NORTH COUNTY NEUROSURGERY

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Anticoagulant & Antiplatelet Tapering

A quick reference for patients on blood-thinning medications who are scheduled for surgery.

Medications that thin the blood or prevent clots must usually be held or adjusted around surgery to reduce bleeding. The right plan depends on the medication, the reason you were prescribed it, and your individual cardiac and clotting risk. This card summarizes the default framework — but every plan should be confirmed with the physician who prescribed the medication.

Never stop a blood thinner without coordination

Stopping a blood thinner can be dangerous if you were prescribed it for a drug-eluting coronary stent, a mechanical heart valve, atrial fibrillation with high stroke risk, or recent clot. Every blood thinner stop should be coordinated with the prescribing physician (cardiology, hematology, or primary care) and with our office.

Medication-by-medication defaults

Aspirin — Dr. Winograd's protocol

- ASA 81 mg (low-dose, cardiac protection): continue through surgery unless otherwise discussed. Do not stop without coordinating with the prescriber.
- ASA 325 mg (full-dose): switch down to ASA 81 mg for the week before surgery.
- Optimal plan when safe: if your primary care physician or cardiologist agrees, stop ASA (81 or 325) for 1 week before and 1 week after surgery. This minimizes bleeding risk when cardiac history allows.

Plavix (clopidogrel), Effient (prasugrel), Brilinta (ticagrelor)

- Plavix / Effient: hold 7 days before surgery.
- Brilinta: hold 5 days before surgery.
- Cardiology clearance REQUIRED — these agents are often prescribed after a stent or recent heart attack. Stopping too early can cause stent thrombosis.

Eliquis (apixaban), Xarelto (rivaroxaban), Pradaxa (dabigatran), Savaysa (edoxaban)

- Hold more than 72 hours before surgery as a minimum. Longer holds are acceptable when approved by the prescriber.
- After surgery: remain off for at least 7 days. Ideal: 2 weeks off post-op when clinically safe.
- For atrial fibrillation, mechanical valves, or recent VTE: bridging may be needed — coordinate with cardiology or hematology.

Warfarin (Coumadin)

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- Typically held 5 days before surgery, with INR check 1–2 days before surgery (goal INR < 1.4 for most cases).
- Bridging with a short-acting anticoagulant (enoxaparin/Lovenox or heparin drip) is often used for high-risk indications.
- The specific bridge plan is coordinated with the prescribing physician.

NSAIDs (ibuprofen, naproxen, Celebrex, Mobic, diclofenac)

- Hold 7 days before surgery.
- Tylenol (acetaminophen) is OK throughout.
- Be careful with combination cold, sinus, and headache medications — many contain NSAIDs. Read labels.

Fish oil, vitamin E, garlic, ginkgo, ginseng, St. John's wort

- Hold 7 days before surgery — each increases bleeding risk or interacts with anesthesia.

When to resume after surgery

The resume date for each medication is procedure-specific and depends on bleeding risk, post-op concerns, and the medication's pharmacology. Dr. Winograd will review the resume plan with you at discharge and at your post-op visit. As a general rule: aspirin-only regimens often resume within a week; DOACs and warfarin are held longer (minimum 7 days; ideal 2 weeks for DOACs); stent-related antiplatelet therapy is resumed on a cardiology-coordinated schedule.

If you are unsure — call

Every patient's anticoagulation plan is reviewed individually. If any instruction here conflicts with what you were told by the prescribing physician, the hospital's pre-operative education / anesthesia phone call or visit, or our office — please call us at (442) 273-5056 so we can sort it out before the day of surgery.

— Evan Winograd, MD

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