



Specification report for educational and outreach content and activities

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Improving the Identification and Management of Patients with Atrial Fibrillation (AF) in Order to Reduce Stroke Risk and Venous Thromboembolism (VTE) in Eastern Europe

Grant ID 42537945

Introduction

This report lists the outcomes of the joint partners/stakeholders co-creative sessions for DEEPRAFT's educational and outreach efforts. Specifically in this document we present

- i) The doctor's educational content and activities for the workshops, based on contemporary Atrial Fibrillation / Venous Thrombo-Embolicism (AF/VTE) research and best practices. This includes the two Virtual Patient (VP) cases from clinical case to full branching narrative storyboarding.
- ii) The public's/patients' educational content and activities for the infodays based on contemporary AF/VTE research and best practices. This includes the 10 vignettes as full branching narrative storyboards and the basic scaffolding for the printed material (leaflets etc.)
- iii) Both doctors' and patients' social media resources for creating enduring, continuous, engaged communities of support and education regarding AF/VTE

This document includes, beyond this short introduction, the VP/vignette methodology chapter in which we provide a short description for authoring the VPs and vignettes that will be used for the outreach activities. It also includes a non-digital resources section in which the methodology and conceptualization for the printed infographics is presented. Finally, in the digital outreach facilitation, the social media conceptualization and strategy is described regarding the DEEPRAFT's doctor and patient engagement through targeted use of social media platforms like LinkedIn and Facebook. Finally, in the APPENDIX, a detailed archive of the branching narrative storyboards for the VPs and vignettes, as they have been incorporated in OpenLabyrinth, is presented.

VP/Vignette Methodology

In developing the VPs/vignettes for use in the project's outreach activities, a straightforward, collaborative, methodology has been followed. This process consists of three major steps:

- I. **Defining the clinical scenario**
In this step, several collaborative sessions between the project's doctors have been conducted. These have been both physical meetings, as well as teleconferences. In these sessions the core scenarios for both AF and VTE have been proposed, revised and refined into two specific, complex cases that have been described in detail in strict medical fashion.
- II. **Authoring the case as a branching narrative, including visual and narrative resources.**
In this step the doctors that were involved in the authoring team were instructed on a short primer for authoring branching narratives with simple authoring tools like graphical presentation software. After the aforementioned short primer the project's doctors created a series of branching narratives that were immediately transferrable in the VP digital

platform that would be used for deployment of these assets, that is the OpenLabyrinth VP platform (<https://openlabyrinth.ca/>).

III. Parsing the cases into the OpenLabyrinth VP platform for wide use.

After the full branching narratives of the cases have been locked in to the format that was immediately applicable to the digital platform of choice, the content was passed into AUTH's VP repository (<http://vp.med.auth.gr/ariadne>). The final relevant material is presented in D2.1

In this document we present the following, relevant, outcomes of this process.

- A. The abstracts of the two cases for doctors education on AF/VTE (Fig.1, Fig.2)
- B. The detailed branching narratives for both cases and vignettes in the presentation format that was used by the project's technical staff to parse them into the OpenLabyrinth platform (APPENDIX)

The vignettes, given their straightforward content were authored directly as branching narratives hence they are only presented as such here.

Clinical scenario: ATRIAL FIBRILLATION

Mr CJ is a 65-year-old man with a prior history of poorly controlled hypertension, who is admitted to the emergency department unit at his local hospital complaining of palpitations and dizziness. He says he thinks his heart is beating too fast in an unsynchronized way, and this has persisted for several hours. He recalls similar short-lived symptoms during the last 6 months but did not seek medical advice ('why bother when it quickly goes away by itself?'). Examination by the doctor on-call reveals the following: an irregular heart rate of 140 beats per minute; blood pressure of 150/94; respirations 18 per minute; no fever; O₂ sat is 94% on room air. Lung auscultation is normal bilaterally and neck veins are not distended. There is no leg edema. Mr CJ's anxiety is heightened while being examined. He looks at the doctor, hoping for some calming words. The doctor nods with sympathy and fetches the Electrocardiogram machine seeking to confirm the suspected diagnosis. He knew Mr CJ is having his first diagnosis of an arrhythmia, called Atrial Fibrillation. Atrial fibrillation is an arrhythmia in which the electrical activity of the heart is disorganized and chaotic, leading to symptoms such as those described by Mr CJ. Indeed, the diagnosis is confirmed by the Electrocardiogram, which shows an irregularly irregular and fast rhythm, resembling rapid Atrial Fibrillation. Mr CJ is reassured that his condition can be safely managed, and is subsequently transferred to the cardiology ward. He is once again relieved and wonders what would happen if he had once again ignored the symptoms instead of going to the hospital. How much worse could it get, really? The answer is, a lot.

Fig.1 Clinical Scenario for Atrial Fibrillation

Clinical Scenario: Venous Thromboembolism

Mrs Maria is a 49 years old lady, working as a secretary in a big law firm. She lives in countryside with Vaggelis, her husband and their teenager adopted daughter. Maria suffers anxiety attacks and was prescribed SSRI fluoxetine by her treating physician.

Today, Maria finally can rest from a very busy week, after returning from a 2-day business trip, accompanying her lower boss in a very important litigation and finishing all the relative and exhausting paperwork. She just woke up from a 10-hour sleep and after leaving her bed, she found herself lying on the mat on the floor next to her bedside table. Maria immediately called for help but by the time her husband climbed the stairs to their bedroom, she was already feeling better and managed to stand up. Vaggelis, made sure Maria was not hurt and asked Maria if she wanted to call their treating physician, but she reassured him she was feeling. She attributed her symptoms to an anxiety attack and heading to the kitchen, she decided to prepare pancakes for breakfast. While cooking alone in the room, she had the impression her breath was not as smooth as usual and the pain in her left calf, the one she first felt two days ago when she stepped out her boss's car was getting more and more annoying. Vaggelis stepped into the kitchen and saw Maria looking pale and leaning on the bench. He immediately called an ambulance and their adventure began.

Fig.2 Clinical Scenario for Venous Thromboembolism

Non-digital Resources.

Accompanying the digital material in the outreach activities, the project team decided to create printed material in the form of leaflets. The goal of such resources would be to serve as a physical reminder of crucial information regarding AF/VTE and to serve as a short guide for disseminating practical information to patients and high-risk demographics.

In that context we decided that the focus of the material would be on action. That is, the leaflets' content would be short, fact based infographics that present minimal but impactful data and are accompanied by direct, valid and useful instructions for the person at risk, or patient to follow. The medical content was authored by doctors of the project and it took into account localization particular of each country.

In this document we present the core scaffoldings of the core content (Fig.3, Fig.4). As the outreach activities are moving forward these scaffoldings will be the basis for the actual leaflets, which will be included in the relevant reports (D3.2)

Τι είναι η Κολπική μαρμαρυγή (ΚΜ)
 Φυσιολογικά, η καρδιά συσπάται με έναν σταθερό ρυθμό.
 Στην ΚΜ, η καρδιά συσπάται εντελώς άρρυθμα, κάτι που
 δυσχεραίνει την ομαλή κυκλοφορία του αίματος



What is Atrial Fibrillation?

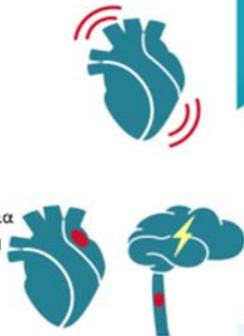
Normally, your heart contracts and relaxes to a regular beat. In atrial fibrillation (also called AFib), the upper chambers of the heart (the atria) beat irregularly (quiver) instead of beating effectively to move blood into the ventricles. Because AFib allows blood to slow down or pool, it increases the risk of clotting, and therefore increases your risk of stroke.

Η ΚΜ σχετίζεται με 5πλάσιο κίνδυνο για εγκεφαλικό!
 Γιατί?

WHY IS AFIB ASSOCIATED WITH A 5X GREATER RISK FOR STROKE?

15% TO 20% OF ALL STROKES ARE ATTRIBUTABLE TO ATRIAL FIBRILLATION

Σχεδόν 1 στα 5 εγκεφαλικά επεισόδια αποδίδονται σε κολπική μαρμαρυγή



- Κατά τη διάρκεια της αρρυθμίας, το αίμα γίνεται πιο στατικό σε μια κοιλότητα της καρδιάς (αριστερός κόλπος).
- Αυτό εγκυμονεί τον κίνδυνο δημιουργίας θρόμβου, ο οποίος στη συνέχεια μπορεί να ταξιδέψει από την καρδιά στην εγκεφαλική κυκλοφορία, προκαλώντας εγκεφαλικό επεισόδιο

POSSIBLE DEATH LOSS OF INDEPENDENCE PARALYSIS PHYSICAL DISABILITY

Symptoms of Atrial Fibrillation

- Fluttering in your chest
- Racing heartbeat
- Skipped heartbeats
- Shortness of breath
- Extra heartbeats
- Fatigue
- Lightheadedness

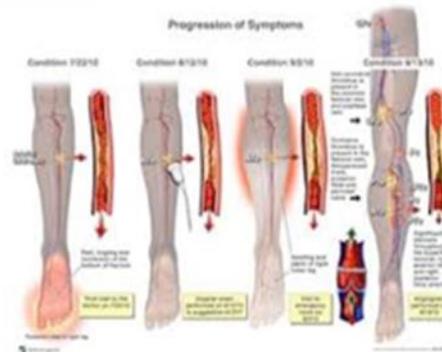
Some people have no symptoms at all!

Ποια είναι τα συμπτώματα;



Fig.3 Core parts of conceptual scaffolding for AF leaflet

Οι φλέβες είναι αιμοφόρα αγγεία που μεταφέρουν αίμα από ολόκληρο το σώμα, πίσω στη καρδιά. Οι πιο συχνές μορφές φλεβικής νόσου είναι η εν τω βάθει φλεβοθρόμβωση και η πνευμονική εμβολή



Η εν τω βάθει φλεβοθρόμβωση και η πνευμονική εμβολή ονομάζονται με έναν όρο φλεβική θρομβοεμβολική νόσος, σαν μια ενιαία νοσολογική οντότητα

- Συμπτώματα εν τω βάθει φλεβοθρόμβωσης
 - Πόνος
 - Ερυθρότητα
 - Ευαισθησία και πρήξιμο στα κάτω άκρα



Fig.4 Core parts of conceptual scaffolding for VTE leaflet

Digital outreach facilitation

Given the scope of DEEPRAFT the most efficient avenue for achieving its goals of doctor-patient engagement, co-creation and multilayered impact is the utilization of social media platforms. Fig.5 outlines the large-scale view of this approach.

Specifically, we propose the creation of a sustainable community through two social media groups, one in Facebook for patients and one in LinkedIn for doctors. The Facebook group will be specific for each participating country so that the general population of them can communicate in their native language, while the LinkedIn group will be developed in English, in order to foster collaboration between doctors of the different participating countries. Initial population of these groups will consist of the participating doctors of the project and their personal patients, on a voluntary basis, while we expect that wide dissemination of these platforms during the project's infodays and workshops will contribute to even wider participation. While the Facebook groups will be relatively easy to participate in, with members being enrolled automatically, the LinkedIn group will be moderated and participation will be humanly verified so that only true medical professionals will participate in it.

This two-pronged community will allow for doctor patient networking through cross-posting of professional advice in the form of LinkedIn articles that will be reproduced in the Facebook Groups. Additionally, survey tools like Google forms and surveys will be used for realizing overall evaluation and impact assessment of the project's continuous outreach endeavor. Additionally, using opinion polls and other online tools, the members of this community will be participating in the co-development of the outreach program as it evolves during its lifetime.

Detailed templates for the specific Groups will be added in the relevant deliverables as they become available.

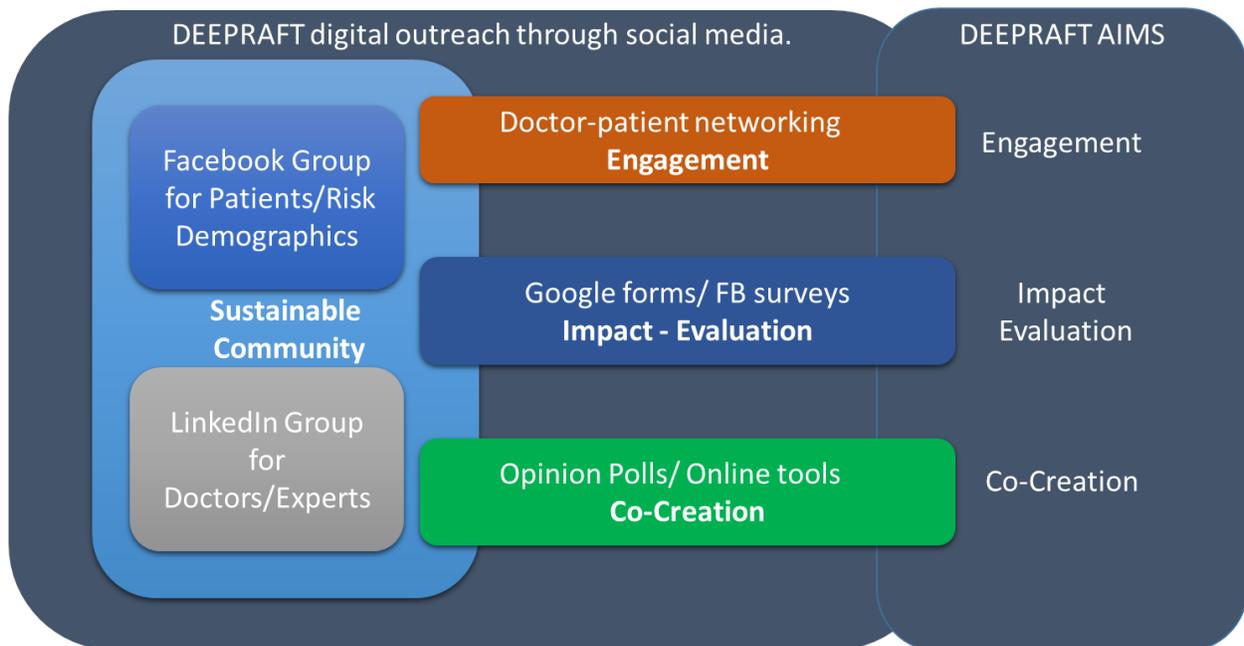


Fig.5 DEEPRAFT's digital outreach architecture

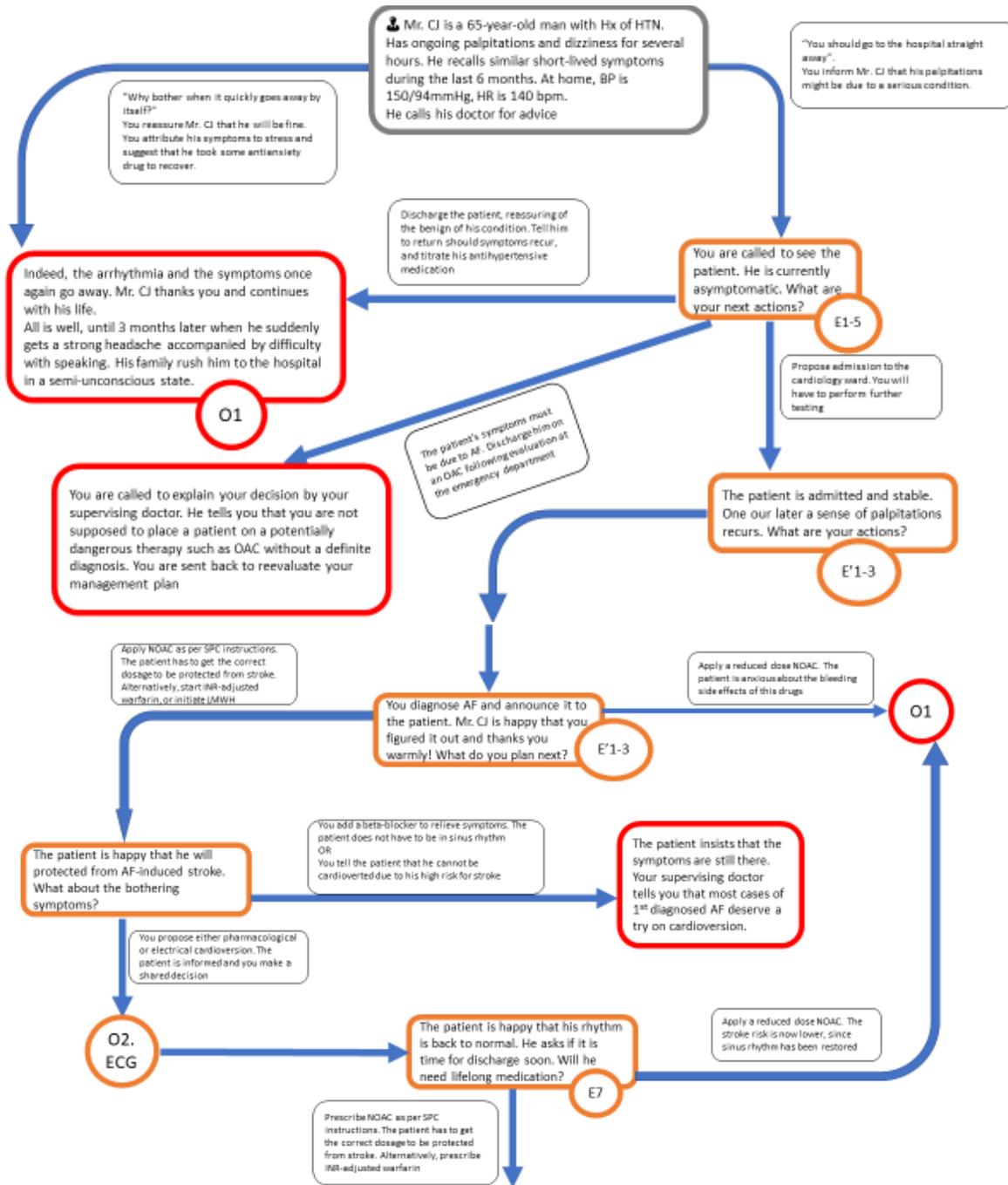
APPENDIX

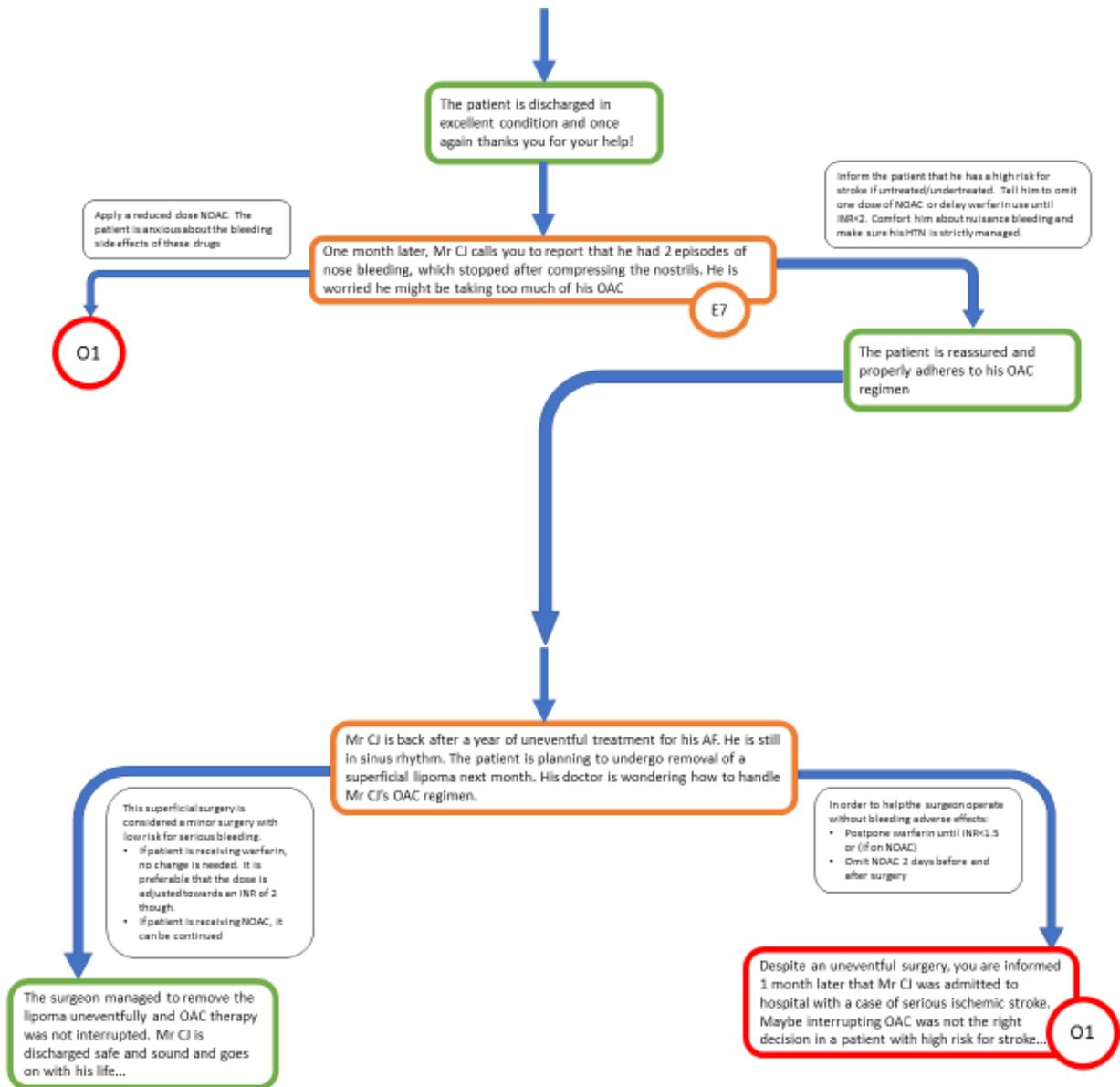
NOTE: Alphanumeric and latin numeral designations in these cases (e.g. A, O1, E1-5, I, IX etc.) refer to digital and physical resources provided by the authors to support the cases. These include x-ray photos, cardiograms and other visual aids. These are excluded in this document but are included in the VP cases as they are presented in D2.1.

NOTE: In the vignettes, wherever there are multiple choices and one of them is underlined, it is understood that the underlined choice is the correct one that moves the narrative to the next question. All others are wrong and the “in case of wrong answer” narrative applies.

Clinical Scenarios

Atrial Fibrillation



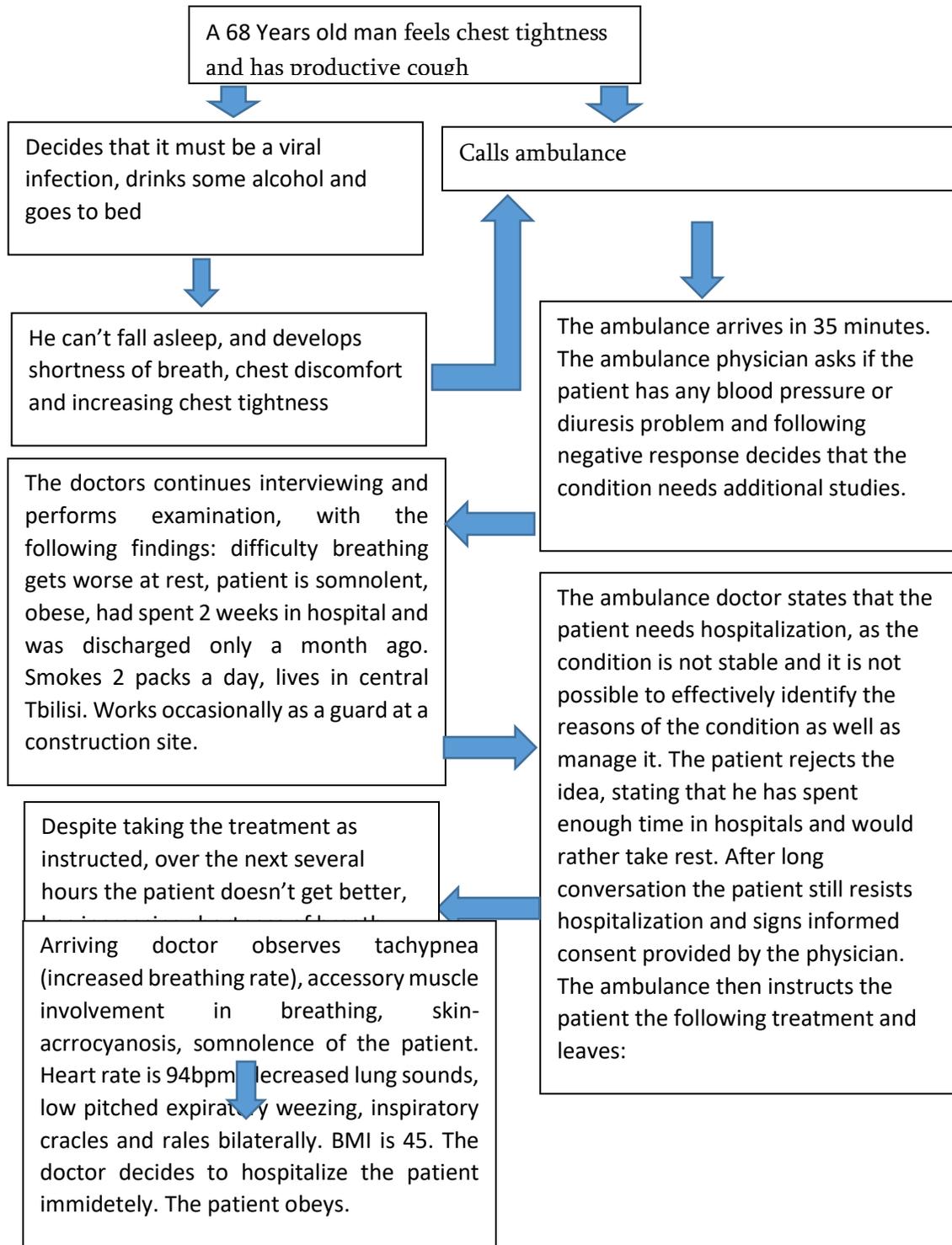




XII

Patient Vignettes

Vignette #1 (Tutorial – Linear Scenario)



Vignette #2

Brief general information:

My name is George, I am a 66-year-old man with a history of obesity, hypertension, obstructive sleep apnea, and a love for alcoholic drinks. I have been experiencing palpitations and fatigue which come and go during the last 3-days.

Question 1: What do I need to do?

- See a doctor/call an ambulance
- Self-medicate with antianxiety drugs/ get some rest/ reduce alcohol consumption
- Ignore symptoms
- Wait for another bout of symptoms to seek medical help

In case of wrong answer:

After my actions, my symptoms once again went away. I go on with my life, until I have another recurrence one week later. This time I also experience slurred speech, which gets noticed by my wife. We call an ambulance, rush to the hospital, and are informed that I have suffered a severe ischemic stroke, probably due to my underlying arrhythmia (atrial fibrillation). I wish I had sought medical advice earlier!!

At hospital, they informed me that I have a first diagnosis of AF.

Question 2: What would be best suitable for me?

- Ask the doctors to fix the irregular rhythm immediately. These symptoms are bothering me too much.
- Insist on outpatient management of my condition
- Follow doctors' advice; my condition could turn out catastrophic if left untreated

In case of wrong answer:

- 1) Despite my desire to have my rhythm immediately restored, the doctors inform me that doing so may pose a significant risk of stroke following cardioversion. This is due to my not receiving any anticoagulation therapy in the previous month, and also due to my late presentation (i.e., more than 2 days following initiation of symptoms)
- 2) I am informed that before being discharged, I have to undergo a series of examinations (including echo, lab work). This would be preferably done as an inpatient.

My doctor offered me two routes of treatment. Either taking anticoagulants for 21 days or performing a transesophageal study, before correcting the arrhythmia.

Question 3: What should I do?

- A friend of mine had AF and was given medication which restored the arrhythmia in a couple of hours. I should ask for the same treatment.

- A friend of mine went on to have catheter ablation for AF and was free of arrhythmias thereafter. I should ask for a relevant referral

- I should discuss with my doctor the benefits and risks of each option I was offered. This is a shared decision

- Leave the hospital and get another opinion

In case of wrong answer:

- 1) Despite my desire to have my rhythm immediately restored, the doctors inform me that doing so may pose a significant risk of stroke following cardioversion. This is due to my not receiving any anticoagulation therapy in the previous month, and also due to my late presentation (i.e., more than 2 days following initiation of symptoms)
- 2) I am informed that catheter ablation is an advanced technique reserved for selected patients with repeated episodes of atrial fibrillation. I am not a good candidate for this procedure, since this is my first diagnosed episode of AF
- 3) After leaving the hospital on my own will, I am constantly being worried of I made the right decision. My wife rushes me back, once I develop another bout of symptoms, this time with serious tachycardia

I have been told that I will be prescribed anticoagulant drugs (blood thinners) which may cause unwanted bleeding.

Question 4: Are they really necessary for my condition?

- OACs reduce stroke rates in AF patients by at least two-thirds, and my risk for stroke is high

- A friend of mine has AF but is under no blood thinners, maybe I can get away with this drug class

- A friend of mine has AF but is under aspirin, maybe I could get the same treatment

- A friend of mine had AF restored to Sinus Rhythm and took blood thinners only for 1 month. Maybe I could get the same treatment

In case of wrong answer:

- 1) All patients with AF do not have the same risk for adverse events from the arrhythmia. My friend who is under no blood thinners probably has a low-risk, compared to the bleeding risk of such therapy. That is why he takes no relevant medication. I should ask my doctor.
- 2) Aspirin, or any antiplatelet treatment has been proven ineffective in preventing strokes in AF. I should ask my doctor and trust that I get the appropriate treatment for my profile and stroke risk.
- 3) Restoring the rhythm from AF to sinus does not alter significantly one's risk for stroke. If my stroke risk is significantly high, then I should receive OAC therapy regardless of a cardioversion or any restoration to sinus rhythm. My doctor will inform me if I am a candidate for lifelong OAC treatment.

I was prescribed a NOAC and was scheduled for cardioversion 3 weeks following my initial diagnosis.

Question 5: What is the most important thing until my next appointment?

- To lose some weight and reduce alcohol drinking
- To limit my physical activity
- To take my OAC as prescribed and never skip a dose
- To do repetitive blood tests to check if my OAC is efficient

In case of wrong answer:

- 1) Losing weight and reducing alcohol drinking is surely important in every patient's course. Despite in my case it is not the most important thing until my next appointment. I should ask my doctor.
- 2) Limiting physical activity is certainly not required, pending AF cardioversion. I should ask my doctor.
- 3) Blood tests are not required for checking efficacy of the newer OAC agents. Only in case of warfarin or acenocoumarol, should I have my INR regularly checked before cardioversion. My doctor will give me proper advice about any action before my upcoming cardioversion.

Vignette #3

Brief general information:

My name is Nick, I am 55 years old. I lead an active lifestyle and have a busy job in lawyer's firm. I have a prior history of myocardial infarction (7 years ago) and paroxysmal AF (first episode was 6 years ago). I am constantly taking Warfarin. My physician recommends that I regularly measure the INR to monitor the effectiveness of the drug. Today I have brought another set of INR measurements which are outside the desired range (i.e., 2-3).

Question 1: What should I do?

- I am fine with warfarin and have had no adverse events. Why not keep the same regimen?
- My measurements are quite often outside the desired range and I would prefer to avoid regular INR measurements. I could ask my physician if I am a good candidate for the newer drugs (NOAC).
- If I am to stay in the same anticoagulation regimen, I should adjust my dosage and regulate my diet according to my doctor's advice. I might also need more frequent INR measurements.
- I am tired with INR monitoring and I have had no adverse events. I will ask my doctor to suspend my OAC treatment. After all, I am still young and AF causes stroke mainly in the elderly

In case of wrong answer:

- 1) Warfarin treatment should be reconsidered, in case of frequent out of range INR measurements. <My doctor will check how often I am inside the 2-3 INR range. Since my INR seems to be not so well regulated, I would be better off with one of the NOAC medications.
- 2) Patient preference is another reason for switching to NOAC treatment. These drugs allow for no measurements of their effectiveness, given they are dosed and adhered to appropriately.

My doctor offered me a switch to Apixaban twice daily. I am taking my new drug without problems so far.

Question 2: What should I do regarding monitoring of the drug's action?

- Apixaban has a predictable-fixed effect and there is no need for routine testing of its efficacy
- I should do an INR measurement every now and then, I have heard that the NOACs also affect the INR
- I can be sure that the drug works fine, as long as I adhere to my previous diet low in vitamin K
- I will ask a relative/friend, who also takes a NOAC on how to monitor the drug's effectiveness

In case of wrong answer:

- 1) My doctor informed me that there is no need for monitoring the drug's action, once I start Apixaban. It will be of utmost importance, though, that I am given the correct dose, and properly adhere to the drug prescribed.
- 2) I am informed by my doctor that a special diet is not needed when under NOAC treatment. I am free to eat a balanced, healthy diet while taking the drug!

- 3) Asking for non-expert advice is not recommended when being prescribed potentially dangerous drugs, when incorrectly used, such as NOACs. I better off to seek advice by my treating doctor.

I forgot taking my morning dose of Apixaban. Oh, these crazy working hours and anxiety! I just realized it 5 hours later at the office.

Question 3: What am I to do?

- No problem with occasionally missing a dose. The drug's levels are relatively maintained in the bloodstream, so there is no need to worry. This happens to everyone

- Oh my gosh!! I will now double my evening dosage for today

- I will take 1 tablet in the evening. I will catch up tomorrow by taking 3 tablets evenly split through the day and then back to my old schedule. Problem solved!

- I will use the advice from my cardiologist, also found in the drug's SPC. Specifically, the forgotten dose may be taken until 50% of the dosing interval has passed. Hence, I will take my missed dose straight away and take the evening dose as scheduled

In case of wrong answer:

- 1) Missing a dose of a NOAC can lead to disastrous adverse events, such as stroke and permanent disability. I am urged to call my doctor and inform him thoroughly.
- 2) Simply doubling the evening dose to account for the missed morning dose will not cut it. I have to call my doctor right away, to avoid serious adverse events.
- 3) Increasing the dose schedule the following day is not advisable in case of a missed dose. I should follow the drug's SPC instructions according to my doctor's advice.

I was over-excited for not having to avoid green veggies and measure my INR anymore that I accidentally took 2 pills of apixaban this morning

Question 4: What am I to do?

- No more apixaban for today. Tomorrow I will restart my normal dosage schedule. In any case I will tell my doctor about it

- I will take half the dose in the evening so that I won't be left uncovered

- I want to stay away from dangerous bleeding events! Today I will not take it, and tomorrow I will only take my evening dose

- This is quite a dangerous case. I have to go straight to the hospital, even though I have no active bleeding

In case of wrong answer:

-Accidentally taking double the dose of Apixaban can lead to disastrous adverse events, such as bleeding and permanent disability. I am urged to call my doctor and inform him thoroughly, instead of experimenting on the dosage schemes. In case there is no active bleeding, I can be managed at home according to my doctor's advice.

Several days later I have an appointment with a dentist for tooth extraction.

Question 5: Should I tell my doctor that I am taking Apixaban?

- Only if asked

- I will definitely inform the doctor because I am aware of the risks of bleeding

- I will not tell them, because I do not think that this will affect the treatment

- I will not tell them, because the doctor will be afraid to operate me

In case of wrong answer:

-The risk for bleeding varies according to the surgical procedure. In case of a simple tooth extraction, Apixaban therapy is probably to be maintained throughout the procedure. In any case the dentist, as well as my treating doctor have to be informed.

Vignette #4

Brief information:

I am Minie, a 75-year-old woman with rheumatic mitral valve disease treated with a mitral bioprosthesis 10 years ago. I am here at the cardiologist's office for management of my AF. AF was first diagnosed 4 years ago and I have failed numerous electrical cardioversions, hence I am constantly on AF. I still experience a sense of palpitations, especially when I climb stairs, despite taking a small dose of beta-blocker.

Question 1: My primary care physician recommended adding some digoxin to my regimen. What should I do?

- The cardiologist will perform an ECG, revise my medication and blood tests. I might be prescribed a higher dosage of beta-blocker
- Digoxin can be added, since it lowers heart rate and will minimize my symptoms
- Having palpitations is acceptable. I could continue with my current drug list
- I should ask my doctor for another try on electrical cardioversion to relieve my symptoms

In case of wrong answer:

- 1) My cardiologist informed me that digoxin is usually added on top of maximally tolerated beta-blocker therapy. Since I am taking a small dose of beta-blocker, I should first try to raise my beta-blocker dosage instead, provided I am in otherwise good condition. I have to book an appointment with my cardiologist accordingly.
- 2) Having palpitations too often can cause a burden in the quality of life of an AF patient. Moreover, palpitations could be related to rapid AF, which may be deleterious to the heart's contractility in the long term. I have to get proper advice from my cardiologist.
- 3) My cardiologist informed me that there is no point in trying to restore the rhythm anymore. My AF is considered permanent, and there is only point in taking proper anticoagulation and rate control therapy, concerning AF

I have brought my last lab test for evaluation. My INR is 8 and this scares me.

Question 2: What should I do?

- I trust my doctor, he says that as long as I have no active bleeding, I can omit one dose of warfarin and be rechecked tomorrow. I will be inquired about my dosage scheme, diet and concomitant medication
- I should go straight away to the hospital, regardless what my doctor says
- I should completely give up warfarin since it exposes me to dangerous bleeding risk
- I should change to another OAC, there are better choices

In case of wrong answer:

Handling a case of exceedingly high INR value depends upon the INR value itself, as well as on the presence of adverse symptoms (bleeding). In any case I should trust my cardiologist's advice, which will be evidence-based.

Question 3: I am on dose-adjusted warfarin for AF. I have heard of the new drugs for AF, which do not require regular INR testing. What should I do?

- Ask the doctor to switch me to the new drug class. After all, NOACs have been marketed as at least/more efficient than warfarin
- Since my INR is usually in the recommended range, I could avoid monthly testing
- I have had no adverse events from AF till now, maybe an OAC is not necessary for my case
- Follow doctor's advice and stay on warfarin with regular INR monitoring. The new drugs are not suitable for me

In case of wrong answer:

The new drug class, namely NOACs, are not suitable for all cases of AF. Since I am suffering from rheumatic mitral stenosis -related AF, I am not a candidate for any NOAC, says my cardiologist. I should continue on a carefully adjusted Warfarin scheme, repeating INR measurements each month.

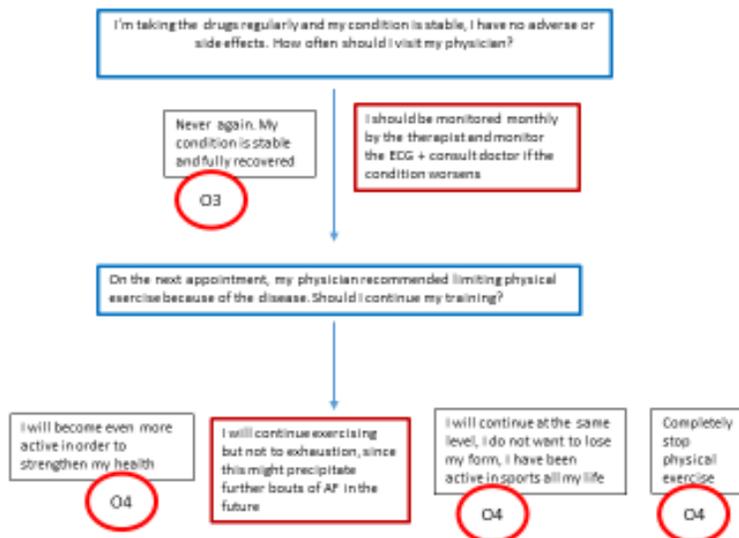
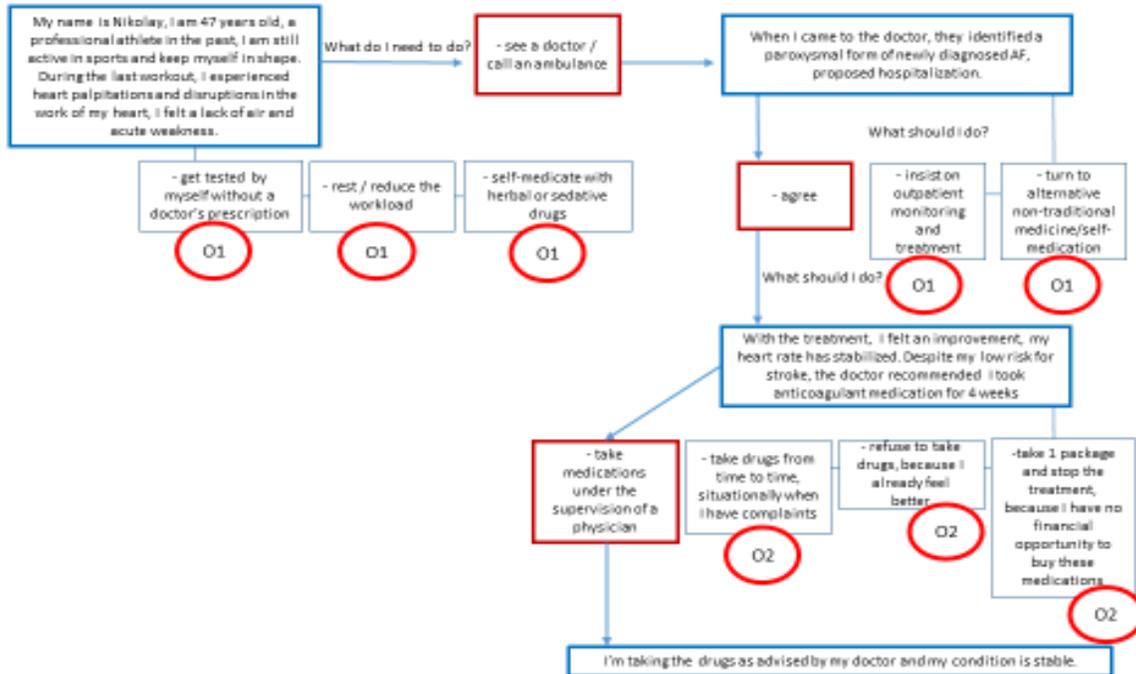
Question 4: I have a scheduled appointment with my dentist in 2 weeks from now, for my regular teeth cleaning. How should I manage my anticoagulation drug?

- Skip a couple of doses. After all, I have never had a thrombotic episode and this will make it easier for my dentist to clean my teeth
- Since my INR is usually in the recommended range, I should just carry on with my warfarin use as usual
- Follow cardiologist's advice and repeat an INR measurement one or two days before my appointment with the dentist. Most probably, I will not have to suspend warfarin for the procedure
- Discuss with my dentist at my appointment for the best way to manage my warfarin scheme

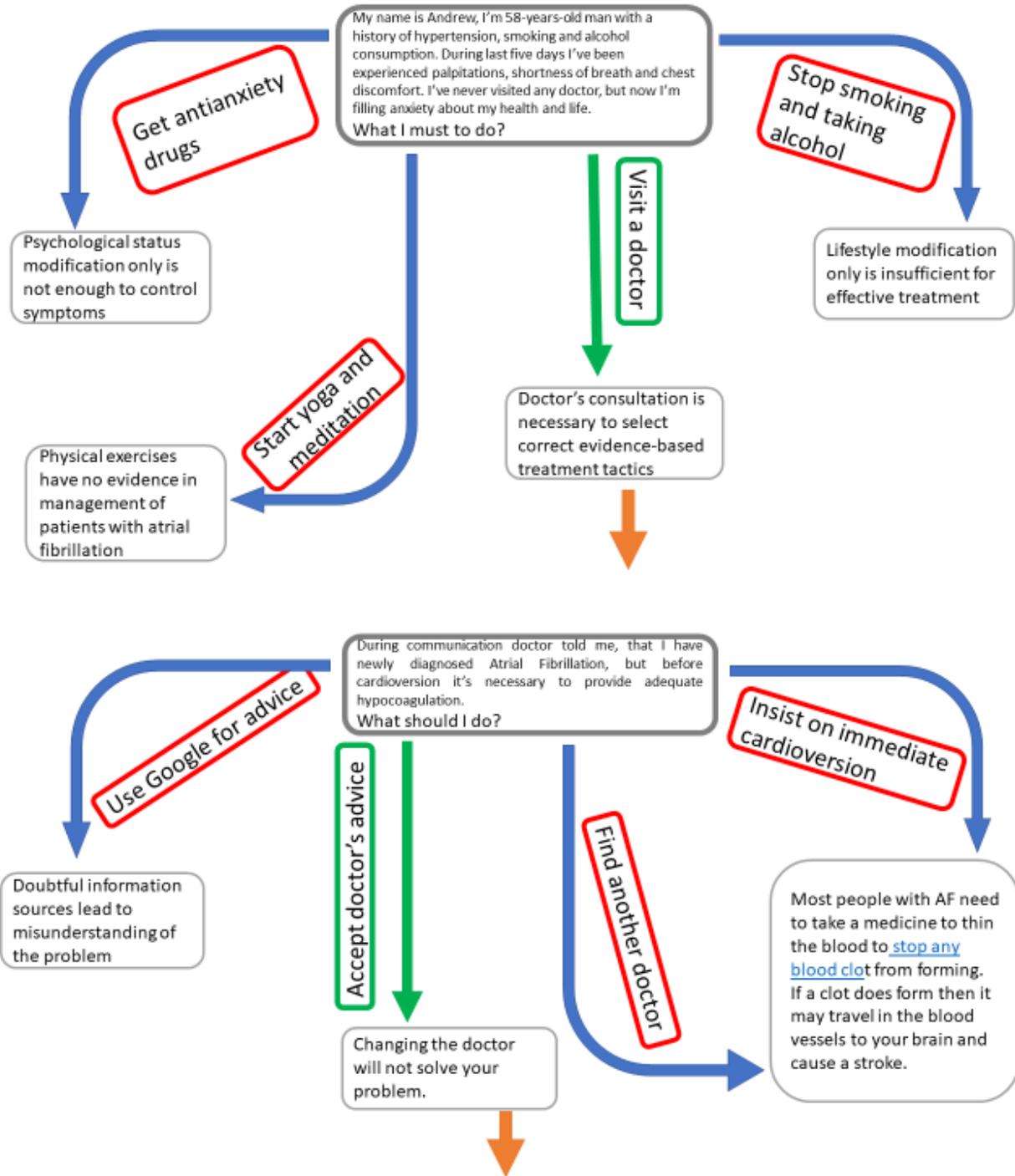
In case of wrong answer:

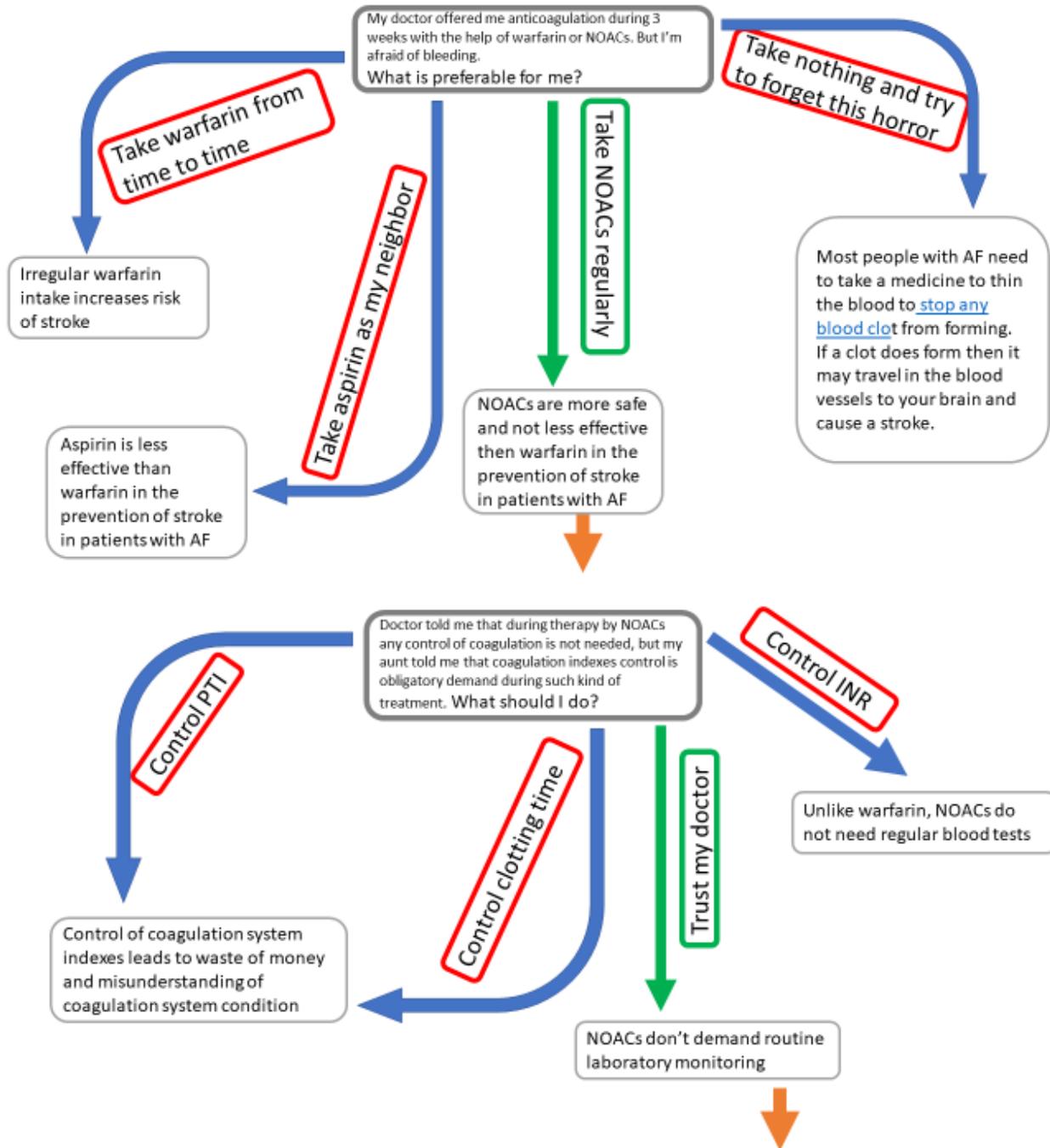
Performing a simple procedure such as teeth cleaning at the dentist will normally not require any adjustment or suspension of Warfarin doses. My cardiologist reiterated that I am at very high risk for stroke due to my mitral stenosis related AF. Despite, it is advised that I checked my INR level a couple of days before the procedure, just to make sure I am within the target INR range, and call my cardiologist for clearance regarding the procedure.

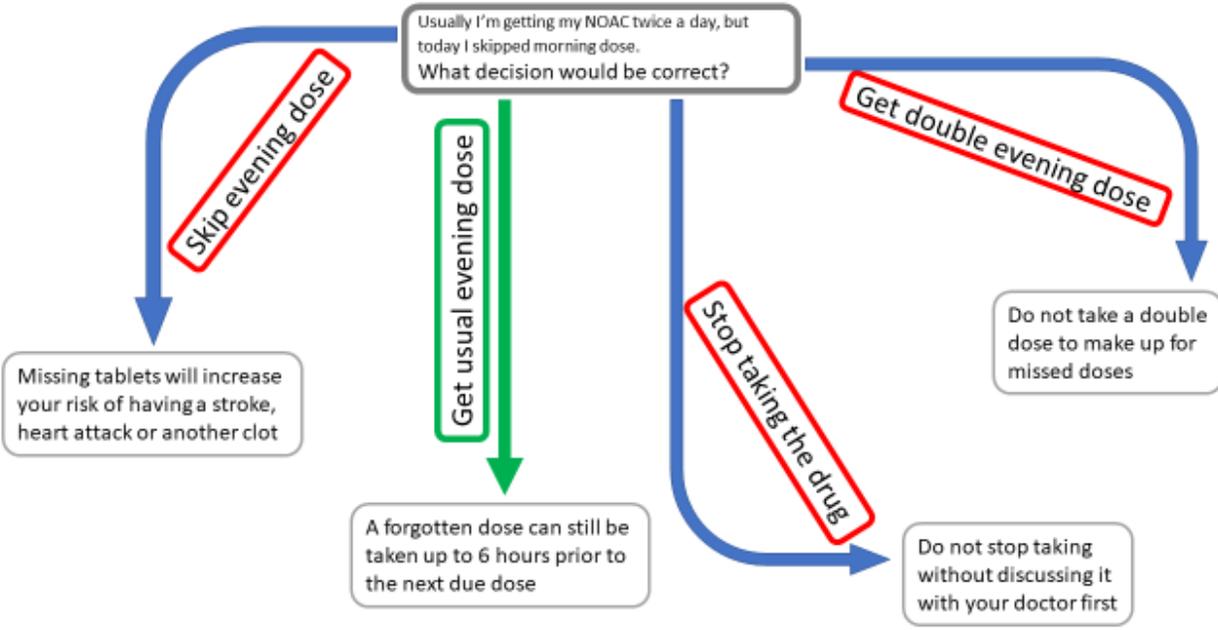
Vignette #5



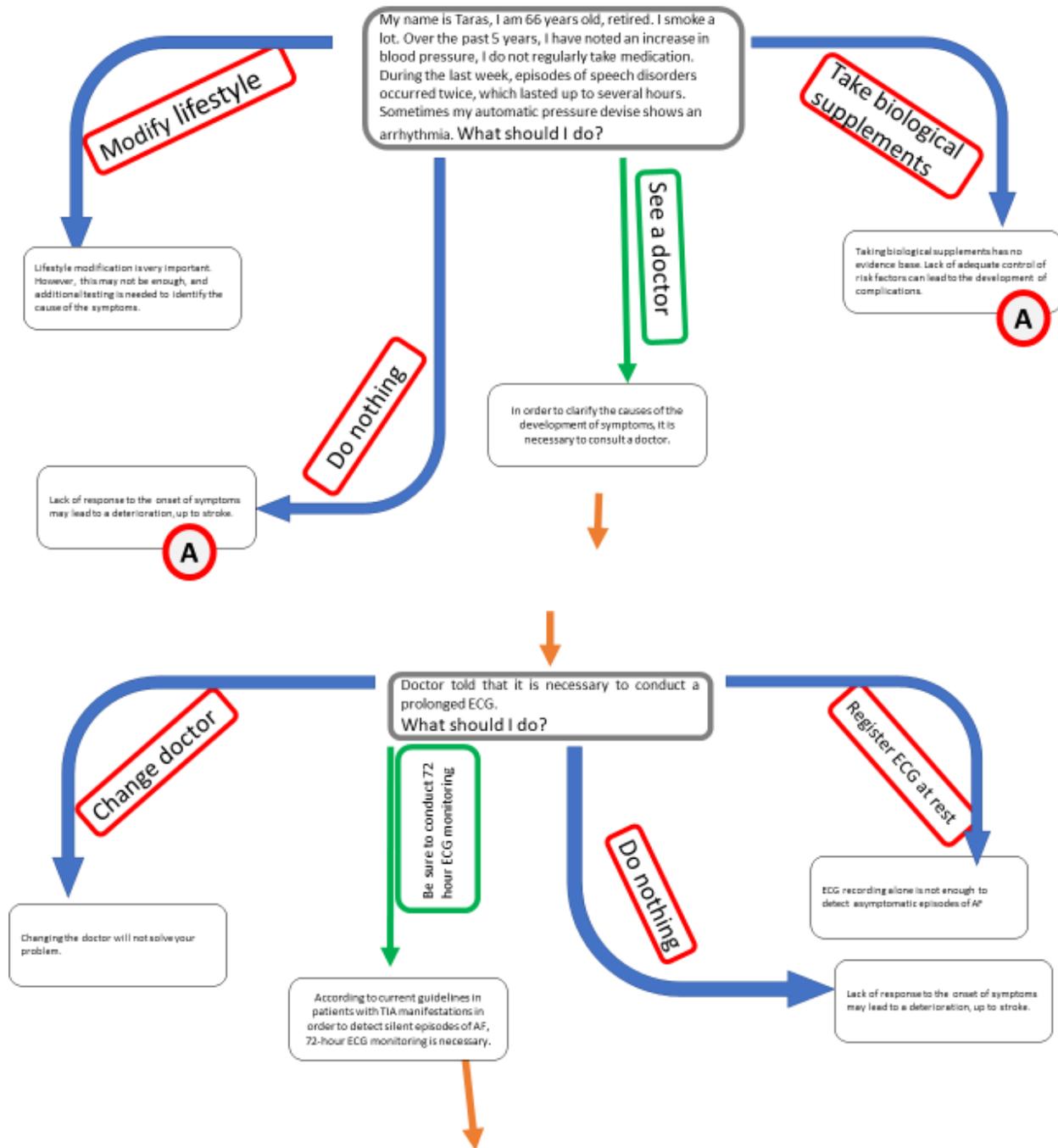
Vignette #8

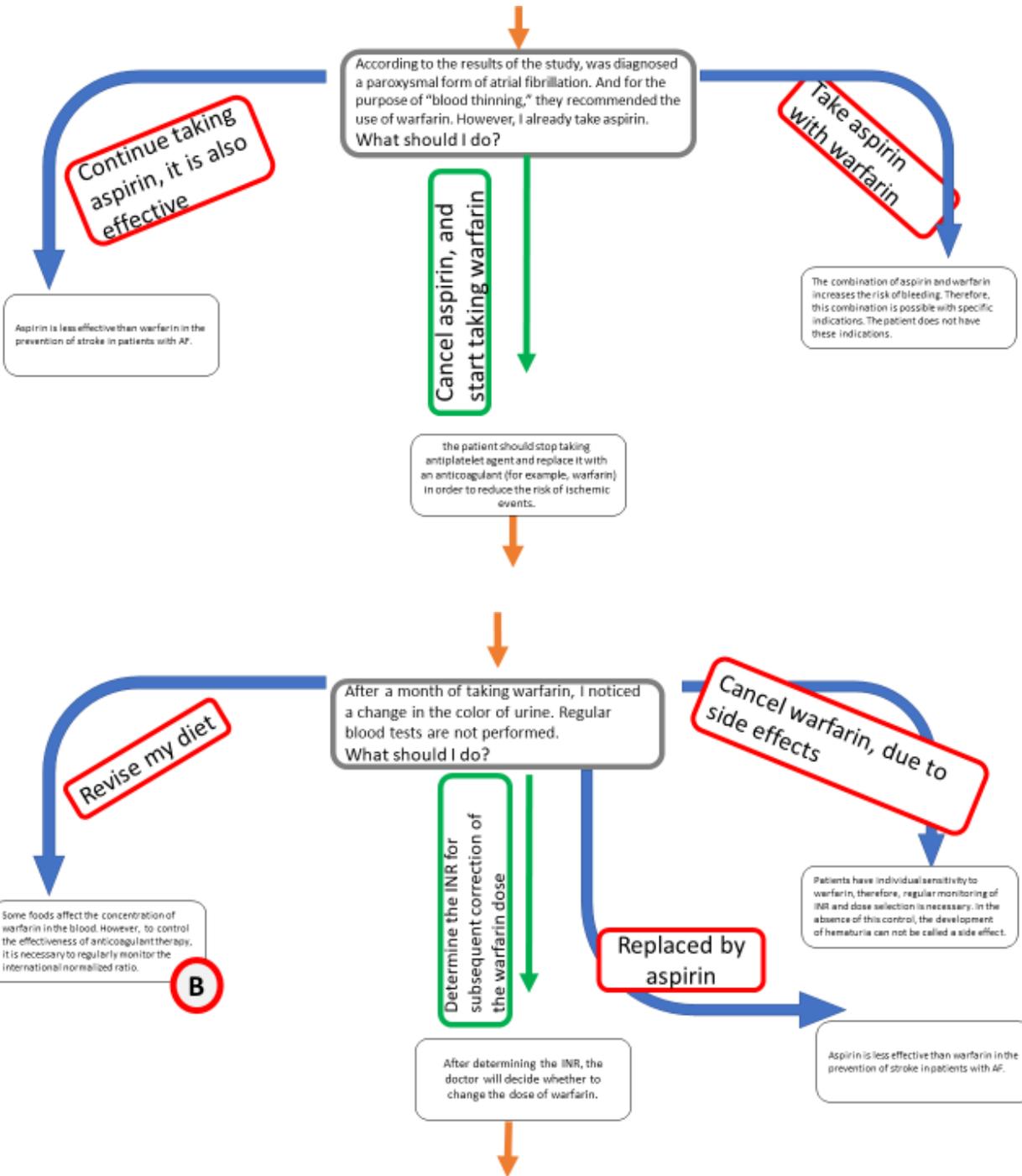


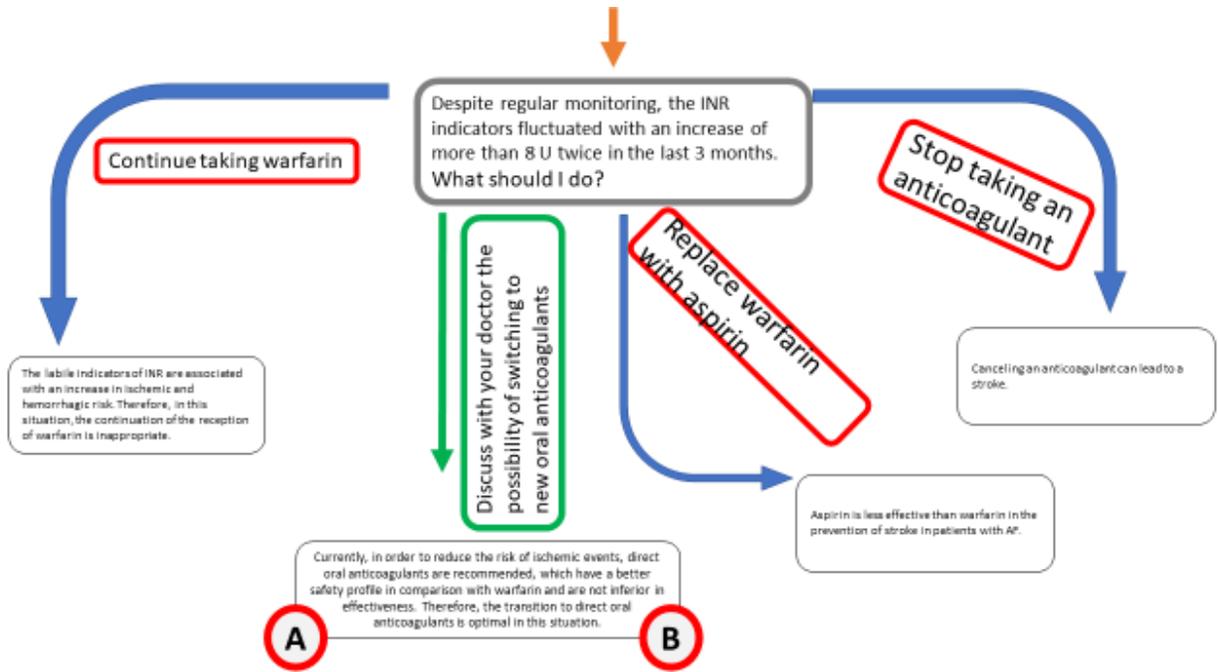




Vignette #9







Vignette #10

