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Case Study - New Guideline Recommendations into Clinical Practice for the Patient with AF

Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Patel:

Hi, this is Manesh Patel on Duke Heart On The Go for an update with the AHA/ACC AFib guidelines and we're going to talk about a case. So, thank you again for joining us. I'm going to try to put some of the key guideline updates into perspective with a case for a patient with atrial fibrillation. This is a patient who's an amalgam of different patients I've taken care of, but I think highlights some of the guideline issues. So, let's get started.

Our patient is Arturo Feliz. He's an 81-year-old gentleman with atrial fibrillation, hypertension, and diabetes. He also has some peripheral neuropathy, and his family who lives with him is concerned about some of his unsteadiness. He also has some pain in his legs during walking. He denies any heart failure symptoms. On exam, he's in chronic atrial fibrillation with a heart rate of 73. He's a retired mechanic and does a lot of things around the house, but you know, doesn't do that much activity outside of the house. He has a few grandkids that live in the neighborhood. The patient also has, on our at least, evaluation, a EGFR of 41 mL/minute with a creatinine of 1.4 and a weight that's a little bit higher than 73 kg. And his current medications include aspirin 81 mg, metformin, amlodipine, atorvastatin or Lipitor, and a multivitamin. And the patient and his family are interested in determining if he should be on an oral anticoagulant and also that he's unsteady at times and what we should do because blood thinning they've heard might help him, but he's recently been diagnosed in the last 6 months with this atrial fibrillation and wanted to know what to do.

So, putting Arturo into context, you know, he's very similar to a lot of patients we care for in the now aging population, 70s and 80s. In fact, sometimes in the prevalence data, sometimes 12 to 13% of people over 65, goes up as you get over 80, will have atrial fibrillation as we go forward in the next 20 to 30 years. So, the new guidelines really stress three or four important points in thinking about Arturo. The first is to understand his risk. And using multiple types of risk evaluations, but understanding that his risk for stroke and systemic embolism, and does that lead to an anticoagulation? Then how do you make the decision with him and his family around anticoagulation or not, so shared decision-making? And then if we decide, which in his case you might given his risk, about anticoagulation, how do you reduce his bleeding? And how do you reduce his risk for bleeding?

And then finally, some new information or at least guideline recommendations about rhythm control? Would you leave Arturo in atrial fibrillation? He's 81, he just got diagnosed with it 6 months ago or so, seems like he's not in heart failure, but how do you make that decision? And are there changes in guideline recommendations there?

So, let's get started with his decision. So, the sort of key questions for me are, should we treat him? So, that's a risk question. Or if we treated him, how would we treat him? With a DOAC? If we use the DOAC, which DOAC? Or at least what dosing? Or should you use left atrial appendage occlusion? Or would you consider warfarin in him? And then do we reduce his bleeding? And do we consider rhythm therapy?

So, I guess I'll start by saying the guidelines again re-emphasize that all of the DOACs significantly reduced – significantly reduced all-cause mortality, stroke, and systemic embolism compared to warfarin. And this is based on the rough meta-analysis, where really the findings were similar, or at least the point estimate was lower on ischemic stroke. But hemorrhagic stroke was significantly less, ICH was significantly less. And that led to an all-cause mortality reduction with the DOACs. And so, importantly, the guidelines favor DOACs over warfarin. And its practical use of those DOACs in these patients in that it's fixed dosing, no need for monitoring, and reduced drug-drug interaction. So, his risk is important. And then if we're going to use a therapy, the DOACs are favored.

And what about his risk? Well, the guidelines talk about using multiple risk sorts of scores. Importantly, the CHA₂DS₂-VASc score is probably the most common risk score. And I think if you look at Arturo's risk score, his risk score, at least he has hypertension, diabetes, and his age is over 75. So right there, he's got a CHA₂DS₂-VASc score of 2 – I'm sorry, 4. And that 4 is likely enough to make you worry about his yearly risk of stroke and systemic embolism.

Now, some people might also discuss should you consider scoring his HAS-BLED or thinking about his hemoglobin? We talked about his creatinine. I'll just highlight when I think about him in clinic, I often think that these patients' highest and sort of most important factor for me, is thinking about their creatinine clearance. And what I mean by that is that the creatinine clearance tells me – because I usually am going to likely lean towards treating these patients because of the significant benefit identified in the guidelines, especially with DOACs and the less bleeding risk compared to warfarin. So, I'm often thinking about his age, his weight, his creatinine, if he's female or male – I mean, if the person is female or male, then that that helps me with their decision-making. So, renal function becomes a really important risk factor and measurement because I want to know how to dose them. So, for Arturo, who's got a CHA₂DS₂-VASc of 4, I think the conversation is that he's certainly got a high risk. And that risk is even elevated a little bit more because he's got renal insufficiency, not clearly presented in CHA₂DS₂-VASc, but I think it's important.

So, I think it's important to think about first having the shared decision-making conversation with him and his wife and his family. And that conversation is about making sure he understands his risk. A CHA₂DS₂-VASc 4 means that he's at least got a 4% risk. It's like bad interest, I tell my patients, every year it's going to keep going up. And so, generally healthy at age 81 and moving around the house. Obviously, we want to encourage him in increasing his activity, but the first visit would be making sure he's understanding his risk of stroke and systemic embolism, and bleeding is real, and we can think about things to reduce his bleeding risk. Likely, we'd likely look for reversible causes. He doesn't have one that's evident but we, in our clinic, would probably still get thyroids and an echocardiogram on him. And through shared decision-making, would make sure we use a DOAC in this patient.

I would make sure you use the right dose. We see a lot of underdosing in people like Arturo, just to highlight this. He does – he only meets one of the three criteria for apixaban reduction, so he shouldn't be on 2.5 mg if you use apixaban. If you use rivaroxaban, he does meet the 50-mg reduction. It's hard to use dabigatran in him with the renal insufficiency, so I would favor one of those. The guidelines have elevated left atrial appendage occlusion to a 2a from a 2b, but I don't think he meets those criteria given that he's such a good candidate for DOAC.

So, starting Arturo on a DOAC is important. And then how do we reduce his bleeding? It's important to recognize that the most powerful thing we can do to reduce his bleeding is actually to stop the aspirin. Stopping the aspirin, which he's on for chronic vascular disease, is a really important opportunity because when you start a DOAC, adding an aspirin to a DOAC for people with chronic vascular disease, coronary or peripheral, doesn't improve any of their efficacy, or let's say downstream thrombotic events, but it really increases their bleeding risk. So, we know from trials like AFIRE in the *New England Journal*, where aspirin and DOAC was compared to a DOAC in patients with AFib, and there was no benefit. Or post PCI trials where we've gone from triple therapy to double therapy and eventually dropped aspirin. In people like Arturo, I would drop the aspirin. And I think that would help.

It's important to also recognize that dose reduction should be evidence based and it doesn't reduce bleeding, actually it might put these patients at high risk. So, you need to make sure that you do other things to reduce his bleeding, not just do dose reduction.

So finally, I think you would start Arturo on a DOAC, you would think about other things you could do like stopping the aspirin. Left atrial appendage occlusion, as I said, I don't think is something I would start in him or consider the conversation yet given his candidacy for DOAC. But as he comes back to clinic, you might, with the echo and in next few months have a conversation if he remains in atrial fibrillation, he's having a lot of symptoms, if he has any evidence of heart failure, that you might consider rhythm control with an ablation strategy, as that's moved up to a class 1 guideline recommendation in people like Arturo. I think first you would anticoagulate him and see how he's doing.

Thank you for watching as we talked about Arturo Feliz, a conversation about the guidelines applied to a patient with atrial fibrillation.

Announcer:

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