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 blamed as the root cause when good time in therapeutic range cannot be achieved. 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] and 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) score may 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 in order to better combat the high stroke burden in Chinese population.

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Disclosures

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