

# ANTICOAGULANTS IN MANAGEMENT OF ISCHEMIC STROKE OR TRANSIENT ISCHEMIC ATTACKS

<b>Cardioembolic Stroke or TIA</b>	
Atrial fibrillation	See Chapter 14 (Noncardiogenic: antiplatelet therapy preferred over warfarin)
Acute MI with LV thrombus	Warfarin (INR 2–3) for 3-month minimum
Cardiomyopathy	The benefits of warfarin with a cardiomyopathy and history of a stroke or TIA has not been determined; considerations to prevent recurrent ischemic events include <ul style="list-style-type: none"> <li>• Warfarin (INR 2–3)</li> <li>• ASA 81 mg daily</li> <li>• Clopidogrel 75 mg daily</li> <li>• ASA 25 mg/dipyridamole 200 mg twice daily</li> </ul>
Native valvular disease	Warfarin (INR 2–3) is reasonable; avoid combination with antiplatelet agent if possible <ul style="list-style-type: none"> <li>• Add aspirin if ischemic stroke or TIA while being treated with adequate warfarin therapy</li> </ul> Antiplatelet therapy can be considered: <ul style="list-style-type: none"> <li>• Mitral annular calcification</li> <li>• Native aortic/nonrheumatic mitral valve and no AF</li> <li>• Mitral valve prolapsed (long-term antiplatelet therapy)</li> </ul>
Prosthetic heart valve	Mechanical valves—warfarin (aortic valve: INR 2–3; mitral valve: INR 2.5–3.5); add ASA 75–100 mg/day if stroke or TIA occurs with therapeutic anticoagulation and bleeding risk is not high. Bioprosthetic—warfarin (INR 2–3) for 3–6 months if no other source identified* <ul style="list-style-type: none"> <li>• Beyond 3–6 months, long-term therapy with ASA 75–100 mg/day preferred over long-term warfarin</li> </ul>

(continued)

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**Anticoagulation Post-Intracranial Hemorrhage**


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ICH, SAH, and SDH	Consider stopping all anticoagulants and antiplatelet agents and reversing their effects; hold anticoagulation for 1–2 weeks. Restarting therapy after an ICH will depend on the risk of recurrent thrombosis or ICH; in patients with a high risk of thromboembolism, warfarin may be restarted 7–10 days after the onset of the original ICH.
Hemorrhagic cerebral infarction	Depending on the situation and risk of thromboembolism, it may be reasonable to continue anticoagulation.

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\*ACCP 2008: "In patients with mechanical heart valves who have additional risk factors for thromboembolism, such as AF, hypercoagulable state, or low ejection fraction, or who have a history of atherosclerotic vascular disease, we recommend the addition of low-dose ASA (50 to 100 mg/day) to long-term VKA therapy (Grade 1B). We suggest ASA not be added to VKA therapy in patients with mechanical heart valves who are at particularly high risk of bleeding, such as in patients with history of GI bleed or in patients >80 years of age (Grade 2C)."

AF: atrial fibrillation, ASA: aspirin, ICH: intracranial hemorrhage, INR: international normalized ratio, LV: left ventricular, MI: myocardial infarction, SAH: subarachnoid hemorrhage, SDH: subdural hematoma, TIA: transient ischemic attack

Sources: Furie KL, Kasner SE, Adams RJ, et al. on behalf of the American Heart Association Stroke Council, Council on Cardiovascular Nursing, Council on Clinical Cardiology, and Interdisciplinary Council on Quality of Care and Outcomes Research. Guidelines for the prevention of stroke in patients with stroke or transient ischemic attack. A guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*. 2010, published online October 21, 2010; <http://stroke.ahajournals.org/cgi/content/full/42/1/227>.

Salem DN, O'Gara PT, Madias C, et al. American College of Chest Physicians. Valvular and structural heart disease: American College of Chest Physicians Evidence-based Clinical Practice Guidelines (8th ed.). *Chest*. 2008;133(6 Suppl):593S-629S.