Response to Letter Regarding Article, “Ischemic Stroke and Intracranial Hemorrhage With Aspirin, Dabigatran, and Warfarin: Impact of Quality of Anticoagulation Control”

We face the same challenge as Dr Feng et al1 in managing Chinese patients with atrial fibrillation (AF). Despite a lower prevalence, AF remains a major health threat, affecting >4 million people in Mainland China. Warfarin therapy is the cornerstone in AF management, which reduces ischemic events by two thirds when good time in therapeutic range can be achieved. However, its use has been disturbingly low among Chinese patients ranging from 5% to 20%. Warfarin is commonly been blamed as the root of the problem. In our study involving a real-world cohort of 8754 Chinese patients with AF, the time in therapeutic range, a measure of the quality of anticoagulation, is embarrassingly low, 38.8%.2 The poor time in treatment range is not only associated with a higher ischemic stroke risk but also with a higher incidence of intracranial hemorrhage. On the contrary, such risks of ischemic stroke and intracranial hemorrhage in patients receiving dabigatran are much lower. Indeed, the risk of ischemic stroke even among patients with time in therapeutic range >70% remains higher than those on dabigatran. Apparently, non–vitamin K antagonist oral anticoagulants seem to be the answer.

However, some commonly quoted arguments by clinicians for not initiating anticoagulation therapy in Chinese patients are not directly related to warfarin therapy itself. These include a perceived lower risk of stroke attributable to AF and a higher risk of intracranial hemorrhage in Chinese when compared with other ethnic groups. In a stark contrast to these beliefs, the risk of ischemic stroke among Chinese patients with AF is at least comparable with that of white in recently published large series. In fact, the stroke risk in those with low CHA2DS2-VASc (congestive heart failure [1 point]; hypertension [1 point]; age 65–74 years [1 point]; age ≥75 years [2 points]; diabetes mellitus [1 point]; prior stroke or transient ischemic attack [2 points]; vascular disease [1 point]; and sex category [female, 1 point] score) can even be 2- to 3-fold higher than the white counterparts. More importantly, net-clinical-benefit analysis (the annual number of ischemic stroke events attributable to treatment strategies) has consistently shown that the optimal antithrombotic therapy for Chinese patients with AF clearly favors oral anticoagulation therapy in almost all combinations of CHA2DS2-VASc (≥1) and HAS-BLED (uncontrolled hypertension [systolic blood pressure >160 mm Hg, 1 point]; abnormal renal function [serum creatinine >200 umol/L, 1 point]; abnormal liver function [cirrhosis or bilirubin >2x upper limits of normal or AST/ALT/ALP >3x upper limits of normal, 1 point]; previous stroke [1 point]; prior major bleeding [1 point]; labile international normalized ratio <60% time in therapeutic range]; age >65 years [elderly, 1 point]; drugs predisposing to bleeding, alcohol (>8 drinks/week) scores, except those with previous intracranial hemorrhage.3,5

After all, with the availability of safer alternatives, and redefinition of the risk of ischemic stroke among Chinese patients with AF, it is time to dedicate resources to raise clinicians’ and patients’ awareness of the condition to better combat the high stroke burden in Chinese population.

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P-H. Chan and J.J. Hai contributed equally.

Disclosures

None.

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