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The Case of Arthur Frank: How Do We Manage Elderly Patients with Atrial Fibrillation?

Announcer:

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Dr. Patel:

Hi, my name is Manesh Patel, Cardiologist at Duke, and I'm joined by a colleague and friend, Sean Pokorney as we talk about a case, Arthur Frank. Time to think about how we treat our atrial fibrillation in elderly patients. Thanks for joining me, Sean.

Dr. Pokorney:

Great. Thanks so much for having me. I'm excited to work through the case together.

Dr. Patel:

Yeah, well, it's an amalgam of patients that I know you and I've seen, and you know, we wanted to present a case of Arthur Frank, an elderly gentleman with atrial fibrillation, to kind of go through some of the issues. I'll give you a little bit of the history and walk through it, and then get your take on a few of the items that are coming up.

So, Arthur is 78, has heart failure and diabetes, and has a creatinine of 1.5 with an estimated GFR of about 41. Now, Arthur is a retired mechanic and worked at one of the international car dealerships in town, has been pretty active most of his life slowed down a little bit with atrial fibrillation, some of the heart failure. And he's coming in after this heart failure, and AFib was newly diagnosed in the last few months with his primary care physician. It's important to recognize that when he first got diagnosed, he was actually sent to one of our EP colleagues, they had a conversation, and Arthur with a little bit of low EF, opted for atrial fibrillation ablation, and then got an ablation. But now, 3 to 6 months after that, even after the so-called blanking period, is still going back in and out of atrial fibrillation.

So, tell me how you think about Arthur, both from the ablation period, like how long after ablation? Because a lot of people go into ablation not wanting to be on anticoagulation, even though we know ablation doesn't mean you'll never be on anticoagulation, often makes your heart failure better, makes your quality of life better. And then if you're treating him, how you think about that? So first, tell me a little bit about Arthur and ablation.

Dr. Pokorney:

Yeah, no, absolutely. I think, you know, there's been a shift in our overall AF care for patients. And this has been driven by really the EAST-AFNET4 trial, which was done in Europe, which took patients who were diagnosed with AFib within the past year, and it randomized them to rate control versus rhythm control with medication or ablation actually, predominantly medical rhythm control therapy since it was done in Europe. And it showed that there was a reduction in the composite of cardiovascular death, stroke, and cardiovascular hospitalization in those patients that got early rhythm control. And that's translated to the – to a shift in the guidelines. And this is actually now in the ACC/AHA/HRS guidelines for atrial fibrillation that were just released in December of 2023. And so, again, there is more of a focus of pursuing rhythm control in these patients and there are these hard clinical outcome benefits. But as you highlighted, there is not necessarily data that ablation, or any form of rhythm control, necessarily reduces the stroke risk sufficiently

that we should change how we approach their overall stroke care. And again, this is in the guidelines, and the guidelines and consensus statement from the Heart Rhythm Society, highlight the fact that we should use CHADS-VASc score before and after ablation, and we shouldn't necessarily deviate from our overall stroke prevention strategy just because a patient has had an ablation or is on an antiarrhythmic medication even if they're not having atrial fibrillation.

And so, I think, you know, if a patient has a strong absolute contraindication to anticoagulation, we should be thinking about left atrial appendage occlusion in some of those patients. But for Arthur in particular, just because Arthur's had an ablation, I would still focus on Arthur's CHADS-VASc score, and I would highlight the fact that he is a high CHADS-VASc score individual, and despite the fact that he may be doing well early after ablation, again, we wouldn't want his first presentation of AFib recurrence to be a stroke. And so, I would continue Arthur on anticoagulation indefinitely.

Dr. Patel:

Yeah, I think that's a key message. You know, ablation is for a lot of things, and it may eventually reduce the burden, but it makes people feel better, stay out of the hospital, may make their EF better, it may actually help them with cardiovascular events. So, ablation is moving up in the guidelines as a variety of different data points are coming to tell us that these patients, especially patients with heart failure, might benefit; however, anticoagulation should be continued.

Well, let's talk about how to treat Arthur. So okay, I agree, we need to treat him long term because his risk is high. What are the things you think about in the story that I've told you in addition to his CHADS-VASc score that affect how you think about treating him?

Dr. Pokorney:

Yeah, so you know, one of the things that always gives me a little bit of pause in these elderly patients that – that do have kidney dysfunction is using dabigatran in particular in these patients just because of the fluctuations you can see in creatinine clearance and the amount of that medication that's cleared renally, that's just a medication that, in Arthur in particular, I would probably shy away from. And I think, you know, as we think about using apixaban and rivaroxaban, for example, in Arthur, you know, it's really important to pay attention to the labeling and the dosing recommendation. And you highlighted the fact that Arthur's creatinine clearance by Cockcroft-Gault is less than 50. And given the fact that it's less than 50, the appropriate dose of rivaroxaban would be 15 mg daily. And it's important to contrast that to apixaban, where with apixaban, you mentioned his creatinine is 1.5, so he has one dose reduction criteria, but he doesn't have a second dose reduction criteria, because he's not low body weight and he's not 80 years of age or older. And so, based on that, despite the fact that we would actually use the lower dose of rivaroxaban in him, we would actually use the higher dose of apixaban, and we would use 5 mg twice daily.

And again, there's inappropriate dosing happening frequently. And this has been demonstrated in registry data, multiple different registries have sort of highlighted this issue. And unfortunately, when you overdose patients that should receive a lower dose based on their risk factors and labeling, what that translates to, is it translates to higher bleeding and no further stroke reduction. And very similarly, when you underdose patients, we see the same thing; when you underdose patients, you don't see a reduction in bleeding, which is what you would hope to accomplish by underdosing, but you do see an increase in the rates of stroke. And so again, making sure that we're finetuning and specifying the dose based on a patient's specific criteria. And in this case, Arthur's creatinine clearance, I think, is really critical.

Dr. Patel:

Yeah, I think that's two big points for this case. One, don't forget to treat patients with atrial fibrillation that are elderly at high risk, even if they've had an ablation. The second is to dose them correctly. Likely wouldn't use warfarin for a variety of reasons, understanding all the newer agents are better than warfarin. And the second thing, I probably wouldn't use dabigatran, as you said, because of the renal dysfunction. And I think this is a patient where at least 10-15% of the time, I see them underdosed with 2.5 mg BID of apixaban sometimes, or I think 15 mg of rivaroxaban, but I've certainly seen people back and forth on that. So, getting the right dose is really important. And I think he'll benefit long-term from that.

And like everything else, also doing rate control, also doing other heart failure medications to help him with that. And if you want to reduce bleeding in someone like Arthur, because often say, is it the patient, the drug, or the dose, right? Try to treat all three, right? Get the right drug, the patient risk, reduce all the risk things you can, and then all the other drugs, NSAIDs, and others, would be important to stop.

Well, thank you for joining me on this case with Arthur. Uh, and we thank you all for listening, and keep treating your patients with atrial fibrillation, remembering that their risk is tied to their comorbidities, not to the duration or what you've done to their AFib.

Dr. Pokorney:

Great, thanks for having me.

Announcer:

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