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Case: Diagnosis & Initial Evaluation of a Patient with Atrial Fibrillation

Announcer Open:
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Dr. Alexander:
Hi, I'm John Alexander, a Professor of Medicine and Cardiology at Duke Health. And today I'm here to talk about the diagnosis and initial evaluation of a patient with atrial fibrillation.

This is our case. She's a 78-year-old woman with hypertension, HFpEF, coronary artery disease, and aortic stenosis. She had a PCI in 2020 and TAVR in 2022. She weighs 64 kg. She's had fluttering in her chest intermittently for 6 weeks. Her heart rate is 126 and irregular. Her blood pressure's 150/70. Her EKG shows atrial fibrillation. Her creatine is 1.3 mg/dL, and her creatinine clearance is 36 mL/minute. Her current medications are aspirin, clopidogrel, Losartan, carvedilol furosemide, and atorvastatin.

So first, let's talk about her thromboembolic risk using the CHADS-VASc score. On the right side of this slide, you can see with her history of heart failure, hypertension, age over 75, vascular disease, and being female, her CHADS-VASc score is 6, which translates to a stroke risk of around 20% a year.

Her options for thromboembolism prophylaxis include aspirin or warfarin with an INR 2 to 3, or one of the DOACs, apixaban 5 mg twice a day, dabigatran 150 mg twice a day, the reduced dose of edoxaban of 30 mg once a day based on a reduced creatinine clearance, or the reduced dose of rivaroxaban 15 mg a day based on her reduced creatinine clearance.

She has a number of modifiable risk factors for bleeding which are important to consider whenever we're starting an oral anticoagulant. Potential modifiable risk factors for bleeding include hypertension, concomitant antiplatelet therapy, NSAIDs, excessive alcohol use, non-adherence to oral anticoagulants, bridging therapy with heparin, poorly controlled warfarin, and then importantly, the choice and dosing of the oral anticoagulant. In her case, hypertension, antiplatelet therapy, and DOAC choice and dosing are relevant.

Related to her antiplatelet therapy, the current ESC guidelines recommend stopping aspirin and clopidogrel if patients are more than a year out from either an acute coronary syndrome or percutaneous intervention.

So, back to the case. First, we would start apixaban 5 mg twice a day. Apixaban has a nice stroke reduction and bleeding profile that fits this patient well, it will reduce her annual risk of stroke from 20 to around 6% per year. Apixaban 5 mg twice a day is preferred over 2.5 mg twice a day, as she does not have two out of the three dose reduction criteria. We would stop her clopidogrel and aspirin to reduce her risk of bleeding with really no known harm, as she's more than a year out from her percutaneous intervention.

And then we would address a number of other AF management issues, including adequate rate control with beta blockers or calcium channel blockers, better blood pressure control which will reduce your stroke and bleeding risk with a goal blood pressure of less than 130/80, cardioversion after 3 to 4 weeks of oral anticoagulation or sooner with the support of transesophageal echocardiography. And then if she has recurrent atrial fibrillation, we would consider rhythm control strategies with anti-arrhythmic drug therapy or atrial

fibrillation ablation. Now importantly, even if she has returned to and maintains sinus rhythm, she remains at increased risk of stroke and so should stay on oral anticoagulant thromboembolism prophylaxis, probably lifelong.

Thank you very much for joining us today.

Announcer Close:
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