Letters to the Editor

Antiplatelet Bridging Is an Option During Perioperative and Periprocedural Management of Antithrombotic Therapy

El puente de antiagregación como opción en el manejo perioperatorio y periprocedimiento del tratamiento antitrombótico

To the Editor,

In relation to the recently-published article by Vivas et al.[1] in *Revista Española de Cardiología*, which, along with the Spanish Society of Cardiology, involved the participation of numerous societies representing all those involved in the decision- making process in the increasingly common scenario of patients on antithrombotic treatment who require an intervention or procedure, I would like to point out the following:

First, the recognition that for clinicians, having documents available in everyday clinical practice that are based on scientific evidence and not just experience and individual practice is invaluable when making decisions. It is true, though, that such a document must serve to inspire the creation of local protocols and also subsequently allow individualized decision-making. The distinguishing feature in this case is that, as the various anesthetic, surgical, and intervention-related societies were involved in the writing, it should be easier to achieve a consensus when different professionals, whose interests sometimes lie in opposing decisions, must reach an agreement on perioperative or periprocedural drug treatment.

It should be noted that, on the one hand, it is clearly accepted in the document and in previous clinical guidelines that patients on anticoagulant treatment, when undergoing certain procedures, should generally (except in low-risk interventions) stop the medication prior to the procedure. On the other hand, it is also well-established that patients on (single) antiplatelet therapy as secondary prevention, given the low risk of bleeding from the procedure and the never negligible thrombotic risk (low, but with catastrophic consequences), should not stop this before an intervention (except in cases of surgery in which minimal bleeding could be very significant, such as neurosurgery).[2]

With the publication of the most recent studies on anticoagulation plus antiplatelet treatment in patients with atrial fibrillation and ischemic heart disease, it has been demonstrated, and it is also reflected in the clinical guidelines, that beyond the first year after a coronary event, patients who require permanent anticoagulation can have an anticoagulant alone as maintenance, and can therefore stop antiplatelet therapy.[3]

In a combination of these scenarios, which occurs not infrequently, there are patients that even with late thrombotic risk, having had a coronary event or stenting, are not on antiplatelets (in line with the guidelines, an anticoagulant alone). When they undergo a procedure (eg, surgery, endoscopic procedures), applying the consensus protocol, the anticoagulant (if used) should be stopped, so the thrombotic risk would not be covered during this time. It would be equivalent to stopping antiplatelet therapy (they would not be on any medication) in patients who, as we just mentioned, should not stop it due to the risk of thrombotic complications.

The document makes frequent reference to heparin bridging, whose use is restricted to patients with high thrombotic risk in whom antiplatelet treatment would not make sense. Maybe, though, for patients with thrombotic risk, mainly coronary patients, who are no longer on antiplatelet therapy (as they are treated with anticoagulants alone), we could establish a bridge with antiplatelet therapy: start single antiplatelet therapy before the intervention so that the patient is taking both medications, then stop the anticoagulant according to the protocol to remove the hemorrhagic risk, perform the intervention continuing the antiplatelet therapy, without affecting the thrombotic or hemorrhagic risk, and then, after restarting the anticoagulant, go back to the original situation with an anticoagulant alone and stop the antiplatelet therapy again.

Naturally, studies are be required to confirm the benefits of this antiplatelet bridge and to establish the exact pre- and postoperative duration, based on the pharmacodynamics of the drugs used, preferably antiplatelets with shorter half-lives. However, their use seems reasonable and could be an option for the above-mentioned scenarios.

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Available online 17 July 2018

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