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Initial Approaches: Starting Anticoagulation Treatment

Announcer Open:

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Dr. Potpara:

Greetings. I'm Tatiana Potpara, Associate Professor from Belgrade University, and today I'll be talking about initial approaches when starting anticoagulant treatment in patients with atrial fibrillation.

Oral anticoagulant therapy is a cornerstone of effective stroke prevention in patients with atrial fibrillation. And in recent decades, there was increasing use of oral anticoagulant therapy that resulted in decreasing stroke rates. However, the rates of major bleeding remained fairly constant, which is largely owing to the improvements in the long-term management of oral anticoagulant therapy, but there is also a residual bleeding risk that is inherent to all anticoagulant therapy itself. And this is why the bleeding risk needs to be balanced against individual risk of stroke in each patient with atrial fibrillation.

However, the individual patient's risk of stroke is not homogeneous among AF patients, but it depends on the presence of specific stroke risk factors. And not all stroke risk factors carry the same weight. The strongest being prior stroke or thromboembolic event, followed by age, whereby, there is 1.5-fold risk increase for each decade.

The most common clinical stroke risk factors have been combined in various stroke risk assessment scores, of which the most validated and most widely used is the CHADS-VASc score, which includes the congestive heart failure, hypertension, age, diabetes, stroke, or prior thromboembolic events, vascular disease, and female sex.

Generally speaking, stroke rates in various real-world cohorts increased with increasing CHADS-VASc score barriers, but the actual stroke rate in different cohorts widely varied depending on the cohort characteristics. This is because, in general, again, clinical risk scores have only a modest predictive value for identifying patients at high risk of actually suffering an outcome event. And you can add more with the stroke risk factors or even biomarkers that would certainly increase the predictive value at least statistically, but the predictivity of a score needs to be balanced against the clinical practicality. Because again, generally, clinical risk scores are inevitably simplifications that are meant to help with clinical decision-making regarding the use of oral anticoagulant therapy.

And this is why the first step in using a stroke risk score should be to identify truly low-risk patients, those who are not going to suffer the stroke event, those would be patients with CHADS-VASc score of 0 in males, or 1 in females, who will not need any stroke prevention therapy. And then consider using oral anticoagulant therapy in all other AF patients, of course, addressing the bleeding risk as well and addressing modifiable bleeding risk factors. Importantly, both stroke and bleeding risks are not static; they change over time, especially stroke risk increasing over time with aging, more comorbidities. And that is why stroke risk needs to be reassessed periodically at follow-up clinical visits.

This has been summarized in both European and U.S. guideline recommended a structured risk factor-based stroke risk assessment

using a validated score such as for example, CHADS-VASc score. And U.S. guidelines also recommend that in patients with a single CHADS-VASc stroke risk factor, additional stroke risk factors can be considered to facilitate optimal clinical decision-making. And oral anticoagulant therapy has been recommended for all AF patients with a CHADS-VASc score of 2 or more in males, or 3 or more in females, while oral anticoagulant therapy should also be considered in patients with a single non-sex CHADS-VASc stroke risk factors. And both guidelines also recommend periodical reassessment of individual patient stroke risk at clinical follow-up visits.

And with that, I will thank you for your kind attention.

Announcer Close:

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