

Oral Anticoagulants for Atrial Fibrillation: Benefits Outweigh Risks for Older Adults

By Christine Kilgore

Atrial fibrillation (AF) causes one in seven strokes overall, and one in four strokes in people over the age of 80, according to the National Institutes of Health — which makes stroke prevention a pillar of AF management. Yet oral anticoagulation (OAC), which reduces the risk of stroke by one-half to two-thirds in people with AF, is underutilized in the assisted living and long-term care population.

“People are always worried about falls and bleeding [from OAC], but it’s really the ischemic strokes, from clots, that cause the most damage — in physical function, in cognitive function, and in quality of life,” said Midge Bowers, DNP, FNP-BC, an associate professor at Duke University who practices at the Duke Cardiology Clinic and treats long-term care residents. “The impact of strokes in older adults is so profound,” she said in an interview. “One in three nursing home residents who have AF have already had a stroke.”

The most recent guidelines on AF from the cardiovascular community — the 2020 AF guidelines from the European Society of Cardiology (*Eur Heart J* 2020;ehaa612) — contain a section on the elderly and frail with AF. Dr. Bowers noted, in which it’s stated that “frailty, comorbidities, and increased risk of falls do not outweigh the benefits of OAC given the small absolute risk of bleeding in anticoagulated elderly patients.” Evidence from randomized controlled trials, meta-analyses, and large registries supports the use of OAC in the frail and elderly with AF, and the newer novel oral anticoagulants (NOACs) appear to have a better overall risk–benefit profile compared with warfarin, the guidelines say.

Meenakshi Patel, MD, CMD, similarly implored her audience at the 2020 Virtual Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine to “have informed discussions with residents and families” about anticoagulation. “Falls and age are not absolute contraindications to oral anticoagulants,” she stressed at the conference. Research has shown that a high risk of falling increases the risk of intracranial hemorrhage (ICH) by almost twofold, but studies also show “there is no difference in that risk of intracranial hemorrhage whether you’re on warfarin, aspirin, or no antithrombotic therapy ... that’s the caveat.”

For “most patients with frequent falls, including injurious falls, the benefits of anticoagulation outweigh the risks of bleeding,” said Dr. Patel, a practicing geriatrician at Valley Medical Primary Care in Centerville, OH, and assistant professor of geriatrics at Wright State University Boonshoft School of Medicine in Dayton.

In an American College of Cardiology 2016 registry study of more than 210,000 AF patients at moderate–high risk for stroke, almost 40% were treated with aspirin alone without OAC (*Am Coll Cardiol* 2016;67:2913–2923). The findings are disheartening, Dr. Patel said, because antiplatelet therapy is recommended as an option only for those at low risk of stroke.

Dr. Bowers found the findings from a LTC study published in 2020 just as frustrating. Almost 10% of 44,373 long-stay residents with AF had OAC discontinued — most often in association with a recent fall, and other times in association with severe activity of daily living dependency and other geriatric conditions (*J Am Geriatr Soc* 2020;68:717–724). Notably, she said, the CHA₂DS₂-VASc stroke risk score (congestive heart failure, hypertension, age ≥75 years, diabetes mellitus, stroke, or transient ischemic attack, vascular disease, age 65–74 years, sex category) was not predictive of discontinuation. (The specific anticoagulant used in the study was not known.)

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Newer Anticoagulants

The CHA₂DS₂-VASc scoring system — which is recommended for stroke risk assessment and anticoagulation decision-making by the European Society of Cardiology and the American Heart Association/American College of Cardiology/Heart Rhythm Society guidelines on AF — puts almost all older residents into moderate-risk or high-risk categories by virtue of their age and gender alone.

It advises OAC for individuals who have a score of 2 or more, or a prior stroke/transient ischemic attack. An age of 75 or older earns 2 points, as does an age of 65–74 plus female gender. Still, using this tool in combination with a structured bleeding-risk assessment tool — such as HAS-BLED (Hypertension, Abnormal renal/liver function, Stroke, Bleeding history or predisposition, Labile international normalized ratio, Elderly [>65 years], Drugs/alcohol concomitantly) — can be very helpful for decision-making that takes into account the risks and benefits, said Drs. Patel and Bowers.

“Anticoagulation really isn’t a cardiology decision — we need to be going over the pros and cons and

making these decisions with patients and their families,” said Dr. Patel in an interview after the Society’s conference. “It’s a discussion that needs to happen.”

NOACs (also called direct oral anticoagulants) carry less risk of ICH compared with warfarin, and they do not require regular monitoring. “Almost all [NOACs] can be used in patients with reduced creatinine clearance, and they’re better than warfarin for stroke or systemic embolism risk, regardless of creatinine clearance or age,” Dr. Patel said at the meeting. “And now there are reversal agents for all these drugs.”

Jonathan Shaatal, MS, RPH, FASCP, director of pharmacy for the Four Seasons Nursing and Rehabilitation Center in Brooklyn, NY, and the founder of a pharmacy consulting practice, told *Caring* that fluctuating international normalized ratios (INRs) in patients on warfarin signal a possible opportunity for switching to a NOAC. “Once we see that the INR is around 2.5, in the lower end of the therapeutic range, we can stop the warfarin and start the NOAC,” he said. He noted that the newer blood thinners are now considered standard therapy by pharmaceutical benefit companies.

NOACs decrease the risk of ICH but increase the risk of gastrointestinal bleeding compared with warfarin, Mr. Shaatal noted. “It’s a matter of asking which one is the lesser of two evils.” Rate control with beta-blockers and sometimes calcium channel blockers is the other main pillar of AF management in the elderly, he said. (Rhythm control is challenging, with antiarrhythmic drugs unlikely

to maintain sinus rhythm in the older patient.)

Good rate control is essential for optimal functional status and participation in activities and therapies, Dr. Bowers said. “Look for subtle signs of worsening AF — breathlessness with either rest or activities, for instance, or more fatigue,” she said. And “continue to treat other conditions that may potentiate AF. By treating the hypertension, the sleep apnea, and the diabetes, you may actually help in controlling AF or reducing episodes.”

Future Changes

Dr. Bowers and Dr. Patel are both watching for insights into the role that OAC may play in the prevention of cognitive impairment. Thus far, research (largely observational studies) has suggested that OAC can reduce or protect against cognitive impairment in patients with AF. “A couple of studies suggest that the NOACs can do a better job,” Dr. Patel said at the meeting. Randomized controlled trials of OAC with cognitive function as an end point are underway.

The potential for screening for silent AF with mobile or wearable devices — as well as detecting suboptimally managed AF — has been gaining attention in the cardiology community and is of huge interest for long-term care, they said. “Often we don’t see AF until there’s an event,” Dr. Patel said. “I think that with smart watches [and other digital technology], we’re finding out there’s a lot going on [asymptomatically].”

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care system as a whole and, depending on Medicare Part A status or other reimbursement issues, often directly to the facility.

Obviously, the regimen is a painful one for residents, who suffer for no benefit and may be placed at risk of dangerous episodes of hypoglycemia. Few clinicians consider the massive time commitment that these needless glucose measurements represent for the nursing staff. Residents must be brought to their rooms while where a licensed nurse — using equipment that must undergo routine quality determinations with controls — then must perform and document the determinations. The nurse must then safely dispose of the lancets and other blood-contaminated supplies. All this represents from five minutes to 20 unpleasant minutes per day per

diabetic resident. Many hours of valuable nursing time are wasted.

Federal requirements list relatively few mandatory roles for the medical director. One of these is to advise the facility regarding care practices, and another is to participate in the Quality Assurance Performance Improvement process. Your desire to lead improvements in documentation and medication utilization are central to your role. As with nearly everything else in long-term care, it will be a process rather than instantaneous change and will be more effective with the collaboration of an interdisciplinary team. But, in the end, you have the potential to lead meaningful change.

Dr. Nichols is past president of the New York Medical Directors Association.