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Case: Approaches to Anticoagulation for Atrial Fibrillation

Announcer Open:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Granger:

Hi. I'm Christopher Granger. I'm a Cardiologist at Duke. And I'm very pleased to discuss approaches in anticoagulation for atrial fibrillation.

And I will base this on a case that I think is a fairly typical case of patients who are relatively high risk and who present a challenge in use of anticoagulation. This is an 89-year-old woman who has paroxysmal atrial fibrillation. That's always a question: Should we treat lower burden paroxysmal AFib? It is a condition that has lower risk of stroke but nonetheless warrants treatment in a high-risk patient like this and anyone with a CHADS-VASc score of at least 2. Low body weight, has a bioprosthetic aortic valve that brings up the issue of prosthetic valves. We know for mechanical prosthetic valves we should use warfarin. But for bioprosthetic or TAVR, it's fine to use DOACs. Creatinine is normal, but creatinine clearance is low. And this is a really important issue, because this is also a high-risk group. And each of the DOACs is at least partially renally eliminated. She falls. And she falls enough so that she'd broken her hip, in fact, while on apixaban. And that's common to fall. And I'll get back to that issue and what should be done after her fractures, and I'll present the choices and then at the end, I'm going to have you make your choice on the post quiz.

So, let me just reiterate that we have extraordinarily effective treatments to prevent stroke for patients with atrial fibrillation. On the left-hand side of this slide, warfarin is very effective. It's not easy to use, and it has higher risk of bleeding and intracranial hemorrhage, but it's a very good treatment. But then DOACs, including in the patient level meta-analysis published by Tony Carnicelli, are substantially better with an additional 20% relative risk reduction in stroke and with a substantially safer profile.

In spite of these benefits, there's underuse of oral anticoagulation for patients with atrial fibrillation and risk factors for stroke. This has been shown in a variety of datasets. Here are data from the Optum data, showing that there was only about 1/3 of patients with new AFib who were treated within a year with oral anticoagulation. And that was particularly underuse in patients with dementia, frailty, and anemia.

There has been this question about whether or not aspirin might be a reasonable alternative. But in fact, it's not. It's neither safe nor effective. And this is most graphically displayed by the AVERROES trial results where apixaban resulted in a 55% lower risk of stroke and not much more bleeding than aspirin in a population deemed inappropriate for warfarin treatment. And in fact, intracranial hemorrhage, there were numerically fewer with apixaban than with aspirin. And this has been seen in other datasets. There really seems to be no increased risk of intracranial hemorrhage with apixaban versus aspirin. So, there's little reason to ever consider use of aspirin in this population.

And in fact, another critically important message for you is that the use of aspirin in addition to anticoagulation provides substantial risk

and no benefit for most patients. So, a simple suggestion, stop aspirin for patients who were on an anticoagulant. And this was really nicely underscored in the AFIRE trial results. This was 2,200 patients with AFib in Japan. They were treated with rivaroxaban at the 15-mg dose. Then they were randomized to rivaroxaban alone or rivaroxaban and a single antiplatelet agent. And what you see is the antiplatelet agent, close to 70% increased risk of major bleeding, that was maybe not so surprising. What was surprisingly, there was no benefit. And this may be - in fact, there was a statistically significantly higher risk of thrombotic events and of death with adding aspirin to anticoagulation for a population of patients with stable coronary disease at least 1 year from ACS or revascularization. And so, this again underscores even for patients with stable coronary disease, generally did not use antiplatelet therapy on top of anticoagulation.

How about patients who are elderly? And here we see from the ARISTOTLE data, that this is a population that gets equal or relative risk reduction and greater absolute risk reduction in the major outcomes, including bleeding, stroke, and mortality. We also see that for patients who fall, as long as they're not hitting their head and getting intracranial hemorrhage that the benefit far outweighs the risk of use of DOACs, including with apixaban than the no anticoagulation.

And finally, with respect to renal disease, and this is data from the COMBINE AF meta-analysis, we see that, if anything, patients who have more impaired renal function down to a creatinine clearance of 25 to 30, have greater benefit compared to warfarin for less bleeding and less stroke and systemic embolism.

So, I've made the point, I hope then, that with respect to these high-risk features, as long as one's careful with the dosing, that generally, these frail and elderly patients with comorbidities get at least as much or greater benefit from anticoagulation with DOACs. And I hope this has been helpful to you.

Announcer Close:

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