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Free Webinar for all Primary Care Professionals

In conjunction with MediConf, this webinar has been organised and fully funded by Bayer plc

A Masterclass in the modern management of Atrial Fibrillation and Venous Thromboembolism; a practical guide for health care professionals working in primary care

Saturday 27th March 2021

9.30am - 12.30pm

Webinar

All delegates will receive

- A pdf of the slides available for download for delegates' personal use
- A certifcate for your appraisal portfolio

Course Accredited for 3 hours CPD

Bayer plc medicinal product(s) will be discussed and relevant prescribing information(s) will be available during the webinar

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Meet the Speakers ...

Professor Ahmet Fuat PhD FRCGP FRCP (London) FRCP (Edinburgh) PGDiP Cardiology

Professor Ahmet Fuat has been a GP in Darlington, Co.Durham for 33 years.

He has been a GPSI Cardiology for 20 years having undertaken a Postgraduate Diploma in Cardiology at Bradford University graduating with distinction. He started the first one stop diagnostic and integrated heart failure clinic in the UK 17 years ago with local colleagues.

His PhD by research in heart failure diagnosis and management including work on natriuretic peptides generated several publications that have informed guidelines and led to the award of an Honorary Professorial Chair at Durham University.

He holds various roles in CVD and research including the immediate past President of the Primary Care Cardiovascular Society (PCCS) which he was instrumental in reforming, CVD Clinical Adviser to the RCGP, CVD and Research Leads for Darlington Primary Care Network (PCN) and Federation, Associate Lead for Industry Research at North East and North Cumbria NIHR CRN. He has recently been elected onto the newly formed Darlington PCN Governing body as a GP member and Chair.

He has a passion for medical education and remains an active lecturer, tutor and researcher. He is on the editorial boards of the British Journal of Cardiology and Primary Care Cardiovascular Journals and a peer reviewer for most high impact Cardiovascular journals and research bodies. His work in community cardiology has been recognised with Fellowships from the RCGP, RCP London and RCP Edinburgh.

Dr Chris Arden

Chris Arden is a GP near Winchester, Hampshire. He also works in community cardiac clinics in Southampton and Winchester as a GPSI in cardiology, assessing patients with suspected heart failure, atrial fibrillation, palpitations, hypertension and valvular heart disease.

The community cardiac service provides echocardiography, ambulatory ECG, blood pressure and event recorder monitoring; receiving consultant mentorship support from secondary care and working in partnership with specialist heart failure and cardiac rehabilitation nursing colleagues.

He does a weekly stress echo clinic at Southampton General Hospital and has BSE accreditation in echocardiography.

Chris Arden is Former Editor-in-Chief of the Primary Care Cardiovascular Journal, a member of the Primary Care Cardiovascular Society, British Society of Echocardiography, British Society of Heart Failure and British Heart Valve Society.

He is on the editorial board of the British Journal of Cardiology.

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Your Learning Agenda ...

A Masterclass in the modern management of Atrial Fibrillation and Venous Thromboembolism; a practical guide for health care professionals working in primary care

The COVID-19 pandemic has had a negative impact on cardiovascular disease (CVD) prevention. Targeted CVD prevention initiatives will directly reduce health inequalities and are highly effective at reducing stroke, myocardial infarction (MI) and other adverse cardiovascular events[1]. Atrial fibrillation (AF) is the most common cardiac arrhythmia and is a major cause of stroke. People with AF have five times the risk of a stroke compared to those with a normal heart rhythm. AF is responsible for around 20–25% of all strokes in the UK and these strokes tend to be more severe[2], and it is estimated there could be another half a million people in the UK with undiagnosed AF[3].

At the same time, with an estimated incidence rate of 1–2 per 1,000 of the population in the UK, venous thromboembolism (VTE) is a significant cause of mortality and disability in England with thousands of deaths directly attributed to it each year. One in twenty people will have VTE during their lifetime. VTE therefore poses a significant burden on the NHS, with an estimated annual cost of £165.1 million[4].

Current NICE guidelines recommend the use of anticoagulants such as warfarin and the direct oral anticoagulants (DOACs) for the prevention of stroke related to non-valvular atrial fibrillation (NVAF) and for the treatment of VTE[5].

This patient case-based webinar will explore how anticoagulation can be optimised to improve patient outcomes in NVAF and VTE. You will have the opportunity to look at practical implementation of relevant guidelines on the detection and management of high-risk cardiovascular conditions, with the goal of improving quality of care for patients at risk of CV events. The webinar then explores how to put the Detect, Protect and Perfect National programme into practice, to tackle the issue of AF-related stroke. The webinar further provides practical guidance on the management of patients with acute VTE, risk of VTE recurrence and for secondary prevention of VTE in patients with cancer-associated thrombosis (CAT).

Reference 1: British Heart Foundation UK Factsheet. Last accessed January 2021. British Heart Foundation. https://www.bhf.org.uk/-/media/files/research/heart-statistics/bhf-cvd-statistics-uk-factsheet.pdf

Reference 2: Improving detection and management of AF. Last accessed January 2021. Oxford academic health science network. https://www.oxfordahsn.org/our-work/adopting-innovation/improving-detection-and-management-of-atrial-fibrillation-af/

Reference 3: Atrial Fibrillation: Information and Resources. Last accessed January 2021. Stroke Association. https://www.stroke.org.uk/professionals/atrial-fibrillation-information-and-resources

Reference 4: All Party Parliamentary Thrombosis Group Annual Review 2019. Last accessed January 2021. APPT Group. https://www.anticoagulationuk.org/downloads/APPTG%20Annual%20Review%202019.pdf

Reference 5: Anticoagulants, including direct acting oral anticoagulants (DOACs). Last accessed January 2021. NICE. https://www.nice.org.uk/advice/ktt16/chapter/Evidence-context

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Your Learning Agenda ...

COURSE CODE 1506

This programme will be led by Professor Ahmet Fuat and Dr Chris Arden

- Enhance your knowledge on how to protect your patients from the risk of cardiovascular events.
- Increase delegates' understanding on the Detect, Protect and Perfect national programme to tackle the issue of AF related Stroke
- Increase delegates' understanding on acute VTE, risks of VTE recurrence and secondary prevention of VTE in patients with CAT

Programme ...

9.30 - 10.45am	Optimising stroke prevention in NVAF; Detect, Protect and Perfect
10.45 - 11.15am	Break and Q&A
11.15 - 12.00pm	Managing VTE in primary care
12.00 - 12.30pm	Q&A

Book online at **https://www.mediconf.co.uk/Event-Details-Preview.aspx?id=1461**

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Bayer plc medicinal product(s) will be discussed and relevant prescribing information(s) will be available during the webinar

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▼Xarelto® (rivaroxaban) 2.5, 10, 15 and 20 mg film-coated tablets & 1mg/ml granules for oral suspension

Prescribing Information (Refer to full Summary of Product Characteristics (SmPC) before prescribing)

Presentation: 2.5mg/10mg/15mg/20mg rivaroxaban tablet & 1mg/ml granules for oral suspension. **Indication(s):** *2.5mg* Xarelto, co-administered with acetylsalicylic acid (ASA) alone or with ASA plus clopidogrel or ticlopidine, is indicated for the prevention of atherothrombotic events in adult patients after an acute coronary syndrome (ACS) with elevated cardiac biomarkers. Xarelto, co-administered with acetylsalicylic acid (ASA), is indicated for the prevention of atherothrombotic events in adult patients with coronary artery disease (CAD) or symptomatic peripheral artery disease (PAD) at high risk of ischaemic events. *10mg* Prevention of venous thromboembolism (VTE) in adult patients undergoing elective hip or knee replacement surgery. Treatment of deep vein thrombosis (DVT) & pulmonary embolism (PE), & prevention of recurrent DVT & PE in adults (see W&P for haemodynamically unstable PE patients). *15mg/20mg* Prevention of stroke & systemic embolism in adult patients with non-valvular atrial fibrillation with one or more risk factors such as congestive heart failure, hypertension, age ≥ 75, diabetes mellitus, prior stroke or transient ischaemic attack (SPAF). Treatment of DVT & PE, & prevention of recurrent DVT & PE in adults (see W&P for haemodynamically unstable PE patients). *Paediatrics: 1mg/ml* – Treatment of VTE and prevention of VTE recurrence in term neonates, infants & toddlers, children, & adolescents aged less than 18 years after at least 5 days of initial parenteral anticoagulation treatment. Treatment of VTE & prevention of VTE recurrence in children & adolescents aged less than 18 years & weighing from 30kg to 50kg (for 15mg) / above 50kg (for 20mg) after at least 5 days of initial parenteral anticoagulation treatment. **Posology & method of administration:** *2.5mg* – Oral *b.i.d.* dose; patients should also take a daily dose of 75 – 100mg ASA or a daily dose of 75 – 100mg ASA in addition to either a daily dose of 75mg clopidogrel or a standard daily dose of ticlopidine. Start Xarelto as soon as possible after stabilisation, including revascularisation for ACS; at the earliest 24 hours after admission & at discontinuation of parenteral anticoagulation. If dose is missed take next dose, do not double the dose. *10mg – hip or knee replacement surgery:* Oral *o.d.* dose; initial dose taken 6 to 10 hours after surgery provided haemostasis established. *DVT & PE:* When extended prevention of recurrent DVT and PE is indicated (following completion of at least 6 months therapy for DVT or PE), the recommended dose is 10 mg *o.d.*. In patients in whom the risk of recurrent DVT or PE is considered high, such as those with complicated comorbidities, or who have developed recurrent DVT or PE on extended prevention with Xarelto 10 mg *o.d.*, a dose of Xarelto 20 mg *o.d.* should be considered. *15mg/20mg* – Take with food *SPAF:* 20 mg orally *o.d. DVT & PE:* 15 mg *b.i.d.* for 3 weeks followed by 20 mg *o.d.* for continued treatment & prevention of recurrent DVT & PE. Children & adolescents – calculate dose based on body weight: body weight <30kg refer to the SmPC for Xarelto 1mg/ml granules for oral suspension; body weight 30-50kg take 15mg *o.d.*; body weight >50kg take 20mg *o.d.*. Monitor child's weight & review regularly. *All strengths* - Refer to SmPC for full information on duration of therapy & converting to/from Vitamin K antagonists (VKA) or parenteral anticoagulants. ***Special populations:*** Patients undergoing cardioversion: Xarelto can be initiated or continued in patients who may require cardioversion. Patients with non-valvular atrial fibrillation who undergo PCI (percutaneous coronary intervention) with stent placement: There is limited experience of a reduced dose of 15 mg Xarelto once daily (or 10 mg Xarelto once daily for patients with moderate renal impairment [creatinine clearance 30 – 49 ml/min]) in addition to a P2Y12 inhibitor for a maximum of 12 months in patients with non-valvular atrial fibrillation who require oral anticoagulation & undergo PCI with stent placement. ***Renal impairment:*** mild (creatinine clearance 50-80 ml/min) - no dose adjustment; *2.5mg /10mg* - moderate (creatinine clearance 30-49 ml/min) – no dose adjustment. *15mg/20mg* – adults with moderate (creatinine clearance 30-49 ml/min) & severe (creatinine clearance 15-29ml/min) - *SPAF:* reduce dose to 15mg *o.d.*, *DVT & PE:* 15 mg *b.i.d.* for 3 weeks, thereafter 20mg *o.d.* Consider reduction from 20mg to 15mg *o.d.* if patient's bleeding risk outweighs risk for recurrent DVT & PE; children & adolescents with moderate or severe renal impairment (glomerular filtration rate <50 mL/min/1.73 m^2) – not recommended; *All strengths* – Severe impairment: limited data indicate rivaroxaban concentrations are significantly increased, use with caution. Creatinine clearance <15 ml/min - not recommended. ***Hepatic impairment:*** Do not use in patients with coagulopathy & clinically relevant bleeding risk including cirrhotic patients with Child Pugh B & C ***Paediatrics:*** Only for treatment of VTE & prevention of VTE recurrence. **Contra-indications:** Hypersensitivity to active substance or any excipient; active clinically significant bleeding; lesion or condition considered to confer a significant risk for major bleeding (refer to SmPC); concomitant treatment with any other anticoagulants except under specific circumstances of switching anticoagulant therapy or when unfractionated heparin is given at doses necessary to maintain an open central venous or arterial catheter; hepatic disease associated with coagulopathy & clinically relevant bleeding risk including cirrhotic patients with Child Pugh B & C; pregnancy & breast feeding. *2.5mg* - concomitant treatment of ACS with antiplatelet therapy in patients with a prior stroke or transient ischaemic attack; concomitant treatment of CAD/PAD with ASA in patients with previous haemorrhagic or lacunar stroke, or any stroke within a month. **Warnings & precautions (W&P):** Clinical surveillance in line with anticoagulant practice is recommended throughout the treatment period. Discontinue if severe haemorrhage occurs. Increasing age may increase haemorrhagic risk. Xarelto should be discontinued at the first appearance of a severe skin rash, or any other sign of hypersensitivity in conjunction with mucosal lesions. 1mg/ml oral suspension - sodium benzoate may increase jaundice in newborn infants (up to 4 weeks old). *Not recommended:* in patients with an increased bleeding risk (refer to SmPC); in patients receiving concomitant systemic treatment with strong concurrent CYP3A4- & P-gp-inhibitors, i.e. azole-antimycotics or HIV protease inhibitors; in patients with prosthetic heart valves; for patients with a history of thrombosis diagnosed with antiphospholipid syndrome; Xarelto should not be used for thromboprophylaxis in patients having recently undergone transcatheter aortic valve replacement (TAVR); *2.5mg* treatment in combination with antiplatelet agents other than ASA & clopidogrel/ticlopidine; *10mg/15mg/20mg* in haemodynamically unstable PE patients or patients who require thrombolysis or pulmonary embolectomy; *1mg/1ml* in children less than 6 months of age who at birth had <37 weeks of gestation, a body weight of <2.6 kg, or had <10 days of oral feeding; in children ≥1 year old with moderate or severe renal impairment (glomerular filtration rate <50 mL/min/1.73 m^2); in children ≤1 year old with serum creatinine results >97.5th percentile. *Use with caution:* in patients treated concomitantly with medicines affecting haemostasis; when neuraxial anaesthesia or spinal/epidural puncture is employed; in patients at risk of ulcerative gastrointestinal disease (prophylactic treatment may be considered); *2.5mg* in patients ≥75 years of age or with lower body weight (<60kg); in CAD patients with severe symptomatic heart failure. Patients on treatment with Xarelto & ASA or Xarelto & ASA plus clopidogrel/ticlopidine should only receive concomitant treatment with NSAIDs if the benefit outweighs the bleeding risk. *2.5mg/10mg* in patients with moderate renal impairment concomitantly receiving other medicinal products which increase rivaroxaban plasma concentrations; *15mg/20mg* in patients with renal impairment concomitantly receiving other medicinal products which increase rivaroxaban plasma concentrations; *1mg/ml* in children with cerebral vein & sinus thrombosis who have a CNS infection. *All strengths* – There is no need for monitoring of coagulation parameters during treatment with rivaroxaban in clinical routine, if clinically indicated rivaroxaban levels can be measured by calibrated quantitative anti-Factor Xa tests. Xarelto tablets contains lactose. **Interactions:** Concomitant use with strong inhibitors of both CYP3A4 & P-gp not recommended as clinically relevant increased rivaroxaban plasma concentrations are observed. Avoid co-administration with dronedarone. Use with caution in patients concomitantly receiving NSAIDs, ASA or platelet aggregation inhibitors due to the increased bleeding risk; use with caution in patients concomitantly receiving SSRIs/SNRIs due to a possible increased bleeding risk. Concomitant use of strong CYP3A4 inducers should be avoided unless patient is closely observed for signs & symptoms of thrombosis. **Pregnancy & breast feeding:** Contra-indicated. **Effects on ability to drive & use machines:** syncope (uncommon) & dizziness (common) were reported. Patients experiencing these effects should not drive or use machines. **Undesirable effects:** *Common:* anaemia, dizziness, headache (in children: very common), eye haemorrhage, hypotension, haematoma, epistaxis (in children: very common), haemoptysis, gingival bleeding, GI tract haemorrhage, GI & abdominal pains, dyspepsia, nausea, constipation, diarrhoea, vomiting (in children: very common), increase in transaminases, pruritus, rash, ecchymosis, cutaneous & subcutaneous haemorrhage, pain in extremity, urogenital tract haemorrhage (menorrhagia *very common* in women <55 yrs treated for DVT, PE & prevention of recurrence, common in female adolescents after menarche), renal impairment, fever (in children: very common), peripheral oedema, decreased general strength & energy, post-procedural haemorrhage, contusion, wound secretion. *Serious: cf. CI/Warnings & Precautions – in addition:* thrombocytosis, thrombocytopenia (in children: common), Stevens-Johnson syndrome/Toxic Epidermal Necrolysis, DRESS syndrome, anaphylactic reactions including shock, angioedema & allergic oedema, occult bleeding/haemorrhage from any tissue (e.g. cerebral & intracranial, haemarthrosis, muscle) which may lead to complications (incl. compartment syndrome, renal failure, fatal outcome), syncope, tachycardia (in children: common), hepatic impairment, cholestasis & hepatitis (incl. hepatocellular injury), increases in bilirubin (in children: common), blood alkaline phosphatase & GGT, increased conjugated bilirubin, jaundice, vascular pseudoaneurysm following percutaneous vascular intervention. Prescribers should consult SmPC in relation to full side effect information. **Overdose:** A specific reversal agent is available, refer to the SmPC for andexanet alfa. **Legal Category:** POM. **Package Quantities & Basic NHS Costs:** *2.5mg* - 56 tablets: £50.40. *10mg* - 10 tablets: £18.00, 30 tablets: £54.00 & 100 tablets: £180.00. *15mg* – 14 tablets: £25.20, 28 tablets: £50.40, 42 tablets: £75.60, 100 tablets: £180.00; *20mg* – 28 tablets: £50.40, 100 tablets £180.00; Treatment Initiation pack (42 tablets of 15mg, 7 tablets of 20mg): £88.20 *1mg/ml* – 100ml bottle: £9.00, 250ml bottle: £18.00 **MA Number(s):** *2.5mg* - EU/1/08/472/025-035, 041, 046-047. *10mg* - EU/1/08/472/001-10, 022, 042-045 *15mg/20mg* - EU/1/08/472/011-21, 023-024, 036-040, 048-049. *1mg/ml* - EU/1/08/472/050-051. **Further information available from:** Bayer plc, 400 South Oak Way, Reading, RG2 6AD, U.K. Telephone: 0118 206 3000. **Date of preparation:** January 2021

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