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Letter to the Editors-in-Chief

Resumption of anticoagulant therapy after anticoagulant-related gastrointestinal bleeding

Dr. Editor,

We agree that substantial uncertainty exists regarding the net clinical benefit of resuming oral anticoagulants (OACs) after gastrointestinal bleeding (GI). As shown in our review, there are no randomized trials to inform clinical practice in this setting [1]. After OAC-related GI bleeding, the main clinical conundrum is whether and when to re-initiate OAC to prevent thrombosis and death while minimizing re-bleeding. As described in our study and summarized in the recent letter to the editor, potential sources of bias prevent definitive conclusions regarding OAC resumption strategies in such patients. What is apparent, however, is that GI bleeding is not a trivial complication of OAC therapy. Representing about 40% of major bleeding complications, GI bleeds are associated with substantial short-term mortality risk. In a substudy of the ARISTOTLE trial (Apixaban for Reduction in Stroke and Other Thromboembolic Events in Atrial Fibrillation), patients with major non-intracranial bleeding had a high mortality rate (9.2% in 30 days) and a 12-fold increased risk of all-cause death compared to patients without such bleeds [2]. Similarly, recent data from the REVERSE-AD (Reversal Effects of Idarucizumab on Active Dabigatran) study showed high 30- and 90-day mortality rates of 11% and 15%, respectively among patients treated with idarucizumab for dabigatran-associated GI bleeds [3]. Importantly, the high risk of death appears to be only partially explained by thrombotic events.

We are not aware of ongoing randomized trials designed to answer the question of whether, when and how OACs should be resumed after GI bleeds. However, these would be welcomed as even in high-quality prospective observational studies potential sources of bias cannot be definitively excluded. We agree that such trials may also provide valuable information about patient subgroups which may derive the most benefit from ongoing OAC therapy. Currently, a substantial proportion of patients with indications for OACs either do not receive them or are treated with reduced doses for which the benefits and harms have not been established likely in large part due to concerns about bleeding [4–7]. With expanding indications and increasing prevalence of candidates for OACs, bleeding complications, especially from GI sources, represent a growing major source of iatrogenic harm.

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