Stroke Patients With Suspected Atrial Fibrillation Should NOT Be Started on Anticoagulation WHILE AWAITING the Results of Long-Term Cardiac Monitoring

Michael Katsnelson, MD; Ralph L. Sacco, MD, MS, FAHA, FAAN

Cryptogenic stroke is a frustrating diagnosis. For the patient who is looking for explanations, for the family members worrying and caring for their loved one, and, perhaps most of all, for the physician trained to localize, identify, and prevent a recurrent stroke. With a large proportion of ischemic strokes (20–30%) still classified as having no definite cause, this diagnostic scenario happens all too often at the bedside. Atrial fibrillation (AF) is a well-established cause of many cardioembolic strokes, but may not always be readily detectable and frequently goes under-recognized by the patient. Occult AF has been found more frequently among cryptogenic stroke patients with prolonged ambulatory cardiac monitoring. Occult AF has been well-documented. In 1 study, fewer than one-third of the palpitation symptoms corresponded to AF, third (32%) of the palpitation symptoms corresponded to AF, and frequently goes under-recognized by the patient. Occult AF has been well-documented. In 1 study, fewer than one-third of the palpitation symptoms corresponded to AF, with a greater percentage (39%) being in sinus rhythm. The patient deserves a careful and thorough cardiac event monitoring. Occult AF has been found more frequently among cryptogenic stroke patients with prolonged ambulatory cardiac monitoring. Longer cardiac monitoring has higher yields, with 60% of AF detected >1 month after the start of monitoring and paroxysmal AF often occurring as rarely as 1 in 10 days. Genomic analysis and biomarker studies have recently identified subpopulations at higher risk for AF, offering a future possibility of screening. Thus, it is reasonable to recommend longer monitoring with an implantable loop recorder, if the initial 30-day period fails to reveal AF, especially if our patient has genetic or serologic susceptibilities indicating a higher likelihood of AF.

We would favor initiating antiplatelet therapy to prevent a recurrence while we gather more definitive information about the presence of AF. Subjecting her to the bleeding risks associated with any oral anticoagulants, new or old, would be risky in the absence of a definitive cardioembolic source. The bleeding risks in this patient with peptic ulcer disease are increased and also need to be addressed. Even antiplatelet therapy will need to be monitored closely, and the proper treatment of her underlying gastrointestinal disease needs to be initiated.

Assuming we later diagnosed AF, we would need to weigh the risks and benefits of oral anticoagulants. Based on her other comorbid features, her CHADS2 (Congestive Heart Failure, Hypertension, Age ≥75, Diabetes and Stroke/TIA) score is 5, which places her in a moderate risk group and corresponds to 12.5% yearly risk of stroke. Using oral anticoagulants would be the most effective way to reduce her chance of a recurrent stroke but also increase the risk of hemorrhage. Warfarin is only within range slightly more than 50% of the time in patients who do manage to take it regularly in a community setting. Moreover, her renal disease also complicates the decision process. Warfarin has been shown to be harder to dose appropriately and to have more hemorrhagic complications in patients with severe kidney disease. Recent clinical trials of dabigatran and rivaroxaban have excluded patients with CrCl <30 because of similar concerns and both drugs (dabigatran only at the 150mg dose) had statistically higher rates of gastrointestinal bleeding compared with warfarin. In our patient with CrCl of 30 and peptic ulcer disease, we would favor instituting a course of lower dose dabigatran or rivaroxaban after the diagnosis of AF was certain.

As stroke clinicians we strive to do our best to prevent a stroke recurrence, but we also must remember the words in our Hippocratic Oath: “I will follow that system of regimen which, according to my ability and judgment, I consider for
the benefit of my patients, and abstain from whatever is deleterious.” While waiting for a definitive diagnosis of AF in this patient, the safest therapy includes a statin, an antiplatelet agent, and effective control of blood pressure and glucose. Although it may be tempting to attribute a cardiac source as the presumptive cause of an embolic-looking infarct in a patient with cryptogenic stroke, the risks of the therapy calls for a more certain diagnosis.

Disclosures

None.

References

Stroke Patients With Suspected Atrial Fibrillation Should NOT Be Started on Anticoagulation WHILE AWAITING the Results of Long-Term Cardiac Monitoring

Michael Katsnelson and Ralph L. Sacco

*Stroke*. 2013;44:300-301; originally published online December 13, 2012;
doi: 10.1161/STROKEAHA.112.658260

*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2012 American Heart Association, Inc. All rights reserved.
Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://stroke.ahajournals.org/content/44/1/300

**Permissions**: Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Stroke* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

**Reprints**: Information about reprints can be found online at:
http://www.lww.com/reprints

**Subscriptions**: Information about subscribing to *Stroke* is online at:
http://stroke.ahajournals.org//subscriptions/