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Trade off: Ischemic/Thrombotic vs Bleeding

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum. Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Lopes:
Hello, this is CME on ReachMD, and I'm Dr. Renato Lopes, and I'll be discussing today the trade-off between ischemic and bleeding events in patients with atrial fibrillation.

So every time we are facing a patient with atrial fibrillation where we decided that we need to use an anticoagulation, we don't have to deal with stroke prevention. So in other words, try to reduce the risk of stroke, which is the primary objective in patients with atrial fibrillation. But at the same time, I need to pay attention on the risk of bleeding because we've learned over the years that bleeding is a marker of bad outcomes. So every time a patient has a bleed, even if it's a minor bleed, it is associated with worse subsequent outcomes.

So I can now really uncouple the risk of thrombosis and the risk of ischemic events from the risk of bleeding. I have to try to treat patients as a whole, taking into account both types of risks and, therefore, try to find what I've been calling the anti-traumatic sweet spot. In other words, I have to take into account all patient's characteristics and then, based on that and based on the risk of stroke and the risk of bleeding, decide what might be the best agent to be used, at the best dose, for the right patient population that can give me the greatest reduction in ischemic events at a minimal cost of bleeding. If we do that, then we've really found the anti-traumatic sweet spots.

Particularly in atrial fibrillation, we leave the dilemma of reducing ischemic stroke with oral anticoagulants, but in a way that I can minimize the risk of the major complication of an anticoagulation therapy, which is intracranial hemorrhage. So that's the dilemma that we have to live in every single patient that we decide to treat with oral anticoagulation.

The good news is that in the last 15 years, with the new era of the DOACs, we had tremendous advance in not only the efficacy of these agents, but particularly in terms of safety, with these drugs being overall safer than warfarin, particularly in reducing the risk of intracranial hemorrhage compared to warfarin. And because of that, we had also less fatal bleeds with the NOACs or DOACs compared to warfarin.

Importantly, dosing is also very relevant in the discussion because we learned from the trials. Because some of the trials, some of the pivotal trials, tested a low-dose regimen of NOAC and a higher-dose regimen of NOACs compared to warfarin. This was the case with dabigatran 110 mg twice daily or edoxaban 30 mg once daily. And what we learned is that as we go down in the dosing, we start being safer. Of course, there is less drug on board, we have less bleeds, but we started seeing a cost associated with that, which is an increase in ischemic events, such as ischemic strokes or even myocardial infraction.

That's why, when we talk about sweet spot, it's all about being efficacious, reducing ischemic events at the same time that we can reduce bleeding events. So it's not helpful if I'm just efficacious but I'm not safe. And it's not helpful if I'm very safe but I'm not efficacious. In other words, I can be very safe, but if I increase, for example, the risk of stroke, it doesn't help. So the key here is to be efficacious, to

have high efficacy in reducing ischemic events and being safe. In other words, minimizing the risk of bleeding as much as possible. And if we do that, we will have found the anti-traumatic sweet spot which should be the goal for every single patient that we treat with oral anticoagulants in our clinical practice.

Thank you very much for listening.

Announcer:
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