Table 3. *Summary of guidelines about anticoagulation for stroke prevention in patients with established CKD and non-valvular AF.*

Association or approving authority	Summary of guidelines
Kidney Disease Improving Global Outcomes	"Team-based, multidisciplinary active communication, particularly involving the nephrologist, cardiologist (or cardiac electrophysiologist), primary care physician, and when possible, clinical pharmacist, may be useful to evaluate the risk-benefit of any decision regarding choice of VKA or a DOAC" [1]
American Heart Association	Dabigatran 150 mg twice daily in patients with CrCl > 30 mL/min Rivaroxaban 20 mg od for patients with CrCl > 50 mL/min Apixaban 5 mg twice daily for patients with no more than 1 of the following characteristics: age ≥ 80 years, serum creatinine ≥ 1.5 mg/dL, or body weight ≤ 60 kg Apixaban 2.5 mg twice daily for patients with at least 2 of the following: ≥ 80 years, body mass ≤ 60 kg, or serum creatinine ≥ 1.5 mg/dL74 CHA_2DS_2-VASc score ≥ 2 in men or ≥ 3 in women and eCrCl < 15 mL/min or on dialysis, reasonable to prescribe warfarin (INR 2.0-3.0) or apixaban For moderate to severe CKD (serum creatinine ≥ 1.5 mg/dL [apixaban], CrCl 15-30 mL/min [dabigatran], CrCl 15-50 mL/min [rivaroxaban], or CrCl 15-50 mL/min [edoxaban]) with an elevated CHA_2DS_2-VASc score, reduced doses of direct thrombin or factor Xa inhibitors should be considered [2]
European Society of Cardiology	Rivaroxaban 15 mg od if CrCl 30-49 mL/min Apixaban 2.5 mg twice daily if Cr ≥ 1.5 mg/dL, and age ≥ 80 years or weight ≤ 60 kg Edoxaban 30 mg daily if CrCl < 50 mL/min In dialysis patients: no consensus; controlled studies of anticoagulants (VKAs and NOAC) in AF patients receiving dialysis are needed [27]