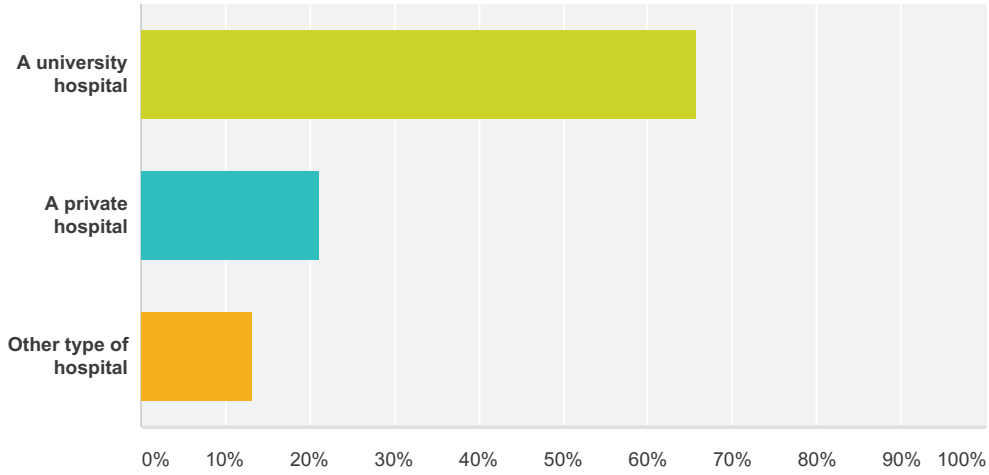
Q1 Is your Institution:

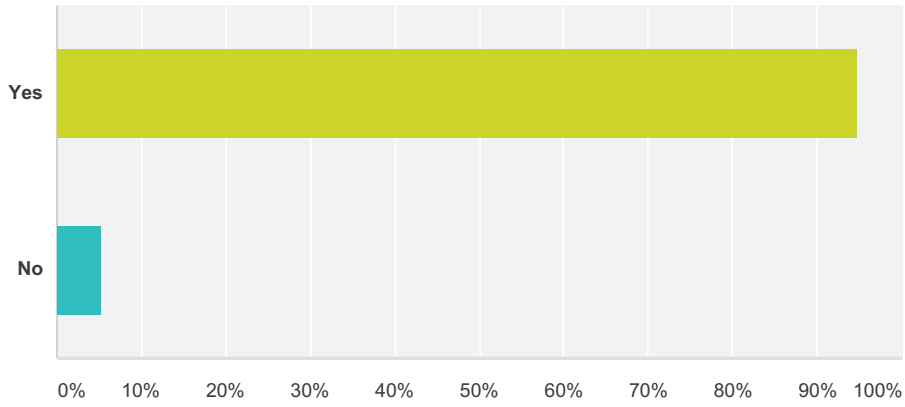
Answered: 38 Skipped: 0



Answer Choices	Responses	
A university hospital	**65.79%**	25
A private hospital	**21.05%**	8
Other type of hospital	**13.16%**	5
Total		**38**

Q4 Would you be comfortable if we acknowledge your centre in the Europace Journal and on the Website?

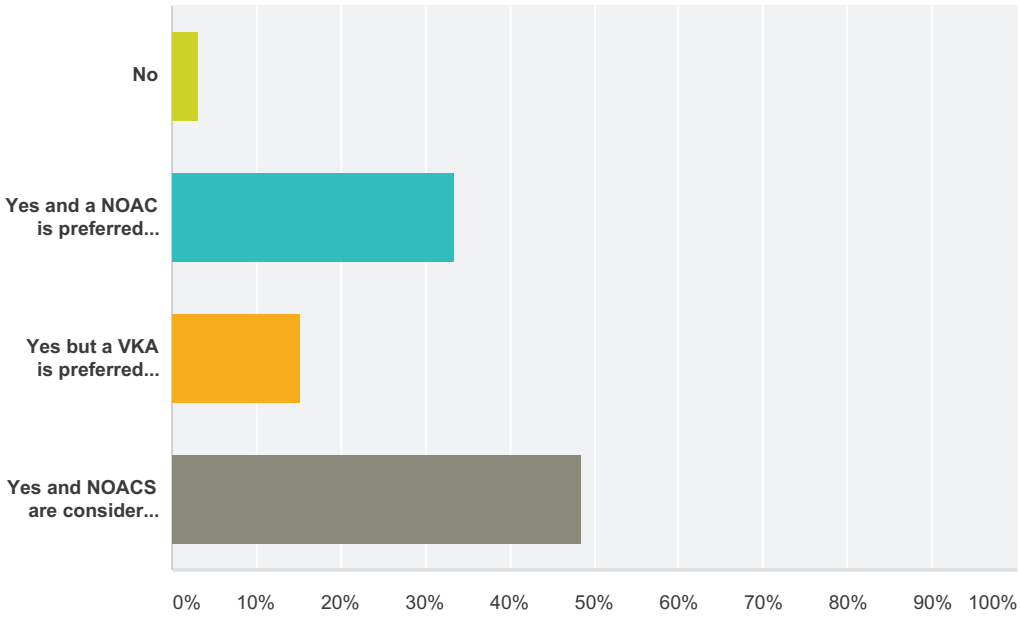
Answered: 38 Skipped: 0



Answer Choices	Responses	
Yes	**94.74%**	36
No	**5.26%**	2
Total		**38**

Q5 Do you use non-vitamin K antagonist oral anticoagulants (NOACs) for stroke prophylaxis at your hospital?

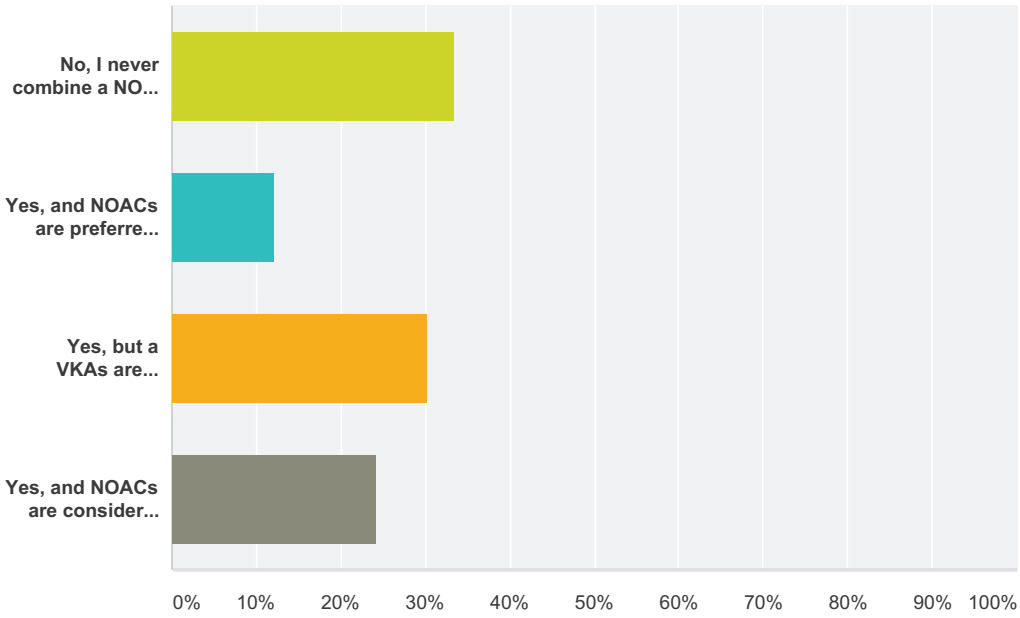
Answered: 33 Skipped: 5



Answer Choices	Responses	
No	**3.03%**	1
Yes and a NOAC is preferred to viatmin K antagonists (VKAs)	**33.33%**	11
Yes but a VKA is preferred to NOAC	**15.15%**	5
Yes and NOACS are considered equal to VKAs	**48.48%**	16
Total		**33**

Q6 Do you use NOACs in combination with dual antiplatelet therapy (DAPT) in non-valvular AF patients undergoing PCI?

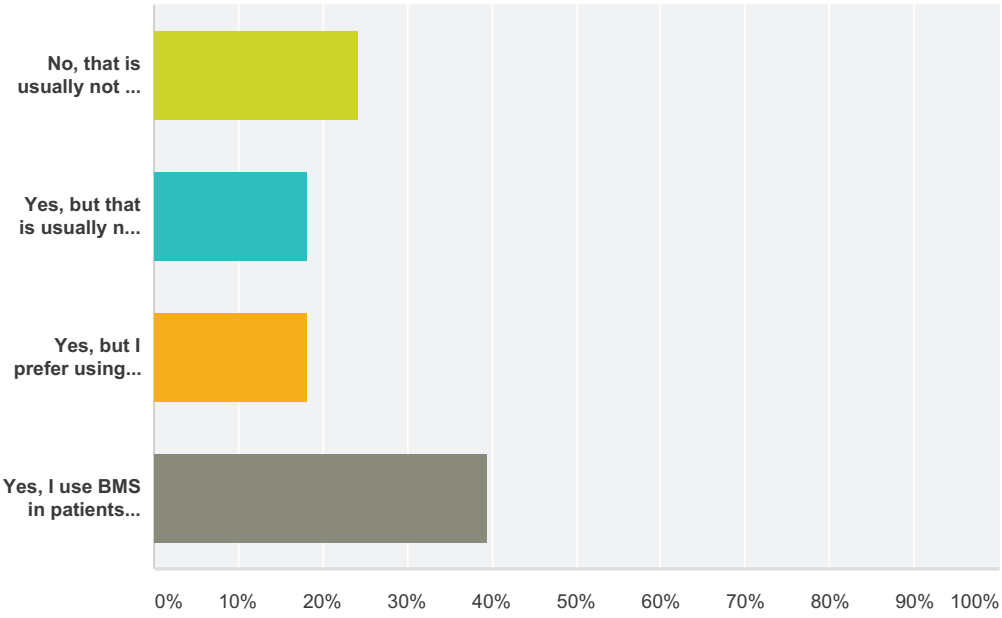
Answered: 33 Skipped: 5



Answer Choices	Responses	
No, I never combine a NOAC with DAPT	**33.33%**	11
Yes, and NOACs are preferred to VKAs in this situation	**12.12%**	4
Yes, but a VKAs are preferred to NOACs in this situation	**30.30%**	10
Yes, and NOACs are considered equal to VKAs in this situation	**24.24%**	8
Total		**33**

Q7 In case of acute myocardial infarction, do you consider using bare metal stents (BMS) rather than drug eluting stents (DES) in patients requiring oral anticoagulation due to atial fibrillation and who are at high bleeding risk (i.e., a HAS BLED of ≥3)?

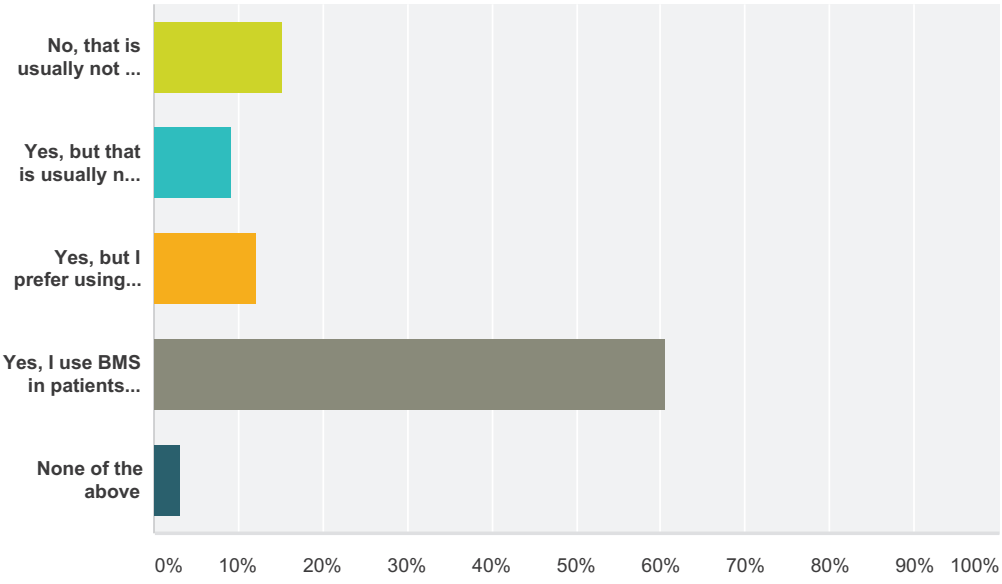
Answered: 33 Skipped: 5



Answer Choices	Responses	
No, that is usually not an option	24.24%	8
Yes, but that is usually not an option	18.18%	6
Yes, but I prefer using DES	18.18%	6
Yes, I use BMS in patients with a high bleeding risk	39.39%	13
Total		**33**

Q8 In case of elective PCI, do you consider using bare metal stents (BMS) rather than drug eluting stents (DES) in patients requiring oral anticoagulation who are at high bleeding risk (i.e., a HAS BLED of ≥3)?

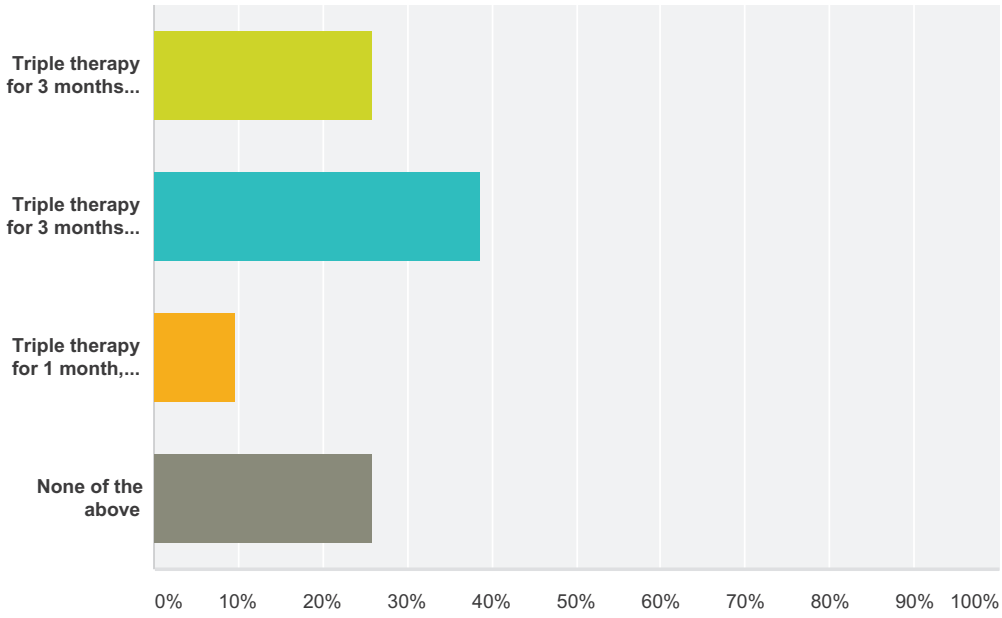
Answered: 33 Skipped: 5



Answer Choices	Responses	
No, that is usually not an option	15.15%	5
Yes, but that is usually not an option	9.09%	3
Yes, but I prefer using DES	12.12%	4
Yes, I use BMS in patients with a high bleeding risk	60.61%	20
None of the above	3.03%	1
Total		33

Q9 In patients with a DES who need the triple therapy with an OAC plus aspirin (75–100 mg/day) and clopidogrel 75 mg/day, I treat the patient as follows:

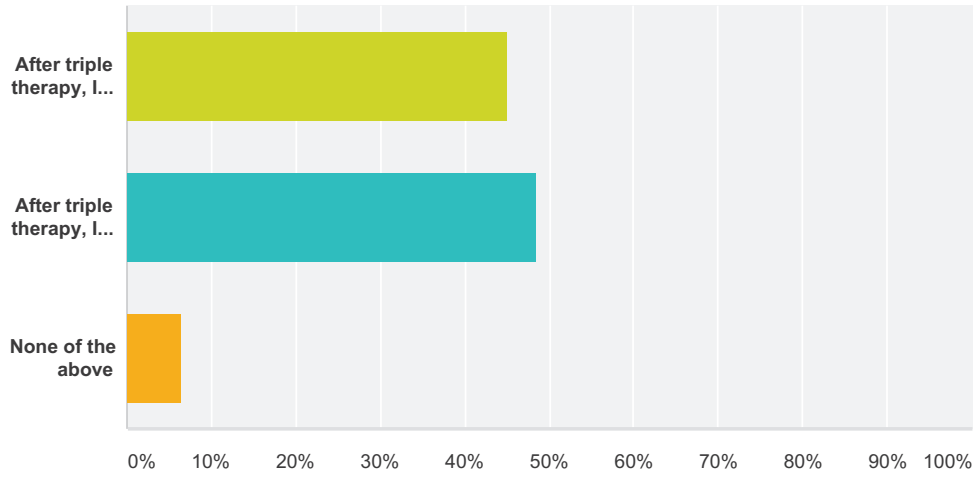
Answered: 31 Skipped: 7



Answer Choices	Responses	
Triple therapy for 3 months, followed by 6 months of dual therapy	**25.81%**	8
Triple therapy for 3 months, followed by 12 months of dual therapy	**38.71%**	12
Triple therapy for 1 month, followed by 3 months of dual therapy	**9.68%**	3
None of the above	**25.81%**	8
Total		**31**

Q10 In patients with a DES and after triple therapy, which platelet inhibitor do you prefer?

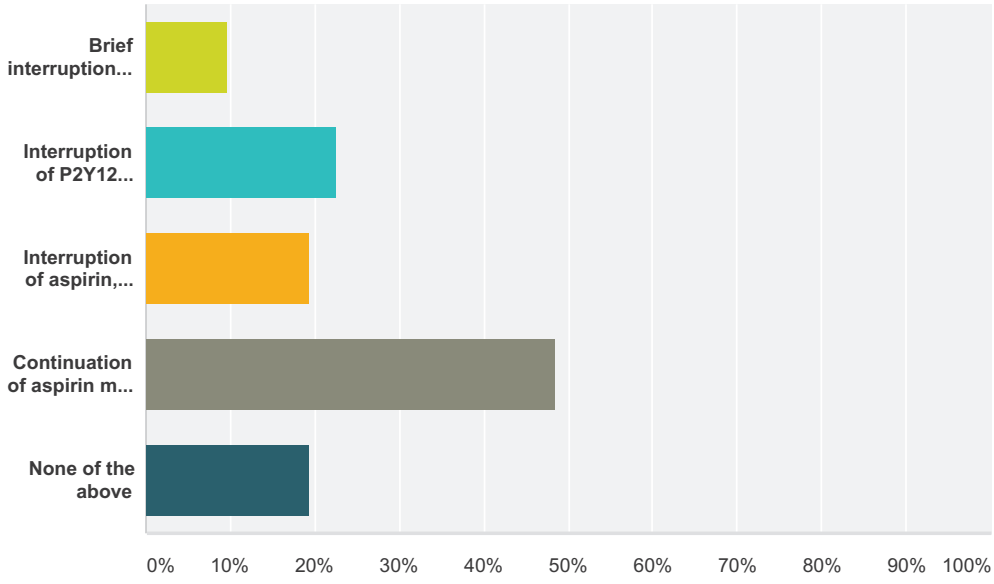
Answered: 31 Skipped: 7



Answer Choices	Responses	
After triple therapy, I prefer OAC plus aspirin	**45.16%**	14
After triple therapy, I prefer OAC plus Clopidogrel	**48.39%**	15
None of the above	**6.45%**	2
Total		**31**

Q11 How do you handle the anti-platelet therapy in an AF patient with a newly implanted stent during non-cardiac surgery such as a hip replacement (please, tick all that apply)?

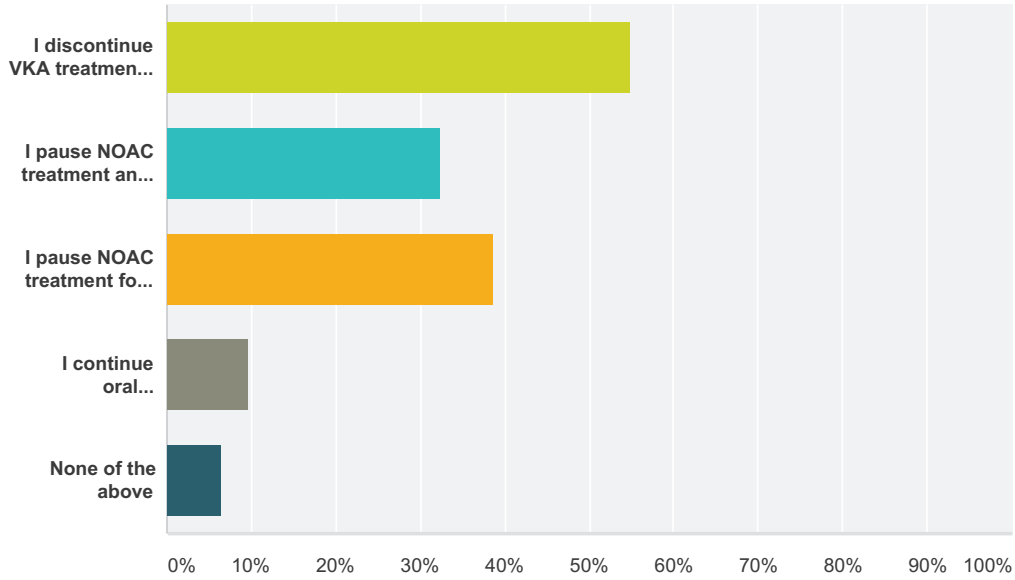
Answered: 31 Skipped: 7



Answer Choices	Responses
Brief interruption of both aspirin and P2Y12 inhibitor (clopidogrel, prasugrel, ticagrelor)	9.68% 3
Interruption of P2Y12 inhibitor (clopidogrel, prasugrel, ticagrelor), whilst aspirin should be continued for 4 weeks after BMS implantation and for 3–12 months after DES implantation, unless the risk of surgical bleeding is high	22.58% 7
Interruption of aspirin, whilst continuation of P2Y12 inhibitor (clopidogrel, prasugrel, ticagrelor) treatment should be considered for 4 weeks after BMS implantation and for 3–12 months after DES implantation, unless the risk of surgical bleeding is high	19.35% 6
Continuation of aspirin may be considered in the peri-operative period, and should be based on an individual decision depending on the peri-operative bleeding risk weighed against the risk of thrombotic complications	48.39% 15
None of the above	19.35% 6
Total Respondents: 31	

Q12 How do you handle the anticoagulation therapy in an AF patient with a newly implanted stent and a highthromboembolic risk (CHA2DS2-VASc score >3) during non-cardiac surgery such as hip replacement (multiple answers possible)

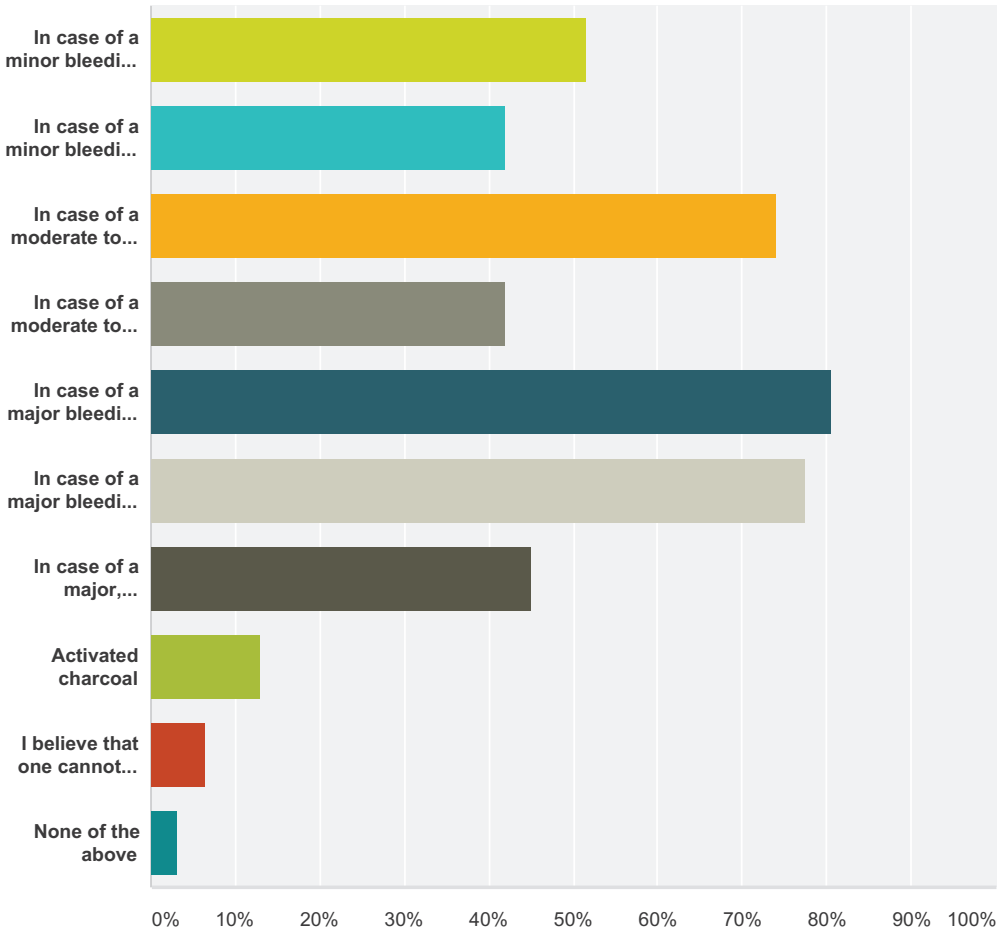
Answered: 31 Skipped: 7



Answer Choices	Responses
I discontinue VKA treatment and use bridging therapy with unfractionated heparin (UFH) or therapeutic-dose low molecular weight heparin (LMWH)	**54.84%** 17
I pause NOAC treatment and use bridging therapy with unfractionated heparin (UFH) or therapeutic-dose low molecular weight heparin (LMWH)	**32.26%** 10
I pause NOAC treatment for 2-4 days without any bridging therapy	**38.71%** 12
I continue oral anticoagulant therapy with either a VKA or a NOAC	**9.68%** 3
None of the above	**6.45%** 2
Total Respondents: 31	

Q13 How do you manage bleeding in an AF patient taking a NOAC (multiple answers possible)?

Answered: 31 Skipped: 7

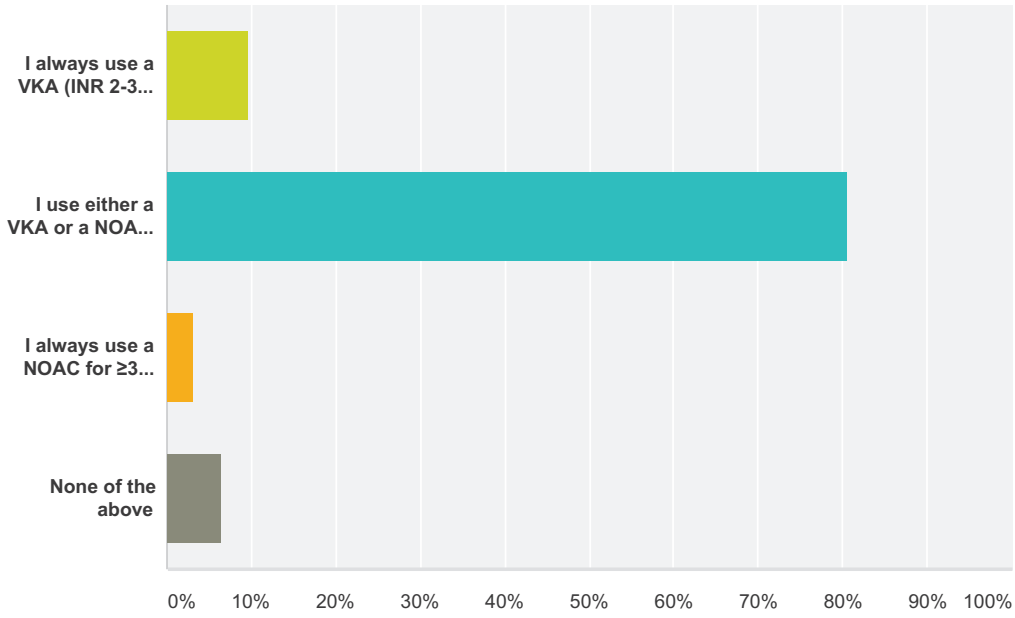


Answer Choices	Responses
In case of a minor bleeding I continue treatment	**51.61%** 16
In case of a minor bleeding I delay next dose or discontinue treatment temporarily	**41.94%** 13
In case of a moderate to severe bleeding I use symptomatic therapy/supportive measures (e.g., mechanical compression of the bleeding site, fluid replacement, blood transfusion, etc.)	**74.19%** 23
In case of a moderate to severe bleeding I delay next dose or discontinue treatment permanently	**41.94%** 13
In case of a major bleeding I use symptomatic therapy/supportive measures (e.g., mechanical compression of the bleeding site, fluid replacement, blood transfusion, etc.	**80.65%** 25
In case of a major bleeding I use treatment with a prothrombin complex concentrate (PCC) or activated recombinant factor VII (NovoSeven®)	**77.42%** 24
In case of a major, life-threatening dabigatran-related bleeding I use dialysis	**45.16%** 14
Activated charcoal	**12.90%** 4

I believe that one cannot adequately manage a NOAC-related bleeding, as no specific antidote is available	**6.45%**	2
None of the above	**3.23%**	1
Total Respondents: 31		

Q14 When considering the initiation of oral anticoagulant therapy before electrical cardioversion for AF, which anticoagulant do you prefer?

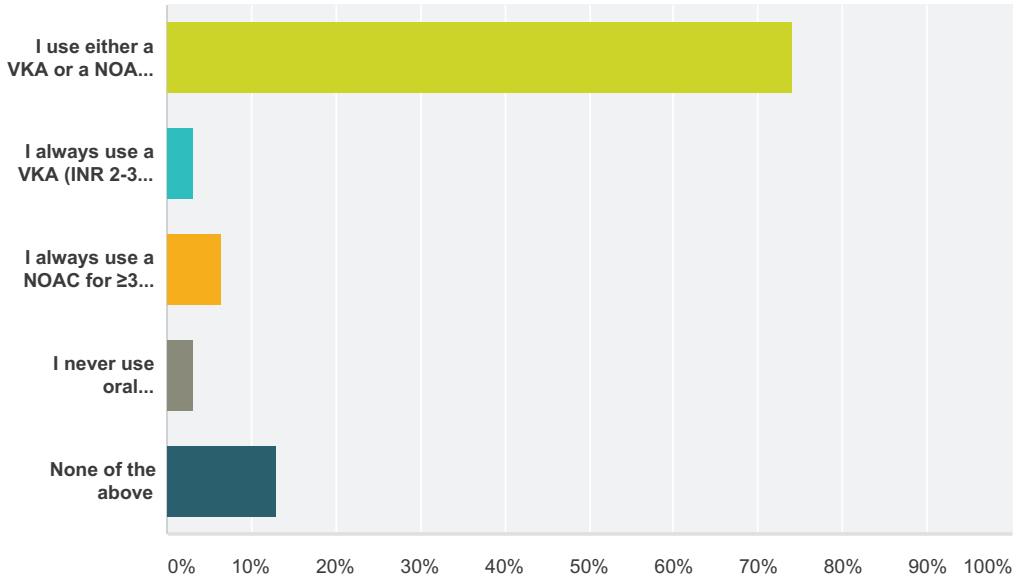
Answered: 31 Skipped: 7



Answer Choices	Responses	
I always use a VKA (INR 2-3), for ≥3 weeks prior to the procedure	**9.68%**	3
I use either a VKA or a NOAC for ≥3 weeks prior to the procedure	**80.65%**	25
I always use a NOAC for ≥3 weeks before electrical cardioversion	**3.23%**	1
None of the above	**6.45%**	2
Total		**31**

Q15 When considering the initiation of oral anticoagulant therapy before pharmacological cardioversion for AF, which anticoagulant do you prefer?

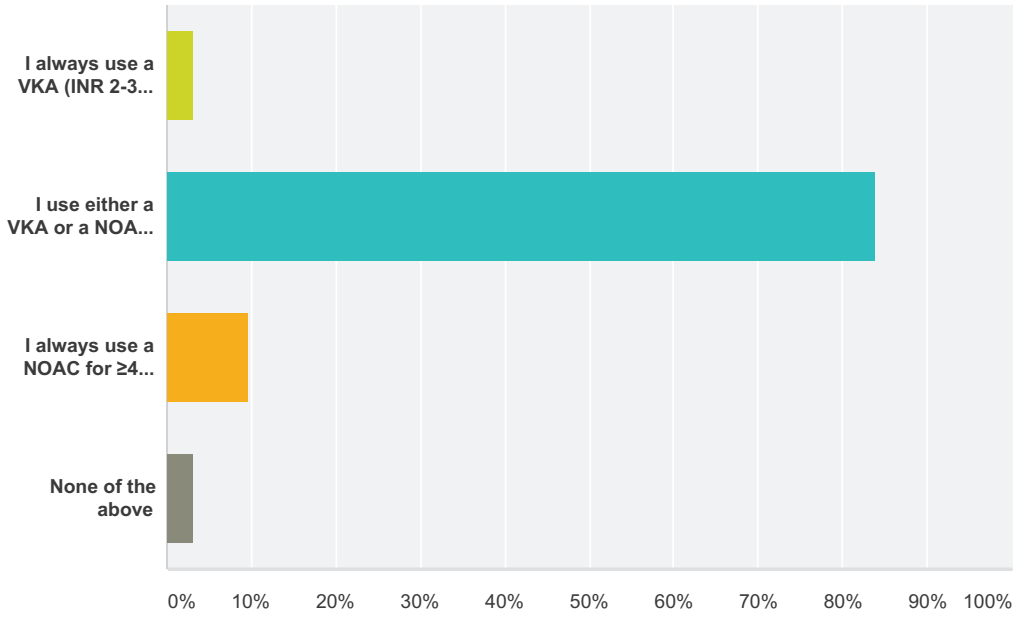
Answered: 31 Skipped: 7



Answer Choices	Responses	
I use either a VKA or a NOAC for ≥3 weeks prior to the procedure	**74.19%**	23
I always use a VKA (INR 2-3) for ≥3 weeks prior to the procedure	**3.23%**	1
I always use a NOAC for ≥3 weeks before electrical cardioversion	**6.45%**	2
I never use oral anticoagulation before pharmacological cardioversion	**3.23%**	1
None of the above	**12.90%**	4
Total		**31**

Q16 After electrical cardioversion for AF, which anticoagulant do you prefer (applies only to patients with CHA2DS2-VASc score > or equal 1) ?

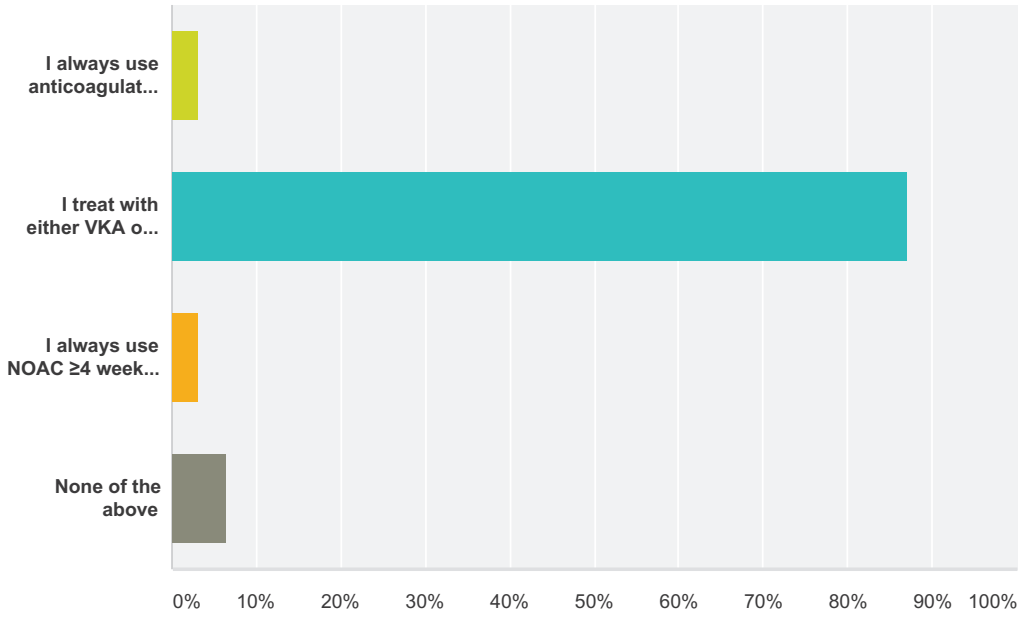
Answered: 31 Skipped: 7



Answer Choices	Responses	
I always use a VKA (INR 2-3) for ≥4 weeks after the procedure	**3.23%**	1
I use either a VKA or a NOAC for ≥ 4 weeks after the procedure	**83.87%**	26
I always use a NOAC for ≥4 weeks after electrical cardioversion	**9.68%**	3
None of the above	**3.23%**	1
Total		**31**

Q17 After medical cardioversion for AF, which anticoagulant do you prefer (applies only to patients with a CHA2DS2-VASc score > or equal 1 ?

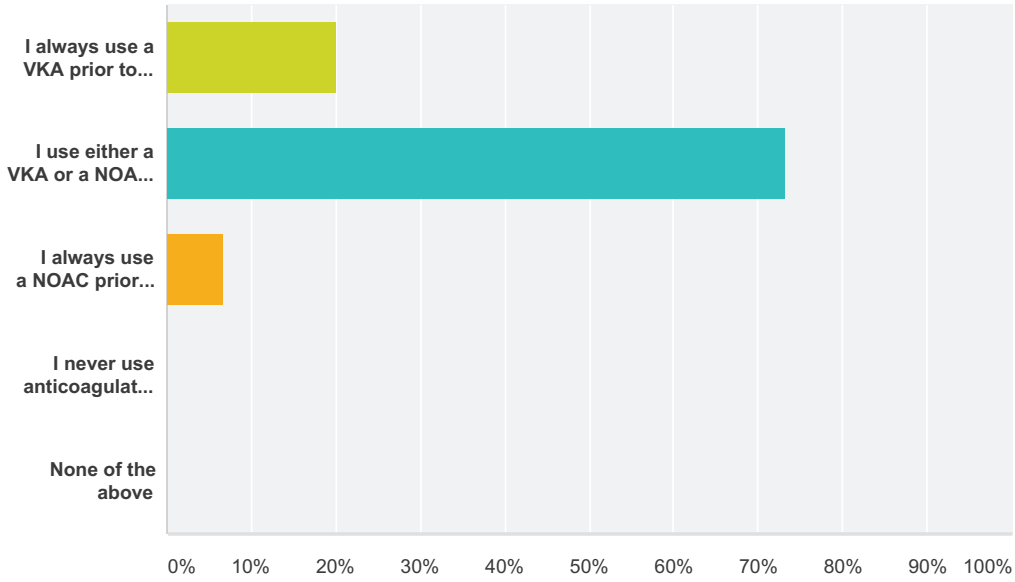
Answered: 31 Skipped: 7



Answer Choices	Responses	
I always use anticoagulation (INR 2-3) ≥4 weeks after the procedure	**3.23%**	1
I treat with either VKA or NOAC ≥4 weeks after the procedure	**87.10%**	27
I always use NOAC ≥4 weeks after electrical cardioversion	**3.23%**	1
None of the above	**6.45%**	2
Total		**31**

Q18 When considering the initiation of oral anticoagulant therapy before AF catheter ablation, which anticoagulant do you prefer?

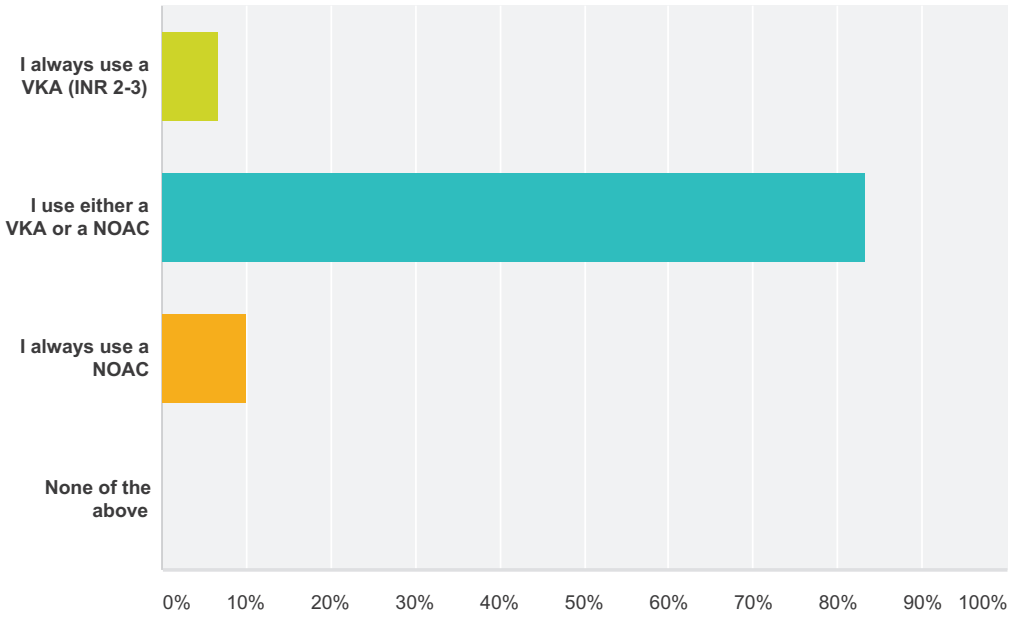
Answered: 30 Skipped: 8



Answer Choices	Responses	
I always use a VKA prior to the procedure	**20.00%**	6
I use either a VKA or a NOAC prior to the procedure	**73.33%**	22
I always use a NOAC prior to the procedure	**6.67%**	2
I never use anticoagulation prior to the procedure	**0.00%**	0
None of the above	**0.00%**	0
Total		**30**

Q19 After catheter ablation which anticoagulant do you prefer if the patient has a CHA2DS2-VASc score ≥2?

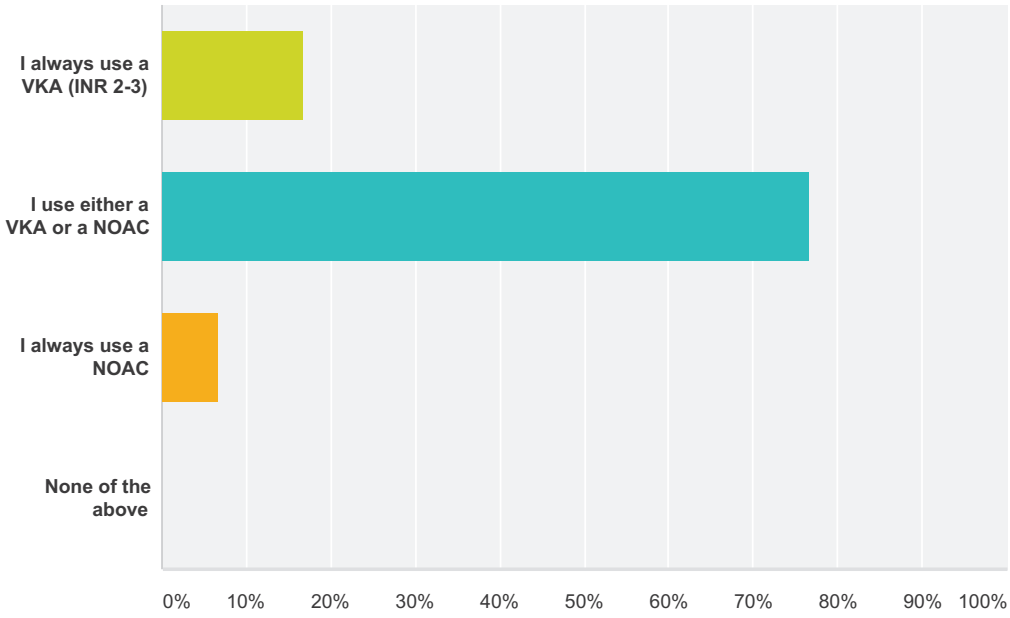
Answered: 30 Skipped: 8



Answer Choices	Responses	
I always use a VKA (INR 2-3)	**6.67%**	2
I use either a VKA or a NOAC	**83.33%**	25
I always use a NOAC	**10.00%**	3
None of the above	**0.00%**	0
Total		**30**

Q20 Which oral anticoagulation do you prefer to a patient with moderate (i.e. creatinine clearance 30–49 mL/min) renal impairment (multiple answers possible)?

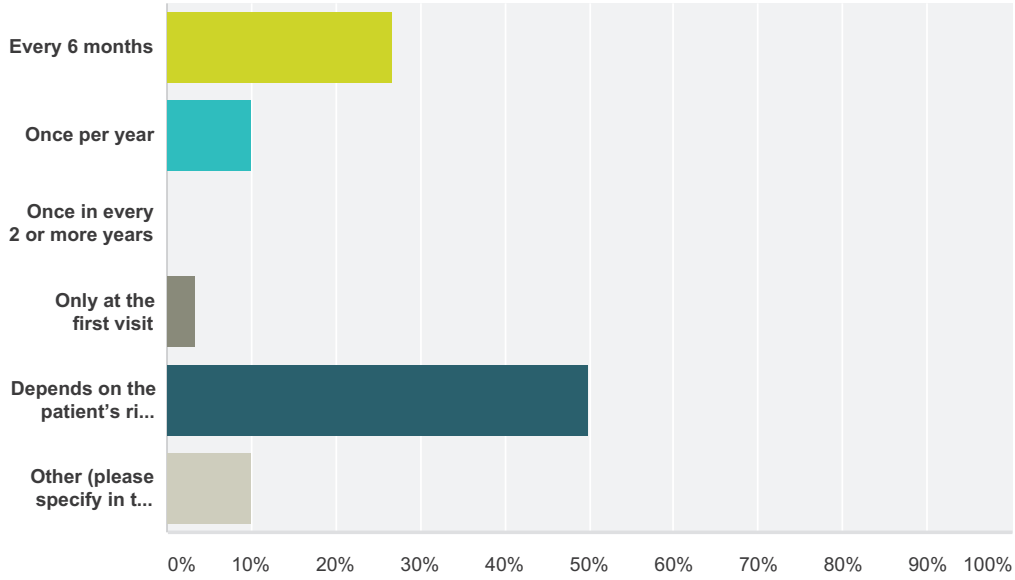
Answered: 30 Skipped: 8



Answer Choices	Responses	
I always use a VKA (INR 2-3)	**16.67%**	5
I use either a VKA or a NOAC	**76.67%**	23
I always use a NOAC	**6.67%**	2
None of the above	**0.00%**	0
Total		**30**

Q21 How often do you re-assess patients treated with a NOAC?

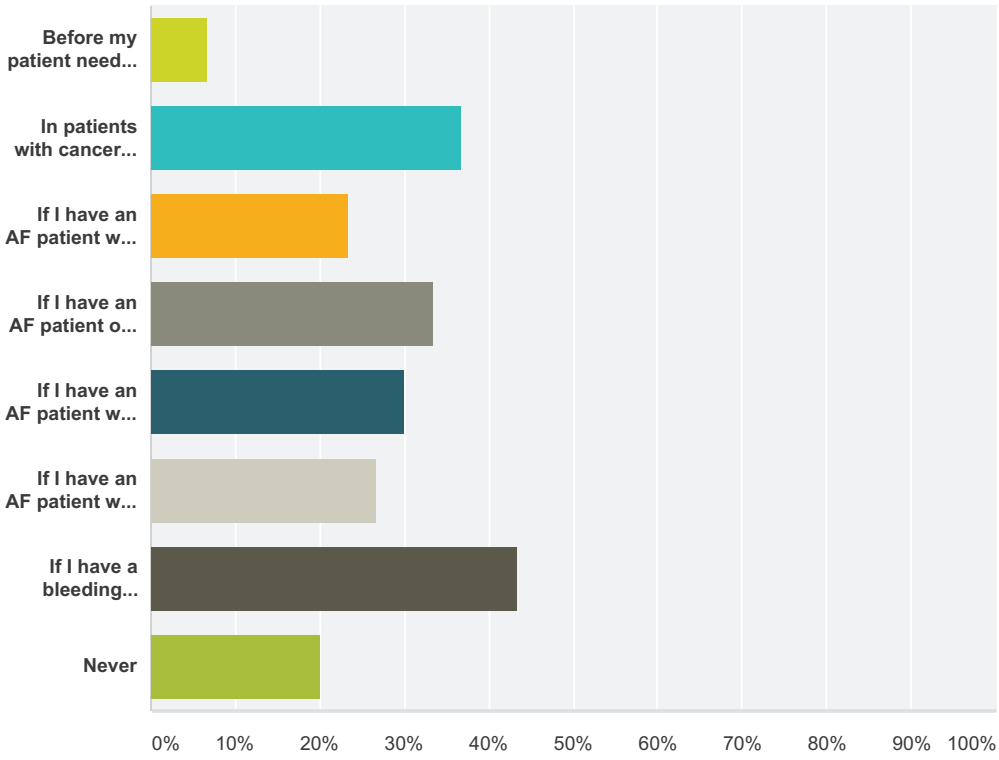
Answered: 30 Skipped: 8



Answer Choices	Responses	
Every 6 months	**26.67%**	8
Once per year	**10.00%**	3
Once in every 2 or more years	**0.00%**	0
Only at the first visit	**3.33%**	1
Depends on the patient's risk profile (frailty, GI bleeding, cancer, co-medication)	**50.00%**	15
Other (please specify in the box below)	**10.00%**	3
Total		**30**

Q22 When do you consider consulting a specialist or colleague regarding the use of NOAC (please, tick all that apply)?

Answered: 30 Skipped: 8



Answer Choices	Responses	
Before my patient needs non-cardiac surgery (bridging)	6.67%	2
In patients with cancer malignancy	36.67%	11
If I have an AF patient with myocardial infarction who needs a PCI	23.33%	7
If I have an AF patient on dual or triple antithrombotic therapy	33.33%	10
If I have an AF patient with renal impairment	30.00%	9
If I have an AF patient with a high risk of bleeding (i.e., a HAS-BLED score of ≥3)	26.67%	8
If I have a bleeding patient	43.33%	13
Never	20.00%	6
Total Respondents: 30		