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Editorial

Challenges in the Anticoagulation of Patients with Atrial Fibrillation

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Atrial Fibrillation (AF) is a major and growing concern in the world and its prevalence of AF increases with age. The prevalence of AF in elderly increases. In this scenario, by 2050, the number of elderly people is estimated to triple, increasing the risks of stroke by about 5 times in patients with AF. It is associated with a 2x increased risk of CV death within 1 year of observation.

According to the World Health Organization [WHO], 17.9 million people die because of CVD worldwide, accounting for 31% of all global deaths; of these, 85% of CVD deaths are due to heart attacks and strokes.

In this universe of patients, we face difficulties of diagnosis, inappropriate medical conduct, failures in patient care, adherence to anticoagulant therapy due to lack of knowledge of the risks and benefits of this treatment, and also an inadequate follow-up.

When addressing this treatment gap, it is crucial to raise awareness about the impact of AF and its related events on the individual, his social and family life, as well as on health systems and governments. The occurrence of a cerebral thromboembolic event compromises not only the individual but also all levels connected to him/her, with a significant social and economic damage.

We must promote actions in various spheres of government that promote equal access of the population to health services, hierarchical with clear and precise information, referral and counter-referral flows that allow not only to develop and implement strategies for early diagnosis of AF, as well as adequate anticoagulant treatment.

It is known that medical education must be optimized, clarifying doubts, and emphasizing the importance of appropriate anticoagulation, its impact on the life of the patient and family, and providing data from the literature that corroborate the anticoagulation safely and effectively.

Scores such as the CHA2DS2VASc and HAS BLED should be explained and routinely used by professionals indicating which patients are eligible for prophylactic full anticoagulation, and which ones with higher bleeding risk, which we should pay more attention to.

Despite being inexpensive, anticoagulation with warfarin has the disadvantages of a delayed onset and termination of action, a variable response with dose, a narrow therapeutic window, extensive interaction with medications and diet, as well as inconvenient INR control.

The European Society of Cardiology in 2016 reinforces that in those patients with risk factors for stroke, monotherapy with antiplatelet agents (aspirin) is not recommended, regardless of the risk of stroke (class II, harmful level d evidence A and B).

Robust studies for anticoagulation in patients with AF such as ARISTOLE (apixaban), RELY (dabigatran), ROKET AF (rivaroxaban) and ENGAGE AF (edoxaban) demonstrates their efficacy and safety in anticoagulation compared to warfarin, with lower hemorrhagic risk in the elderly population, including intracranial hemorrhage.

We must, however, consider the indications and contraindications for its use, individualize our conduct, i.e., for a given patient, consider the most appropriate anticoagulation and explain why he is being anticoagulated and its risks [1-10].

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