitude: stroke often has a permanent impact on the quality of life, bleeding events usually are
19 restricted to short-term complications. To account for these differences, the declining exponential
20 approximation of life expectancy was calculated to approximate the life expectancy, using the
21 population parameters as reported by Statistics Netherlands and the AF incidence as reported in
22 literature.¹² The effect of the modified Rankin Scale score on the life expectancy was derived from
23 Chiu et al.¹³ As a base-case, data for 75-80 year-old women was applied.

24 Calculated life expectancies were converted into Quality Adjusted Life Expectancies using utility
25 values. For the stroke survivors, long-term utility values were used to differentiate the mild (modified
26 Rankin Scale 0-3) and severe (4-5) groups. The impact on the quality of life of major bleeding was
27 assumed to be negligible. Death was set to a quality of life of 0.

1 **Simulation of INR**

2 Warfarin is usually interrupted five days prior to the procedure.² This INR course has been modelled
3 using a natural exponential function (see Equation 1), where the constant factor p was set to -0.18 /day
4 to gradually reach an INR of 1 in five days.

5 Equation 1: $2.5e^{pt}$

Equation 2: e^{qt}

6 The INR course after the procedure has been modelled using Equation 2. For the base-case, all
7 patients are assumed to reach an INR of 2.5 in 10 days, thus Equation 2 is capped after this period.

8 This is a conservative estimate, though not unrealistic, in clinical practice. The uncertainty of the INR
9 trajectory was modelled by varying the variable q , with a mean of 0.092 (normally distributed, 95%
10 Confidence Interval (CI): 0.069 - 0.18). The impact of the INR trajectory was explored using separate
11 scenarios where a post-operative therapeutic INR of 2.5 was reached post-operatively in 5, 10 or 15
12 days (fixed).

13 **Sensitivity analyses**

14 Random samples of the distribution for the model parameters were used in a Monte Carlo simulation
15 consisting of 10,000 calculations. The results were recorded and used to calculate the mean and both
16 the 2.5th and 97.5th percentile score, to approach the 95% CI of the mean. Results were considered
17 statistically significant at the conventional cut-off at $p=0.05$. As a base case warfarin was considered,
18 being the most used VKA in Europe.¹⁴ Acenocoumarol and phenprocoumon were considered as
19 alternatives, where the preprocedural period was changed to three and seven days respectively, to
20 account for the different half-lives of these VKAs.¹⁵

21 **Results**

22 In figure 2 the stroke and bleeding rates are displayed for the base case. The rates of strokes ranged
23 from less than 0.02% to almost 10% for the non- bridging group and less than 0.01% to almost 6% for
24 the bridging group for the different CHA₂DS₂-VASc scores; bleeding rates varied from 0.03% to over
25 4% for low and high HAS-BLED scores for the non-bridging group and almost 1% to almost 10% for
26 the bridging cohort. For the outcomes using the CHADS₂ scores, see supplementary figure S1.

1 Figure 3 shows whether our simulation support bridging or not and whether the result was significant
2 for the various age categories and both women and men, the results are stratified by CHA₂DS₂-VASc
3 and HAS-BLED scores. As an example, for a female patient, aged 76, with a CHA₂DS₂-VASc score
4 of 4 and a HAS-BLED score of 3 we do not expect a benefit if she is bridged. In general, the benefit
5 of bridging was greater in younger patients and at higher CHA₂DS₂-VASc scores. For HAS-BLED
6 scores of 3 and higher, no statistically significant benefit of bridging was found, regardless of the
7 stroke risk. Figure 3 is based on the Monte Carlo simulation, which is displayed in more detail in the
8 supplementary figures S2 and S3; the equivalents using the CHADS₂ stroke risk scores are displayed
9 in supplementary figures S4 and S5.

10 For the base case (women 75-80 years old), figure 4 displays the effect of the amount of days it takes
11 to reach therapeutic INR values and the three different VKAs (warfarin, acenocoumarol and
12 phenprocoumon). Small differences were found between the three VKAs: at low risks of bleeding,
13 bridging likely to be beneficial for patients on phenprocoumon from a CHA₂DS₂-VASc score of 5
14 compared to a score of 7 for patients on acenocoumarol. The benefit of bridging gets more
15 pronounced when it takes longer to reach an INR of 2.5. If an INR of 2.5 was reached within 5 days,
16 periprocedural bridging was never significantly beneficial, for both low and high bleeding risk
17 patients. Reaching a therapeutic INR within 10 or 15 days marked the difference between having a
18 significant benefit of periprocedural bridging at a CHA₂DS₂-VASc score of 5 or 4 respectively. The
19 CHADS₂ equivalents of figure 4 are displayed in supplementary figure S6.

20 **Discussion**

21 The results of the base case analysis showed that stroke risk, bleeding risk, type of VKA and time to
22 reach therapeutic INR are important factors to consider while deciding whether to apply
23 periprocedural bridging anticoagulation. According to our evaluation, patients at a high risk of
24 bleeding (HAS-BLED ≥ 3) are very unlikely to ever benefit from periprocedural bridging: the mean
25 shows a decreased life expectancy in all cases, although usually not significant.

1 Patients with lower HAS-BLED scores may benefit if they have an elevated risk of stroke (CHA₂DS₂-
2 VASc 6 or higher, CHADS₂ 4 or higher, 3 or higher for the age categories 55-65). Within the total AF
3 population, around 18% of patients would have a sufficiently high stroke risk as defined by our
4 calculated threshold value.¹⁰ Since the HAS-BLED score is not reported per CHA₂DS₂-VASc group,
5 we do not know which proportion of this group would have a low HAS-BLED. The bleeding risk and
6 stroke risk scores have corresponding predictors and consequently it is expected that only a very small
7 number of patients with a high stroke risk would have a low bleeding risk. Therefore, we speculate
8 that the patient group that could benefit from bridging anticoagulation according to our calculations,
9 will be very small.

10 We found only slight differences between acenocoumarol, phenprocoumon and warfarin. For patients
11 with a low bleeding risk, bridging acenocoumarol is significantly beneficial from a CHA₂DS₂-VASc
12 of 7 and higher, as opposed to a CHA₂DS₂-VASc of 6 and higher for warfarin and phenprocoumon.
13 Our calculations stress the importance of post-procedural INR management: if patients reach a
14 therapeutic INR within five days, strokes will occur less frequently, thus reducing the potential benefit
15 of bridging. For patients in which it takes 10 or 15 days to reach an INR of 2.5, periprocedural
16 bridging is only likely to be beneficial at higher CHA₂DS₂-VASc or CHADS₂ scores. We expect the
17 time to reach therapeutic INR will mainly depend on the patient-specific INR management, but it
18 might also depend on the used VKA: e.g. for patients on phenprocoumon it may take longer to reach
19 therapeutic INR.¹⁶ In clinical settings, the VKA used and the individual patient's history regarding
20 INR management could be taken into account when deciding whether to bridge or not.

21 Our results show a lot of uncertainty around the calculated means, especially for patients with high
22 HAS-BLED scores. This is a result of the limited number of events, especially strokes, found within
23 clinical studies. More real-life data could enhance the reliability of the results, for example within the
24 context of a large multi-centre registry. The stroke risks in the model are calculated using the risk
25 stratification schemes from the clinical setting to determine the necessity of anticoagulation, which
26 may not be valid to use as a decision tool in surgical settings. Regarding the post-procedural stroke

1 risk for AF patients, it would be preferable to use specific stratified stroke rates from the surgical
2 setting, however, these numbers are not available.

3 The included strokes in the model are ischaemic, since most perioperative strokes are ischemic instead
4 of haemorrhagic, and data reliably differentiating ischemic and haemorrhagic strokes is rare.¹⁷

5 Transient ischemic attacks were not included in the model, because their the relative risk with
6 warfarin treatment vs. non-treatment is not significant.¹⁸ Systemic embolisms were also not included,
7 as the odds ratio of warfarin vs. placebo is not significant.¹⁹

8 The evidence for post-operative bleeding rates that incorporates both the HAS-BLED score and the
9 effect of LMWHs is not available. This obstacle was tackled by using the effect of periprocedural
10 bridging from the BRIDGE trial and the effect of the HAS-BLED score from Omran et al.^{3,11}

11 Procedure-specific bleeding rates were not incorporated in the model, as the necessary data that could
12 support this analysis, was not available in literature.. The patient-specific bleeding rate, which we
13 have included using HAS-BLED scores, can be used to approximate the procedure-specific bleeding
14 rates: for procedures with high bleeding risks, bridging will be highly unlikely to be beneficial, while
15 we may underestimate the benefit of bridging for low-risk procedures. However, for procedures with
16 low bleeding risks, interrupting VKA treatment is not indicated, making our model superfluous.²

17 Thrombotic risk was not included in the model, since this is equal in both treatment arms.

18 The BRIDGE trial previously concluded that forgoing anticoagulation bridging is not inferior to
19 perioperative bridging with low-molecular-weight heparin for the prevention of arterial
20 thromboembolism and decreased the risk of major bleeding.³ This evaluation demonstrated that for
21 specific AF patients, bridging is expected to be beneficial. Within the BRIDGE trial, patients with
22 relatively low stroke risks were included: CHADS₂ 2.3 (± 1.03) and 2.4 (± 1.07) for the non-bridging
23 and bridging groups respectively.³ These patients also do not benefit from periprocedural bridging in
24 the base case of our simulation.

25 Dunn et al. previously found that bridging anticoagulation was preferred at an annual stroke rate of
26 $>5.6\%$, which would correspond to a CHADS₂ score between 2 and 3.^{4,6} This outcome is comparable

1 to our results, though in our model the difference is only significant from a CHADS₂ score of 2 (age
2 55-65) or 4 (age 65-85). Compared to the article by Dunn et al., we were able to incorporate more
3 recent evidence to support the model, such as the BRIDGE trial.^{3,6} A more recent simulation study by
4 Pappas et al. simulated net clinical benefit using population parameters for stroke and bleeding.⁷ As
5 we used the quality adjusted life expectancy as the main outcome, we were able to take the long-term
6 effects of strokes into account. Another difference is that we have incorporated increased risks, as
7 compared to the population parameters, for bleeding and stroke post-procedurally.^{3,11}

8 Current guidelines already advice to consider the risk of stroke, the patient-related bleeding risk and
9 the bleeding risk of the procedure.² The results of our model confirm this and, additionally, make it
10 possible to identify more specific patient groups where bridging may be beneficial.

11 Our analysis stresses the importance of the post-procedural time to therapeutic INR. Limited research
12 is available that focusses on the time it takes for AF patients to reach therapeutic INR levels after
13 interrupting a VKA in the clinical setting. Frequent monitoring of the INR and tailored post-
14 procedural VKA usage schemes seems to have a critical role in minimizing the risk of stroke.

15 Currently, it is recommended that VKAs are reinitiated at the previous dose, however, there may be
16 an opportunity to develop individualized dosing regimens to improve the time to reach therapeutic
17 INR. Specifically, in the clinical setting, focussing on the optimal organization of post-procedural
18 INR management for all VKA users may yield greater benefits than bridging the small subpopulation
19 of VKA users that we identified may benefit from this.

20 In conclusion, our results show that only a small subset of AF patients is expected to benefit from
21 bridging anticoagulation: those at a high risk of stroke ($CHA_2DS_2-VASc \geq 6$, $CHADS_2 \geq 4$) and also
22 at a low risk of bleeding ($HAS-BLED \leq 2$).

23 **Acknowledgements**

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26 the development of the model.

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2

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15

1 **Figure Legends**

2 **Figure 1 Markov model**

3 The schematic representation of the Markov model used to simulate the perioperative period for atrial
4 fibrillation patients on vitamin K antagonists. Circles represent health states, squares represent events
5 and arrows indicate transitions.

6 **Figure 2: Stroke and bleeding outcomes in the simulation**

7 Outcomes reported are for women of 75-80 years old. Left: stratified by CHA₂DS₂-VASc score as a
8 percentage of the population. Right: stratified by HAS-BLED score as a percentage of the population

9 CHA₂DS₂-VASc: congestive heart failure, hypertension, age, diabetes, stroke, transient ischemic
10 attack or thromboembolism, vascular disease, age and sex

11 HAS-BLED: Hypertension, abnormal renal and liver function, stroke, bleeding, labile INR, elderly,
12 drugs/alcohol

13 **Figure 3: Bridging benefit decision matrix[representative figure]**

14 Stratified by CHA₂DS₂-VASc and HAS-BLED scores, for various age categories and both sexes.

15 CHA₂DS₂-VASc: congestive heart failure, hypertension, age, diabetes, stroke, transient ischemic
16 attack or thromboembolism, vascular disease, age and sex

17 HAS-BLED: Hypertension, abnormal renal and liver function, stroke, bleeding, labile INR, elderly,
18 drugs/alcohol

19 **Figure 4: Effect of various vitamin K antagonists and time to reach therapeutic INR on quality-
20 adjusted life expectancy difference of bridging**

21 Stratified by CHA₂DS₂-VASc and HAS-BLED scores, results are for the base case, women of 75-80
22 years old, including the 95% confidence interval of the probabilistic sensitivity analysis.

23 CHA₂DS₂-VASc: congestive heart failure, hypertension, age, diabetes, stroke, transient ischemic
24 attack or thromboembolism, vascular disease, age and sex

- 1 HAS-BLED: Hypertension, abnormal renal and liver function, stroke, bleeding, labile INR, elderly,
- 2 drugs/alcohol