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Antithrombotics and Amyloid Therapy: Balancing Risk

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Episode 5

Dr. Weisman:
I'm Dr. Weisman. Here with me today is Dr. Cabral.

Many patients with Alzheimer's disease also require cardiovascular medications, making treatment decisions increasingly complicated. How do we approach patients receiving antithrombotic therapy who may be also candidates for anti-amyloid therapy? Dr. Cabral?

Dr. Cabral:
Great, great question. So this comes up frequently because our patient population is exactly the population that's on these kinds of medications and has more cardiovascular disease and atrial fibrillation, things like that. So you can't just treat Alzheimer's in isolation, right? And so really, first, number one, you need to get a really comprehensive, detailed medication review because anticoagulants carry different risks with these anti-amyloid therapies than do antiplatelets, right?

And so in practice, it's really an individual assessment, and of course, we need to know, does their baseline MRI show any kind of preexisting hemorrhages or anything like that? And that's going to be a different conversation.

And so if someone needs anticoagulation for something, it could be an alternative could be used. So non-valvular atrial fibrillation. So before they initiate anti-amyloid therapy, are they willing to have a Watchman device implanted? And so that happens, and that's happening a lot around the country and the world and working well.

Now, other things, other indications, you can't just stop anticoagulation. And so those are situations where really having to weigh the risks and the benefits. American Academy of Neurology recommends that anticoagulation medications are contraindicated in patients receiving anti-amyloid monoclonal therapy because of the increased bleeding risk, of course.

And we have seen in the real world that probably the majority of the devastating intracerebral hemorrhages that have occurred with people on anti-amyloid therapies are related to them getting also some kind of concomitant anticoagulants, and I think most often it's been TPA when they present to the emergency department with stroke-like symptoms. And so that's an area where we've learned a lot. And these individuals who were in the clinical trials unfortunately had a bad outcome, and we've shifted our approach to this.

Now, it's also recommended to do APOE4 testing before you initiate these treatments. And so do they have increased risk of potential ARIA-H because of that? And so you're weighing all of these different factors.

So it looks like in terms of if we shift to talking about antiplatelets such as aspirin, there seems to be no increased risk of ARIA-H, increased bleeding, when a person's taking antiplatelets or aspirin monotherapy. Now, in terms of dual therapy antiplatelets, we don't really have much data on that, but it's just up to clinical judgment, and it's not a complete contraindication by any means. Also, things like NSAIDs and other things that could impact hemostasis.

So yeah, I think that covers it. What do you think, Dr. Weisman?

Dr. Weisman:
Well, I think that it's a huge risk. It's been a matter of enormous conversations because the people were included in the trial, and where the FDA label states that we are to treat people in accordance with the trial population, so the trial population included people on anticoagulation. So it's not contrary to the AAN, a contraindication, but it is a huge risk.

So the way that I approach patients with it personally is just say that the drug can give you this thing called ARIA-H. Lecanemab and donanemab can give you ARIA, and that can make you bleed. But if you can't clot, you can convert a microhemorrhage into a macrohemorrhage, and then we're talking nursing home or morgue. And so far, I've not had a lot of people say yes to that with that kind of brutal honesty. But that's, I think, what it really takes. If they can get off anticoagulation, exactly right, then that's the way to go.

So that's my approach. Anything to add there?

Dr. Cabral:
No, yeah, I think you bring up maybe what I'm inferring. So maybe clinicians who aren't as familiar with this, we may have patients that they have a lot of risks. So say they're on anticoagulation, they're an APOE4 carrier, and they are so motivated to start these treatments that we have to rein them in and really lay out those risks that way.

So I think we're used to expecting we're going to have to encourage people who are good candidates, but actually this alternate, contrary situation can occur. And so it's good to have the scripting in advance to be prepared to talk to patients and families about this.

Dr. Weisman:
Totally. And that's been a great bite-sized discussion. Our time's up. Thanks for listening.

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