New oral anticoagulants and perioperative management of anticoagulant/antiplatelet agents

The article by Rahman and Latona (*AFP* December 2014)[1] is an excellent review and will be a very useful resource for family physicians!

Dipyridamole was one antiplatelet agent still in relatively common use not discussed by the authors. Dipyridamole does not increase the bleeding time and does not require cessation in patients undergoing surgery. It has been studied as a sole agent to protect patients with drug eluting coronary artery stents required to undergo non-cardiac surgery.[2] The range of interval from stenting to the surgery was 4–74 weeks with a mean of 31 weeks. The authors concluded from the 56 patients who underwent surgery that there were no adverse cardiac events and no excess bleeding episodes in the peri-operative period. The authors postulated that dipyridamole may act through inhibition of aggregation response to collagen.[2]

In my experience relating to my ischaemic stroke patients on antiplatelet therapy, treating dentists and surgeons only occasionally make contact requesting information facilitating risk stratification for perioperative thromboembolism. More commonly, antiplatelet agents are ceased and procedures proceed without consultation.

I put up for discussion that in the select group of ischaemic stroke patients on dual aspirin and dipyridamole therapy requiring elective surgery, these patients should continue on the dipyridamole. This would provide a modicum of protection, which has to be better than the current 'keep your fingers crossed approach' that currently appears to be the norm when dual therapy is ceased for generally a minimum of 10 days!

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References

1. Rahman A, Latona J. New oral anticoagulants and perioperative management of anticoagulant/antiplatelet agent. Aust Fam Physician 2014;43:861–66.
2. Magd AKA, Ragy HI, Sawasany MM, et al. Can dipyridamole safely replace clopidogrel/ASA in DES patients undergoing non-cardiac surgery? Am J Cardiol 2007;100:126L.

Dear editor

Dipyridamole is a pyrimidopyrimidine derivative that has both antiplatelet and vasodilating actions.

Modified-release dipyridamole in combination with aspirin is recommended as an option to prevent occlusive vascular events for people who have had recurrent ischaemic stroke/transient ischaemic attack. Dipyridamole is at times used in myocardial perfusion scan studies but generally not recommended following stent insertion. It has limited clinical data in that clinical setting.

In a small pilot study,[1] all patients were able to undergo premature stoppage of routine anti-platelet agents and undergo non-cardiac surgery safely under coverage of dipyridamole 450 mg/day without any excess intra-operative bleeding or adverse cardiac events. In the absence of large randomised trials, it is difficult to know whether the findings are a true reflection of a protective effect of dipyridamole or just a chance finding.

It reversibly inhibit platelet function so the activity is dependent on the half-life (10 hours). In high-bleeding-risk surgery, if an anti-platelet effect is not desired, dipyridamole could be stopped 2 days (unless taking in combination with aspirin) prior to surgery.

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Reference

1. Magd AKA, Ragy HI, Sawasany MM, et al. Can dipyridamole safely replace clopidogrel/ASA in DES patients undergoing non-cardiac surgery? Am J Cardiol 2007;100:126L.

Letters to the Editor

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