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Latest Guidance on Anticoagulation in Special AF Patient Populations

Announcer:
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Dr. Pokorney:
I'm Sean Pokorney, an electrophysiologist and Assistant Professor of Medicine at Duke University. Thanks so much for joining me to discuss the latest guidance on anticoagulation in special atrial fibrillation patient populations.

I think that one of the important populations to discuss is the population with obesity and concomitant atrial fibrillation. We certainly know that obesity is a strong risk factor for atrial fibrillation and that as your body mass index increases, the chances of having atrial fibrillation also increase along with that, both for men and for women. One of the key factors around obesity as it relates to atrial fibrillation is the fact that there are so many comorbidities that exist between obesity and atrial fibrillation. And those include things like heart failure, as well as sleep apnea, in particular. And we know from good data, that treatment of sleep apnea also does reduce the rates of atrial fibrillation. And so, some of these other comorbidities exist in combination with obesity. Hypertension, you know, is another one that should be included in that as well.

We know that treatment of obesity can be helpful both for the primary and secondary prevention of atrial fibrillation. And so, lifestyle modification is a key way that we manage our patients with atrial fibrillation. Again, there's good data looking at reduction in body mass index and weight loss after ablation, demonstrating a reduction in recurrence of atrial fibrillation when patients are able to achieve weight loss. And that's really related to both these comorbidities, the factors around sleep apnea, hypertension, heart failure, as well as the just concomitant atrial myopathy that exists in patients with atrial fibrillation.

When we think about specifically anticoagulation in patients with obesity that have concomitant atrial fibrillation, you know, it's another topic that's really important to talk through. The ISTH guidelines from 2016 had originally recommended that warfarin be used for patients with body mass indexes greater than or equal to 40. And that was because there's less data on that patient population. However, when you look across the clinical trials, the clinical trials of the factor Xa inhibitors as well as with dabigatran, you see that the meta-analysis data really shows that even in patients with these significantly elevated body mass indexes, those patients still tend to benefit from the DOACs more than they do from warfarin. Again, they have similar rates of bleeding, similar rates of stroke with DOAC relative to warfarin. And so, those benefits of the DOACs are really preserved, even in this overweight population.

I will say that when you get to body weights greater than 140 kg, those patients are not well studied. Even in the clinical trials, they're not well represented. The population that really the AHA/ACC guidelines expands to is really this population that's greater than 120 kg up to the 140-kg cut-off where we do have strong meta-analysis data. But again, the benefits of DOACs remain consistent for that population relative to warfarin.

When we think about patients that have had bariatric surgery, many patients now that have obesity may have had bariatric surgery. And the guidelines say that it's reasonable to choose warfarin over the DOACs because of concerns of drug absorption. I'll say that in my

clinical practice, I routinely use DOACs in this patient population, and I think it's reasonable to use the DOACs, but again, the guidelines do specifically mention that it's reasonable to use warfarin.

Another population that's of interest beyond the obese population is patients with kidney disease. And patients with chronic kidney disease and atrial fibrillation are also quite common. And some of the challenges around selecting anticoagulants can be complex in this patient population. And I would say that again, there's really a class 1 recommendation to use the DOACs in patients with CKD stage 3. There's a 2a indication to use the DOACs over warfarin in CKD stage 4. And as well, it's reasonable to use the DOACs, particularly apixaban, even in patients with end-stage renal disease on hemodialysis.

The final population to maybe talk about is the population with liver disease. And so, patients with mild or moderate liver disease are patients that it's reasonable to use a DOAC in. Patients that have moderate liver disease or severe liver disease with concomitant atrial fibrillation, those patients we should not use rivaroxaban.

So again, thanks so much for joining on this conversation around the special populations with atrial fibrillation. I hope that you enjoyed the discussion.

Announcer:
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