Impact of Anticoagulation on Poststroke Mortality in Ischemic Stroke Patients With Atrial Fibrillation

To the Editor:

We read with great interest the recent study by Andersen and Olsen regarding the usefulness of anticoagulation treatment in reducing poststroke mortality in patients with ischemic stroke (IS) and atrial fibrillation (AF). The authors, after evaluating data from a prospective nationwide registry, concluded that IS patients with AF and no contraindication to oral anticoagulants (OA) had an almost 50% reduction in the hazard of death when secondary prevention with anticoagulation treatment was instituted. This effect was independent of age, stroke severity, and stroke risk factors.1 The former findings raise certain potential clinical implications regarding the optimal management of IS survivors with AF, because in a previous randomized controlled trial no significant benefit of oral anticoagulation on poststroke mortality was identified.2

Our group has previously investigated the efficacy and safety of OA for secondary prevention in specific subgroups of IS patients with AF (age older than 75 years, moderate-to-severe stroke severity) that have been under-represented or excluded from randomized controlled trials. Interestingly, we documented similar results to the findings of Andersen and Olsen. More specifically, OA decreased the risk of recurrent thromboembolism (stroke and systemic embolism) by approximately two-thirds (HR=0.31 for patients older than 75 years; HR=0.36 for patients with moderate-to-severe stroke) and halved the risk of poststroke mortality (HR=0.47 for patients older than 75 years; HR=0.44 for patients with moderate-to-severe stroke) after adjustment for demographic characteristics and cardiovascular risk factors.3,4

In people older than 75 years, AF is the most important single cause of IS,5 whereas AF patients with disabling stroke carry a high intrinsic risk of recurrent thromboembolism.6,7 In view of the limited randomized data regarding the effect of OA on long-term prognosis of patients with moderate-to-severe IS and aged older than 75 years, which has led to a significant underuse of anticoagulation therapy in these 2 stroke subgroups,8 Andersen and Olsen may consider comparing the benefit of OA between patients of 75 or younger and those older than 75 years old, as well as between patients with mild and moderate-to-severe stroke. Should a higher preventive effect of anticoagulation be identified in patients of older age and more severe strokes, then this finding may constitute an important argument in favor of the wider implementation of OA in these 2 under-treated IS subgroups. Additionally, it would be interesting to evaluate the influence of AF profile (chronic versus intermittent) on poststroke mortality in this large nationwide stroke registry, because recent studies have indicated that intermittency of rhythm does not appear to affect stroke risk when other risk factors are considered.3,4,9

In the absence of definitive evidence from randomized controlled trials, the data from this large prospective Danish cohort, although obtained in a nonrandomized and uncontrolled setting, provide useful information regarding the potential beneficial impact of oral anticoagulation on the risk of poststroke mortality and strengthen the case of wider but judicious use of OA in IS survivors with no contraindication to antithrombotic therapy, regardless of their age or stroke severity.

Disclosures

None.

Georgios Tsivgoulis, MD
Neurosonology and Stroke Research Program
Barrow Neurological Institute
Phoenix, Ariz
Department of Neurology
University of Athens School of Medicine
Athens, Greece

Sofia Vassilopoulou, MD
Konstantinos Spengos, MD
Department of Neurology
University of Athens School of Medicine
Athens, Greece


(Stroke. 2007;38:e61.)
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Stroke is available at http://www.strokeaha.org

DOI: 10.1161/STROKEAHA.107.484030
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Stroke. 2007;38:e61; originally published online May 17, 2007;
doi: 10.1161/STROKEAHA.107.484030
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0039-2499. Online ISSN: 1524-4628

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