Use of Antithrombotic Therapy in Patients With Atrial Fibrillation in Primary Care. Importance of INR Control

Uso del tratamiento antitrombótico en pacientes con fibrilación auricular en atención primaria. Importancia del control del INR

To the Editor,

It was with great interest that we read the letter by Barrios et al[1] about the use of antithrombotic therapy by applying the CHA_2DS_2-VASc scale in patients with atrial fibrillation in primary care. Their objective was to determine whether there were any differences in the use of antithrombotic therapy, depending on whether the $CHADS_2$ or CHA_2DS_2-VASc scale was applied. To do this, they analyzed data from the VAL-FAAP study,[2] a registry constructed in primary care between September 2009 and May 2010. The authors affirm that antithrombotic therapy use is far from optimal, since they found that oral anticoagulants were used in 44.3% of patients with CHA_2DS_2-VASc 0 but not in 33.5% of patients with CHA_2DS_2-VASc ≥ 2 (ie, 66.5% received oral anticoagulation). They conclude that in Spain treatment to prevent thromboembolic complications is administered inadequately and is apparently prescribed independently of the risk stratification scale being used.

On the basis of the findings in the aforementioned letter,[1] we would ask the following questions: Can we consider that antithrombotic therapy use is "far from optimal" or "inadequate"? Can we determine that its use is "far from optimal" without taking account of International Normalized Ratio (INR) control? Currently, what is the role of the new anticoagulants that require no INR monitoring? In our opinion, the CHA_2DS_2-VASc scale should not have been used, nor should the European Society of Cardiology 2010 recommendations for oral anticoagulant use, since they were subsequent to the construction of the VAL-FAAP registry. Perhaps the results should be interpreted from a more positive perspective in the light of recent publications[3–5] showing clear improvements in the use of this treatment. Kirchhof et al[3] analyzed the management of atrial fibrillation in seven European countries, including Spain, between January 2012 and January 2013 (post–VAL-FAAP) and, in fact, found that 85.6% of patients with CHA_2DS_2-VASc ≥ 2 received oral anticoagulants, a far higher percentage than that reported in the VAL-FAAP study. Furthermore, they also found that 62.5% of patients with CHA_2DS_2-VASc 0 received oral anticoagulants and stressed that only 35% of patients treated with acenocoumarol had INR values within the therapeutic range in their last 3 determinations, which constitutes a high added risk of bleeding or thrombotic complications. Recently, Lip et al[4] have shown that 70.9% of patients with CHA_2DS_2-VASc ≥ 2 receive oral anticoagulants. They also reported that new anticoagulation agents were administered to 6.9% of all patients receiving anticoagulation therapy. Focussing on data from primary care in Spain, Lobos-Bejarano et al[5] found that 84.1% of all patients with atrial fibrillation received anticoagulation therapy. Of these,

68.8% had $CHADS_2$ ≥ 2 vs 31.2% with $CHADS_2$ ≤ 1. Of patients receiving oral anticoagulants, 66% had their last INR value within the therapeutic range.

These findings show a positive tendency in antithrombotic therapy use, although there remains room for improvement. They also help us reflect on what is most important in antithrombotic therapy. Clearly, correct indication is fundamental but we should never forget the importance of adequate INR control in these patients, since severe bleeding complications can be fatal. We are convinced that primary care can play a fundamental role in identifying patients with inadequate control of anticoagulation with vitamin K antagonists, in which case, we should consider using the new anticoagulants. Currently, these drugs are clearly underused, despite being much safer in terms of bleeding complications because they require no dose adjustment as a function of the patient's INR value and represent an important therapeutic advance.[4] We should remember that our final objective is to prevent complications in patients with atrial fibrillation, which is impossible with inadequate control.

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