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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Anticoagulation Management of AF: What Has Changed?

Announcer:
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Dr. Pokorney:
I'm Sean Pokorney, Assistant Professor of Medicine at Duke University. Thanks so much for joining me today to discuss Anticoagulation Management of Atrial Fibrillation: What Has Changed in the Most Recent ACC/AHA Guidelines.

And what I want to really focus on is some of the antithrombotic therapy recommendations that have been made in the most recent Guidelines. And so, one thing that hasn't changed, but I think is important to always mention, is the fact that patients who are male patients and have a CHA_2DS_2-VASc score of 2, or female patients who have CHA_2DS_2-VASc score of 3, have a Class 1A indication for anticoagulation. And the recommendation is really to use DOACs instead of using warfarin in these patients, and that's a class effect. And that's really a recommendation that's based on the 4 pivotal clinical trials across the DOACs and the meta-analysis that showed that there's a dramatic reduction – over 50% reduction – in intracranial hemorrhage with the DOACs relative to warfarin, and also a reduction in all-cause mortality with the DOACs relative to warfarin. And so, there's that class effect recommendation.

And the reason that I highlight this being so critical is we know that there's rampant under treatment of patients and we know that only about 60% of patients that have a guideline indication for anticoagulation receive that anticoagulant treatment. And so, it is important to keep in mind that this recommendation exists, and it's a strong Class 1 recommendation with a level of evidence of A.

Another thing that I wanted to highlight, because this is actually a change in the Guidelines relative to the prior updated Guidelines from 2019, is the recommendations around male patients with the CHA_2DS_2-VASc of 1 and female patients with a CHA_2DS_2-VASc of 2. The previous Guideline update from 2019 had given a Class 2B recommendation for anticoagulation in those patients, and that recommendation has actually been elevated in these most recent guidelines. It's now a Class 2A recommendation to treat these patients with anticoagulation, again, with a preference being for a class effect using DOACs relative to using warfarin or vitamin K antagonists.

Another important feature of the most recent guidelines is two of the Class 3 recommendations that have been highlighted, and they're both around aspirin and antiplatelet use. And again, these are really critical because what we know is that when you use aspirin in combination with an anticoagulant, the risk of having bleeding events is about 50% higher and so, we really want to take patients who don't have a strong indication for aspirin and get those patients off aspirin therapy when they are also on an anticoagulant.

And so, for patients that have not had a recent MI, that have not had a recent stent or recent bypass surgery, those are patients that we should be stopping aspirin therapy when we're putting those patients on anticoagulation. Again, that's a Class 3 recommendation to use aspirin or antithrombotic agents in those patients. Similarly, for patients that don't have risk factors for stroke, if you're CHA_2DS_2-VASc is 0 for men, or 1 for female patients, in those patients it's a Class 3 recommendation to use aspirin as a stroke prevention therapy.

Again, these patients that you're putting on aspirin are not benefiting from it because they don't receive stroke reduction from aspirin, and they do just have increased risks of bleeding. So again, Class 3 recommendation to use aspirin in patients for stroke prevention when you're not using an antithrombotic therapy.

And so, really again, it's important to keep in mind that there's widespread undertreatment of patients who have a Guideline indication for anticoagulation, that there's a strong recommendation – Class 1 recommendation – to use DOACs across the class of agents in favor of warfarin. And again remember to not use aspirin in patients that don't have a clear indication for aspirin outside of stroke prevention.

Thanks so much for joining me to discuss this issue of anticoagulation and the newest guidelines.

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