Antithrombotics in intracerebral hemorrhage in the era of novel agents and antidotes: A review

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ABSTRACT

Intracerebral hemorrhage (ICH)1 is characterized by the pathological accumulation of blood within the brain parenchyma, most commonly associated with hypertension, arteriovenous malformations, or trauma. However, it can also present in patients receiving antithrombotic drugs, either anticoagulants such as acenocoumarol/warfarin—novel oral anticoagulants or antiplatelets, for the prevention and treatment of thromboembolic disease. The purpose of this review is to present current bibliographic data regarding ICH irrespective of the cause, as well as post-hemorrhage use of antithrombotic agents. Moreover, this review attempts to provide guidelines concerning the termination, inversion, and of course resumption of antithrombotic therapy.
INTRODUCTION

Intracerebral hemorrhage (ICH) is defined as the accumulation of blood within the cerebral parenchyma and accounts for 15% of all strokes.\textsuperscript{1-4} It is caused by a variety of factors and seems to have a more devastating effect on patients compared to ischemic strokes. In general, clinical presentations are associated with the location of the hematoma in the brain parenchyma and the size of the hemorrhagic clot. As the hemorrhage expands, it causes inflammation and edema in the surrounding regions, which lead to an increase in intracranial pressure (ICP), herniation, and neurological deterioration.

On the other hand, there are numerous conditions, like thromboembolic events including deep vein thrombosis (DVT), pulmonary embolism (PE), myocardial infarction (MI), as well as atrial fibrillation (AF) and the presence of mechanical heart valves, for the prevention and treatment of which antithrombotic therapy, such as acenocoumarol is absolutely indicated. Despite the benefit in lowering the mortality risk after such events, antithrombotic agents are linked to increased hemorrhagic risk, including ICH. Therefore, a protocol needs to be established in order to examine bleeding and ischemic risks and determine the optimal time point for discontinuation, reversal, and resumption of antithrombotic therapy. This review addresses the above issues according to the latest guidelines.

BACKGROUND—ICH CLASSIFICATION

ICH can be classified as either primary or secondary, on the basis of the underlying cause of bleeding. Primary ICH is usually the result of arterial hypertension and/or cerebral amyloid angiopathy (CAA), whereas secondary ICH is related to tumors or vascular malformations (such as aneurysms, cerebral cavernous malformations, arteriovenous malformations).

In the acute phase of ICH, the initial hematoma is created by the extravasation of blood from the ruptured vessel until it is controlled by pressure from the nearby tissue. A secondary hematoma is very likely to form as an expansion of the initial one, due to a mechanism quite relative to that of the primary ICH.\textsuperscript{5,6} Secondary ICH is lesion-dependent, for example, from vascular malformations that lead to disruption of normal architecture of the vessel wall, making it thinner and more fragile even to subtle changes in haemodynamics.\textsuperscript{7} In addition, as mentioned above, secondary ICH is also related to intracranial tumors, through the mechanism of neoangiogenesis.\textsuperscript{8,9}

ICH represents 10–20% of all strokes and has twice the incidence of subarachnoid hemorrhage.\textsuperscript{10,11}
The overall incidence of ICH is 24.6 cases per 100,000 person-years and has not changed since 1980, according to a large meta-analysis.12

ICH is divided in two main categories, lobar and deep hemorrhages.13,14 Lobar ICH in cortical and subcortical areas accounts for 15–30% of the cases, whereas deep ICH in the internal capsule and basal ganglia is encountered in 35–70% of cases. The rest include cerebellum hemorrhage and brainstem hemorrhage in 5–10% of ICH cases.

**RISK FACTORS**

Hypertension seems to be one of the major risk factors for ICH, making it absolutely necessary for hypertensive patients to strictly control their blood pressure levels.15 Hypertensive patients have 3.5-fold increased risk for ICH and more precisely, when blood pressure values are > 160/90 mmHg, the risk can be increased ninefold.16,17 The second most important risk factor is the deposition of amyloid within the media and adventitia, mainly of cortical vessels18,19 and is often correlated to the development of lobar ICH.20,21 Apart from that, age seems to play an important role, as the incidence of ICH increases after 55 years, whereas after the age of 85 the overall odds are the highest.22 Recent clinical trials have shown that low serum triglyceride levels are associated with increased risk of ICH and more particularly with deep or infratentorial cerebral minor bleedings.17,23 Other significant risk factors include diabetes mellitus,16,24 high LDL cholesterol and hyperuricemia,25 previous cerebrovascular accidents of any kind, alcohol consumption,26 smoking and recreational drug use (heroin, cocaine, amphetamine, ecstasy).27,28 Finally, anticoagulation, with either acenocoumarol/warfarin or NOACs, is established as a high-ranking risk factor for ICH.29–32 Moreover, while aspirin is also estimated to be a potential risk factor for ICH,33 its beneficial effect on preventing ischemic events and improving mortality seems to be much more significant. Compared to the general population, patients receiving anticoagulants are 7–10 times more inclined to develop ICH.34,35 As has been demonstrated in several clinical trials, risk factors for anticoagulant-associated ICH (AAICH) include: (1) older age, (2) history of ischemic ictus, (3) hypertension, (4) leukoaraisis, and (5) aggressive anticoagulation.34,36,37

**ANTITHROMBOTIC THERAPY**

Antithrombotic drugs are subdivided into three major categories, according to the underlying mechanism of action, displayed in Table 1.

*The Most Commonly Used Antiplatelet Drugs*

Aspirin is the most popular antiplatelet agent. It inhibits the production of thromboxane A2 by acetylating a serine residue near the active site of platelet cyclooxygenase-1 (COX-1), and its action lasts a platelet’s lifetime. Aspirin (with or without clopidogrel) is indicated for the treatment of coronary artery disease, carotid artery disease, and lower extremity artery disease38 and has dose-related side-effects such as peptic ulcers

| Antithrombotic Drugs | Treatment Strategy |
|----------------------|--------------------|
| Antiplatelet drugs   | Main choice for arterial thrombosis |
| Anticoagulants       | Prevention and treatment of venous thromboembolism |
|                      | Treatment of arterial thrombosis in acute setting |
| Fibrinolytic agents  | Direct action in dissolving existing thrombus and are the preferred therapeutic regimen in selected patients for the acute treatment of thrombosis |

TABLE 1. Antithrombotic Agents and Their Use in Thrombosis
complicated with bleeding and perforation. Platelets contain two kinds of receptors: (1) P2Y1 which induces aggregation and shape changes and (2) P2Y12 which increases platelets adhesiveness and inhibits adenylyl cyclase causing platelet activation (Table 2).

GPIIb/IIIa is a platelet-surface integrin that undergoes transformation when platelets are activated and acts as a surface receptor for fibrinogen and von Willebrand factor. Antagonists of this glucoprotein can act as antiplatelet agents and are often used in combination with aspirin or heparin in the setting of ACS patients undergoing PCI. Bleeding is their major side-effect.

### ANTICOAGULATION

The most widely used anticoagulants are: (1) warfarin, (2) heparin and derivative substances and (3) NOACs (dabigatran, rivaroxaban, apixaban and edoxaban) since 2000.

Warfarin is a vitamin K antagonist and is usually prescribed in patients with DVT, PE, AF, and mechanical prosthetic heart valves. In order for vitamin K antagonists to be effective, international normalized ratio (INR) must be strictly maintained within a therapeutic ratio of 2.0–3.0.

Novel oral anticoagulants (NOACs) or direct oral anticoagulants (DOACs) include direct inhibitors of factor IIa, such as dabigatran and argatroban, and direct inhibitors of factor Xa, such as rivaroxaban, apixaban, and edoxaban. Dabigatran has a reversal agent, idarucizumab, which is a humanized monoclonal antibody fragment approved in 2015 by the FDA. It has an initial and terminal half-life time of 47 min and 10.3 h respectively, and its recommended dose is 5 g of intravenous administration with no need for modification on renal or hepatic impairment. Most frequent adverse effects are hypokalemia, delirium, constipation, pyrexia, pneumonia, and headache. A recombinant modified version of human activated factor X, andexanet alpha, acts as a decoy receptor and reverses the effects of FXa inhibitors. The drug was approved as an antidote for rivaroxaban and apixaban by the FDA in 2018. It has a half-life elimination of 5–7 h, and the dose of andexanet alfa is based on the rivaroxaban or apixaban dose. The most common adverse effects are infusion-related reactions, thromboembolic events, intracranial bleeding, and gastrointestinal bleeding.

There are several studies in the international literature that support the safety of NOACs and document lower rates of ICH in comparison to warfarin. ARISTOTLE trial\(^{39}\) has verified that apixaban can reduce stroke or embolism by 55\% when compared to aspirin, and have comparable rates of ICH episodes.\(^{40,41}\) RE-LY study has stated that dabigatran presented with 20\% lower bleeding rate but with akin effect in preventing stroke or systemic embolism with warfarin.\(^{42,43}\) A study for rivaroxaban, ROCKET-AF, reported annual rate for ICH at 0.8\% versus 1.2\% with warfarin,\(^{44}\) after one daily dose for prevention of stroke and embolism in AF.

### TABLE 2. P2Y12 Receptor Antagonists

| Thienopyridine | Mechanism of Action | Half-life Time | Main Adverse Effects |
|---------------|---------------------|---------------|---------------------|
| Clopidogrel   | Irreversible inhibitor of P2Y12 receptors | 6 h parent drug, 30 min active metabolite | Upper respiratory tract infection, chest pain, headache, flulike syndrome |
| Prasugrel     | Irreversible inhibitor of P2Y12 receptors | 7 h | Bleeding, anemia, atrial fibrillation, back pain, dyspnea, headache |
| Ticagrelor    | Reversible inhibitor of P2Y12 receptors | 7 h | Nausea, vomiting, diarrhea, severe agranulocytosis, thrombopenia |
Heparin activates antithrombin III, which is an inhibitor of thrombin and consequently of blood clotting. It inhibits the conversion of fibrinogen to fibrin and the activation of factor VIII. Classic heparin is metabolized in the liver and the reticuloendothelial system and has a half-life time of 60’–90’. Low molecular weight heparins (LMWHs) inhibit only the clotting factor Xa by binding to antithrombin, in contrast to classical heparin that can inhibit factor IIa as well.

Fibrinolytic drugs are used for in-hospital treatment in the acute setting for: acute MI, ischemic stroke, acute peripheral arterial thrombosis, and massive PE. They consist of streptokinase, tissue-type plasminogen activator (t-PA), and recombinant plasminogen activator (r-PA). The most commonly used antithrombotic drugs are summarized in Table 3.

**TABLE 3. Commonly Used Antithrombotic Drugs and Pharmacological Features**

| Antithrombotic Drug | Half Life | Duration of Action | Reversible | Treatment Strategy |
|---------------------|-----------|--------------------|------------|--------------------|
| Classic heparin     | 1.5 h     | 2.5–4 h            | Yes        | Protamine          |
| LMWH dalteparin/ardeparin | 3–5 h | 8–12 h depending on renal function | Partially | Protamine and factor VIIa |
| Enoxaparin         | 7 h       | 8–12 h depending on renal function | Partially | Protamine and factor VIIa |
| Fondaparinux       | 17–21 h   | 2–4 days depending on renal function | Limited evidence | Factor VIIa |
| Apixaban           | 8–15 h    | 24 h               | No         | No known antidote from human studies |
| Rivaroxaban        | 7–11 h    | 8–12 h             | No         | No known antidote from human studies |
| Dabigatran         | 817 h     |                    | No         | (1) Prothrombin complex concentrate (2) Idarucizumab |
| Warfarin           | 40 h      | 2–5 days           | Yes        | Vitamin K,Prothrombin complex concentrate, factor VIIa, FFP |
| Aspirin            | 2–4.5 h   | 5–7 days           | No         | Platelets          |
| Clopidogrel        | 6 h       | 5–7 days           | No         | Platelets          |
| Prasugrel          | 7 h       | 5–9 days           | No         | Platelets          |
| Ticlopidine        | 12 h      | 4–10 days          | Yes        | Methylprednisolone |
| Ticagrelor         | 7–8.5 h   | 24–48 h            | Yes        | Platelet inhibition subsides competitively. Platelets |

LMWH, Low molecular weight heparins.
about 0.6–1.0%, whilst the annual risk of ICH relapse in patients who survived a first episode is in the range of 2–3%. This is translated to a 10-fold increase in relative risk and an absolute annual risk increase of 2% in the general population. In addition, after the first ictus of an ICH without anticoagulation therapy, the reported rate of 3-month recurrence ranges between 0.4 and 3%. Patients with ICH associated with anticoagulation therapy usually show larger hematomas and poorer prognosis with a 3-month mortality of about 54%. However, it has been documented that abrupt reversal of warfarin is of utmost importance in the effort for prevention of hematoma enlargement.

**ATRIAL FIBRILLATION AND ICH**

AF presents with a prevalence of approximately 3% in patients > 20 years old. One-year stroke risk in AF patients ranges between 1.9–18.2 and 0–15.2, as determined by two scoring systems, CHADS2 and CHA2DS2VASC scores respectively. Another scoring system, the HAS-BLED Score, can help evaluate the annual risk of spontaneous major bleeding in AF patients, from 1.02 to 12.50 bleeds per 100 patient-years. Literature has a variety of scoring systems for stratifying the bleeding risk, such as ATRIA and HEMORR2HAGE and the most recent one, ORBIT by O'Brien et al. in 2015 (Table 4).

Patients with AF can benefit the most from anticoagulant treatment. It is documented that adjusted-dose warfarin can reduce ischemic stroke by approximately 60%. Nevertheless, warfarin increases the rates of ICH recurrence by 3–5% and is commonly linked to more extensive hematomas, as well as worse prognosis with 3-month mortality at about 54%. The most popular antiplatelet agent, aspirin, has been correlated with an increased relative risk of 1.4–1.8 for an initial ICH. The combination of aspirin plus warfarin can increase the relative risk of ICH 2–4 times in comparison to monotherapy of warfarin. Moreover, oral anticoagulation has been associated with a higher 30-day case fatality after lobar ICH, compared to no antithrombotic treatment. Two large meta-analyses of AF patients documented decreased relative risk of ICH (RR = 0.48) on NOACs, in contradiction to warfarin. They also supported the fact that NOACs reduced ICH incidence in patients with AF by almost 50%, compared to vitamin K antagonist users.

**PROPHYLACTIC OR THERAPEUTIC ANTICOAGULATION REGIMEN FOR VENOUS THROMBOEMBOLISM**

Venous thromboembolism (VTE) consists of two major categories: (1) DVT and (2) PE. PE is observed in 1–5% of ICH patients, 2–4 weeks after the ictus, and surprisingly enough does not accompany a clinically symptomatic DVT. Evidence-based literature suggests the use of clinical scoring systems such as Modified Wells Scoring and Revised Geneva Scoring in order to estimate the clinical probability of PE.

### TABLE 4. ORBIT Scoring System for Patient Bleeding Risk Stratification

| Risk Factors              | Points | Patients Risk Stratification     |
|---------------------------|--------|----------------------------------|
| Age > 75 y                | 1      | Low risk (0–2 points)            |
| History of anemia         | 2      | Intermediate risk (3 points)     |
| Bleeding history          | 2      | High risk (≥ 4 points)           |
| Kidney dysfunction        | 1      |                                  |
| On antiplatelet agents    | 1      |                                  |
There is no consensus regarding the most appropriate time and treatment protocol of DVT prophylaxis in neurosurgical patients. Prophylaxis includes compression stockings and/or antithrombotic therapy. When only compression stockings are used for DVT prophylaxis after neurosurgical procedures, DVT is found in 32% of patients. Despite the fact that the use of classic heparin reduces DVT and PE incidence by 40–50%, it also raises the ICH risk rate from 1–3.9% to 10.9%. LMWH reduces the relative risk of VTE by 38% and presents with an ICH risk of 2.2–2.6%, whereas patients without antithrombotic treatment have an ICH risk of 0.8–2.6%. Even though there are various LMWH agents available, the safety of only enoxaparin is mainly supported in neurosurgical procedures. The safe administration of enoxaparin has also been documented for VTE prophylaxis without augmenting the risk of ICH deterioration after 24 h of a secondary ICH due to a head injury. Prophylactic dose of LMWH or unfractionated heparin (UFH) has been considered to be safe for administration in hemiplegic patients after 3–4 days from an ICH episode and once its progression has stopped.

Patients with mechanical heart valves must be on antithrombotic therapy despite the possibility of an ICH. A recent meta-analysis has certified that warfarin reduced the risk of thrombosis in patients with prosthetic valves from 1.8 to 0.2 per 100 patient-years, and the incidence of major embolism by 80%. The greatest risk for a thromboembolic episode is during the first month of valve replacement, when almost 20% of all episodes are encountered. Lastly, it should be stated that NOACs have not yet been approved for patients with prosthetic valves.

**RESUMING ANTITHROMBOTIC THERAPY**

The risk for a thromboembolic episode as well as the risk of ICH recurrence is increasing over time. On the contrary, the risk for an ICH enlargement is documented to be higher during the first days of the event. Oral anticoagulants reduce the risk for an ischemic episode and their reinitiation after an ICH is generally recommended. Stratified data show that the mortality risk rate of a stroke in the group of patients who resumed anticoagulant treatment was 3.6%, whereas the group that did not resume presented with a mortality risk rate of 7.6%. The risk of ICH recurrence of the first group was 3.6% in contrast to the risk of the second group, which was over 5.1%. Stratification of patients in groups revealed that patients suffering from AF who resumed therapy presented with an incidence rate for ischemic events of 8.2% whereas the non-treatment group had an incidence rate over 37.5%. However, it has been reported that AF patients who discontinued their treatment presented with a greater stroke risk of 10–48% than the risk of developing an ICH which was 0–9%. It is a fact that patients with a mechanical valve have a high risk of thromboembolic events and must restart antithrombotic therapy. Moreover, NOACs may be considered as a safe choice for AF or VTE patients after an AAICH. The available data show an advantage in reinitiating anticoagulation therapy after 4–8 weeks, taking into consideration the fact that the causative factor of bleeding has been dealt with and the anticoagulant agent presents a low bleeding risk.

Anticoagulation therapy still remains a matter of controversy concerning the most appropriate time point for restarting anticoagulants after an ICH event. Even though there is no consensus, most studies agree on restarting antithrombotic therapy 7–14 days after an ICH episode. The use of reversal agents must be taken into consideration because they can temporarily change the coagulation profile of the patient and increase the thromboembolic risk. Heparin or oral anticoagulants are considered to be safe for resumption on day 3 or day 7, respectively after an ICH event without changing the rebleeding risk.
ICH SURGICAL TREATMENT

Even though surgical evacuation for deep ICH does not improve patients’ survival, it is recommended for posterior fossa ICH whose maximum diameter is greater than 3 cm, and /or with a rapid neurological deterioration or with a mass effect on brainstem.89,106–109 The biggest trial conducted for ICH was the STICH trial.110 It included 1,033 patients with primary deep ICH and concluded that surgery did not offer a statistically significant benefit in survival over conservative treatment. Other surgical techniques such as minimal invasive techniques did not offer a significant benefit as investigated in the MISTIE107 clinical trial.

The 30-day mortality of ICH is above 40%111 and near 50% at 1 year.20,112 The ICH Score by Hemphill is a grading scale used to predict 30-day mortality in ICH patients, most of the times contributing to the surgical decision. This scoring system ranges from 0 to 6113–118 and includes five criteria: (1) GCS score, (2) ICH volume, (3) co-existence or not of intraventricular hemorrhage (IVH), (4) the origin of the ICH, supra- or infratentorial and (5) age. Each parameter is scored with one relevant credit, and the total sum corresponds to 30-day mortality. Furthermore, according to other studies, the outcome in medium and large-sized ICH could be assessed on admission by using the Canadian Stroke Scale, ICH location, and fibrinogen levels.119

COMPLICATIONS

ICH is a condition accompanied by severe complications. A list of them is presented in Table 5.

HEMATOMA EXPANSION

ICH continues to expand for up to 6 h in patients not receiving anticoagulation therapy, and up to 24 h in coagulopathy-associated bleedings.56,99,120 Moreover, the perihematoma edema starts to develop and reaches its maximum size at 72 h, usually persisting for 5 days, and in some cases lasting for up to 15 days.121 The formation of the initial hematoma is followed by a second phase of shearing and bleeding from multiple ruptures in the surrounding vasculature.5,6,122 It is widely accepted that the shape, speed, space distribution, and the ratio of the amount of blood in an ICH is multifactorial. Primary ICH can expand and produce a mass effect on the brain, and therefore stopping the hematoma expansion may improve the outcome in ICH patients. Nevertheless, it is still uncertain if an ICH recurrence is due to a nearby but separate site event or it is a continuation of the initial event.

DISCUSSION

The size of an ICH is one of the most important factors that can determine a patient’s prognosis. The discontinuation and reversal of antithrombotics is of great importance in preventing hemorrhage enhancement during the first hours after an ICH event. Reversal agents for NOACs are under development. In October 2015, the FDA approved idarucizumab as a reversal agent for dabigatran123 and in 2018andexanet alfa as a reversal agent of FXa-inhibitors (apixaban, edoxaban, rivaroxaban).124,125

If urgent surgery (in < 48 h) is indicated, given that NOACs have half-lives of 14–17 h and normal coagulation improves after 12 h, surgery

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TABLE 5. Most Common Complications of ICH

| Complication                        |
|------------------------------------|
| Deep venous thrombosis             |
| Pulmonary embolism                 |
| Neurological deficits or death      |
| Aspiration pneumonia               |
| Seizures                           |
| Hydrocephalus                      |
| Spasticity                         |
| Urinary complications              |
| Neuropathic pain                   |
| Cerebral herniation                |

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should be delayed as long as possible. If waiting is not an option, a hematologist should be consulted to discuss the possibility for an antidote. If surgery is not necessary in the first 48 h, it can be performed 48 h after the last dose of NOACs.

High blood pressure is the leading cause of acute primary ICH.\textsuperscript{126,127} It is reported that high systolic blood pressure is associated with ICH enlargement and thus mortality.\textsuperscript{127–129} According to 2015 guidelines by AHA/ASA (American Heart Association/American Stroke Association), immediate lowering to 140 mmHg is recommended in ICH patients with systolic blood pressure between 150 and 220 mmHg and with no contraindication to acute blood pressure treatment. If systolic blood pressure is > 220 mmHg, acute reduction by a continuous intravenous infusion and blood pressure monitoring are recommended.

ICH recurrence annual rates in survivors are 2–3%, and antithrombotic therapy is linked to an increased risk of recurrence. Warfarin-associated ICH is usually more extensive and is associated with a worse prognosis, with a 3-month mortality rate of approximately 54%.

Resuming antithrombotic therapy is an equilibrium between the risk of an ICH recurrence and the risk of an embolic ictus in case of discontinuation of therapy permanently. Patients with AF on oral anticoagulants must be stratified for a major bleeding event by using a scoring system, either HASBLED Score or by the most recent one ORBIT. Consecutively, these patients are also stratified for an ischemic stroke event, using CHADS2 and CHA2DS2VASc scoring systems. One-year thromboembolic risk according to these scores fluctuates between 0 and 20%, whereas the same risk of an ICH recurrence after resuming anticoagulants is 2.5–8%. Kuramatsu et al.\textsuperscript{95} and Nielsen et al.\textsuperscript{130} in 2015 reported a difference in the ICH recurrence risk within the first year, between patients who resumed anticoagulant treatment and those who did not. Nevertheless, both studies reported that the risk for an embolic episode within 1 year was almost double in patients who did not resume their antithrombotic therapy.

In spite of the fact that there is no consensus for the optimal timing of resuming anticoagulant therapy after an ICH event, most of the studies support the resumption of the antithrombotic treatment after 7–14 days.\textsuperscript{88,99–104} Restarting heparin or oral anticoagulants after an ICH event is reported to be safe on day 3 or day 7 respectively, without increasing the rebleeding risk.\textsuperscript{105} The newer category of NOACs is included in therapeutic strategies as a safe treatment option for restarting in AF patients after a warfarin-associated ICH according to recent guidelines of the European Heart Rhythm Association in 2018.\textsuperscript{75,131} According to guidelines of ESC in 2016 restarting oral anticoagulation is supported when the drug of choice has low bleeding risk after 4–8 weeks.\textsuperscript{132} In patients with prosthetic mechanical valves resuming anticoagulant therapy is of the utmost importance. The 3-month risk for an ischemic event in patients who have mitral or aortic valve bioprosthesis is approximately 17%. For a mechanical mitral valve, the annual risk of a stroke is 22%, whereas in aortic mechanical prosthesis the annual risk is over 12%. A retrospective study reported restarting warfarin in patients with mechanical valves after 14–20 days without any thromboembolic events in a 6-month follow-up.\textsuperscript{133} However, there is no consensus on the optimal timing of resumption of anticoagulation therapy. A study carried out by worldwide experts concluded that after an ICH, anticoagulation therapy in patients with a prosthetic heart valve should be reinstated 2–14 days after the event.\textsuperscript{99}

CONCLUSIONS

Patients who present with an ICH due to any cause must discontinue oral anticoagulation for a restricted period of time. Nevertheless, restarting antithrombotic therapy is still considered to be a matter of debate. In AF patients with ICH,
oral anticoagulation with an agent of low intracranial bleeding risk is recommended to be reinitiated in 4–8 weeks. In patients with prosthetic mechanical valves, anticoagulation is suggested to be reinstated 10 days after the onset of ICH. In cases of DVT and/or PE, therapeutic doses of enoxaparin are recommended after the fourth day of the onset of an ICH and after it has been confirmed that the hematoma is not expanding any further. Nevertheless, the optimal timing of restarting antithrombotic treatment is a matter of discussion between a multidisciplinary team consisting of a stroke specialist, a cardiologist, and a neurosurgeon, who will individualize the therapeutic strategy.

CONFLICTS OF INTEREST
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No datasets were generated for this review.

COMPLIANCE WITH ETHICAL STANDARDS
No ethics approval needed for this review.

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