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How Do We Translate Real-World AF Data Into Everyday Clinical Practice?

Announcer:
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Dr. Lopes:
Hello, this is CME on ReachMD, and I'm Dr. Renato Lopes. Here with me today is Dr. Valeria Caso. Valeria, welcome.

Dr. Caso:
Hello.

Dr. Lopes:
Valeria, can you review the best practice for ongoing oral anticoagulation treatment in atrial fibrillation?

Dr. Caso:
Thank you very much, Renato, for this question. Currently, based on the European cardiology guideline from the European Society of Cardiology, the first choice in treating patients with atrial fibrillation are DOAC. So for the first time, this was clearly identified because DOAC at the same level as vitamin K antagonist. So, finally, we're at the point that, based on the data that we have from randomized trials and also from the real-world evidence, that there is a better safety and efficacy profile.

Why efficacy? Because it's considered noninferior because it's safer, and patients will continue to maintain their treatment.

Second point for me, I always, as a neurologist, because I see when things are going wrong, is also give the right dose to the right patient. So if there's an indication for the full dose, give the full dose. If there's an indication that you have to give lower doses based on guideline, then go for the lower dose. And important is that once you have identified atrial fibrillation and you start anticoagulation, it's not that you can say, okay, game over for me. No, you have to take care of those patients. It means that you know the European Society of Cardiology have this care slogan: Continue to monitor. Because your patient will change. And especially when you have low profile with patient, continue to monitor this patient because it's important to understand, even with the low CHA2DS-VASc score, that maybe when it's below 2, now 1, that you have to start anticoagulation.

Dr. Lopes:
That's great, Valeria. I think that's a great overview and summary of the key aspects of anticoagulation for atrial fibrillation. And I think, even with warfarin being so effective in preventing stroke, I think now we have overwhelming data that we can add additional 20% relative risk reduction in the rates of stroke and systemic embolism with DOACs when compared to warfarin. And also, I think that's an important point to highlight is the low role of aspirin for stroke prevention in atrial fibrillation. I think that's a key point that we still see about 20% to 25% in clinical practice, patients using aspirin with the objective to have strokes prevented. And we know now that aspirin will probably cause more harm in this scenario, and now it's a Class 3 recommendation, level of evidence A. So we have high level of certainty that aspirin really does not add much in stroke prevention in atrial fibrillation.

So with that, that is our time. We hope this treatment review gave you something to think about, and thanks for tuning in.

Announcer:
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