Response to Letter by Testa et al

Response:

We appreciate the thoughtful comments of Testa et al, particularly regarding the pivotal issue of stroke prevention among elderly individuals with atrial fibrillation. In our study, patients with planned cardioversion were treated with warfarin consistent with current guidelines.1 Antiplatelet agents would not be used in this setting. Based on risk factors, the patients in our study were predominantly classified as high risk for stroke. Aspirin in this group would not be considered a surrogate for warfarin. For each patient who was not discharged on warfarin, we ascertained the reason directly either from the discharge record or the treating physician. Among patients considered to have a contraindication to warfarin, 18 patients (9%, not 18% as cited by Testa et al) were alternatively treated with aspirin plus clopidogrel. Currently, aspirin is the only alternative for warfarin ineligible patients. Aspirin has been shown to be only modestly efficacious in preventing stroke among patients with atrial fibrillation (19% stroke reduction).2 The efficacy of dual antiplatelet therapy versus aspirin monotherapy among patients who are warfarin ineligible has yet to be determined. This specific question is being addressed in the ongoing ACTIVE A arm of the ACTIVE trial.3 Testa et al cite the results of the recently published ACTIVE W trial which compared clopidogrel plus aspirin to oral anticoagulation and bears no relevance to a warfarin ineligible subset. Regarding dose of aspirin, we found that hemorrhage was the only independent predictor of receiving low dose versus full-strength aspirin at hospital discharge (adjusted odds ratio, 5.4 [95% CI 2.1 to 13.7]).

Twenty-two percent of the patients in our study were discharged on no antithrombotic therapy. Table 4 in our article provides a full account of the cited warfarin contraindications for these 44 patients who were discharged on neither warfarin nor aspirin. Fifty-two percent of these patients had current or recurrent extracranial hemorrhage or prior intracranial hemorrhage. Stroke prevention is particularly challenging among patients with a propensity for bleeding which often leads to cessation of therapy. The optimal management of these patients has yet to be defined.

It is important to note that guidelines, although evidence-based, are derived from trial populations that are often trial-eligible based on a favorably low bleeding risk profile. Among the older, hospitalized patients with atrial fibrillation in our study, the prevalence of risk factors for stroke was rivaled by the increased presence of potential contraindications to anticoagulant therapy. Given the devastating consequences of an atrial fibrillation–related stroke and the associated 30-day mortality of 24%,4 the risk to benefit analysis continues to weigh in favor of anticoagulation. In clinical care, the practical challenge lies in maintaining patients on oral anticoagulant therapy, particularly after a hemorrhagic event. To the degree that anticoagulation intensity contributes to bleeding risk, newer drugs with wider therapeutic margins and shorter half-lives should help to minimize this risk. To the extent that frequent monitoring is a barrier to the use of vitamin K antagonists, newer drugs without this requirement should help to extend therapy to more of those for whom it is indicated.

Disclosures

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