DWAC Bristol CCG

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Declaration of Conflict of Interests

Dr Jim Moore FRCP Edin
GP and GPwSI in Cardiology, Cheltenham

West of England Academic Health Science Network Clinical lead for DWAC project
DWAC Bristol CCG Clinical Champion
NICE Guideline Committee member -Chronic Heart Failure
National Heart Failure Audit Steering group
Alliance for Heart failure Steering Group
Chair of the GLOS CCG Circulatory Clinical Programme Group

In the last year Honoraria received from Bayer for various activities including attending and participating in educational events and advisory boards

Antithrombotic therapy in AF and co-existing vascular disease

The optimal strategy to balance the risk of bleeding events and recurrent ischaemic events in people needing antiplatelets and anticoagulants is subject to debate as

- Specifically designed and powered studies to guide management are not available.
- The choice of therapy and its duration is individualised, based on atherothrombotic risk, cardioembolic risk, and bleeding risk
- Dual antiplatelet therapy reduces the risk of ischaemic cardiac events
- Anticoagulants reduce the risk of AF related thrombotic stroke
- The combination of dual-antiplatelet therapy plus anticoagulant increases the risk of bleeding events by about **2-4 times** compared to anticoagulant or aspirin alone

Antithrombotic therapy in AF and co-existing vascular disease

- Routine use of prasugrel and ticagrelor in combination with a NOAC is not recommended due to the increased risk of major bleeding.
- The period of dual antiplatelet therapy plus anticoagulant should be as short as possible(1-6 months) followed by single antiplatelet therapy plus anticoagulant for up to 12 months then lifelong anticoagulant alone.
- Where a NOAC is used with an antiplatelet, the lower tested effective dose to reduce the risk of stroke may be considered.
- Gastroprotection with a proton pump inhibitor should be considered in all patients on any combination of antiplatelets and anticoagulants.
- **Patients with stable coronary artery disease (defined by European guidelines as no acute ischaemic events or PCI/stent procedure in the preceding 12 months) and concurrent AF can be managed with anticoagulation alone in almost all cases.**

ESC 2014

European Heart Journal Advance Access published August 25, 2014

European Heart Journal
doi:10.1093/eurheartj/ehu298

CURRENT OPINION

Management of antithrombotic therapy in atrial fibrillation patients presenting with acute coronary syndrome and/or undergoing percutaneous coronary or valve interventions: a joint consensus document of the European Society of Cardiology Working Group on Thrombosis, European Heart Rhythm Association (EHRA), European Association of Percutaneous Cardiovascular Interventions (EAPCI) and European Association of Acute Cardiac Care (ACCA) endorsed by the Heart Rhythm Society (HRS) and Asia-Pacific Heart Rhythm Society (APHRS)

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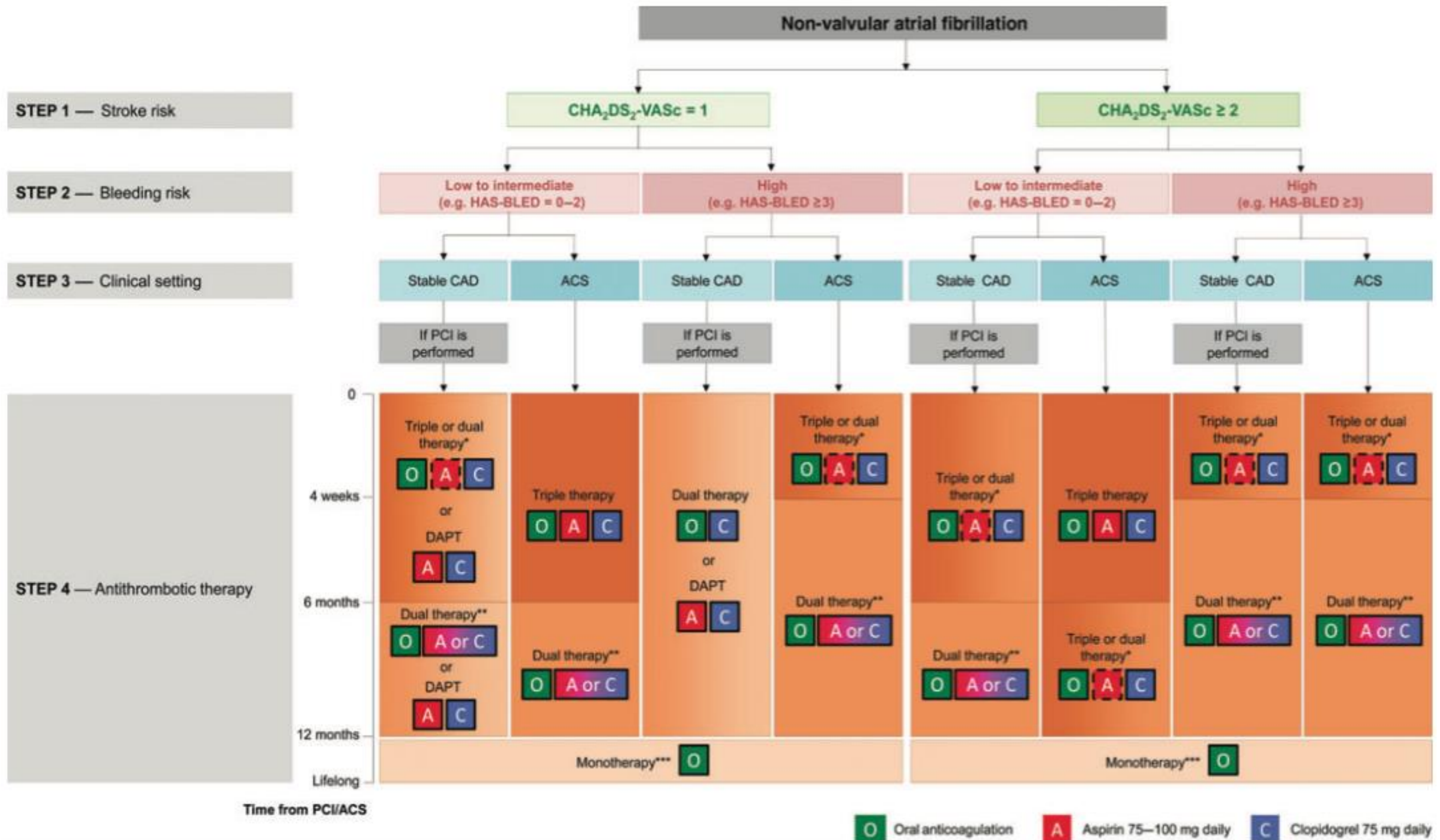
Anticoagulation and antiplatelet therapy



Overview

Patients with AF and CAD may need combination Rx:

Oral Anticoagulation (OAC) + Antiplatelet(s) (AP)

ESC 2014 guidance:

- For patients with AF and stable CAD (with no ACS or PCI within 1 year):
  - Anticoagulant only will suffice
- For patients with AF who have had a PCI or ACS within a year:
  - 1st 4 weeks to 6 months:
    - Anticoagulation plus dual antiplatelet Rx (exact period depends on whether stent is used, type of stent and bleeding risk)
  - Until 12 months:
    - Anticoagulation plus single antiplatelet Rx (aspirin 75mg or clopidogrel)

- Dual or triple therapy ↑ ↑ bleeding risk
- (Discuss with cardiologist before stopping any AP < 1 year post PCI/ACS)

Minimal data available for NOACs with newer Aps (ie ticagrelor & prasugrel)

1. Cutlip D *et al.* Long-term antiplatelet therapy after coronary artery stenting in stable patients. UpToDate. Available at: http://www.uptodate.com/contents/long-term-antiplatelet-therapy-after-coronary-artery-stenting-in-stable-patients. Last accessed January 2017

Antithrombotic therapy in AF and co-existing vascular disease

- Patients with significant carotid atherosclerosis and AF may require the combination of antiplatelet and anticoagulation therapy and should be discussed with a stroke physician
- Patients with AF and PAD can be managed with anticoagulant alone

Single episode of AF :what is the risk

“Atrial fibrillation begets Atrial Fibrillation : a study in chronically instrumented goats “

Wijffels, Allessie et al 1995

Single episode of AF :what is the risk

Summary

- **AF is almost always a chronic disease** – atrial electrical and structural remodeling
- Confirm the detail single events where possible (including ECG)
- Infection ,alcohol and other triggers for episodes recognised
- PAF – more episodes are asymptomatic than symptomatic
- Standard assessment of stroke and bleeding risk important and guides decision making around further management
- Discussion with patient or relatives important

EMBRACE Study

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Atrial Fibrillation in Patients with Cryptogenic Stroke

David J. Gladstone, M.D., Ph.D., Melanie Spring, M.D., Paul Dorian, M.D., Val Panzov, M.D., Kevin E. Thorpe, M.Math., Judith Hall, M.Sc., Haris Vaid, B.Sc., Martin O'Donnell, M.B., Ph.D., Andreas Laupacis, M.D., Robert Côté, M.D., Mukul Sharma, M.D., John A. Blakely, M.D., Ashfaq Shuaib, M.D., Vladimir Hachinski, M.D., D.Sc., Shelagh B. Coutts, M.B., Ch.B., M.D., Demetrios J. Sahlas, M.D., Phil Teal, M.D., Samuel Yip, M.D., J. David Spence, M.D., Brian Buck, M.D., Steve Verreault, M.D., Leanne K. Casaubon, M.D., Andrew Penn, M.D., Daniel Selchen, M.D., Albert Jin, M.D., David Howse, M.D., Manu Mehdiratta, M.D., Karl Boyle, M.B., B.Ch., Richard Aviv, M.B., Ch.B., Moira K. Kapral, M.D., and Muhammad Mamdani, Pharm.D., M.P.H., for the EMBRACE Investigators and Coordinators*

N Engl J Med 2014; 370:2467-2477 | June 26, 2014 | DOI: 10.1056/NEJMoa1311376

Thank you!

Any questions ?

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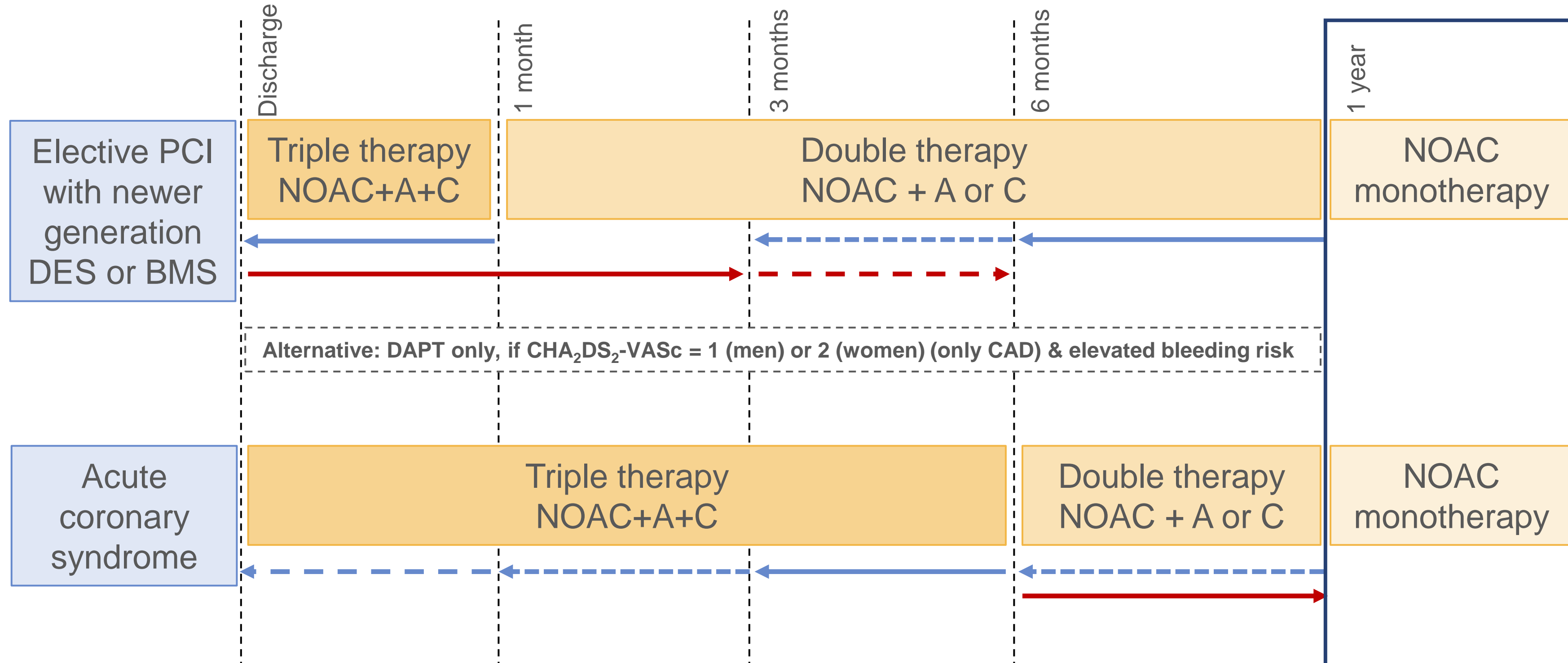
Overview[1]



Factors to shorten combination therapy

- (Uncorrectable) high bleeding risk
- Low atherothrombotic risk (by REACH or SYNTAX score if elective?; GRACE ≥118 if ACS?)

Factors to lengthen combination therapy

- First-generation DES-circa 2000-2008 ↑ risk stent thrombosis
- High antherothrombotic risk (scores as above; stenting of the left main, proximal left anterior descending, proximal bifurcation; recurrent Mis; etc.) and low bleeding risk

1. Lip et al. Europace 2011;13:723-46

ESC guidelines

- OAC are the foundation therapy- add antiplatelets
- Four steps:

  - Step 1 Stroke Risk- CHADSVAC
  - Step 2 Bleeding Risk- HASBLED
  - Step 3 Clinical Setting- Stable CAD or ACS
  - Step 4 Antithrombotic Therapy

CHA_2DS_2-VASc Score

		Score
C	Congestive Heart Failure/LV Dysfunction	1
H	Hypertension	1
A	Age ≥ 75 Years	2
D	Diabetes Mellitus	1
S	Stroke (TIA/TE)	2
V	Vascular Disease[a]	1
A	Age 65-74 Years	1
S	Sex (female)	1

a. Prior myocardial infarction, peripheral artery disease, aortic plaque.
LV = left ventricular; TE = thromboembolism; TIA = transient ischemic attack

HAS-BLED Bleeding Risk Score		
H	Hypertension (>160 mmHg)	1
A	Abnormal renal / liver function (1 pt ea)	1 – 2
S	Stroke (usu lacunar)	1
B	Bleeding (hx or predisposition, anemia)	1
L	Labile INRs	1
E	Elderly (>65 yrs)	1
D	Drugs or Alcohol (1 pt ea)	1 – 2

European Heart Journal doi:10.1093/eurheartj/ehu298

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- Routine use of P2Y12 inhibitors (prasugrel and ticagrelor) in combination with a NOAC is not recommended due to the increased risk of major bleeding.
- The period of dual antiplatelet therapy plus anticoagulant should be as short as possible (e.g. not exceeding 6 months for patients at low risk of bleeding or 4 weeks for patients at high risk of bleeding). This can be followed by single antiplatelet therapy plus anticoagulant for up to 12 months then lifelong anticoagulant.
- Where a NOAC is used with an antiplatelet, the lower tested effective dose to reduce the risk of stroke may be considered.
- Gastroprotection with a proton pump inhibitor should be considered in all patients on any combination of antiplatelets and anticoagulants.
- **Patients with stable coronary artery disease (defined by European guidelines as no acute ischaemic events or PCI/stent procedure in the preceding 12 months) and concurrent AF can be managed with anticoagulation alone.**