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Opinion Article

Management of Antiphospholipid Antibody Syndrome (APS) in Intracardiac Thrombus

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DESCRIPTION

Venous or arterial thrombosis, as well as pregnancy-related morbidity, is characteristics of the Antiphospholipid Syndrome (APS), which is present in patients with persistent antiphospholipid Antibody Levels (aPLs). The most severe form of APS, known as catastrophic APS, causes individuals with aPLs to experience multi-organ failure as a result of fast development of micro-vascular thrombosis. APS and catastrophic APS patients are known to have a high risk of recurrent thrombosis, which can still happen despite anticoagulant medication. While antithrombotic medication continues to be the cornerstone of care, bleeding symptoms can complicate management and raise morbidity. Patients with consistently high levels of aPL, especially those who test positive for the lupus anticoagulant, anticardiolipin antibodies, and anti-2GPI antibodies (triple positivity), appear to be at higher risk for thrombosis and pregnancy complications, whereas isolated aPL positivity seems to be associated with low risk. Clinicians may find it easier to weigh the advantages and disadvantages of anticoagulation if they are aware that patients with APS have various thrombotic risk profiles. Particularly for arterial thrombosis and recurrent thrombosis, the best kind, degree, and length of anticoagulation to use in treating APS remain debatable. Further research is needed to define the thrombotic risk in APS and assess both anticoagulant and non-anticoagulant therapy, both conventional and cutting-edge.

Management of intracardiac thrombus

Patients with APS who have intra-cardiac thrombi require adequate maintenance of anticoagulant treatment. The function of surgical intervention is still debatable. The thrombus should be surgically removed as soon as feasible, and enough maintenance anticoagulation medication should be given, to prevent the repeated intra-cardiac thrombotic episodes. The 2003 expert group advised treatment with the anticoagulant warfarin coupled with advice from a heart surgeon. There are currently no randomized trials contrasting various treatment approaches for this unusual APS consequence. Throughout the past three decades, APS management has undergone constant change. Even though, the mainstay of APS treatment continues to be antiplatelet and anticoagulant medications. Anticoagulation (mostly warfarin or heparin) is also the cornerstone of therapy for the different cardiac problems linked to APS, as we covered in great depth. There is not enough data to support the use of Direct Oral Anticoagulants (DOACs) in individuals with thrombotic APS signs because their role in controlling these symptoms is currently unknown. According to the risk classification of each patient, the current trend attempts to provide individually tailored treatment solutions.

Antithrombotic treatment of APS

Antithrombotic medication is the cornerstone of treatment for APS patients due to the high risk of recurrent thromboembolism that characterizes this disorder. The best antithrombotic medication, level of anticoagulation, and length of therapy, particularly for non-venous thrombotic episodes, are still up for debate. The balance between thrombosis and hemorrhage in APS patients further complicates treatment because many of these patients have thrombocytopenia, coagulopathy, and other comorbidities that enhance the risk of bleeding. According to a systematic review of major bleeding rates in APS patients, the frequency ranges between 0.57% and 10% annually. Major bleeding occurred in 6 occurrences per 100 patient-years (95% CI, 1.6-15.0) and cerebral hemorrhage was 1.5 per 100 patient-years (95% CI, 0.04-8.4) in an investigation of 66 patients with APS receiving oral anticoagulation with a target international normalized ratio (INR) of 3.5.

CONCLUSION

The most frequent venous and arterial thromboembolism symptoms and recurrent miscarriages are associated with APS, a prothrombotic condition with a variety of presentations. It has been difficult to investigate this illness and there has been debate over the best treatments due to the heterogeneity in the antibodies that are essential to the diagnosis of APS and the varied clinical presentation. Individuals with persistently positive

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aPLs, particularly those who have triple positivity, as well as those who have experienced arterial thrombosis or recurrent thrombosis despite antithrombotic medication, are at a higher risk of developing thrombosis. The best kind and length of antithrombotic therapy can be chosen by taking into account the thrombotic risk profile of APS patients. Individuals with CAPS have a very prothrombotic phenotype and need antithrombotic treatment and immunosuppression to treat the inflammatory response that is a feature of this illness. Future research will be necessary to improve our knowledge of this condition, characterize thrombotic risk more fully, and assess the effectiveness of both traditional and novel anticoagulant and non-anticoagulant therapies. These studies will also need to be tailored to each patient's unique risk factors and preferences.