Abstract: P2542

Adherence to the 2016-2018 ESC guidelines for stroke prevention in atrial fibrillation: an Italian field practice in a cohort of geriatric patients.

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Background: the 2016 and 2018 ESC guidelines for stroke prevention in atrial fibrillation (AF) recommend the use of non-vitamin K antagonist oral anticoagulants (NOACs) in all AF patients except for the EHRA type 1, for which remains the indication to vitamin K antagonist oral anticoagulants (VKAs).

Purpose: to evaluate the adherence to the ESC guidelines in the management of anticoagulant therapy (OAC) in the prevention of cardioembolism in geriatric (age = 65) AF patients at 3 medical-geriatric inpatient wards of the Sant’Orsola Hospital in Bologna (Emilia Romagna region, Italy).

Methods: Between April 1st and October 1st 2018, 138 consecutive AF inpatients were prospectively enrolled at the start or at the change or at the interruption of the OAC.

Results: the main characteristics of the cohort were: mean age 84,6 years (range 65-102), M/F = 64/74, mean Charlson score 4,4, mean ADL/IADL 3,45/2,01 and mean CHA2DS2VASC/ HAS-BLED scores 5/3. Thirty-eight percent (N=52) of patients needed walking aids. Polypharmacy (intake of = 5 drugs) was present in 31,9% (N=44) of patients and anemia in 50% (N=69: acute 6,5%, chronic 34,8%, mixed 8,7%).

Half of the patients (N=69) presented new onset AF.

Only 68% of patients (N=47) with known AF (N=69) were in OAC (37,6% in VKAs and 30,4% in NOACs).

At the admission, the mean INR of AF in VKAs was 3,53 (range 1,54-10).

The hospital decision on the anticoagulation in 91 patients (22 with known AF not in OAC at home, and 69 with new-onset AF), defined as "naïve" to OAC, was evaluated: 26,3% (N=24) started NOACs, 45% (N=41)VKA, 8,7% (N= 8) anticoagulant low molecular weight heparin (EBPM), and 20% (N=18) didn’t start OAC. The decision was supported by consultant cardiologists and/or angiologists in 72,5% of cases (N=66).

The choice of the VKAs was mainly due to chronic kidney disease (CKD) and acute kidney failure. Patients who started NOACs were significantly younger than those who started VKAs (age: 78,2 vs 86,5; p < 0.001) and had a better preserved renal function (Cockroft-Gault GFR: 69,6 vs 48,1 ml/min; p < 0.001). However, the mean GFR of VKAs patients was clearly above the lower limit set by the guidelines.

The main causes of the switching between NOACs and VKAs (N=14, 10,1%) were stroke-TIA occurrence (N=7, 57,1%) and CKD (N=4, 28,5%).

OAC was definitively interrupted (N=31, 22,4%) mostly for severe clinical conditions (N=16, 51,6%) and anemia (N=7, 22,5%).

Probably it's worth to question if the current guidelines provide reliable indications regarding the safety and manageability of the NOACs in the presence of the most common geriatric syndromes.
Conclusions: in this "real life" cohort the deviation from the ESC guidelines was 52%. According to the guidelines only 11 (26,8%) of the patients who started VKAs would have been excluded from treatment with NOACs. Our experience underlines the presence of "fear" in the use of NOACs in geriatric patients, in particular with CKD.

Probably it’s worth to question if the current guidelines provide reliable indications regarding the safety and manageability of the NOACs in the presence of the most common geriatric syndromes.