EDITORIAL

The state of oral anticoagulant therapy in patients with atrial fibrillation in Spain

La situación del tratamiento anticoagulante oral en pacientes con fibrilación auricular en España

Ischemic stroke in atrial fibrillation is common.\(^1\) Stroke prevention by anticoagulants is indicated for most patients with atrial fibrillation, i.e. those with a CHADS\(_2\)VASc score of 2 or more.\(^2\) Consideration should be given to also anticoagulate patients with only one stroke risk factor. This treatment is recommended by European guidelines and supported by good evidence.\(^4\)

Implementation of guidelines is not always optimal and sometimes poor.\(^5\) There are many factors that influence the decision for anticoagulant therapy,\(^6,7\) including patient information and education, healthcare and socio economic settings, demographics and patient comorbidities\(^8-10\) as well as factors driven by physician concerns.\(^11\)

In this issue of the Revista Clínica Española,\(^12\) analysis of 12514 Spanish patients enrolled into the REACT-AF study is reported. The authors report the use of anticoagulation by vitamin K antagonists or non-vitamin K antagonist oral anticoagulants with stroke risk, also considering bleeding risk. They also assessed risk for stroke based on smoking, alcohol consumption, duration of non-valvular AF, history of chronic renal impairment, concomitant drugs and type of antithrombotic therapy.

In this study 60% of all patients underwent treatment with VKA, with hypertension and diabetes as the most common risk factors of stroke. One-third were treated only with antiplatelet therapy. The majority of them were suitable for oral anticoagulation as per ESC guidance. 80% of the patients not receiving an anticoagulant could have benefitted from anticoagulation according to ESC guidelines. Around 1% only were on non-vitamin K antagonist therapy. Overall, the adequate use of oral anticoagulation for stroke prevention in AF patients is lower in the Spanish REACT-AF cohort than in other European cohorts such as the PREFER-AF with similar number of patients on antiplatelet agents but significantly higher number of patients on oral anticoagulants (80%) and novel agents (11%) (Especially Dabigatran)\(^11\) and in the EROP AF registry.\(^11\) The sample size and also the timing of the two registries might explain some of these differences.

Only around half of the patient population continuously adhered to their prescribed VKA treatment and only one-third renewed their prescriptions for VKA for the duration of treatment. Also a significant number of patients on anticoagulation stopped by two years and five years. The dosage monitoring of VKA could only be reliably assessed in a minute subset of all patients. Of those on VKA and with sufficient INR values available, only 1/5th were in the therapeutic range more than 70%, of the time. The time in therapeutic range across the whole subgroup was 55%. This TTR is in the range of other reports,\(^13\) and lower than the TTR found in large recent trials.\(^15\)

Was anticoagulation in the Spanish REACT-AF patients beneficial? The incidence of stroke was found to be 0.3/100 person-years in patients on VKA and 0.6/100 person-years in patients receiving antiplatelet therapy. The stroke incidence was considerably higher at 3.1/100 person-years in patients with no antithrombotic therapy. The incidence of bleeding including major GI bleeding was not different between patients treated with VKA and those on antiplatelet agents. Hemorrhagic strokes were halved in patients treated with VKA compared to antiplatelet and no therapy.

Only 1% of the patients were treated with non-vitamin K antagonist anticoagulants, less than that in other recent reports, reflecting a relatively slow uptake of NOAC therapy in Spain.\(^12\) This simple observation highlights that patient access to recently approved cardiovascular therapies is not equal across Europe. The reasons for such inequalities are multi-fold, but it raises a certain concern.

This study, like many others, is inherently prone to selection bias. In Spain they took data from the Cagedim database, which is populated by electronic records from 300 primary care physicians. Hence, enrolment was unbiased,
while information bias can play a role here, as it is dependant on the quality of data in the database.

In short, this study informs us of the state of anticoagulation therapy in AF patients in Spain highlighting underuse and suboptimal adherence to anticoagulation as areas where improvements may be possible. It also brings into attention a gap between ESC guidelines and clinical practice. This will help healthcare professionals in future treatment decisions and further underlines the importance of education and information of patients and health care professionals. Structured care pathways may be another means to improve the use of evidence-based therapies. AF patients in need for oral anticoagulation but not receiving VKA therapy may also benefit from the use of non-vitamin K antagonist anticoagulants. Patient information and education about the condition, adequate access to anticoagulation therapy, and possibly structured and nurse-led atrial fibrillation services may improve the management of patients with atrial fibrillation in Spain.

References


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