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Risk Factors & Comorbidities Associated with Atrial Fibrillation

Announcer Open:
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Dr. Granger:
Hi. I'm Chris Granger, Cardiologist at Duke. And I'm pleased to discuss with you today managing comorbidities to improve outcome in atrial fibrillation.

And in this elderly population that develops atrial fibrillation, AFib is a condition in the context of comorbidities. And managing these comorbidities improves health and outcomes. It can reduce the burden of AFib, improve quality of life, very importantly reduce the risk of stroke, the most feared complication by many patients, and the risk of death. And managing these comorbidities reduces also the risk of either developing AFib if a person's not yet at AFib, or the burden of AFib. And an integrated approach is key to treating symptoms and risk of stroke for patients with AFib.

And this comes from the European Society of Cardiology guidelines, and simply outlines the factors that go into the consideration of management of patients with AFib, including aging, ethnicity, men have somewhat more AFib than women, genetics, and then the comorbidities, both chronic and acute, that increase the risk of atrial fibrillation. And I'll go through a few of these that are particularly important.

One is simply the general concept of lifestyle and risk factor modification. This was nicely outlined by a Scientific Statement and from the AHA, with the conclusion that weight loss, moderate exercise, controlling blood pressure, and treating heart of failure are particularly important opportunities to reduce AFib risk and to prevent its progression.

Example of this comes from the SPRINT trial, where there was this more than 20% reduction in the development of new AFib in a population of patients being treated for hypertension with more effective treatment of the blood pressure.

The concept of the ABC pathway I think is a useful one from the European guidelines: A is for measures to prevent stroke, B is for better symptom control, and C is for comorbidities and cardiovascular risk factor management. And each of these is very important to our patients.

One area that's become much more clear in the last few years is that even modest amounts of alcohol will increase the likelihood of AFib, both occurrence of AFib and worsening of paroxysmal AFib. And there was even a randomized trial published in *New England Journal of Medicine* showing this fairly substantial increased risk of AFib recurrence with modest amounts of alcohol consumption.

On the other hand, coffee drinking is not associated with increased risk of AFib. In fact, from the observational studies, this is from the UK Biobank, drinking two or three cups of caffeinated coffee a day, if anything, was associated with lower risk of atrial fibrillation. So, coffee seems to be okay.

The concept of the integrated AFib management team is so important because there are so many factors that need to be taken into account to improve outcome. And this includes the family, the cardiologist, and primary care doctor, the pharmacist, the nurse, and then then all the other care providers that might provide care around, for example, what do you do around procedures, withholding doses of anticoagulation, and what do you do around hospitalizations and surgical procedures?

So, what I've tried to do is to tell you that comorbidities are very common in patients with atrial fibrillation. The most important comorbidities are older age, renal disease, heart failure, frailty. The treating hypertension and obesity and heart failure with goal-directed medical therapy are very important to reducing the occurrence and the burden of atrial fibrillation. The treatment effects of DOACs are consistent across the major comorbidities and subgroups, and so we need to be using these especially in the high-risk population to prevent stroke. And the DOACs, particularly apixaban, have consistent benefits with respect to lower bleeding risk in the groups at highest risk for bleeding. And then education of the patient, the patient's family, the primary care providers, even the people involved in the system at the level of clinic management, are important to close the gap between high-quality evidence and clinical practice.

Thanks for your attention.

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