



Azərbaycan
Kardiologiya
Cəmiyyəti




Ahıl və komorbid xəstələrdə AF




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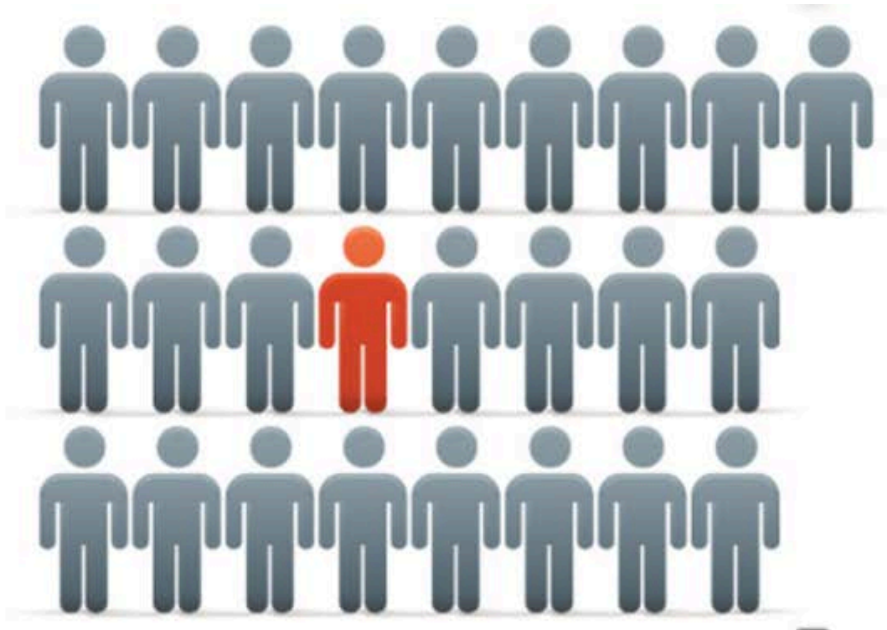
AF almost not comes alone
- demək olar ki, tək gəlmir ..

Lone AF does hardly exist in daily practice

Terminology that should be abandoned

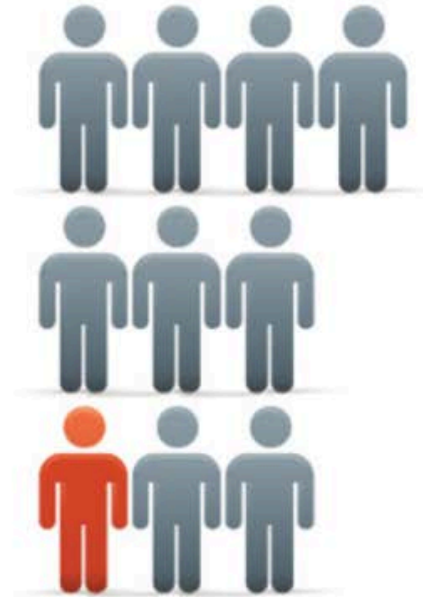
AF pattern	Definition
Lone AF	<p>A historical descriptor. Increasing knowledge about the pathophysiology of AF shows that in every patient a cause is present.</p> <p>Hence, this term is potentially confusing and should be abandoned.</p>

yaş - major risk faktorudur



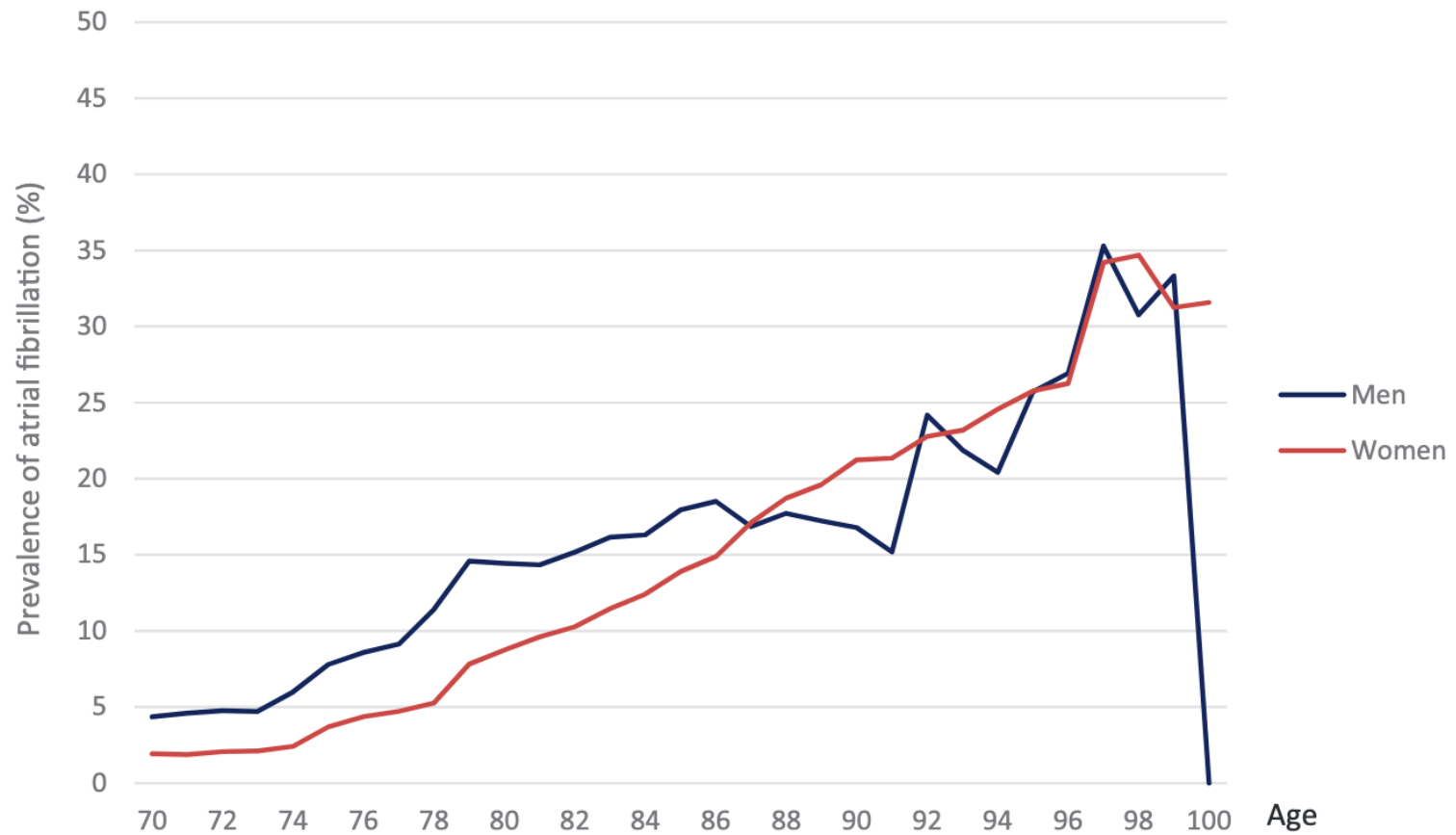
+ 60 yaş

25 nəfərdən 1



+ 80 yaş

10 nəfərdən 1



Age	70	75	80	85	90	95	100
Men	n = 1,356	n = 1,001	n = 658	n = 362	n = 143	n = 35	n = 3
Women	n = 1,195	n = 1,250	n = 1,065	n = 770	n = 405	n = 132	n = 19

Prevalence of atrial fibrillation at ages 70–100 years in three population-based cohorts of men and women.

Non-modifiable

Modifiable

- Advancing age
- Male gender
- Ethnicity
- Genetic background
- Height

Others

- Air pollution
- Non CV surgery

Vagal and adrenergic stimuli

- Psychosocial stress
- Alcohol
- Caffeine
- Drugs

Inflammation

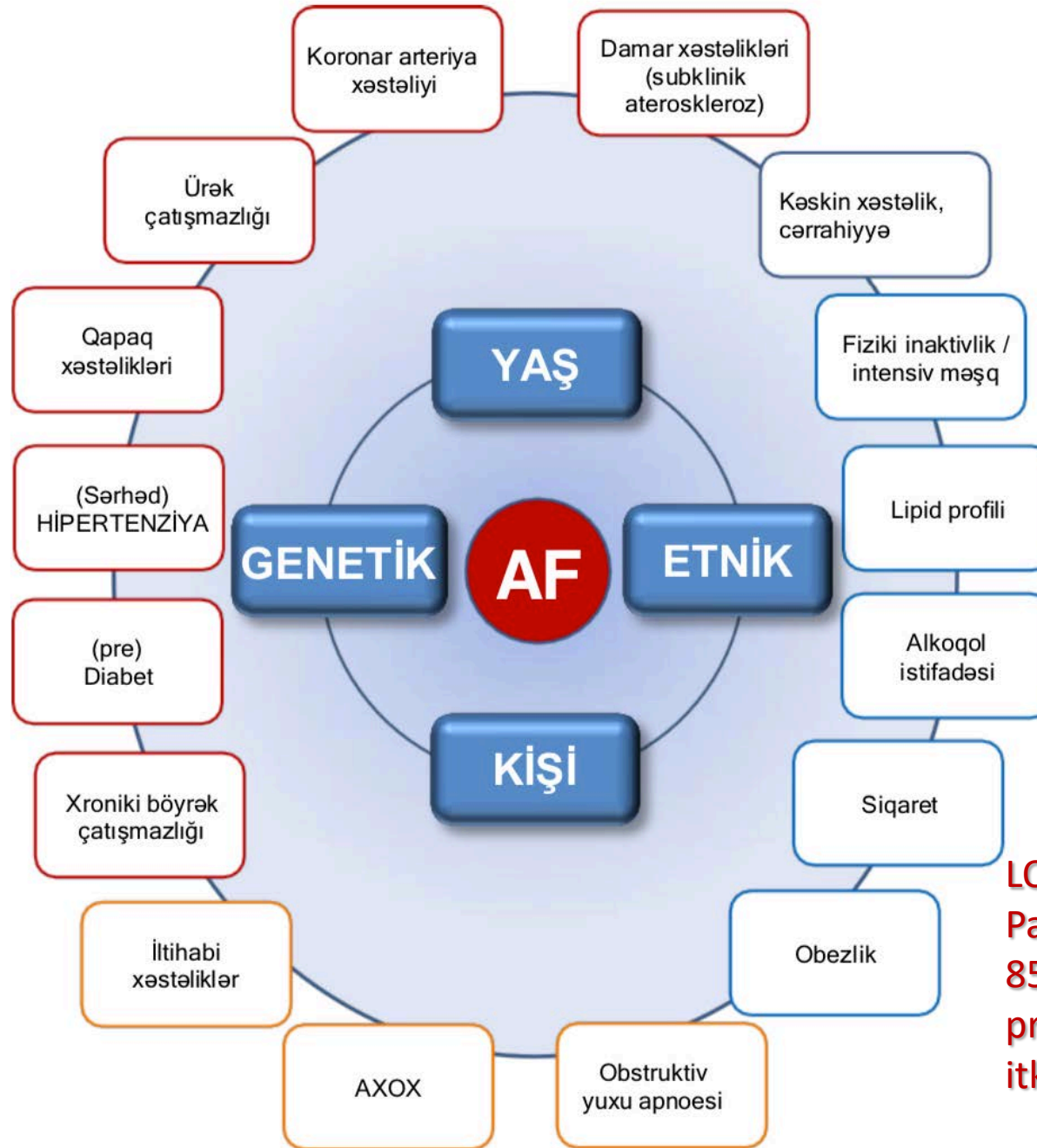
- Acute illness
- Sepsis
- Inflammatory diseases

Atrial stretch

- HFpEF and HFrEF
- Valvular disease
- Excessive exercise
- COPD
- Obstructive sleep apnea syndrome
- Hyperthyroidism

Endothelial dysfunction

- Coronary artery disease
- Hypertension
- High-normal blood pressure
- (Pre-) diabetes mellitus
- Obesity
- Physical inactivity
- Renal dysfunction
- Smoking



LOSE-AF [Weight Loss in Elderly Patients With AtrialFibrillation]) 60-85 yaş arası xəstələrdə ikincil profilaktika və AF yükü ilə bağlı çəki itkisinin faydalarını qiymətləndirir.

Primary and Secondary Prevention

- Opportunistic screening
- Weight loss efforts
- Physical activity
- Decrease alcohol intake
- Management of HTN and DM



Avoiding Adverse Drug Reactions

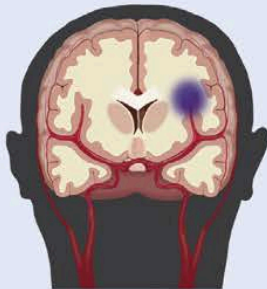
- Assistance of pharmacologists to assess drug-drug interactions and appropriate dosing
- Ensure serum digoxin concentration <1.2 ng/ml
- Syncope and falls/injuries are higher with use of AAD, especially amiodarone



Management of Older Patients with Atrial Fibrillation

Reduction of Stroke Risk

- Opportunistic screening?
- Use guideline-directed risk scores for stroke prevention and bleeding
- Avoid underprescribing of OAC



Reduction of Bleeding Risk

- Assessment of modifiable bleeding risk factors
- Occupational and physical therapists to identify ways to avoid falls
- Strength training and balancing is vital
- If patient needs DAPT and OAC, use DAPT for the shortest time necessary



Management of Atrial Fibrillation in Patients 75 Years and Older



JACC State-of-the-Art Review

Annabelle Santos Volgman, MD,^a Gatha Nair, MD,^a Radmila Lyubarova, MD,^b Faisal M. Merchant, MD,^c Pamela Mason,^d Anne B. Curtis, MD,^e Nanette K. Wenger, MD,^c Neelum T. Aggarwal, MD,^f James N. Kirkpatrick, MD,^g Emelia J. Benjamin, MD, ScM,^h on behalf of the ACC Geriatric Cardiology and Electrophysiology Councils

- **1990-2019-cu illərdə AF-prevelansı global miqyasda iki dəfə artaraq 2019-cu ildə 59,7 milyon nəfərə çatıb**
 - ➡ 65-74 yaş ilə Afli xəstələr insult riski baxımından 1 alırlar, yaşı ≥ 75 2 bal alırlar.
 - ➡ Yəni ≥ 65 bütün xəstələr insult üçün əlavə risk altındadır. Bir əlavə faktor olmadıqda belə, antikoagulyant terapiyanın başlanması vacibdir.
 - ✓ Dərman istifadəsi yaşlı xəstələrdə çətindir
 - ✓ Yaşlı pasientlər qanama riski yüksəkdir (kəllədaxili, mədə-bağırsaq və ya travmatik qanaxma) – antikoagulan müalicə bunu daha da aggreve edir

müalicədə - simptomların yaxşılaşdırılması və insult profilaktikası

Atrial fibrilasiya tromboembolik insultun ən mühüm səbəblərindən biridir və
işemik insultun tezliyi və nəticələri yaşla artır.

**AF-də insult riski - 5 dəfə artır və yaşlı yetkinlərdə AF- insultların təxminən 25%-dən
məsuldur.**

Digər tərəfdən, AF ilə bağlı işemik stoke AF ilə əlaqəli olmayan insultlardan 2 dəfə yüksək ölüm riskinə
malikdir; nevrolojik ağırlaşma daha çox rast gəlinir.

➡ HAS-BLED qanama risk skoru istifadə edilir

➡ > 3 bal alırsa, qanama baxımından yüksək risk qrupunda olub, bu da antikoagulan müalicə istifadə gərəksinimini ortadan qaldırma, doz əyarı edilməlidir, düzəldilə bilən faktorlar düzəlməlidir.

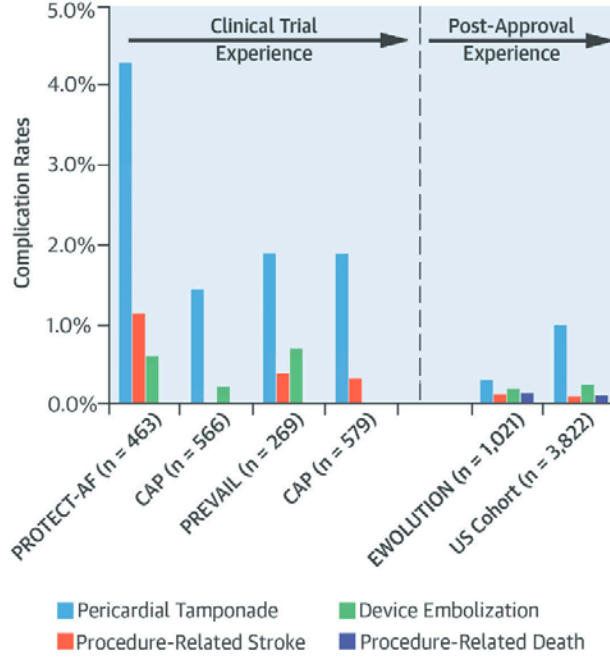
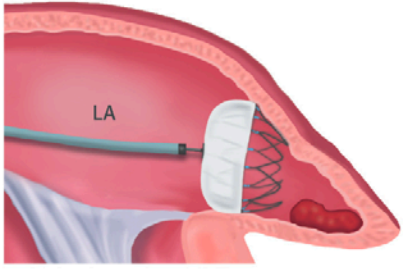
➡ NOACların warfarine üstünlükləri - yaşlı xəstələrdə daha da vaciblik qazanır,

➡ Klinik tədqiqatlarda belə INR təqiblər ilə warfarin'in təsiri müalicə limitləri içərisində tutulma
başarısı - %58–68 nisbətindədir

➡ Yaşlı xəstələrdə warfarin'in farmakokinetik və farmakodinamik xüsusiyyətləri daha da qarışıq
olub, yüksəlmiş INR səviyyələrinin normala dönməsi də zaman alır

➡ Yaşlıların istifadə etdiyi dərman miqdarı çox olduğu üçün dərmanların öz aralarında təsirlənməsi
qanama riskini daha da artırır, NOAClarda bu qarşılıqlı təsirlənmə daha azdır

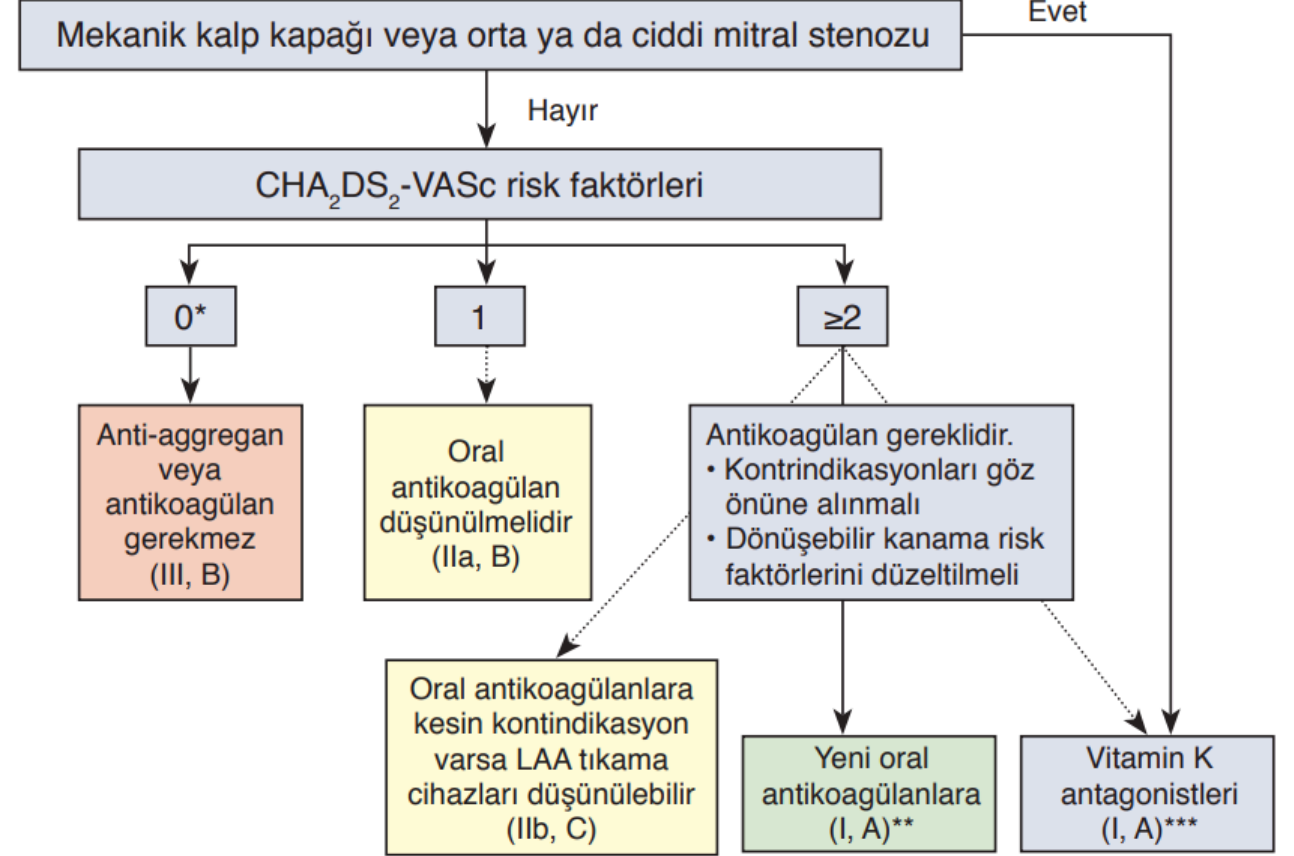
Major Complication Rates Across Watchman Clinical Studies



Procedural Parameters	Aggregate Clinical Data
Number of Procedures	6,720
Implantation Success, %	94.9%
Complication Rates	
Pericardial Tamponade	1.24%
Procedure-Related Stroke	0.18%
Device Embolization	0.25%
Procedure-Related Death	0.06%

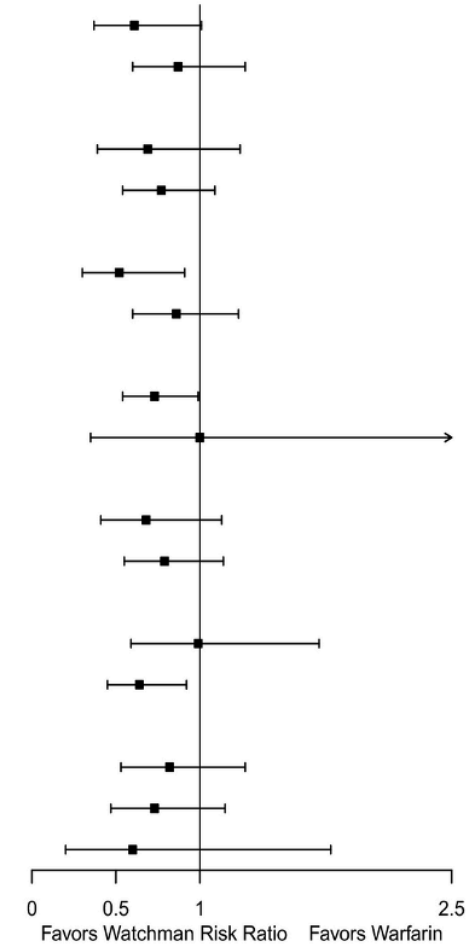
Reddy, V.Y. et al. J Am Coll Cardiol. 2017;69(3):253-61.

(Top left) Placement of the Watchman device to sequester the left atrial appendage from the systemic circulation. (Bottom left) Table summarizing the aggregate procedural parameter outcomes and complication rates after combining the >6,000 patients receiving the device in the FDA clinical trials (PROTECT-AF, PREVAIL, CAP, and CAP2) and the post-approval studies (EWOLUTION and the present post-FDA approval U.S. cohort). (Right) Graph comparing the complication rates of the 4 major procedure-related complications (pericardial tamponade, procedure-related stroke, device embolization, and procedure-related death) across the various Watchman clinical studies. CAP = Continued Access to PROTECT-AF; CAP2 = Continued Access to PREVAIL; EWOLUTION = Registry on Watchman Outcomes in Real-Life Utilization; FDA = U.S. Food and Drug Administration; PREVAIL = Prospective Randomized Evaluation of the Watchman LAA Closure Device in Patients With Atrial Fibrillation Versus Long Term Warfarin Therapy; PROTECT-AF = Watchman Left Atrial Appendage System for Embolic PROTECTION in Patients With Atrial Fibrillation.



*: Diğer risk faktörleri olmadan kadınları da kapsar. **: İlave stroke risk faktörü olmayan kadınlarda IIa, B. ***: Mekanik kalp kapağı veya mitral stenozu olanlarda I, B.

Subgroup	Patients	Watchman Events (%)	Warfarin Events (%)	ARR (95% CI)	P
Age < 75	592	2.49	4.07	1.58 (0.05, 3.20)	0.04
Age >= 75	522	6.16	7.06	0.90 (-1.47, 3.28)	0.46
Females	332	3.81	5.50	1.69 (-0.91, 4.29)	0.18
Males	782	4.24	5.53	1.30 (-0.38, 2.97)	0.12
Prior stroke or TIA	252	4.68	8.92	4.25 (0.58, 7.91)	0.02
No stroke or TIA	862	3.91	4.57	0.66 (-0.81, 2.14)	0.38
Hypertension	1007	3.99	5.48	1.49 (0.04, 2.95)	0.04
No hypertension	107	5.10	5.10	0.00 (-5.12, 5.13)	1.00
Heart failure	285	5.59	8.29	2.69 (-0.79, 6.17)	0.12
No heart failure	829	3.62	4.59	0.96 (-0.52, 2.44)	0.20
Diabetes	317	5.33	5.38	0.05 (-2.63, 2.73)	0.97
No diabetes	797	3.59	5.59	2.00 (0.35, 3.65)	0.01
CHADS2 = 1-2	715	3.12	3.82	0.70 (-0.77, 2.18)	0.34
CHADS2 = 3-4	342	5.96	8.15	2.19 (-0.90, 5.28)	0.16
CHADS2 = 5-6	56	6.72	11.27	4.55 (-4.41, 13.51)	0.30



Vivek Y. Reddy. Journal of the American Heart Association. Net Clinical Benefit of Left Atrial Appendage Closure Versus Warfarin in Patients With Atrial Fibrillation: A Pooled Analysis of the Randomized PROTECT-AF and PREVAIL Studies, Volume: 8, Issue: 23, DOI: (10.1161/JAHA.119.013525)

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Risk factors for ICH

Modifiable

- (Uncontrolled) hypertension
- Low LDL/triglycerides
- Excessive alcohol consumption
- Current smoking
- Concomitant antiplatelet drugs
- Anticoagulant therapy
- Sympathomimetic drugs (cocaine, heroin, amphetamine, ephedrine, etc.)

Non-modifiable

- Older age
- Male sex
- Asian ethnicity
- Chronic kidney disease
- Cerebral disease:
 - ♦ Cerebral amyloid angiopathy
 - ♦ Small vessel disease

(Re)institution of OAC: Decision-making post ICH in patients with AF

Consider risk factors for recurrent ICH

Address modifiable bleeding risk factors

Weight the risks and benefits of OAC (re)institution
in consultation with neurologist/stroke specialist

OAC use (with/without cerebral disease):
(observational data, RCTs are ongoing)

- Significant decrease in stroke and mortality
- Comparable risk for recurrent ICH vs. OAC non-use

OAC
Class IIa,
LoE C

2–4 weeks
after ICH

Irreversible cause of
ICH, non-modifiable
risk factors, etc.

**LAA
occlusion**
Class IIb, LoE B

No stroke
prevention
therapy

RCTs are ongoing

Additional considerations:

- No reversible/treatable cause of ICH
- ICH during OAC interruption
- ICH on adequate or underdosed OAC
- The need for concomitant antiplatelet therapy (e.g., ACS/PCI)

CMB on cerebral imaging:

- The risk of ICH increases with the presence and increasing CMB burden, but
- Regardless of CMB presence, burden and distribution, the absolute risk of ischaemic stroke is consistently substantially higher than that of ICH in post-stroke/ TIA patients

≥10 CMBs:
64 IS vs. 27 ICH events/1000 person-years
>20 CMBs:
73 IS vs. 39 ICH events/1000 person-years

ritm kontrolu/sürət kontrolu

- Yaşlılarda kardioversiya müvəqqəti faktorlar mövcuduğunda düşünülə bilər - (post-operatif AF gibi)
- Yaşlılarda proaritmi başda olmaqla - anti-aritmik dərman toksikiliyi riski və digər dərmanlarla təsirlənmə nisbəti yüksəkdir
- Ritm kontrolü strategiyası – antikogulan vacibliyini ortadan qaldırmır
- AFFIRM tədqiqatında insultların çoxu antikoagulan stoplanınca ortaya çıxır

ritm kontrolü/sürat kontrolü

Tablo 3. Atriyal fibrilasyonda hız kontrolü ile ritim kontrolünü karşılaştıran randomize çalışmalar

Çalışma	Hasta sayısı	Takip süresi	Sinüs ritimi sağlanan hastalar	İnme/Emboli		Mortalite	
				Hız kontrolü grubu	Ritim kontrolü grubu	Hız kontrolü grubu	Ritim kontrolü grubu
AFFIRM ^[32]	4060	3.5 yıl	%35 ve %63	88/2027 (%4)	93/2033 (%5)	310/2027 (%15)	56/2033 (%3)
RACE ^[33]	522	2.3 yıl	%10 ve %39	7/256 (%3)	16/266 (%6)	18/258 (%7)	18/266 (%7)
PIAF ^[34]	252	1 yıl	%10 ve %56	0/125	2/127 (%2)	2/125 (%2)	2/127 (%2)
STAF ^[35]	200	1.6 yıl	%11 ve %26	2/200 (%1)	5/100 (% 5)	8/100 (%8)	4/100 (%4)
HOT-CAFE ^[36]	205	1.7 yıl	Ritm kontrol grubunda %64	1/101 (%1)	1/101 (%1)	1/101 (%1)	3/104 (%3)

Recommendations for Rate Control

- ▶ Control ventricular rate with Beta-Blocker or Non-Dihydropyridine Calcium Channel Antagonist for AF
- ▶ A heart rate control (resting heart rate < 80 bpm) strategy is reasonable for symptomatic management in AF
- ▶ A lenient rate-control strategy (resting heart rate < 110bpm) maybe reasonable when patient asymptomatic & LV systolic function preserved
- ▶ Non-Dihydropyridine Calcium Channel Antagonists should NOT be used in decompensated HF

Yaşlılarda böyrək funksiyaları, komorbidliyə görə digər dərmanlardan istifadə ehtiyacı və dərmanların farmakodinamik və farmakokinetik xüsusiyyətlərinin dəyişməsi, bradikardiya diqqət etmək lazımdır, istirahət sürətinin 110/dəq civarında tutulması kifayətdir.

➡ AV node ablasiyası və pacemaker implantasiyası- ideal dozalarda maddəciklərin sürətini aşağı salan dərmanların kombinasiyasına baxmayaraq, sürətin idarə edilməsinə nail olmaq mümkün deyilsə və ya dərmana qarşı dözümsüzlük varsa

- **AV node ablasiyası ilə ritmə nəzarət və ya daimi kardiostimulyator implantasiyası,**
- AV node ablasiyası permanent Afli yaşlı xəstələrdə bir seçim kimi görünür, çünki bir çox xəstələrdə çoxlu dərman qəbulu problemdir,
- **AF olan xəstələrdə də xəstə sinus sindromu (bradikardiya-taxikardiya sindromu) varsa, bu qərarı qəbul etmək daha asandır. Xüsusilə sol mədəciyin sistolik funksiyası pozulmuş xəstələrdə AV ablasiyondan sonra tək kameralı pacing əvəzinə biventrikulyar pacing həyat keyfiyyətini, sol mədəciyin funksiyasını və ürək çatışmazlığı əlamətlərini daha dramatik şəkildə yaxşılaşdırır.**

ritm kontrolu/sürət kontolu

- ➡ Yaşlı xəstələrdə -böyrək funksiyaları, müşayiət olunan xəstəliklərlə əlaqədar digər dərmanlardan istifadə ehtiyacı, dərman vasitələrinin (amiodaron, dofetilid) farmakodinamik və farmakokinetik xüsusiyyətlərinin dəyişməsi nəzərə alınmaqla doza dəyişiklikləri aparılmalıdır.
- ➡ Ancaq onsuz da daha ciddi yan təsirləri olan antiaritmik dərmanların istifadəsi yaşlılarda daha çox çətinlik yaradır. Kateter ablasyonu da ilk seçim ola bilər, antiaritmik dərman müalicəsi əvəzinə xəstə ilə bütün variantları müzakirə edir.

ritm kontrolu/sürət kontolu

- ➡ Tək bir mərkəzin dəyərləndirilməsində, 80 yaşdan aşağı 717 xəstə ilə 80 yaşdan yuxarı 35 xəstənin ablasiya nəticələri qarşılaşdırılmış, 1 ilin sonunda sinus ritmində qalma nisbəti daha yaşlı qrupda %78 ikən, daha gənc qrupda %75 olmuşdur ($p=0.78$). İşləm ağırlaşması - bənzər olub, amma xəstəxana yatışı yaşlılarda daha uzun olmuşdur (2.9 ± 7.7 və 2.1 ± 1.1 gün, $p=0.001$).
- ➡ 5 illik təqibdə AF nüxsü yaşlı qrupda daha yüksək olmuşdur.

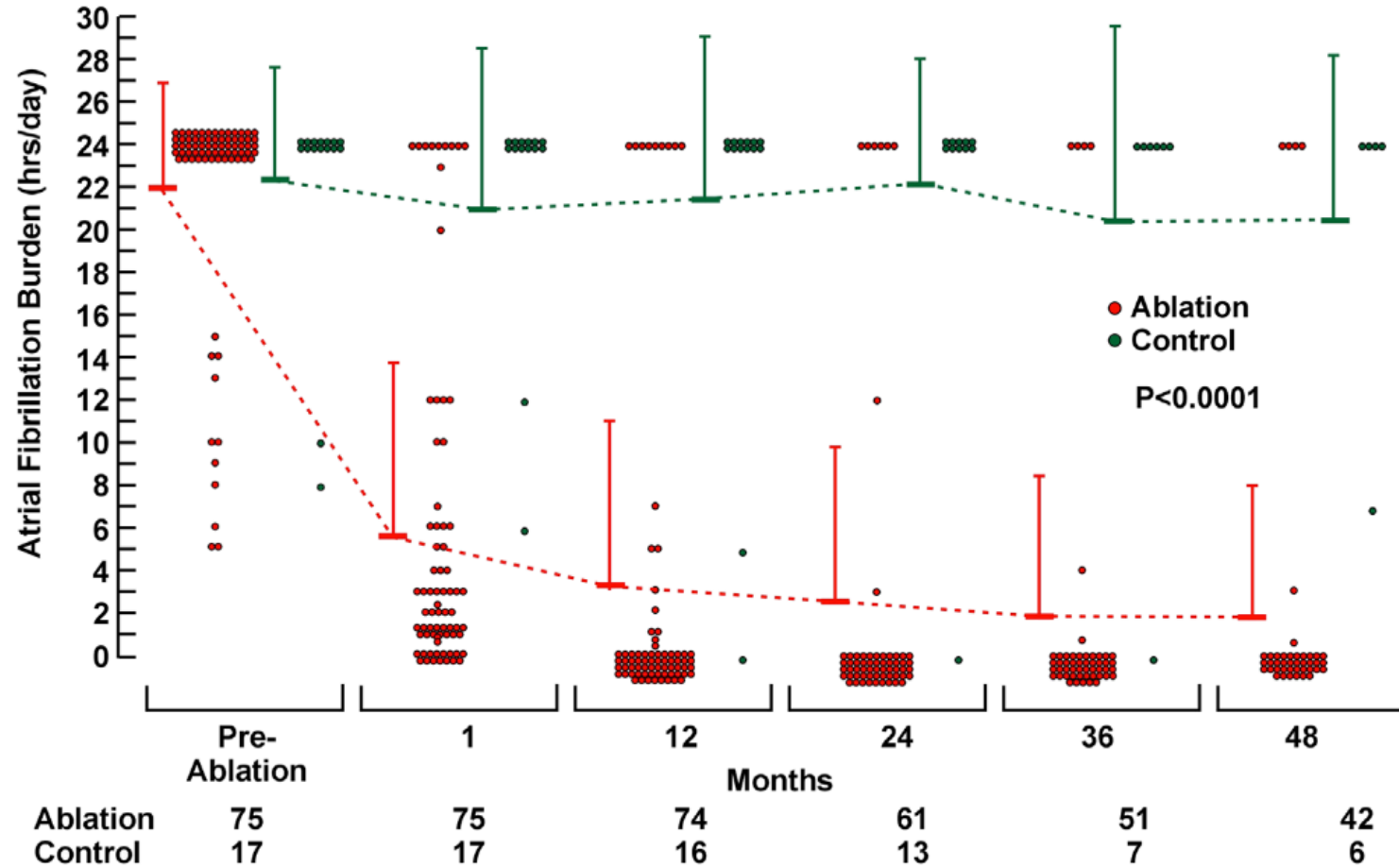
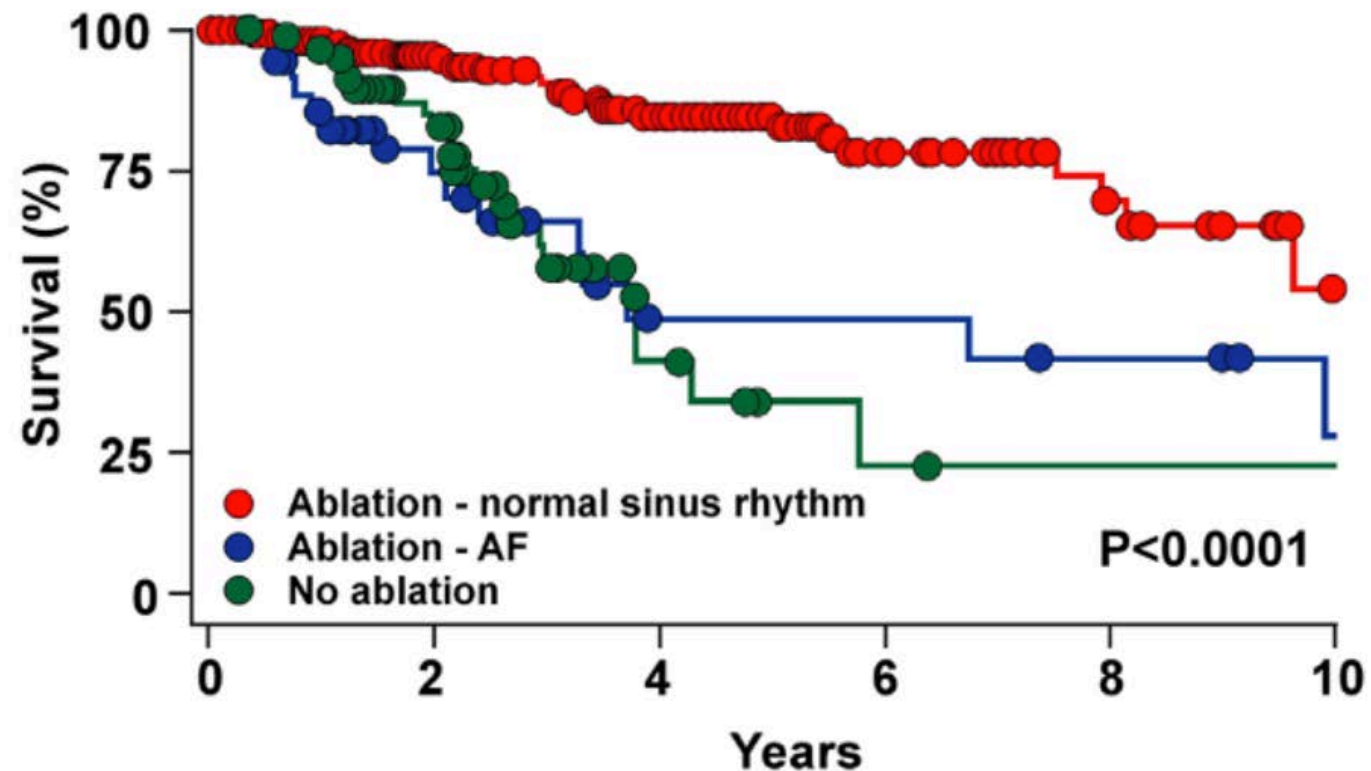


Figure 1 Comparison of 4-year atrial tachycardia/atrial fibrillation (AT/AF) burden between group 1 and group 2 patients with an implantable device. *circle* represents AT/AF burden of individual patients at a given time point. *Red* indicates group 1; *green* indicates group 2.



	0	2	4	6	8	10
# Left	216	117	69	33	15	4
in	45	18	7	7	7	5
Study	63	37	7	2	1	1

Figure 2 Kaplan–Meier curve demonstrating improved survival in patients who remained in sinus rhythm after atrial fibrillation (AF) ablation from all-cause mortality compared to patients who remained in AF fibrillation after ablation and patients who did not undergo catheter ablation.

antikoagulanlar

Table 4. 2019 American Geriatrics Society Beers Criteria[®] for Potentially Inappropriate Medications: Drugs To Be Used With Caution in Older Adults^a

Drug(s)	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation
Dabigatran Rivaroxaban ** Apixiban is preferred	Increased risk of gastrointestinal bleeding compared with warfarin and reported rates with other direct oral anticoagulants when used for long-term treatment of VTE or atrial fibrillation in adults ≥ 75 years.	Use with caution for treatment of VTE or atrial fibrillation in adults ≥ 75 years	Moderate	Strong

antikoagulanlar

TABLE 2 Dosage Adjustment for Direct-Acting Oral Anticoagulants for Prevention of Stroke With Atrial Fibrillation for Age and Other Factors According to the United States, Canadian, and European Recommendations

	Apixaban	Dabigatran	Edoxaban	Rivaroxaban
U.S. Food and Drug Administration				
Standard dose	5 mg twice daily	150 mg twice daily ^a	60 mg once daily (CrCl >50 and ≤95 mL/min)	20 mg once daily (with meal)
Reduced dose	2.5 mg twice daily	75 mg twice daily	30 mg once daily	15 mg once daily (with meal)
	if 2 of 3 criteria present: age ≥80, body weight ≤60 kg or sCr ≥1.5 mg/dL (133 μmol/L) or concomitant use of strong combined P-gp/CYP3A inhibitors (eg, ketoconazole, itraconazole, ritonavir).	CrCl 15-30 mL/min, or CrCl 30-50 and concomitant use of strong combined P-gp/CYP3A inhibitors (eg, ketoconazole, itraconazole, ritonavir) or with dronedarone. CrCl <15, no dose recommendation	CrCl 15-50 mL/min	CrCl 15-49 mL/min or concomitant use of strong combined P-gp/ CYP3A inhibitors (eg, ketoconazole, itraconazole, ritonavir).
Health Canada				
Standard dose	5 mg twice daily	150 mg twice daily ^{b,c}	60 mg once daily	20 mg once daily ^b
Reduced dose	2.5 mg twice daily	110 mg twice daily ^{b,c}	30 mg once daily	15 mg once daily ^b
	if 2 of 3 criteria present: age ≥80; body weight ≤60 kg; or sCr ≥1.5 mg/dL (133 μmol/L) or concomitant use of strong combined P-gp/ CYP3A inhibitors (eg, ketoconazole, itraconazole, ritonavir).	Age ≥80 years; At higher risk of bleeding, (including age ≥75 years with ≥1 risk factor for bleeding)	CrCl 30-50 mL/min; body weight ≤60 kg; or concomitant use of strong combined P-gp/CYP3A inhibitors (eg, ketoconazole, itraconazole, ritonavir).	CrCl 30-49 mL/min
European Medicines Agency				
Standard dose	5 mg twice daily	150 mg twice daily ^b	60 mg once daily ^d	20 mg once daily
Reduced dose	2.5 mg twice daily	110 mg twice daily ^b	30 mg once daily	15 mg once daily
	if 2 of 3 criteria present: age ≥80; body weight ≤60 kg; or sCr ≥1.5 mg/dL (133 μmol/L) or CrCl 15-29 mL/min	Age ≥80 years; increased bleeding risk; concomitant use of verapamil	CrCl 15-50 mL/min, or body weight ≤60 kg, or concomitant use of strong combined P-gp/ CYP3A inhibitors or dronedarone (eg, ketoconazole, itraconazole, ritonavir).	CrCl 15-49 mL/min

Note: additional drug interactions may require dose adjustments and appropriate labels should be accessed as additional considerations for reduced doses may be listed. ^a110 mg is not approved for use in atrial fibrillation in the United States but the formulation is available for use in venous thromboembolism. ^bContraindicated in combination with dronedarone or strong combined P-gp/CYP3A inhibitor. ^cContraindicated if CrCl <30 mL/min. ^dDo not use if CrCl >95 mL/min. Note: The authors acknowledge Dr Janice Schwartz for providing assistance with this table.

CrCl = creatinine clearance; sCr = serum creatinine; P-gp/CYP3A = P-glycoprotein/cytochrome P450 3A4/5.



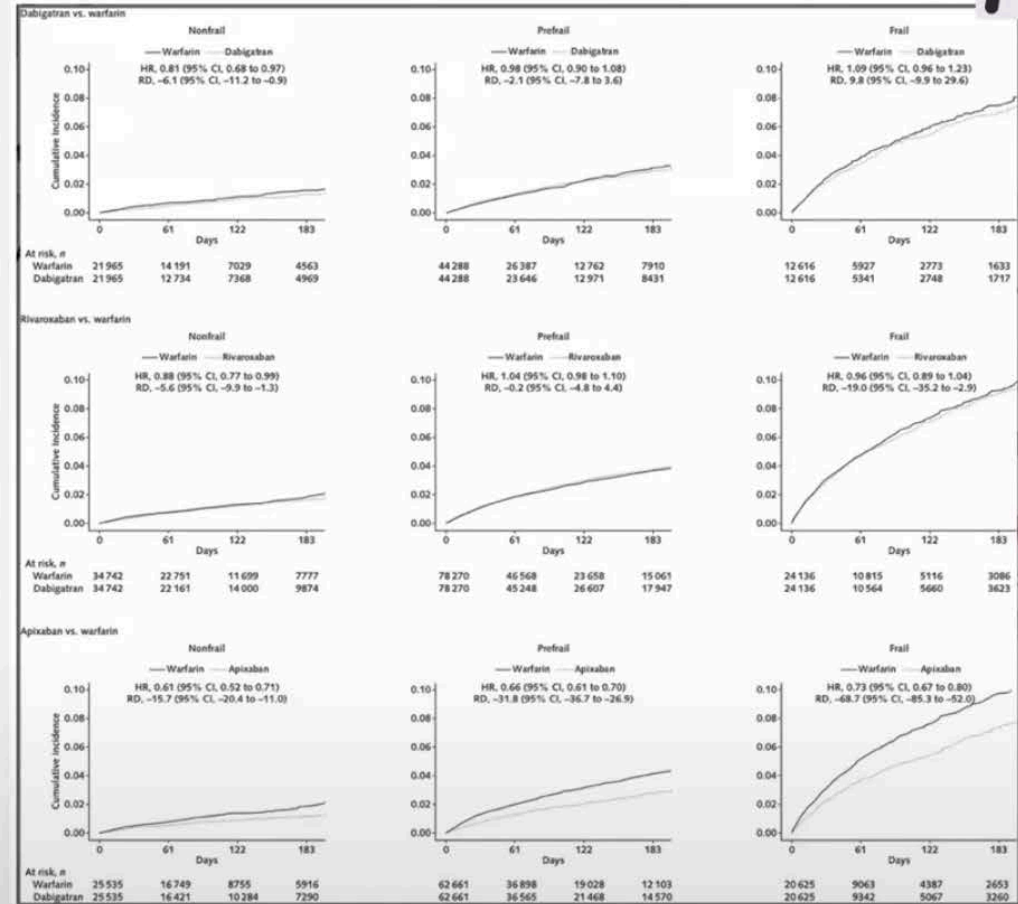
əldən düşmüşlük (frailty) və OAC

- Frailty – a state of increased vulnerability to physiologic stressors related to a decline in physiologic reserve
 - A reflection of biological age rather than chronological age
 - Increasing awareness of frailty over past decade and its association with adverse outcomes (disability, morbidity, mortality)
- Older adults with AF 4x more likely to be frail than older adults without AF
- Frailty relevant in AF, as it is a commonly cited reason for OAC under-prescription



OAC & FRAILTY

- Post hoc analysis of ENGAGE AF-TIMI 48 - 20% frail (cumulative deficits)
 - Risk of stroke and major bleeding increased with every 0.1 increase in frailty index
 - Edoxaban efficacy & safety unaffected by frailty, with lower risk of bleeding than warfarin in all **EXCEPT** those with severe frailty
- Cohort study investigating incidence of all-cause death, ischemic stroke and major bleeding by OAC in Medicare patients with AF
 - Apixaban reduced 1° endpoint - ALL FRAILTY levels
 - Dabigatran & Rivaroxaban only in non-frail





OAC & FRAILTY

- Overall frailty is a marker of increased risk – increased risk of stroke, bleeding & mortality
- Apixaban and Edoxaban have evidence of retained efficacy and safety in frailty
- Caution use of DOAC in advanced/severe frailty - due to ↑ risk of bleeding and competing mortality risks in this group





OAC & MULTIMORBIDITY

- Multimorbidity (MM) defined as 2 or more chronic medical conditions
- Associated with poor health outcomes
- UK Biobank study - AF pts with ≥ 4 comorbidities have 6-fold higher risk of mortality
- Research and clinical practice guidelines exclude those with MM, making extrapolation to real world pts difficult
- GWTG-AF registry used to assess MM in AF – found higher MM burden associated with lower odds of OAC prescription



OAC & MULTIMORBIDITY

- Post-hoc analysis of ARISTOTLE on multimorbidity

- Stroke/SE, death and major bleeding all increased with MM
- Efficacy and safety of Apixaban preserved, even in highest MM group

- Post-hoc analysis of ENGAGE-AF-TIMI 48 on multimorbidity

- Charlson comorbidity index ≥ 4 had increased stroke/SE, bleeding and mortality
- Efficacy and safety of Edoxaban preserved, independent of degree of MM



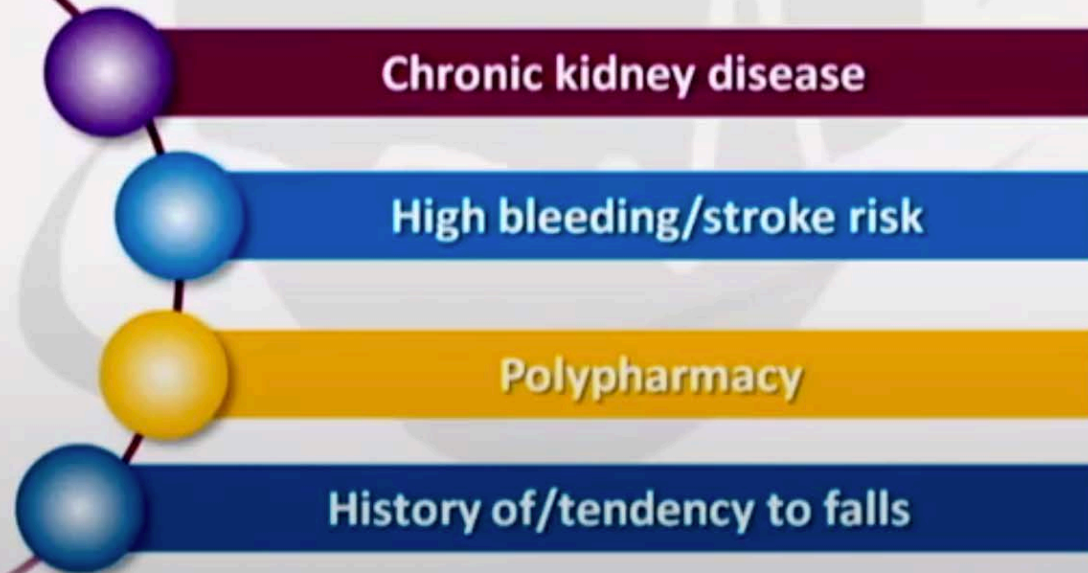
OAC & FALLS

- Risk of fall increases with age; ~1 in 3 adults ≥ 65 yrs and nearly 50% of those ≥ 80 yrs suffer from at least 1 fall annually
- Falls NOT a contraindication to OAC; fall risk should be assessed and modified
 - Deprescribing fall-increasing drugs, hearing or visual aids, OT home safety assessment, mobility aid, balance-improving exercises
- Falls on OAC predispose to ICH, however absolute risk of ICH with fall generally lower than risk of stroke in most older adults with AF
 - DOACs associated with lower risk of ICH (inc. traumatic)

Elderly patients with AF in clinical practice have a high proportion of comorbidities

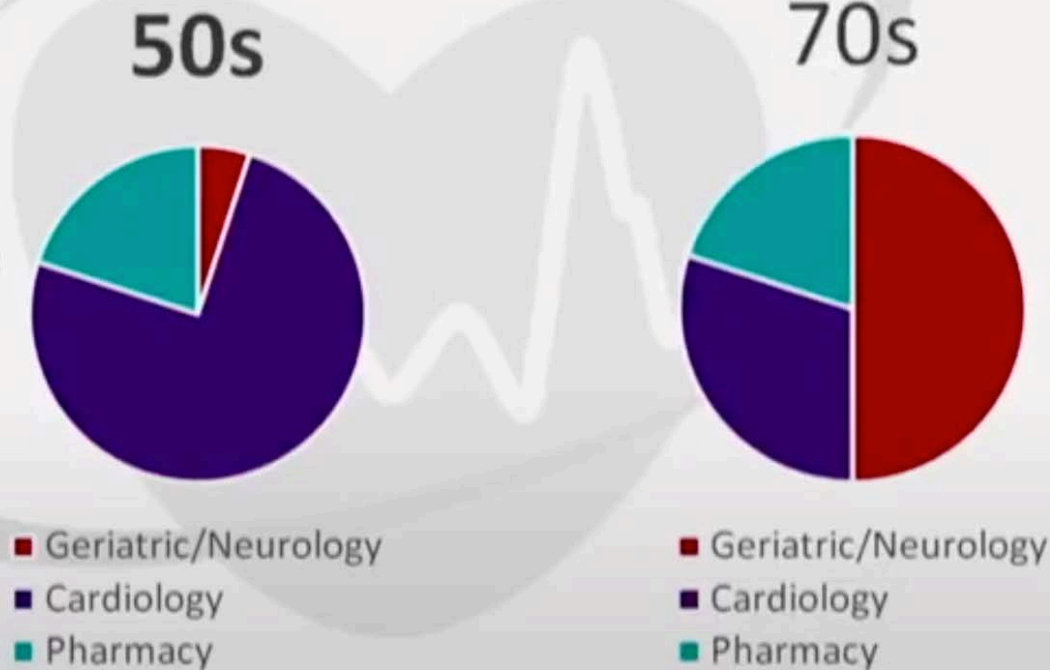
Elderly AF patients often present with multiple comorbidities^{1,2} and are less likely to be treated with oral anticoagulation due to their perceived frailty and higher risk of bleeding³

- Comorbidities/clinical conditions of concern in the elderly population include:^{1,2}



As our AF patients evolve –An Interdisciplinary Approach Needed !

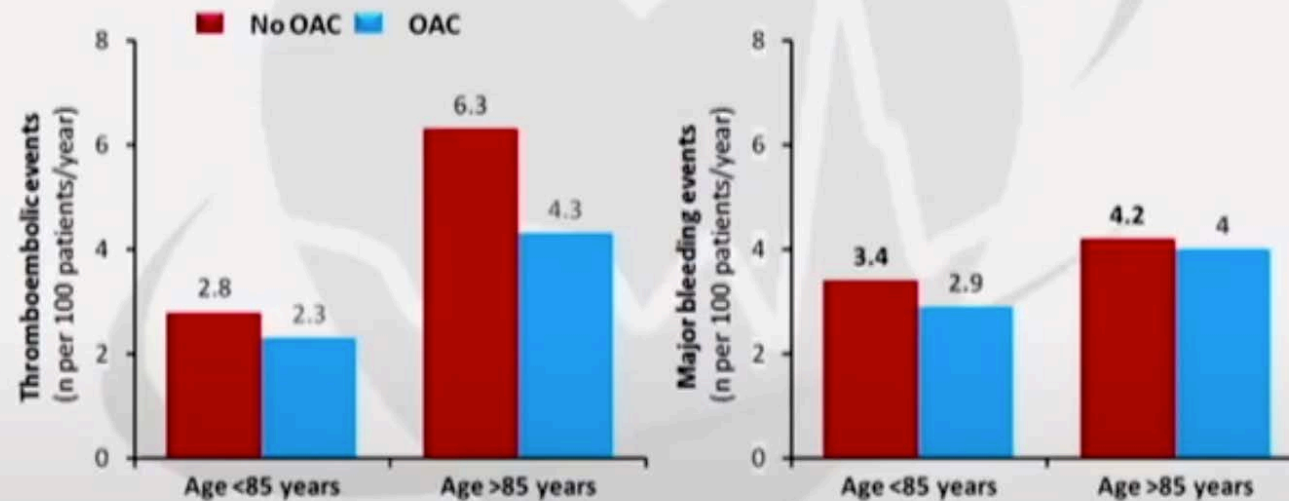
- **Renal function**
- **Weight**
- **Co-morbidities**
- **Falls**
- **Frailty**



And clinical nutrition

Risk of stroke increased with age more than risk of bleeding; absolute benefit of OAC was highest in very elderly patients

PREFER in AF registry (n=6,412): Age-related outcomes in patients years receiving OAC or no OAC (antiplatelet therapy only or no antithrombotic drug)¹



1. Patti G, et al. J Am Heart Assoc 2017;6 pii e005857. DOI: 10.1161/JAHA.117.005857;
2. Ansell J. J Am Heart Assoc 2017;6 pii: e006864. DOI: 10.1161/JAHA.117.006864.

evə götürüləcək mesaj

Opportunistic screening for AF is successful in detecting asymptomatic, but treatment outcome studies are needed.

Secondary prevention of AF is effective and should be encouraged, such as weight loss, decrease or eliminate alcohol intake, tobacco cessation, optimal control of hypertension, and diabetes.

Mortality difference in rate vs rhythm control is not well established, but syncope and fall-related injuries were higher with AADs, especially amiodarone.

Mortality may be increased in patients with digoxin with SDC >1.2 ng/mL.

The most common reason for the nonprescription of OACs in those with ≥ 6 comorbidities was frequent falls/frailty. Modeling data suggests that the risk of falls should rarely be a contraindication to anticoagulation.

Underutilization and inappropriate dosing occur more commonly in older-age patients.

Catheter ablation may not be as beneficial over antiarrhythmic drug therapy for rhythm control in patients aged ≥ 75 y in randomized controlled trials.

Renal impairment and the use of VKA, but not age ≥ 75 y, were associated with bleeding.

LAO in patients aged ≥ 75 y may be safe, but further studies are needed to establish safety and efficacy.

It has not yet been established whether anticoagulation (novel anticoagulants compared to warfarin) can decrease cognitive decline; a large randomized controlled trial is underway.

A shared decision-making approach is crucial in the management of AF in older adults.