Corrigendum: Portal vein thrombosis – a primer for the general physician

Authors: Mohammad Haris[A] and Jecko Thachil[B]

Authors: [A]medical student, University of Manchester, Manchester, UK; [B]consultant haematologist, Manchester Royal Infirmary, Manchester, UK

Clinical Medicine 2016;17:212–9

Mohammad Haris' name was published with the incorrect spelling. The correct spelling is printed above.

Corrigendum: Drug therapy in anticoagulation: which drug for which patient?

Authors: Carolyn M Millar[A] and Mike A Laffan[B]

Authors: [A]clinical senior lecturer, Imperial College, London, UK and consultant haematologist, Imperial College Healthcare NHS Trust, London, UK; [B]professor of haemostasis and thrombosis, Imperial College, London, UK and honorary consultant in haematology, Imperial College Healthcare NHS Trust, London, UK

Clinical Medicine 2016;17:233–44

There were errors in the drug doses published in Table 1 and Table 5.

In Table 1, the correct dose of edoxaban should have been listed as 60 mg od[4] for NVAF and 60 mg od (following ≥5 days LMWH)[4] for VTE; the correct dose for rivaroxaban in ACS is 2.5 mg bd, not 2.5 mg od as originally listed.

In Table 5, the correct dose for dabigatran is 110 mg bd and the correct standard dose for rivaroxaban is 20 mg od.

The corrected tables are published below.

There was an omission in Table 2 – the confidence interval for the primary endpoint SSE for edoxaban was 97.5%.

Table 1. Properties and licensed indications of NOACs

	Dabigatran	Rivaroxaban	Apixaban	Edoxaban
Mechanism of action	**Direct thrombin inhibitor**	**Factor Xa inhibitor**	**Factor Xa inhibitor**	**Factor Xa inhibitor**
T_{max}	2 hours	2–4 hours	1–4 hours	1–2 hours
Elimination half-life	12–17 hours	5–9 hours (young) 11–13 hours (elderly)	12 hours	10–14 hours
P-gp re-secretion	Yes	Yes	Yes	Yes
CYP3A4 metabolised	No	Yes	Yes	Minimal
Renal excretion	Up to 80%	66%	25%	35%
Plasma protein binding	35%	>90%	>90%	>90%
Intake with food required	No	Mandatory	No	No
Hepatic impairment	Not recommended in patients with elevated liver enzymes (>2×ULN)	Contraindicated in hepatic disease associated with coagulopathy and clinically relevant bleeding risk, including cirrhotic patients classified as Child-Pugh B and C.	Contraindicated in hepatic disease associated with coagulopathy and clinically relevant bleeding risk; not recommended severe hepatic impairment (Child-Pugh C); use with caution in patients with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment or in patients with elevated liver enzymes (>2×ULN)	Contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk; not recommended In patients with severe hepatic impairment; use with caution in patients with mild to moderate hepatic impairment and patients with elevated liver enzymes (>2×ULN)
Antidote available	Yes	No	No	No
NICE approved indications and doses				
NVAF	150 mg bd, 110 mg bd[1]	20 mg od[2]	5 mg bd[3]	60 mg od[4]
VTE treatment and secondary prevention	150 mg bd (following ≥5d LMWH)	15 mg bd (initial 21 days), 20 mg od after 21 days	10 mg bd (initial 7 days), 5 mg bd (up to 6 months); 2.5 mg bd after 6 months)	60 mg od (following ≥5 days LMWH)[4]
Prevention of VTE after elective hip or knee replacement	150 mg od	10 mg od	2.5 mg bd	Not licensed
ACS	Not licensed	2.5 mg bd	Not licensed	Not licensed

[1]Dabigatran 110 mg bd dose in NVAF where ≥80 years; consider where CrCl 30–49 mL/min
[2]Dose reduction rivaroxaban in NVAF: 15 mg od where CrCl 30-49 mL/min
[3]Dose reduction apixaban in NVAF: 2.5 mg bd where CrCl 15–29 mL/min or where two of serum creatinine ≥1.5 mg/dL, age ≥80 years, body weight ≤60kg
[4]Dose reduction edoxaban in NVAF and VTE: 30 mg od where one of CrCl 15–49 mL/min, body weight ≤60kg, concomitant use of cyclosporin, dronedarone, erythromycin or ketoconazole
ACS = acute coronary syndrome; bd = twice per day; CrCl = creatinine clearance; LMWH = low molecular weight heparin; NICE = National Institute for Health and Care Excellence; NOAC = non-vitamin K oral anticoagulant; NVAF = non-valvular atrial fibrillation; od = once daily; P-gp = P glycoprotein; T_{max} = time to peak level post ingestion; ULN = upper limit of normal; VTE = venous thromboembolism

Table 5. Dosing in non-valvular atrial fibrillation: renal function, age and body weight

	Dabigatran	Rivaroxaban	Apixaban	Edoxaban
Standard dose	150 mg bd	20 mg od	5 mg bd	60 mg od
Renal function				
CrCl 30–49 mL/min	Consider 110 mg bd	15 mg od	5 mg bd	30 mg od
CrCl 15–29 mL/min	Not recommended	Use with caution	2.5 mg bd	30 mg od
CrCl <15 mL/min	Not recommended	Not recommended	Not recommended	Not recommended
CrCl >95 mL/min	–	–	–	Not recommended
Age	≥80 years: 110 mg bd ≥75 years: consider 110 mg bd	–	2.5 mg bd where two of: > serum creatinine ≥1.5 mg/dL > age ≥80 years > weight ≤60 kg	–
Body weight	–	–	2.5 mg bd where two of: > serum creatinine ≥1.5 mg/dL > age ≥80 years > weight ≤60 kg	30 mg od: > weight ≤60 kg
Others	110 mg bd: > concomitant verapamil > consider where increased risk of bleeding			30 mg od: > concomitant use of cyclosporine, dronedarone, erythromycin or ketoconazole

bd = twice per day; CrCl = creatinine clearance; NVAF = non-valvular atrial fibrillation; od = once daily