

Your Eliquis Dose

A guide for patients, with a kit to share with your cardiologist. Murray Cantor, Healthy Skepticism papers, August 2026.

Why this guide exists

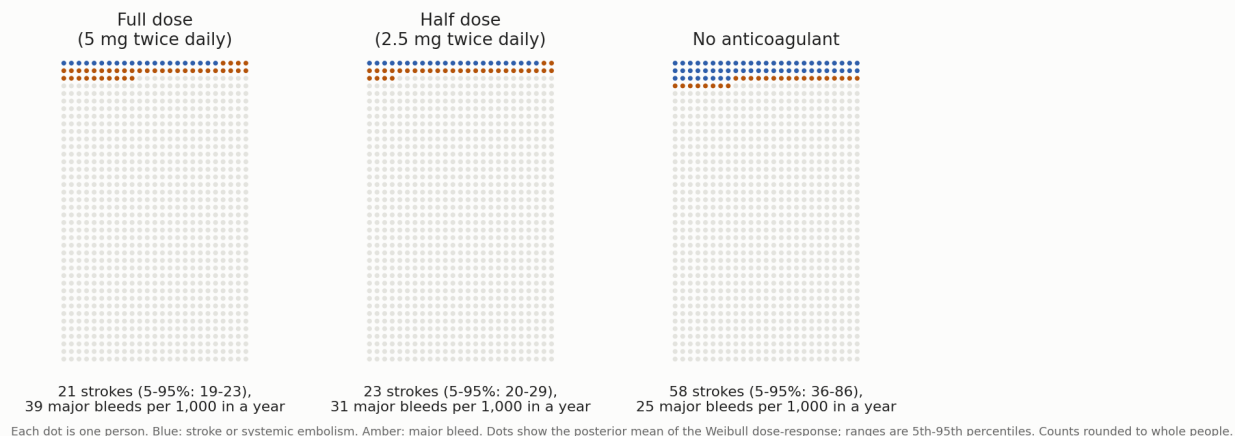
If you have atrial fibrillation, someone has probably prescribed you Eliquis (apixaban) to prevent a stroke, at either the full dose of 5 mg twice a day or the half dose of 2.5 mg twice a day. The rule that decides who gets which dose looks precise: half dose if you meet two of three criteria (age 80 or older, weight 132 pounds or less, a creatinine blood test of 1.5 or higher). What the label does not say is that no clinical trial has ever directly compared the two doses, that the rule was designed as chemistry (matching drug levels in the blood) rather than tested as medicine, and that in practice most people on the half dose do not actually meet the criteria. Meanwhile the question that matters most to you is one the trials never asked at all: not this drug versus an older drug, but this drug versus not taking it.

We built a tool that puts numbers on that question. It is a Bayesian model, a piece of careful bookkeeping that takes the published clinical evidence, keeps honest track of what is known and how well it is known, and turns it into plain answers for a person of a given age, weight, kidney function, and history. Everything in it comes from published studies, every assumption is written down and visible, and the numbers below carry ranges because the evidence itself has gaps. This guide gives you the short version, shows you how to explore your own situation, and, most importantly, tells you how to bring the full analysis to your cardiologist, who knows things about you that no model does.

What the evidence says, in one picture

Here is a year in the life of 1,000 people like one example patient: over 80 years old, normal weight, with reduced kidney function (a creatinine between 1.5 and 2.0). Each dot is a person. Blue dots have a stroke that year; amber dots have a major bleed.

A year among 1,000 people: a patient, over 80, above 132 lb (60 kg), creatinine 1.5-2.0



A year among 1,000 people like the example patient, under each choice. Blue: stroke. Amber: major bleed. The ranges in parentheses reflect what the evidence cannot yet pin down.

Three things stand out, and they hold for every kind of patient we examined. First, the most dangerous choice by far is no anticoagulant at all: for this example patient, roughly 58 strokes per 1,000 people per year untreated, against about 21 on the full dose. The gap between taking the drug and not taking it is several times larger than any difference between the two doses. Second, the price of that protection is more bleeding, about 39 major bleeds per 1,000 on the full dose against about 25 untreated, but the two kinds of event are not equally bad, and this is the part most discussions skip. The bleeding the drug adds is almost entirely the kind that happens outside the skull, in the stomach or gut, which is frightening and serious but which the overwhelming majority of people recover from fully. The most feared bleed, bleeding into the brain, is not measurably increased by Eliquis compared with taking aspirin. Strokes, by contrast, kill or permanently disable about half the people they strike. Count only the events that kill or disable, and the drug wins clearly: about 16 such events per 1,000 on the full dose, against about 36 untreated.

Third, the full-versus-half-dose question, the one the label's rule is about, turns out to be real but small: about 21 strokes versus about 23 per 1,000 for this patient, with the half dose causing somewhat less bleeding. The honest answer is that the evidence cannot yet say precisely how much protection the half dose gives up, and that uncertainty is shown, not hidden, in every number the tool produces. That is exactly the kind of question worth discussing with your cardiologist rather than settling from a rule.

A spreadsheet for you and your cardiologist, together

The numbers above are for one example patient. Yours will differ, and the tool that computes them is an Excel spreadsheet, available on the kit's own page at the

Healthy Skepticism website: healthy-skepticism.com/eliquis.html. It is deliberately simple on its surface: six dropdown menus describe a patient (sex, age group, weight in pounds, a kidney-function value called creatinine, the pattern of the fibrillation, and any history of stroke or mini-stroke), and a table and chart then show that patient's numbers under each choice, full dose, half dose, or no anticoagulant, each with its range of uncertainty.

But this is not a tool to use alone, and this guide is not asking you to. Several of the inputs come from your medical chart, and the outputs take judgment to read well: what counts as your fibrillation pattern, how to weigh a range against a single number, what your other conditions do to the picture. The right way to use the spreadsheet is together with your cardiologist, in the visit: it takes about a minute for them to set the six values from your chart, and then the two of you are looking at the same screen, talking about your numbers rather than about numbers in general. The online copy is locked so that only the six input menus can be changed, which means nobody can break it and nothing can be quietly altered; every formula and every source stays visible for a doctor who wants to check the work.

What to bring to your next appointment

This kit has three parts, and they are aimed at two different readers. This guide is for you. The other two parts are for your cardiologist: a technical paper, "Apixaban and Its Dose," written in the language of the clinical literature, which lays out exactly what evidence the model uses, what it assumes, how it was validated, and where it is most open to challenge; and the address of the online spreadsheet, which your cardiologist can drive with your real numbers in about a minute while you watch. Doctors are rightly skeptical of printouts from the internet, and the paper is built for that skepticism: every number in it traces to a named clinical trial, and the places where judgment was required are flagged as judgment, not buried.

Three questions are worth asking once your cardiologist has set your values and your own numbers are on the screen. If you are on the half dose: "Do I actually meet the label's criteria, and if not, what is the reason for my reduced dose?" That question matters because most half-dose patients do not meet the criteria, and the evidence that the half dose fully protects them is the weakest part of the whole picture. If you are on the full dose and worried about bleeding: "Given my kidney function and history, what does the model say I would give up by reducing, and does anything about me change that?" And whatever dose you are on: "Is there anything about my situation, my other medicines, my risk of falls, my bleeding history, that this model does not capture?" That last question is the most important one, because the answer is almost certainly yes, and it is where your cardiologist's judgment does the work no spreadsheet can.

What this is, and what it is not

This kit is a summary of published evidence, organized honestly. It is not medical advice, and it does not know you. The model deliberately leaves out things your cardiologist will weigh: other medicines that interact with Eliquis, your risk of falling, prior serious bleeds, liver disease, what happened the last time you were on a blood thinner. Its numbers are one-year averages over people who resemble you on six characteristics; you are more than six characteristics. And one instruction stands above everything in this guide: never stop taking a prescribed blood thinner, or change your dose, on your own. Stopping is the one choice the evidence condemns without ambiguity, and the decision to make any change belongs in the conversation this kit is designed to start.

The complete kit, this guide, the papers for your cardiologist, and the locked spreadsheet, lives at healthy-skepticism.com/eliquis.html.