Letters to the Editor

Quality of life in patients with oral anticoagulation therapy

Calidad de vida en pacientes con tratamiento anticoagulante oral

Dear Editor:

According to the work published by Marco et al., the creation of direct oral anticoagulants seems to be close to perfection. These new drugs offer new therapeutic possibilities that cannot be overlooked, calling for a paradigm shift in terms of oral anticoagulation, for a number of reasons (monitoring, interactions). All this might suggest that patients’ quality of life (QOL) would improve thanks to these new drugs, but we first need to know the QOL they have now with their current drugs.

We have conducted a cross-sectional study in order to establish the QOL regarding the oral anticoagulant treatment administered in the township of San Bartolome de las Abiertas (Toledo) (population = 512 inhabitants, year 2013). We have included all of the patients who are receiving treatment (n = 22) since there are no subjects affected by immobilization, serious diseases or cognitive impairment, and all of them agreed to participate. This study group has been matched by age, gender, and working capacity (active/retired) with a control group from the same population. In both groups, a record has been made to establish the number of drugs administered (excluding the oral anticoagulant treatment), their capacity according to the Barthel Index, and the QOL, following the EuroQol-5D questionnaire (EQ-5D) and its visual analogue scale (VAE), all managed by the same observer. In addition, the QOL of subjects for the study group pertaining to the oral anticoagulation treatment has been assessed according to the Sawicki Questionnaire for Patients Receiving Oral Anticoagulation Treatment (QPOA). The QPOA is a questionnaire consisting of 32 questions grouped into 5 levels (satisfaction, self-efficacy, stress, daily limitations and alterations in their social lives), with 6 possible answers in a scale of Likert (1 – 6). The value of each level is the measure of its constituent questions. The QPOA has been validated and adapted to Spanish. The questionnaire has been hetero-managed by a sole administrator. In addition to indicating the treatment, dicumarinic anticoagulation average doses and the last two-month period INR were measured.

Our 44 patients took oral dicumarinic anticoagulants (acencoumarol, presented in doses of 1 and 4 mg), their average age was 76 years (range 52–90), 59% of them were women (n = 26), the average drugs consumed were 6.4 (range 1–12), their average Barthel Index was 92.39 (range 35–100, average: 100), with a standardised average EQ-5D of 0.83 and an average VAE of 76.68 (range 62–90), without statistically significant differences (p > 0.05) in all its variables between the control group and study group. Subjects from the study group were administered weekly an average of 12.4 mg with a 2.58 standard INR (range 1.9–3.75). Only 2 patients were outside of the therapeutic range for the administration of anticoagulants. Anticoagulant treatment is most frequently indicated in patients suffering from atrial fibrillation (50%), followed by mitral valve disease with atrial fibrillation (31.8%). According to the QPOA, our patients were partially satisfied (2.51), with few limitations in their daily lives (2.72), and very few alterations in their social lives (1.51). They had a high self-efficacy or ability to be in control (4.03). Our results are in agreement with the results shown by other studies (Table 1).

Dicumarinic anticoagulants did not affect the patients’ QOL significantly, just as in other similar studies, despite the fact that their average age exceeded that of subjects in other studies, and

<table>
<thead>
<tr>
<th>Study</th>
<th>Age (years)</th>
<th>Sample</th>
<th>Satisfaction</th>
<th>Self-efficacy</th>
<th>Stress</th>
<th>Daily limitations</th>
<th>Social life alterations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criado-Alvarez, 2013</td>
<td>76.2 (9.1)</td>
<td>22</td>
<td>2.51 (0.48)</td>
<td>4.03 (0.86)</td>
<td>2.72 (0.69)</td>
<td>1.51 (0.62)</td>
<td>1.69 (0.33)</td>
</tr>
<tr>
<td>Davila Blazquez et al., 2012</td>
<td>69.0 (10.9)</td>
<td>50</td>
<td>2.78 (0.75)</td>
<td>4.43 (0.59)</td>
<td>3.45 (0.72)</td>
<td>2.51 (0.70)</td>
<td>2.05 (0.64)</td>
</tr>
<tr>
<td>Gonzalez Lopez et al., 2012</td>
<td>&gt;64: 71.7%</td>
<td>120</td>
<td>1.90 (0.80)</td>
<td>4.50 (1.10)</td>
<td>2.90 (1.00)</td>
<td>2.10 (0.90)</td>
<td>1.70 (0.80)</td>
</tr>
<tr>
<td>Yanes Baonza et al., 2005</td>
<td>65.0 (13)</td>
<td>225</td>
<td>5.50 (0.63)</td>
<td>4.83 (1.02)</td>
<td>2.47 (0.84)</td>
<td>1.77 (0.89)</td>
<td>1.34 (0.61)</td>
</tr>
<tr>
<td>Gadisseur et al., 2004</td>
<td>58.1</td>
<td>163</td>
<td>1.71 (0.64)</td>
<td>5.03 (0.88)</td>
<td>5.11 (0.91)</td>
<td>2.05 (0.81)</td>
<td>1.46 (0.62)</td>
</tr>
<tr>
<td>Sawicki, 1999</td>
<td>55.1 (11.9)</td>
<td>179</td>
<td>2.84 (1.41)</td>
<td>4.70 (0.98)</td>
<td>2.19 (1.04)</td>
<td>2.05 (0.75)</td>
<td>2.97 (1.11)</td>
</tr>
</tbody>
</table>

* Personal communication.

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2 Part of this work will be presented as an oral communication in the V Congreso Regional de Castilla-La Mancha de SEMERGEN (Talavera de la Reina, 7 and 8 March 2014).
that they were polymedicated patients taking 6.4 drugs (excluding dicumarinic anticoagulants). The fact that there was a control group and that the subjects from this group had an average QOL, measured according to the EQ-5D test or the Barthel index, that was similar in both groups, rules out the idea that our study sample had a worse QOL. One of the limitations of the study is its small sample size (n = 22), but it represents 100% of the population treated with oral anticoagulants, representing 4.3% of the population, or that 36% of patients are actively working (n = 8).

The patients who participated in this study benefitted from the agility and accessibility to the health system of their townships, with a good problem-solving rate, reflected by the patients’ good INR control, without waiting lists and with closer contact. In some cases, a change of treatment could be suggested, but in view of the results, it does not seem to be necessary due to the closely followed attention that patients receive and the awareness of therapeutic compliance generated by monitoring INR figures. Therefore, new oral anticoagulants may coexist with dicumarinic anticoagulants depending on the clinical and social situation of patients.

References


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Scleromyxedema with neurological symptoms: Successful treatment with immunoglobulins

Scleromyxedema asociado a síntomas neurológicos: tratamiento satisfactorio con immunoglobulinas

Dear Editor:

Scleromyxedema is a variant of the lichen myxedematous, quite infrequent, which appears as whistling papules or a widespread skin-coloured rash, with 1–3 mm diameter, related to skin thickening. It is frequently associated with extra cutaneous manifestations, out of which paraproteinemia type IgG λ is the most frequent. There is neurological deterioration in 10–15% of cases, without consensus on the most effective type of intervention for patients who present it.

We present the case of a 59-year-old female patient, with a 5-month history of developing erythematous-plaque-type injuries infiltrated in the face, upper third of the torso and upper extremities, with bilateral oedema of the hands (Fig. 1), significant consciousness deterioration, and aphasia and dysarthria 2 days before admission.

During the neurological assessment, the patient was awake, fully space-oriented but partially time-oriented, with bradypsychia and inattention. She followed simple commands, with preserved nomination and repetition, but significant ideomotor apraxia. The cranial pairs assessment did not show any significant alteration. The motor assessment showed symmetric bilateral postural fine tremor, without any additional alterations. Sensitivity was preserved, with no signs of brain deterioration or meningeal signs.

Her admission tests showed thyrotropin 1.24 uIU/ml (normal range 0.3–4.2), vitamin B levels 1280 pg/ml (normal range 200–900), normal cerebrospinal fluid (glucose 60 mg/dl, protein 42 mg/dl, leukocytes 3 mm 2 negative for oligoband cells, adenosine deaminase<3 U/l, negative cultures, antistreptolysin O 79.9 U/ml (normal <200), creatinine 0.53 mg/dl (normal 0.5–0.9), C-reactive protein 0.22 mg/dl (normal <0.5), haemogram and plasma electrolytes within normal ranges, negative rheumatoid factor, C3 and C4 complement components within normal ranges, negative antiphospholipid antibodies and anti-B2-glycoprotein 1. The brain MRI, electroencephalogram, and lumbar puncture did not show significant findings.

Scleromyxedema was suggested as a diagnostic hypothesis. A skin biopsy was performed, showing skin with normal orthokeratosis and epidermis. Dermis with fibrosis, mucin reserves, and band superficial dermis proliferation of fibroblasts. Superficial and deep perivascular mild lymphocytic infiltrate. Preserved annex structures. The immunohistochemical test with monoclonal antibodies showed a positive reaction for CD34 and a negative reaction for actin and CD10, confirming the suspected diagnosis of scleromyxedema. An intravenous methylprednisolone pulse treatment was started (500 mg for 2 days). The patient showed progress, with a decrease in skin injuries, but suffered an episode of convulsion, and qualitative consciousness deterioration. The test was completed with electromyography and protein immunofixation in blood and urine, showing the presence of the IgG λ mono-phosphatidylserine.