Letter by Wachter et al Regarding Article “Cost-Effectiveness of Outpatient Cardiac Monitoring to Detect Atrial Fibrillation After Ischemic Stroke”

To the Editor:

We read with great interest the paper of Kamel et al,1 which analyzed the cost-effectiveness of prolonged Holter monitoring for secondary stroke prevention and found net costs of $13.00/quality-adjusted life year gained.

We, however, would like to bring to attention 2 factors that may further increase the cost-effectiveness of prolonged Holter monitoring:

1. The prevalence of patients with paroxysmal atrial fibrillation was estimated for a 7-day-period, although none of the cited studies in the article had actually performed a 7-day-analysis. We would like to corroborate further the findings of Kamel et al with data from our recently published “Find-AF” study, in which 237 patients with cerebral ischemia and sinus rhythm on-admission-electrocardiogram were included. After performing a 7-day Holter-monitoring, we found paroxysmal atrial fibrillation in 28 of 224 atrial fibrillation-naïve patients (12.5%),2 corresponding to approximately twice the assumption of Kamel et al.

2. Ischemic stroke prevention is achieved by oral anticoagulation. Therefore, in our opinion, costs of beta blockers should not be included in cost-effectiveness analysis without some theoretical considerations. Beta blocker therapy may only be used in a small subset of patients with atrial fibrillation who are symptomatic, but has no proven impact on prognosis. Indeed, beta blockers are shown to be only modestly effective in preventing recurrent atrial fibrillation.3 If beta blockers are used for rhythm control, this will in many cases be performed by an exchange for other previously prescribed antihypertensive medication rather than by an additional prescription; we assume this will nearly nullify the effects of beta blocker prescriptions on healthcare costs.

These 2 factors, taken together, could further reduce costs calculated by Kamel et al per quality-adjusted life year from $13.00 to only $5.09. We therefore believe that prolonged electrocardiogram monitoring for at least 7 days should be considered as an inexpensive investigation for secondary stroke prevention and, in consequence, should be used more frequently in clinical practice.

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