Management of anti-phospholipid antibody syndrome

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Management for anti-phospholipid antibody syndrome (APS) includes strict control of additional risk factors for thrombosis, and medications such as Heparin, Warfarin, and Aspirin.

Asymptomatic individuals who are persistently positive for anti-phospholipid antibody (aPL) have a low annual incidence of acute thrombosis. No prophylaxis medication is needed for these patients if there is no risk factor for thrombosis.

For aPL positive high risk individuals, Aspirin (81 mg/day) reduces the risk of thrombosis. Patients should receive thromboprophylaxis with low molecular weight heparin in high risk situations, such as surgery, prolonged immobilization and the puerperium.

For pregnant women with APS, we suggest antepartum and postpartum thromboprophylaxis with low dose ASA ( ). For women with aPL and prior fetal losses at or after 10 weeks of gestation, we suggest combined therapy with low dose ASA and prophylactic low molecular weight heparins (LMWH) during pregnancy (Grade 2C).

For thrombotic events with APS, the first therapy is Low molecular weight (LMW) heparin (Grade 1B). Patients should be transitioned from heparin to warfarin, with an INR range between 2.0 and 3.0 (Grade 1A). If thrombotic events recur during warfarin therapy, the treatment alternatives include increasing the target INR (3.1 to 4.0) or adding low-dose aspirin, LMWH, or HCQ

For catastrophic APS (CAPS), heparin, followed by long-term warfarin and High-dose glucocorticoids (eg, methylprednisolone 1 g intravenously daily for three days) followed by oral or parenteral therapy with the equivalent of 1 to 2 mg/kg of prednisone per day was recommended. If there are features of microangiopathy (eg, thrombocytopenia, microangiopathic hemolytic anemia), plasma exchange (see below) with or without IVIG (eg, 400 mg/kg per day for five days) are added to the above regimen.

Investigational therapies for the APS include autologous stem cell transplantation and rituximab need further studies to conclude.