Letters to the Editor

Safety of Oral Anticoagulation in Elderly Atrial Fibrillation Patients to Prevent Strokes

To the Editor:

With great interest we read the article by Hylek et al who showed that among 405 hospitalized elderly patients with atrial fibrillation, only 51% were discharged on oral anticoagulation (OAC).1 Of the remaining patients, 98% had contraindications. Among patients older than 80 years, falls were the most often physician-cited reasons for not prescribing OAC, followed by hemorrhage. However, the following concerns regard methods, results, interpretation of the data and conclusions drawn from the findings:

1. It would be interesting to know more about the social situation of the patients. Did the presence of care provided at home by relatives or social services influence the decision about OAC? The higher rate of women not receiving OAC suggests an influence of these conditions.

2. Polymedication has been identified as a risk factor for bleeding complications during OAC, either attributable to comorbidity or to drug interactions.2 This factor was not included in the analysis.

3. It would be of interest to have more information about the site and cause of prior hemorrhage in 24% of patients. Most hemorrhagic complications of OAC derive from gastrointestinal or urological sources, and it has been shown that systematic screening for occult fecal blood loss and microhемaturia, and elimination of the bleeding cause, reduces the complication rate of OAC.3 Was screening for fecal and urine blood loss carried out in all included patients?

4. What was the reason for hospital admission of the included patients? How many of them were hospitalized because of a fall? What were the reasons for prior falls in the included patients? Falls can be attributable to various clinical and environmental conditions. Some of them can be eliminated by neurologic, cardiological, orthopedic or physiotherapeutic measures; others can be eliminated by changes in the environment of the patient. How diligently were patients investigated to assess the causes of the falls and to eliminate them?

5. How extensively were the patients educated about their risk of stroke or embolism without OAC? How intensively were “prejudices” and “fears” against OAC searched among patients who refused? It would be interesting to know more about the special reasons for refusal and nonadherence. Was the possibility of self-monitoring of OAC offered to the patients and their relatives?4

6. How precisely were the physicians informed about the benefits and harms of OAC, especially regarding falls and the concomitant risk of cerebral bleeding? In this respect we want to mention the mathematical model comparing the benefits and risks of OAC in community-living, elderly persons based on their risk of falls. According to this model, an elderly patient taking OAC must fall about 295 times in 1 year that OAC is not the optimal therapy.5

The study shows that in real medical life there are a lot of obstacles to OAC, especially concerning elderly patients who might benefit most from it. The study fails, however, to show by which means to overcome these problems and how to manage contraindications in order to abolish them. In view of the benefits of OAC, the presence of contraindications has to be recognized as a challenge to eliminate them, and from our practical experience this seems possible in a considerable number of patients.2,6

Left atrial appendage occlusion, as proposed in the discussion, is in our view no alternative to OAC. Neither surgical nor interventional techniques are efficient.7 Furthermore, it has not been proven by prospective randomized studies to really prevent stroke or embolism, and the mentioned PLAATO device is currently not available. Additionally, because the left atrial appendage might have important endocrine and hemodynamic properties, its elimination might induce more harm than benefit for the patients.8

Safe OAC therapy is feasible also in elderly patients; however, adequate reimbursement for the medical and social efforts associated with this therapy is warranted.3 The increasing number of elderly patients with atrial fibrillation represents a challenge for the physicians and the society to provide them with optimal medical and social care.

Disclosures

None.

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