Interesting Cases from the Emergency Department

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Reversal of Xeralto and Pradax

Pradaxa can be dialysed

Xeralto cannot be dialysed

Case 1-Xeralto

58 year old Caucasian male
24 hr history severe rectal bleeding
Acute onset
Bright red blood with clots
Mild abdominal pain

Medications

Patient was taking Xeralto 10 OD
No other medications

Past Medical History

THA 31 days prior
No history of GI bleed or colorectal problems

Course in the Emergency

Ongoing rectal bleeding 250-500ml bright red blood

Hb on initial assessment 120

Repeat Hb 100 then 74 within 24 hrs

Coags normal

Platelets normal, Cr normal

Course in the Emergency

Transfusion required:
9 units PRBCs to maintain
hemodynamic stability

Course in the Emergency

CT scan showed diverticulosis but no bleed
UGI endoscopy mild gastritis – no bleed

Transferred to tertiary centre

…at the Tertiary centre

BP 134/71
HR 98
RR 20
SaO_2 98% room air
T = 36.0
Looked pale
DRE + fresh blood, mild abdo tend

…at the Tertiary centre

Hb 85
Pt bled overnight and received 1 unit PRBCs

During the next 15 hrs, pt has 2 further bleeds
Received 3 more units

…at the Tertiary centre

Post-transfusion Hb 85

Received another 2 units and started on an IV PPI

BP dropped to 90/57

Fluids increased to 1L every 4 hrs

…at the Tertiary centre

Four further episodes of bleeding over the following 6 hours

BP dropped

Received 2 more units PRBCs

Pt underwent CT mesenteric angiography – no bleed found

…at the Tertiary centre

Next four days, no bleeding
Resumed normal diet
Discharged with Hb 104

Followup colonoscopy at 6 days
and 6 weeks normal

Discussion

17 unit bleed

No source

No platelets transfused

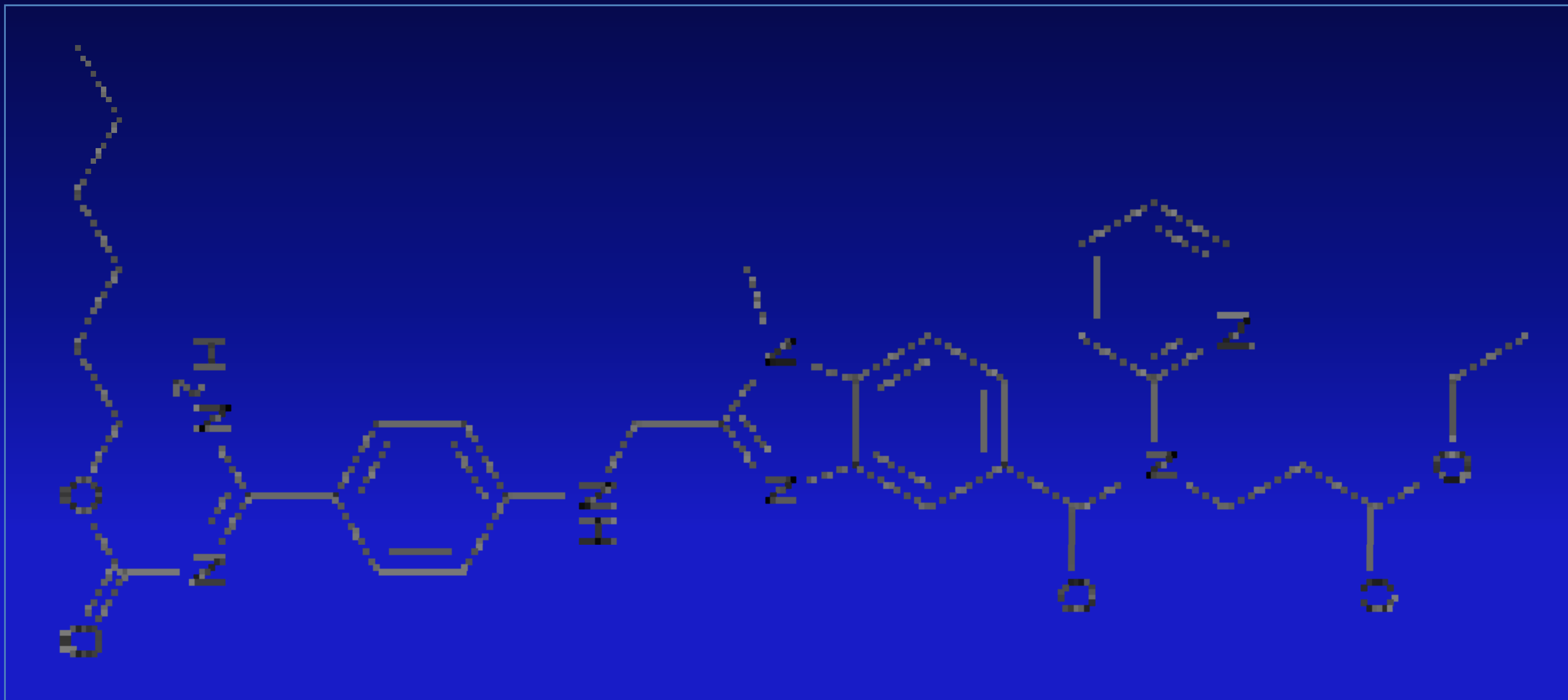
Discussion

Factor Xa inhibitor

RECORD 1 trials randomized double-blind vs enoxaparin showed 6 cases of major bleeding (0.3%)

T1/2 5-9 hours
Cannot be dialysed

Pradax



Case 2 - Pradax

Factor IIa inhibitor
Inhibits Thrombin

Absorbed by charcoal

dialyzable

Case 2

87 male presented with weakness, cough, decreased oral intake.

on pradax 150 bid for atrial fibrillation - CHADS 5 preserved ventricular function

Case 2

1 week earlier, pt presented to Fam MD with increased lower extremity edema.

Found to be in rapid a-fib 120 beats/min

Case 2

Cr 106 umol/L
eGFR – 57ml/min

Verapamil 120 -> 240
Metoprolol 25 -> 100
Furosemide 40 -> 60

Case 2

5 days later pt fell getting out of bed – did not seek medical attention

Pt presented vomiting 3 times and too weak to stand

Physical Exam

Vitals

T = 95.7

BP 102/48

HR 36 AF

SaO_2 96% 2L NP

Physical Exam

JVP 10 cm with HJR
Bibasilar crackles
Abdomen benign
3+ pitting lower leg edema

Labs

K = 6.6

BUN = 45

Cr = 270

ALT = 546

AST = 422

WBC 18 000, Hb 140, Plt 214

PTT 100, INR 6

Fibrinogen 279 (normal)

Lactate elevated

What's wrong with the pt?

Coagulopathy
ARF
Transaminitis
Sepsis

Treatment

2L NS bolus
1mg glucagon
CXR RLL infiltrate – rocephin and levo

Treatment

4 units FFP
15 mg Vit K
5000 IU PCC

Outcome

Resuscitated
7 days in hospital – discharged

Restarted on Coumadin

No further problems

Discussison

Renal failure the cause of the coagulopathy

No Dialysis

Discussison

No source of bleeding found

Strategy – replace coagulation factors

Discussison

No reliable test for the novel anticoagulants and there is no reversal

Some studies suggest rVIIa may help

Monoclonal antibody and per977 being developed as antidote

Discussison

Dialysis is a reliable treatment