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Case: Anticoagulation Considerations for Atrial Fibrillation

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

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Dr. Deitelzweig:
Hello, I'm Dr. Steve Deitelzweig. I serve as the Service Line Physician Leader at Ochsner Health for Hospital Medicine, and a Medical Director for Regional Business Development at Oschner, and Professor of Medicine at the University of Queensland. Today, we'll be discussing the unique situation related to a patient with atrial fibrillation and bleeding.

So, consider this patient that presents to your client. She's an 85-year-old lady. She's 70 kg. She has moderate renal impairment and she's had a GI bleeding ulcer 2 years ago. I have her respective CHADS2-VASc and HAS-BLED scores on there for your review as well.

GI bleeding is the most common outcome of concern from using the OACs, oral anticoagulants. And here, we note from the randomized controlled trials that when the NOACs were compared with the vitamin K antagonists in patients with non-valvular atrial fibrillation, they are not associated with reduction in bleeding, by and large. And in particular, when we look at the patients at high risk of GI bleeding, and you know who those patients are, they tend to have five characteristics: folks at least of the age of 75, maybe have HAS-BLED of at least 3, CKD 3 to 5, they're on co-medications like steroids or NSAIDs or antiplatelets, and lastly might have a comorbid condition like a prior GI bleed or an ulcer. In those folks, the recommendation a few years back from European Society of Cardiology was to consider using vitamin K antagonists or another agent, aside from dabigatran at the 150 mg BID, edoxaban 60, or rivaroxaban 20, recognizing what we see here from the RCTs.

That was the RCTs. As time has gone on, we've had additional RWEs, or real-world evidence. Here's one of which I'm principal co-investigator of with Dr. Lip and others, and it was titled ARISTOPHANES. A very large dataset that comprised up to 56% of the U.S. population, or 180 million lives, CMS, as well as four commercial lives included. And in this analysis, we'd had DOAC versus VKA, and you can see the different DOACs there with the exception of edoxaban because we didn't have a high enough end to include them. And DOAC versus DOAC with looking at the primary effectiveness outcome of stroke, systemic embolism, and safety outcome of major bleeding in the analysis.

And what ARISTOPHANES taught us where we focused on the bleeding aspects, and we had 12 papers come out of this dataset, so expansive, that when we looked at patients who had atrial fibrillation and prior bleeding, and this is not just major GI bleed – major bleeding, it was all bleeding, that if you looked at apixaban in comparison with warfarin, actually, it was the only agent that had actually a reduction. And it was associated with reduction in stroke and major bleeding, in particular GI bleeding. And here, you see rivaroxaban versus warfarin and not associated with a reduction in GI bleeding, in fact, an increase.

In ARISTOPHANES, we also went further beyond NOACs versus VKA and looked at NOACs and NOACs. And these were in patients with atrial fibrillation, and all in prior bleeding. So, not just GI bleeding, not just intracranial bleeding, but all bleeding. And when we looked at the NOAC/NOAC comparison, you see that apixaban was associated with lower major bleeding, and in particular GI bleeding

in comparison to both dabigatran and rivaroxaban. Further, dabigatran was associated with less major bleeding and GI bleeding in comparison to rivaroxaban. And then you see to the far right, the hazard ratios reflecting the point estimates.

We published this in *TAG, Therapeutic Advances in Gastroenterology,* in 2021. And people who had experienced a major versus non-major bleed, GI bleed, while on a NOAC, had that impact, stroke, systemic embolism, and major bleeding. And here you'll note that GI bleeding significantly increased the risk of stroke, systemic embolism, and subsequent major bleeding with a pretty notable hazard ratio of 4.95 compared with the risk without major bleeding.

This was also shown in other independent analyses because in real-world evidence you want to see is it being replicated and that was shown here as well, over a nearly a decade of 2,991 patients, whereby warfarin resumption was associated with an increase of recurrent GI bleed compared to no anticoagulant resumption, and no association between a NOAC resumption of recurrent bleeding with the exception of rivaroxaban there.

So, in summary, clinical practice, ARISTOPHANES subgroups from the real-world evidence, this is claims databases, that those patients who we see with GI bleeding, like our lady, and other recent publications that are certainly poised to improve the management of our NVAF patients.

And I appreciate you taking some time and joining me today.

Announcer Close:
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