Anticoagulation orale dans la FA, un traitement à vie ?

Laurent Fauchier

Cardiologie. CHU Trousseau, Tours

CHRU HÔPITAUX DE TOURS

COEUR THORAX VAISSEAUX

UNIVERSITÉ FRANÇOIS - RABELAIS TOURS FACULTÉ DE MÉDECINE

Statement of Financial Interest

I currently have, or have had over the last two years, an affiliation or financial interests or interests of any order with a company or I receive compensation or fees or research grants with a commercial company :

Speaker's name: Laurent FAUCHIER

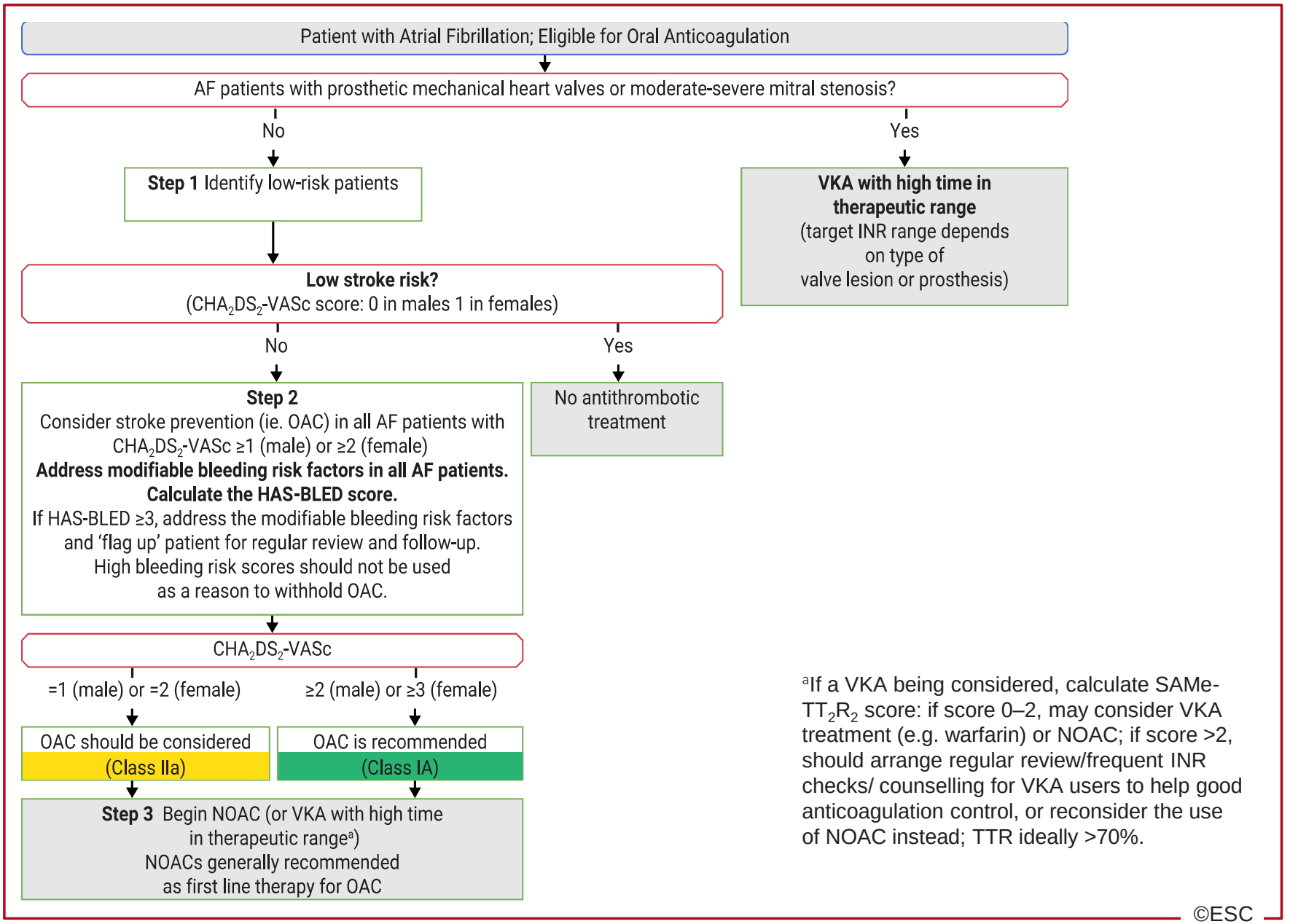
☑ I have the following potential disclosure to report

Speaker or consultant :

AstraZeneca, Bayer, BMS Pfizer, Boehringer Ingelheim, Medtronic,

Novartis, Novo, XO, Zoll.

"ABC": A = Avoid Stroke, Anticoagulation



[a]If a VKA being considered, calculate SAMe-TT_2R_2 score: if score 0–2, may consider VKA treatment (e.g. warfarin) or NOAC; if score >2, should arrange regular review/frequent INR checks/ counselling for VKA users to help good anticoagulation control, or reconsider the use of NOAC instead; TTR ideally >70%.

EORP-AF : stroke prevention

- **AF patients, cardiologists in 250 centres, 27 European countries, 2013 -16**
- **n = 11 096**

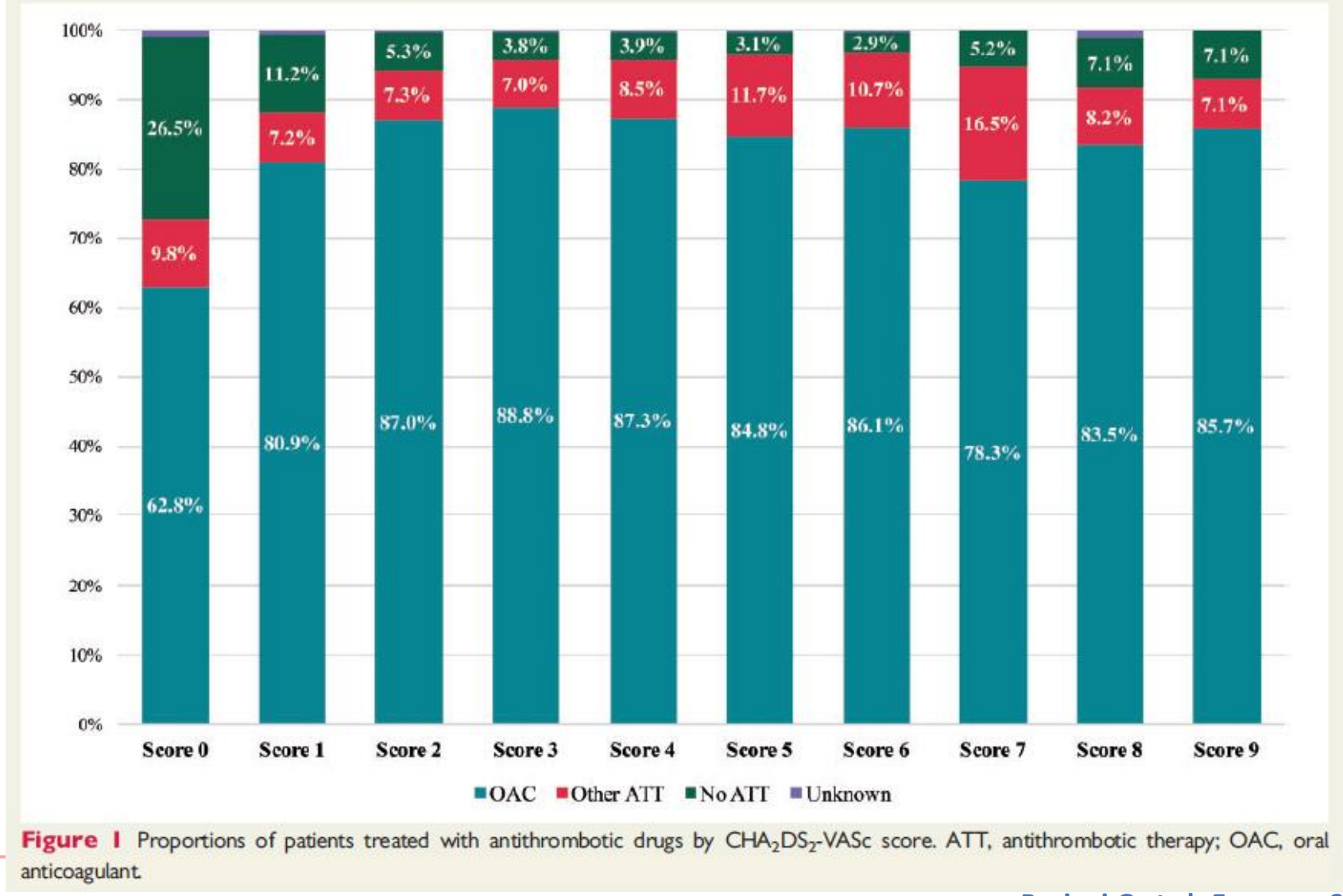
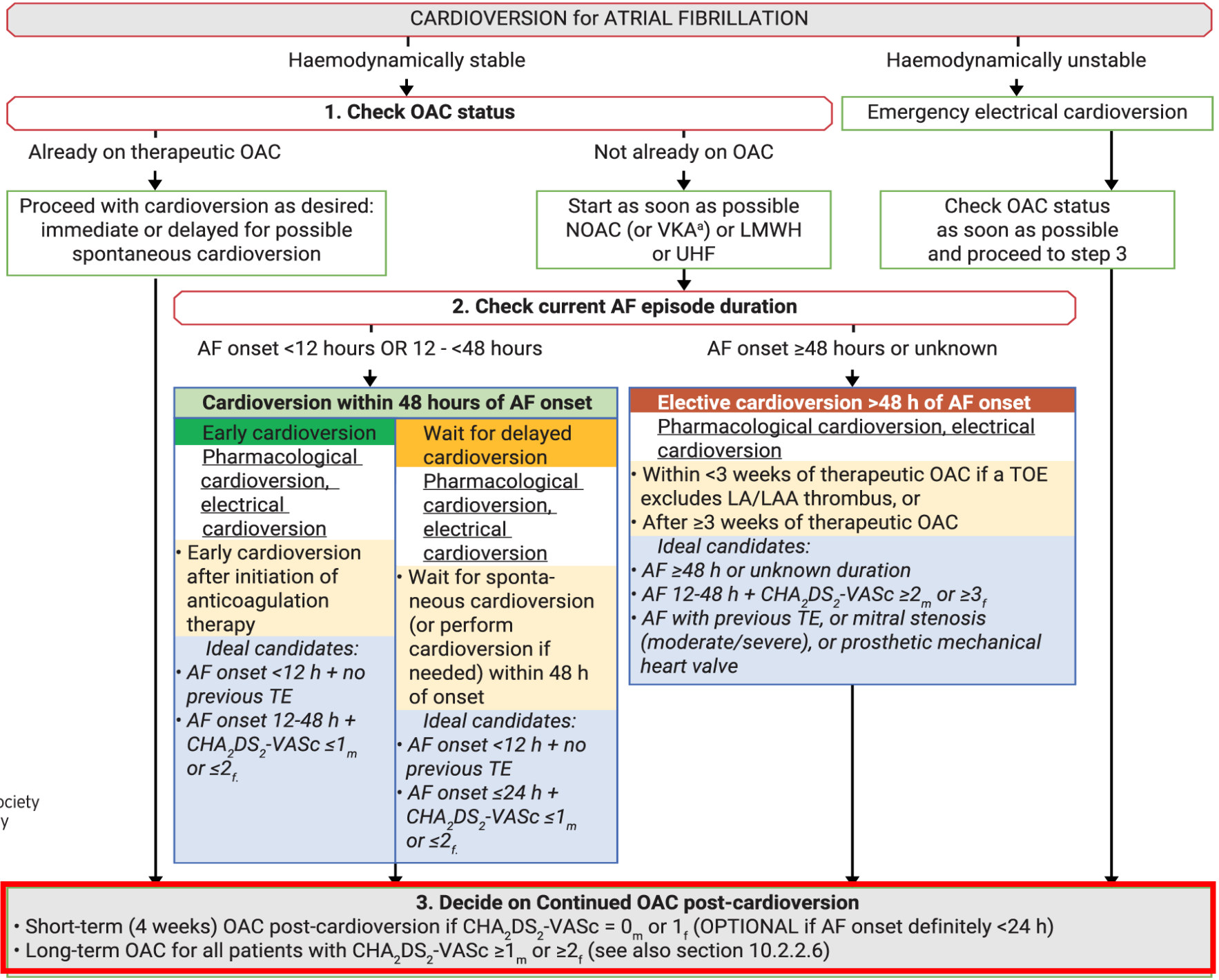


Figure 1 Proportions of patients treated with antithrombotic drugs by CHA_2DS_2-VASc score. ATT, antithrombotic therapy; OAC, oral anticoagulant.

Boriani G et al, *Europace* 2018



ESC European Society of Cardiology

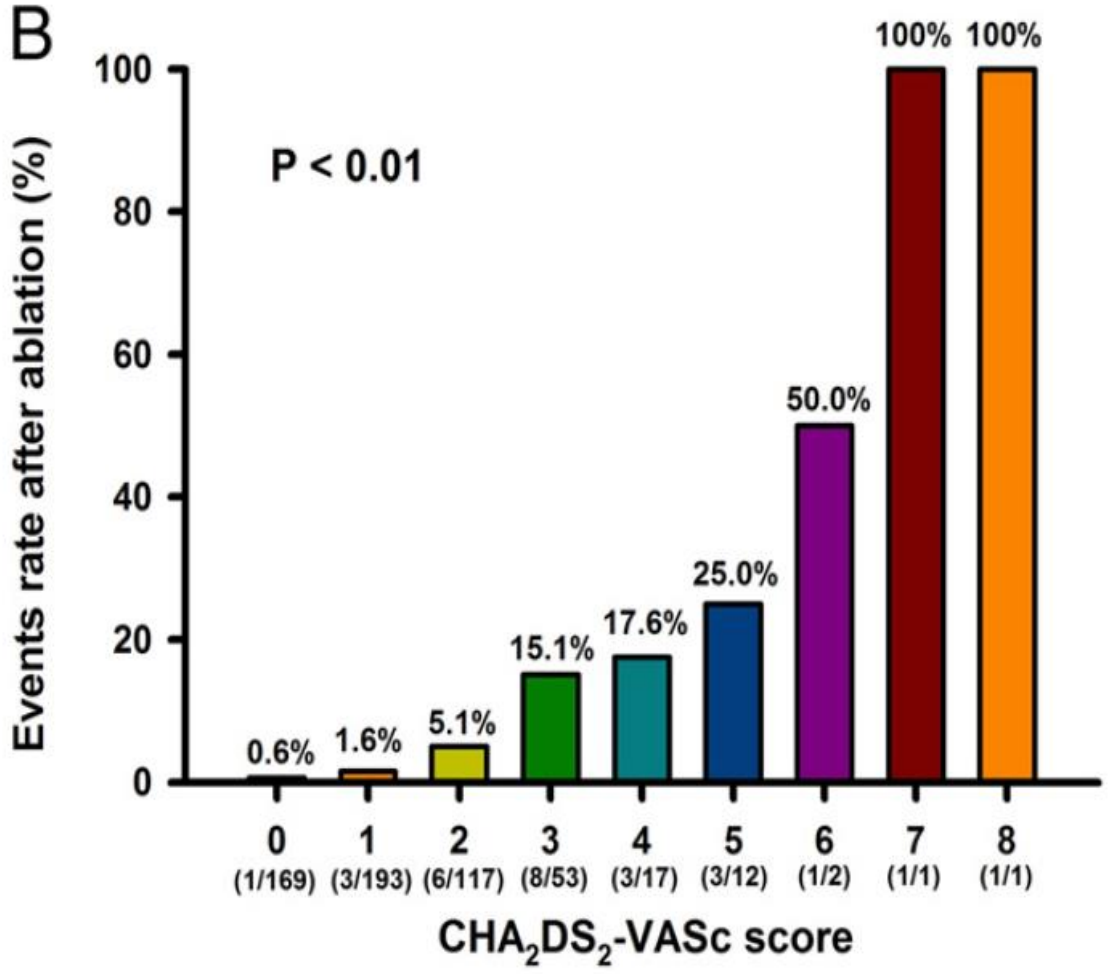
AF ESC Guidelines, *Eur Heart J* 2020

Recommendations for stroke risk management peri catheter ablation (2)

Recommendations	Class	Level
After AF catheter ablation, it is recommended that: • Systemic anticoagulation with warfarin or a NOAC is continued for at least 2 months post ablation, and • Long-term continuation of systemic anticoagulation beyond 2 months post ablation is based on the patient's stroke risk profile and not on the apparent success or failure of the ablation procedure.	I	C

Clinical Outcomes in AF After Catheter Ablation

- 565 patients with AF and catheter ablation
- Endpoint: occurrence of TE events or death during FU after ablation
- Follow-up 39.2±22.6 months, 27 patients (4.8%) with events

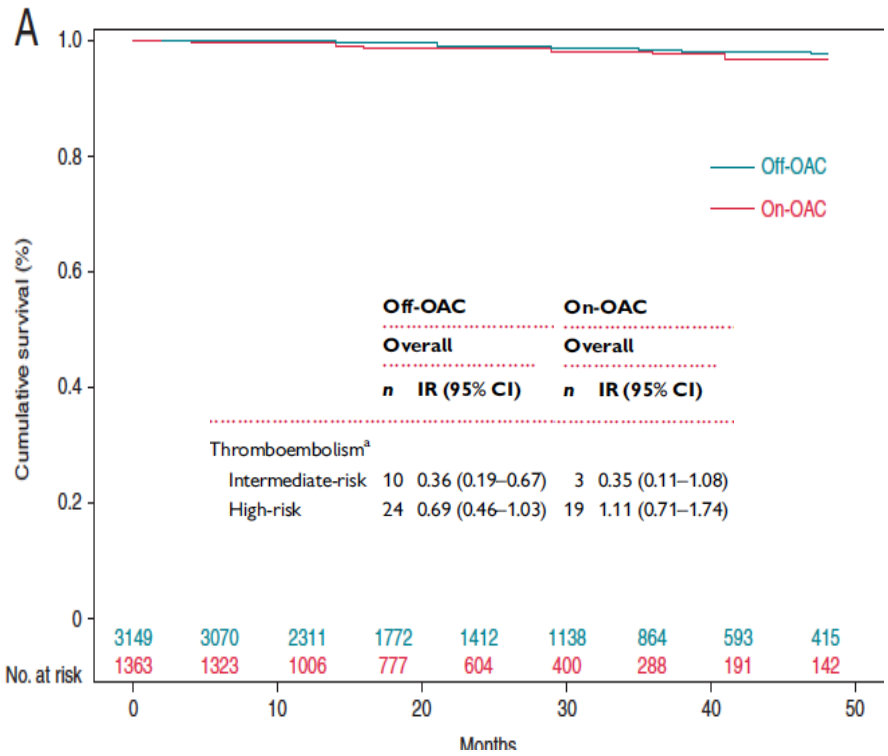


Chao TF et al. *JACC 2011*

Discontinuation of OAC after apparently successful AF ablation

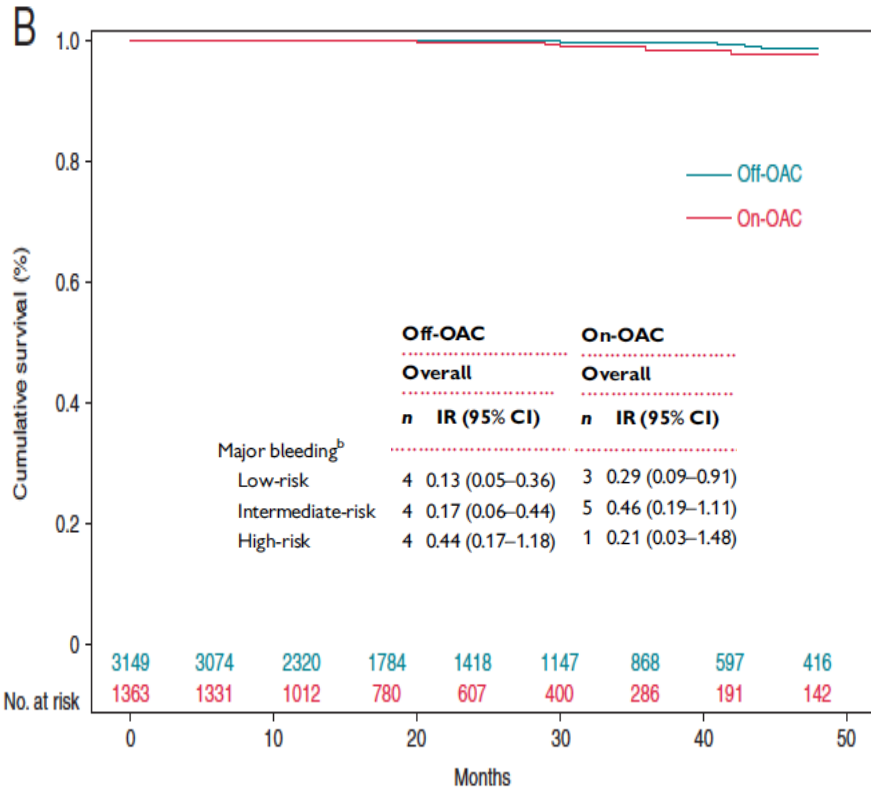
Chinese AF Registry: n =4512, 3149 Off-OAC, 1363 On-OAC

Thromboembolism events:



OAC discontinuation:
adjusted HR 0.71, 95%CI 0.41–1.23
p=0.21

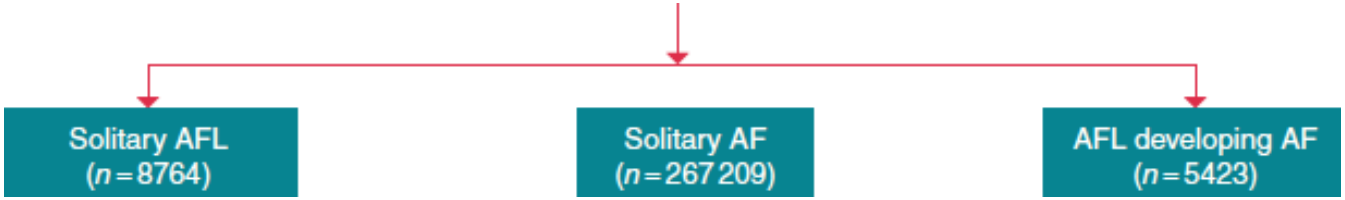
Bleeding events:



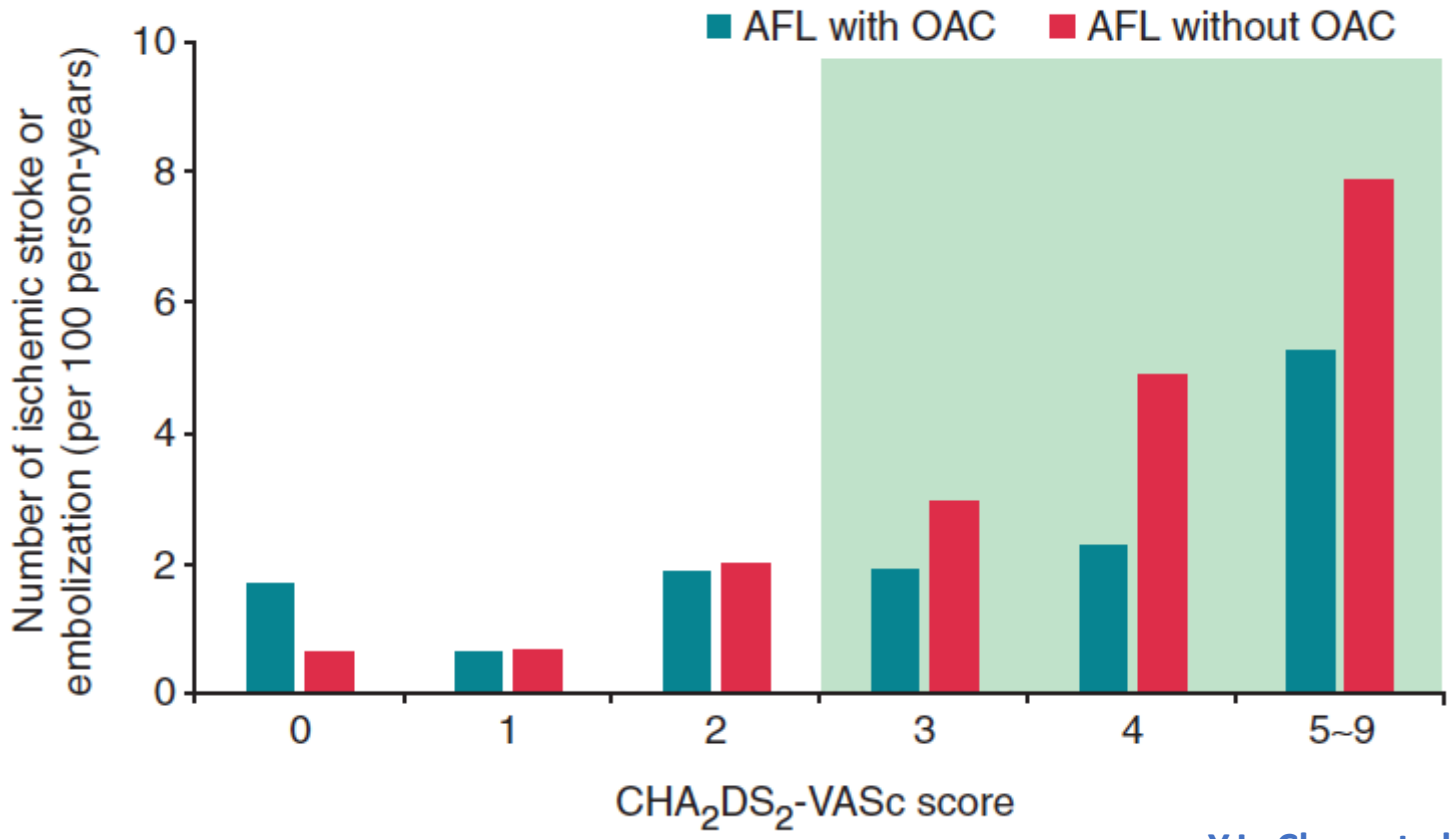
W.-Y. Yang et al. *Europace*, 2020

Atrial flutter with w/o anticoagulant

National Health Insurance Database, Taiwan, 2001-2012



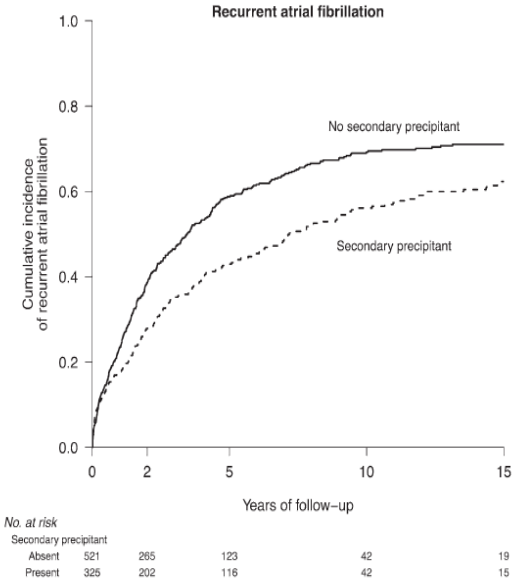
Solitary atrial flutter (AFL):

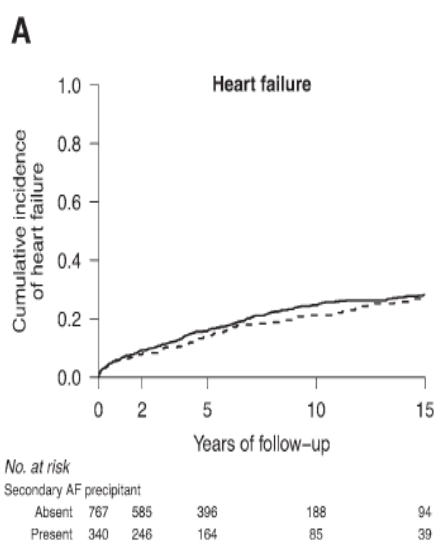


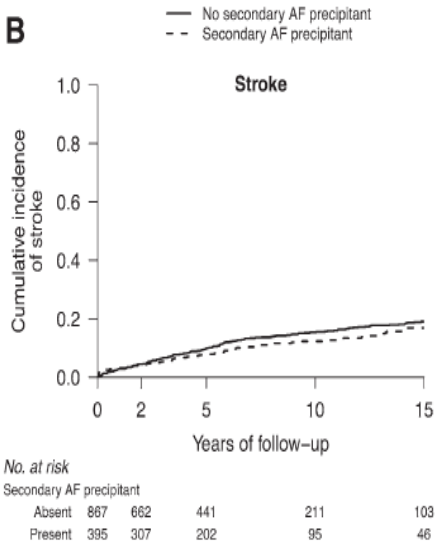
Y.L. Chen et al. *Europace*, 2018

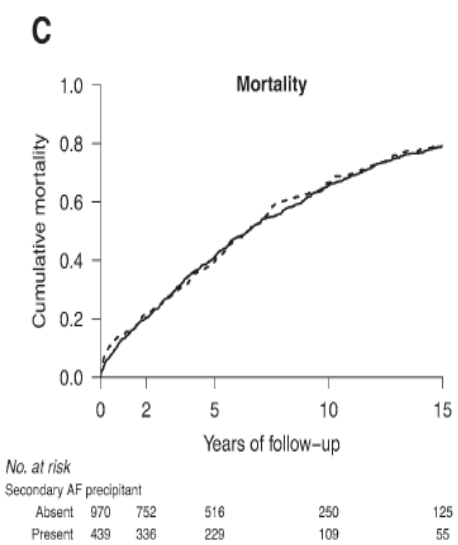
Outcomes of Secondary Atrial Fibrillation

- **1409 Framingham Heart Study participants with new-onset AF**
- **First-detected AF episodes occurring without (n=970) and with (n=439) a secondary precipitant (Non-CV surg 30%, CV surg 20%, acute infection 23%, MI 18%, other 9%)**







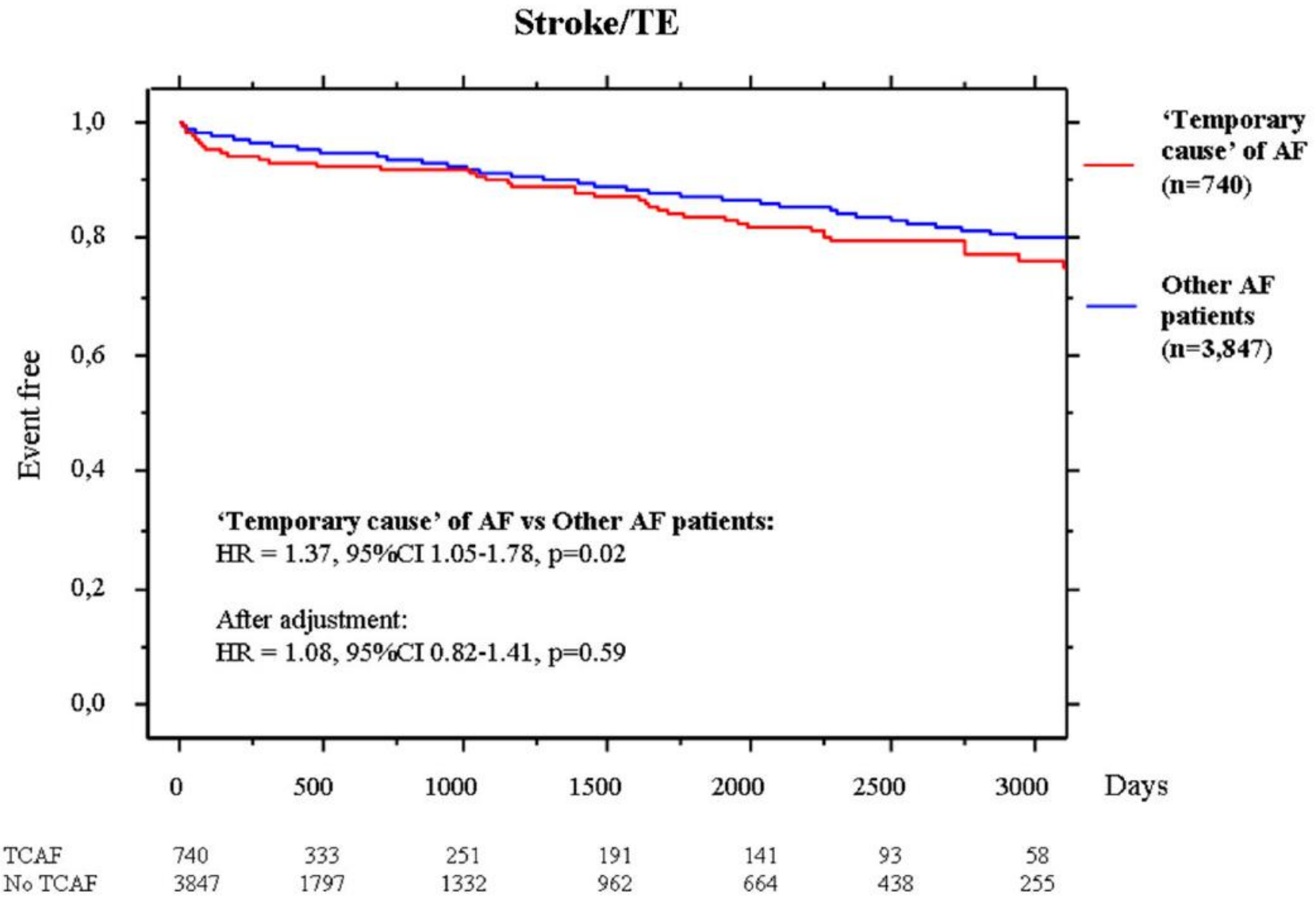


Adjusted HR (95% CI):

0.65 (0.54–0.78) ***p<0.0001*** 0.74 (0.56–0.97) ***p=0.03*** 1.09 (0.79–1.50) ***p=0.79*** 1.00 (0.87–1.15) ***p=0.98***

Lubitz SA, et al. *Circulation* 2015

AF and a presumed "temporary cause"



Fauchier L et al. *Clin Res Cardiol* 2016

AF and a presumed "temporary cause"

Predictors of outcome:

Cardiovascular death/stroke/TE event	Multivariate analysis	
	Hazard ratio (95 % confidence interval)	*p*
Age (per 1-year increase)	1.02 (1.00–1.04)	0.02
Male gender	1.16 (0.80–1.7)	0.43
Heart failure	1.75 (1.20–2.54)	0.004
Hypertension	1.02 (0.71–1.45)	0.92
Diabetes	1.01 (0.65–1.56)	0.98
Vascular disease	4.29 (2.35–7.81)	<0.0001
Coronary artery disease	0.78 (0.43–1.43)	0.42
Valvular disease	0.86 (0.54–1.37)	0.53
Renal insufficiency	1.55 (0.93–2.58)	0.10
Chronic pulmonary disease	0.98 (0.58–1.64)	0.93
Oral anticoagulant treatment	0.44 (0.29–0.67)	0.0001
Antiplatelet treatment	0.42 (0.27–0.66)	0.0001

TE thromboembolism

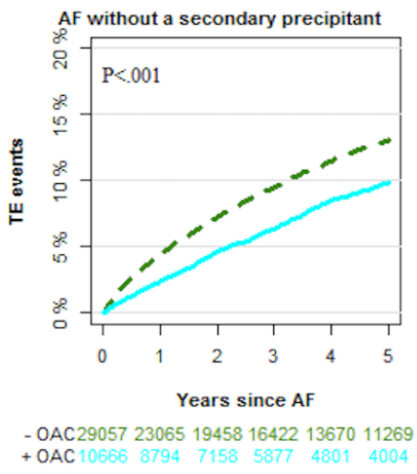
Fauchier L et al. *Clin Res Cardiol* 2016

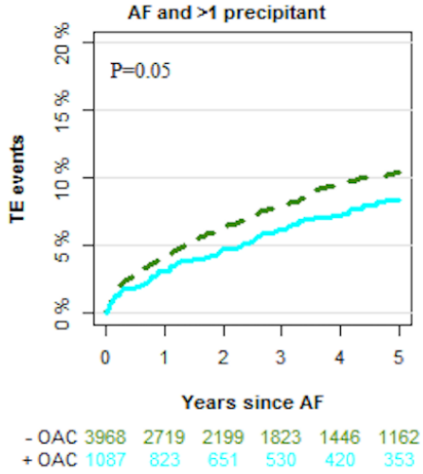
AF with a secondary precipitant

Danish nationwide registries (1996–2015)

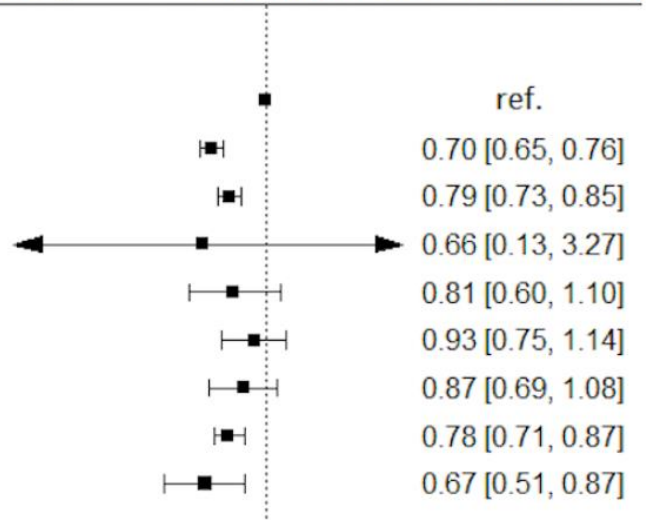
Mathed population

- 39,723 patients with AF with secondary precipitant
  - 335 (0.8%) with alcohol intoxication
  - 2507 (6.3%) with thyrotoxicosis
  - 4773 (12.0%) with myocardial infarction
  - 5229 (13.2%) had had surgery
  - 21,824 (55.0%) with infection
  - 5055 (12.7%) with >1 precipitant
- 39,723 patients with AF without a secondary precipitant





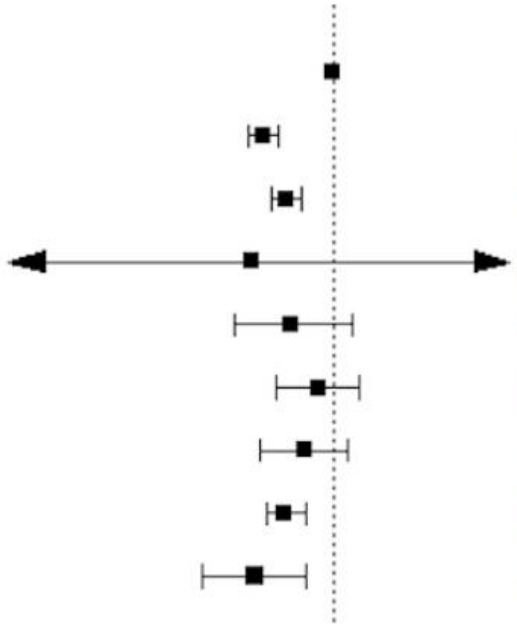
Groups	Events	Person Years	IR*	Crude hazard ratio [95% CI**]	Adjusted hazard ratio [95% CI**]
Thromboembolic event					
No OAC	6633	169258	39.2	ref.	ref.
AF without secondary preciitant	819	33939	24.1	0.72 [0.67-0.78]	0.70 [0.65, 0.76]
AF and any secondary precipitant	<1000	<3500	29.3	0.78 [0.72-0.84]	0.79 [0.73, 0.85]
AF and alcohol intoxication	<3	<150	17	0.71 [0.15-3.31]	0.66 [0.13, 3.27]
AF and thyrotoxicosis	75	4267	17.6	0.81 [0.61-1.09]	0.81 [0.60, 1.10]
AF and myocardial infarction	130	4051	32.1	0.89 [0.72-1.08]	0.93 [0.75, 1.14]
AF after surgery	103	3342	30.8	0.92 [0.74-1.15]	0.87 [0.69, 1.08]
AF and infection	544	16710	32.6	0.76 [0.69-0.84]	0.78 [0.71, 0.87]
AF and >1 precipitant	72	3126	23	0.68 [0.53-0.88]	0.67 [0.51, 0.87]



Gundlund A, et al. *BMJ Open* 2019

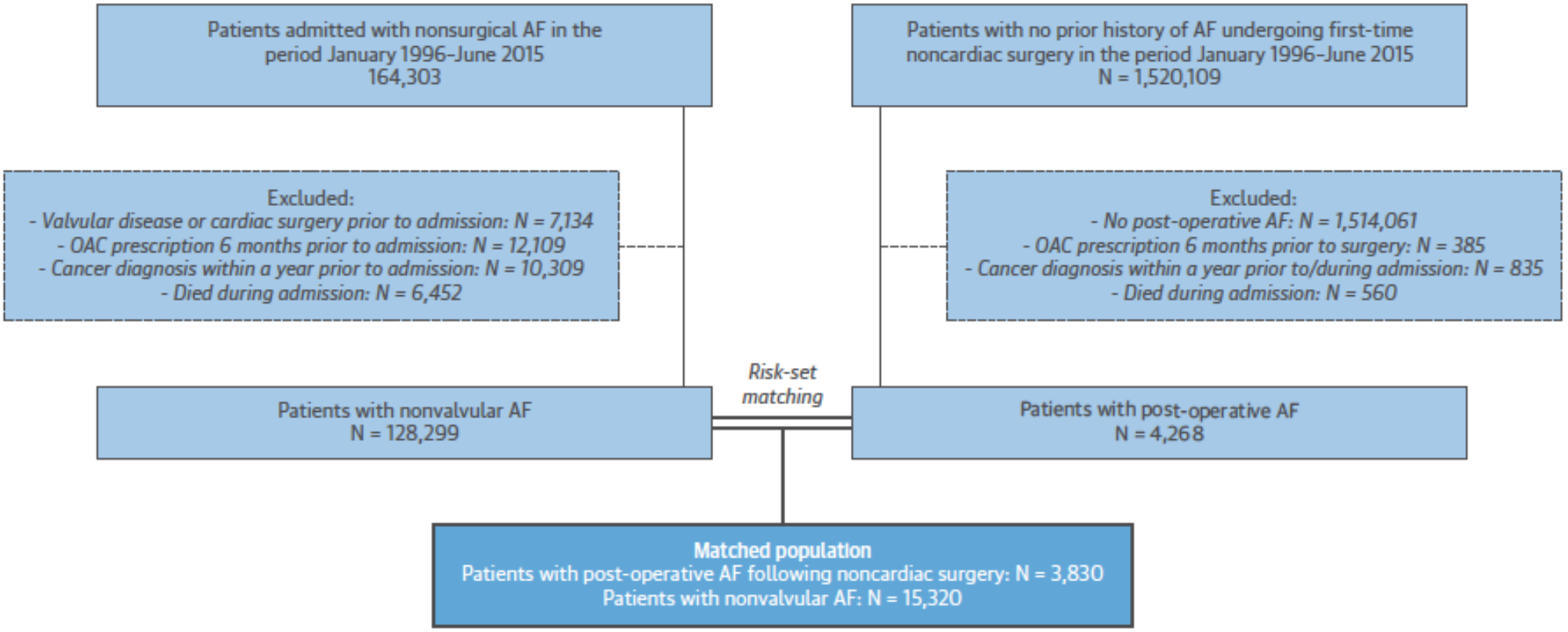
FA avec un facteur précipitant : Bénéfice possible du traitement anticoagulant

Risque thromboembolique	**Hazard ratio (IC 95%)**	**Hazard ratio ajusté (IC 95%)**
Patient sans ACO (référence)	ref.	ref.
ACO, FA sans facteur précipitant	0.72 [0.67-0.78]	0.70 [0.65, 0.76]
ACO, FA et ≥1 facteur précipitant	0.78 [0.72-0.84]	0.79 [0.73, 0.85]
ACO, FA avec consommation alcool	0.71 [0.15-3.31]	0.66 [0.13, 3.27]
ACO, FA et hyperthyroïdie	0.81 [0.61-1.09]	0.81 [0.60, 1.10]
ACO, FA et IDM	0.89 [0.72-1.08]	0.93 [0.75, 1.14]
ACO, FA après chirurgie	0.92 [0.74-1.15]	0.87 [0.69, 1.08]
ACO, FA et infection	0.76 [0.69-0.84]	0.78 [0.71, 0.87]
ACO, FA et ≥2 facteurs précipitants	0.68 [0.53-0.88]	0.67 [0.51, 0.87]



Adapté de Gundlund A, et al. *BMJ Open* 2019

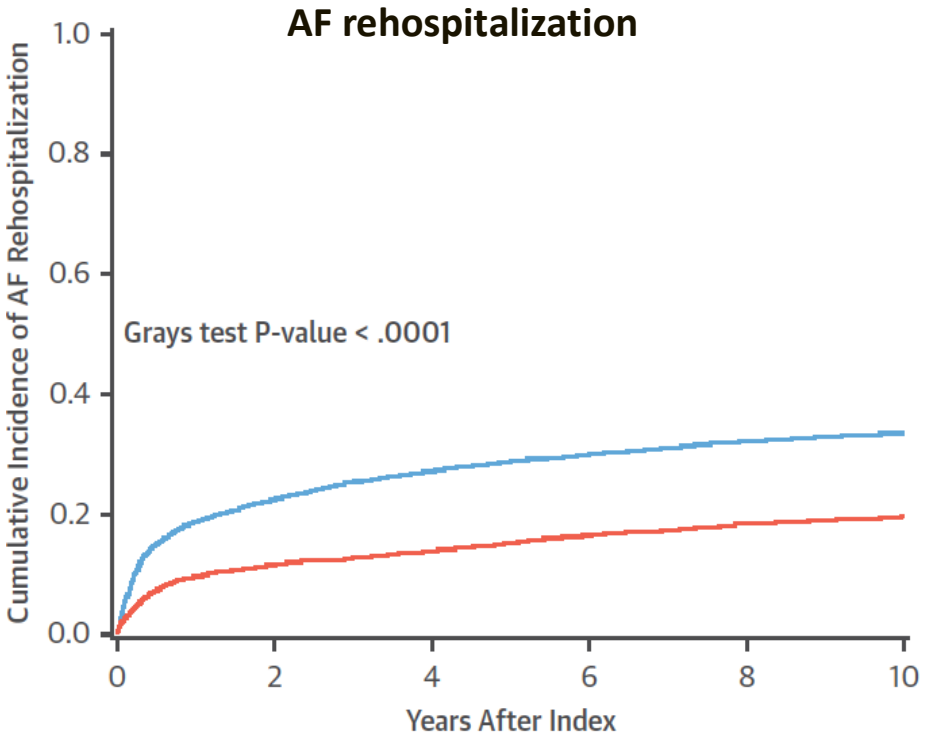
AF After Noncardiac Surgery vs NVAF (1996-2015)

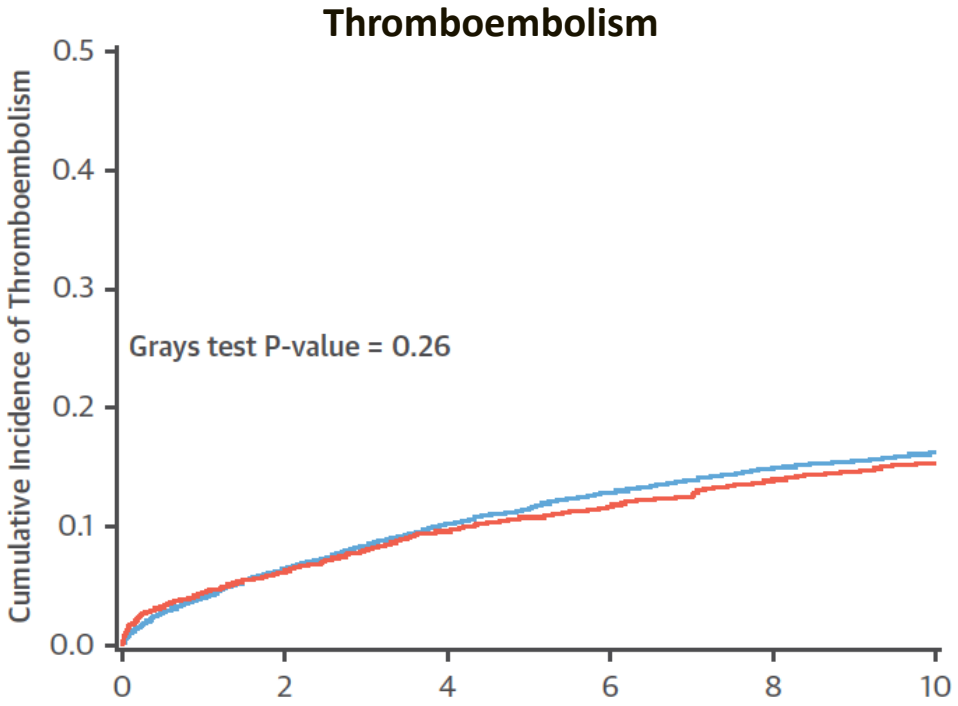


Butt JH et al, *J Am Coll Cardiol* 2018

AF After Noncardiac Surgery vs NVAF (1996-2015)

- 3,830 patients with POAF matched with 15,320 patients with NVAF



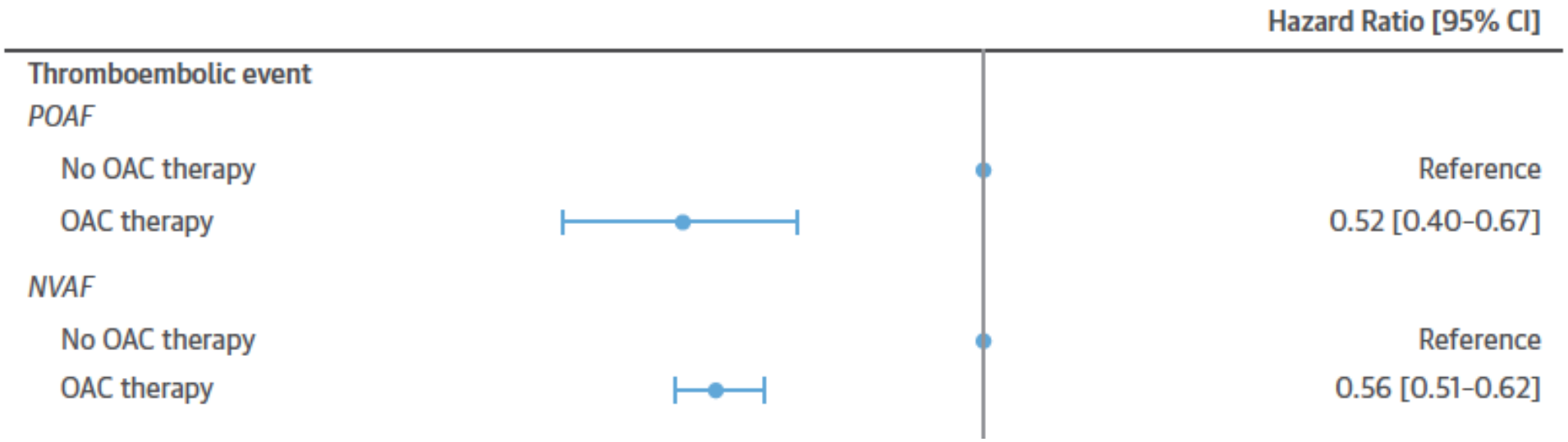


NVAF — POAF Following Non-Cardiac Surgery

Butt JH et al, *J Am Coll Cardiol* 2018

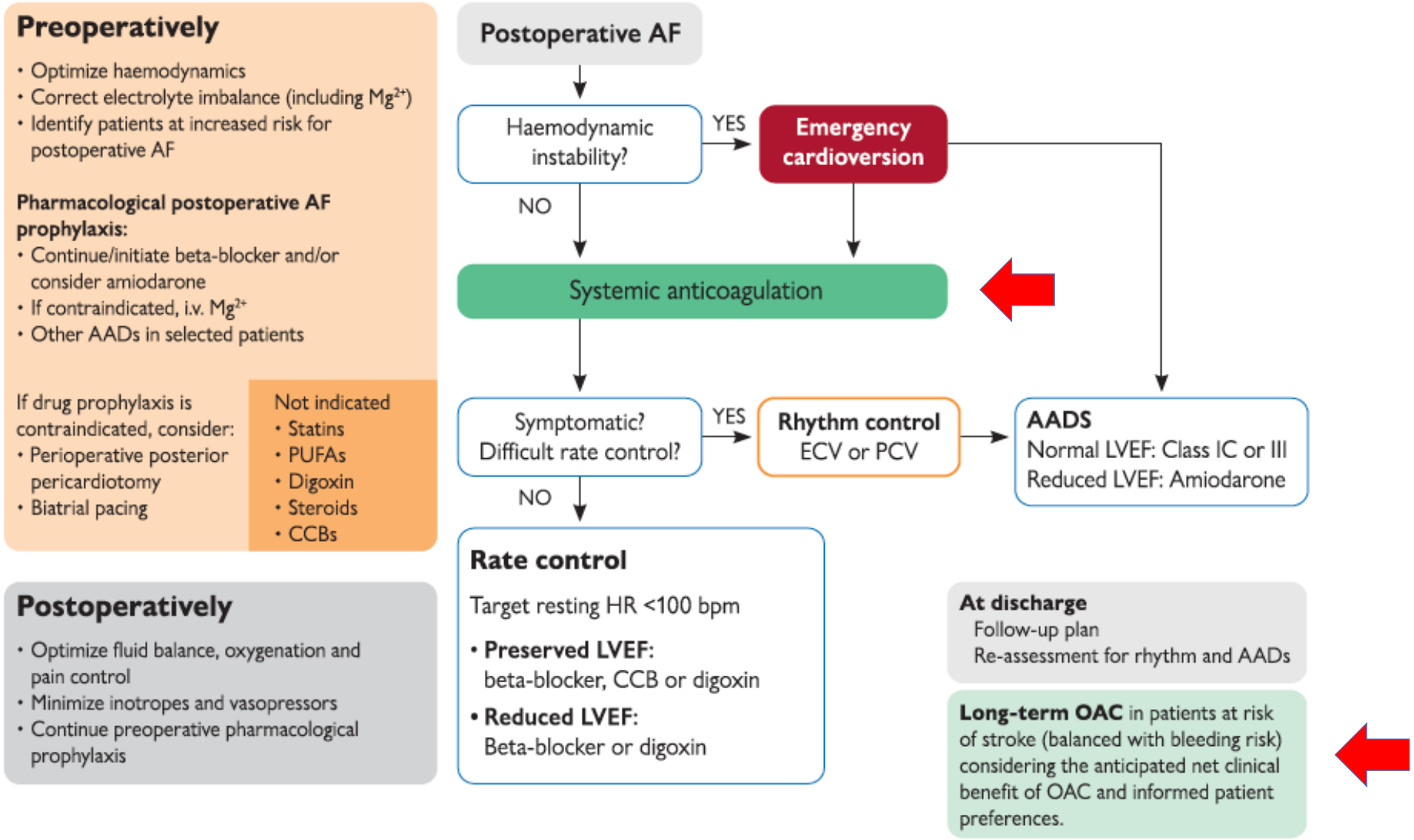
AF After Noncardiac Surgery vs NVAF (1996-2015)

- 3,830 patients with POAF matched with 15,320 patients with NVAF



Butt JH et al, *J Am Coll Cardiol* 2018

Postoperative AF



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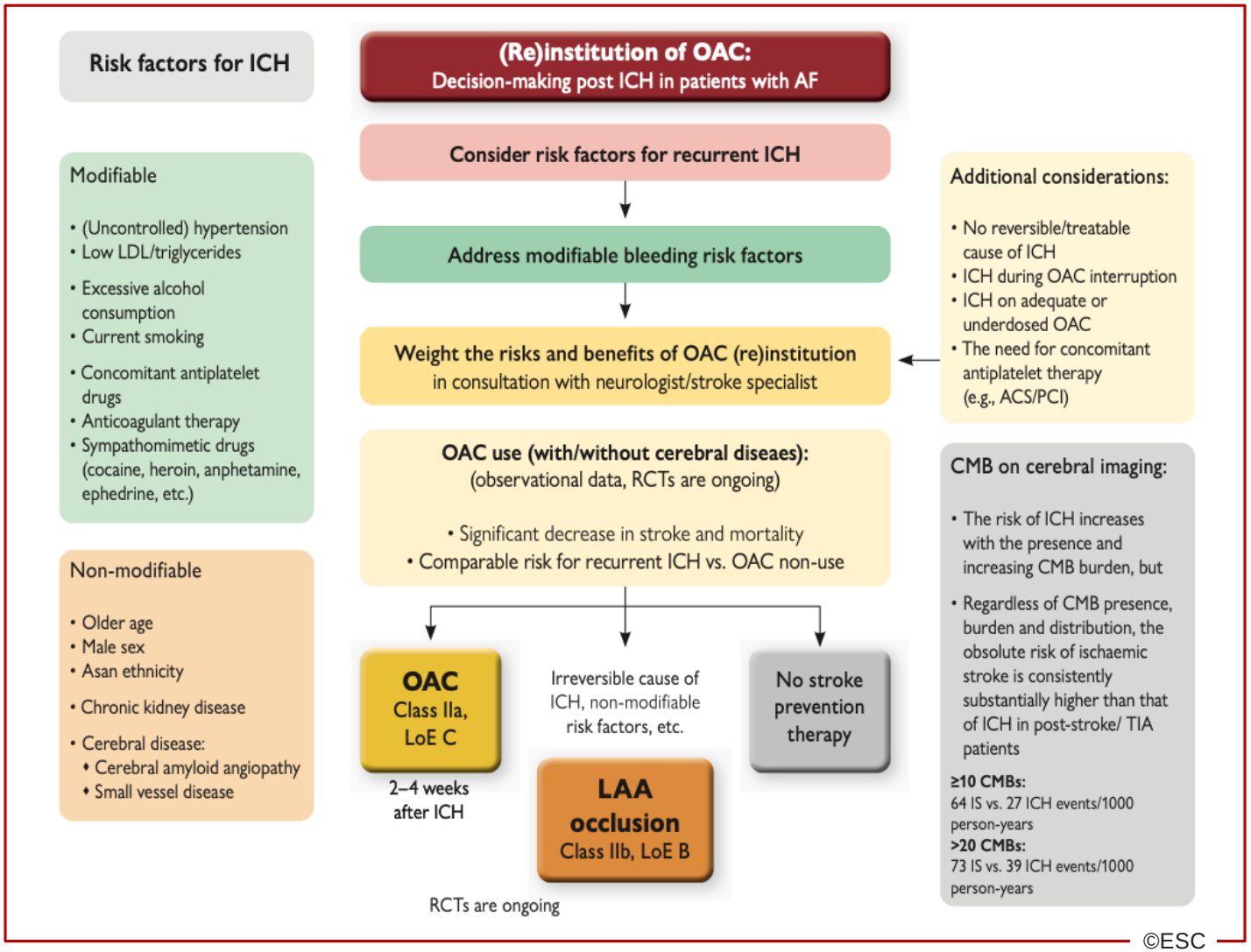
AF ESC Guidelines, *Eur Heart J* 2020

OAC: reinitiation post intracranial bleed



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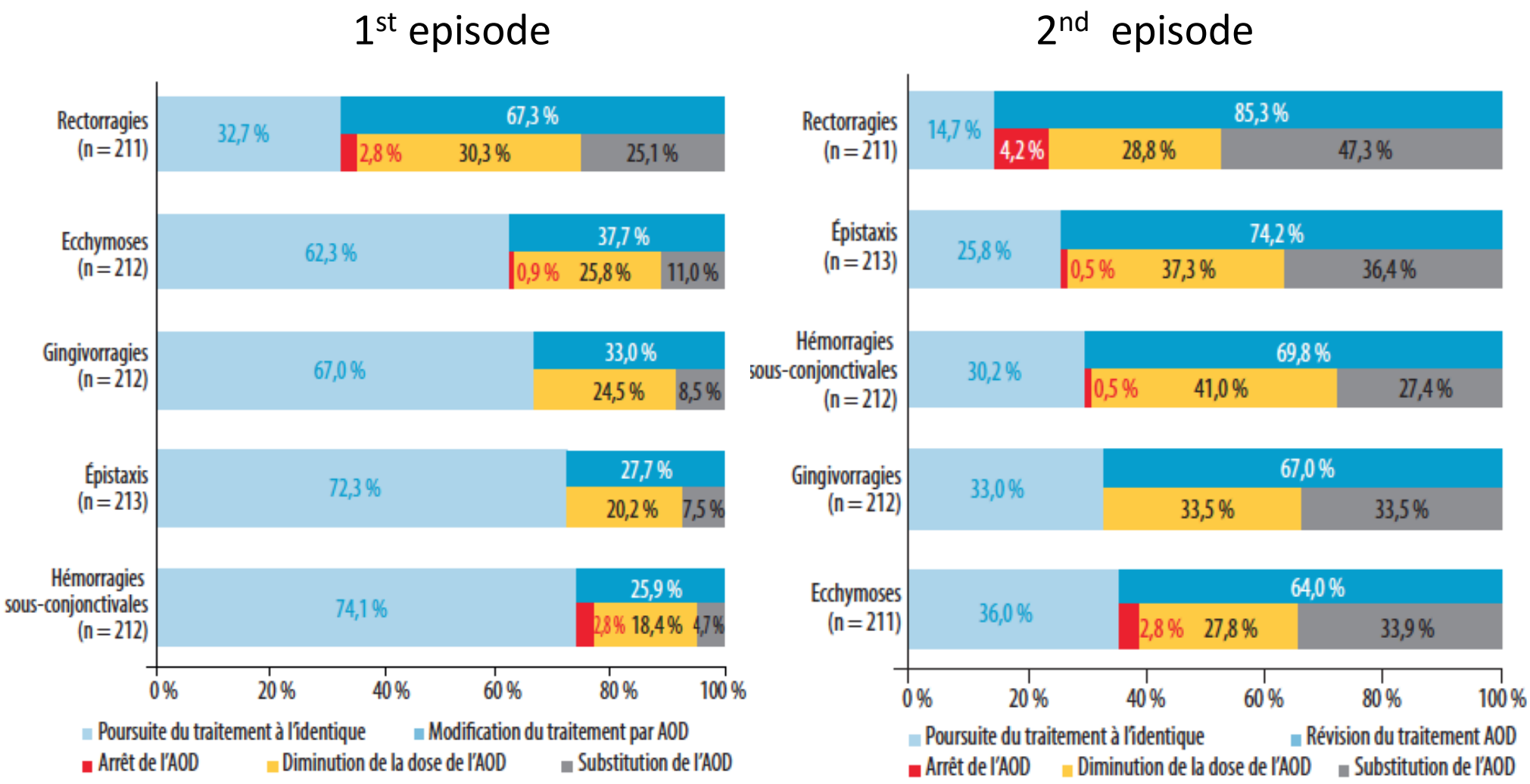
A pooled analysis of individual patient data from cohort studies (n=20 322 patients; 38 cohorts; >35 225 patient-years) showed that although cerebral microbleeds can inform regarding the risk for ICH in patients with recent ischaemic stroke/TIA treated with antithrombotic therapy, the absolute risk of ischaemic stroke is substantially higher than that of ICH, regardless of the presence, burden, or location of cerebral microbleeds

AF ESC Guidelines, *Eur Heart J* 2020

HEMICARD survey: Minor bleeding

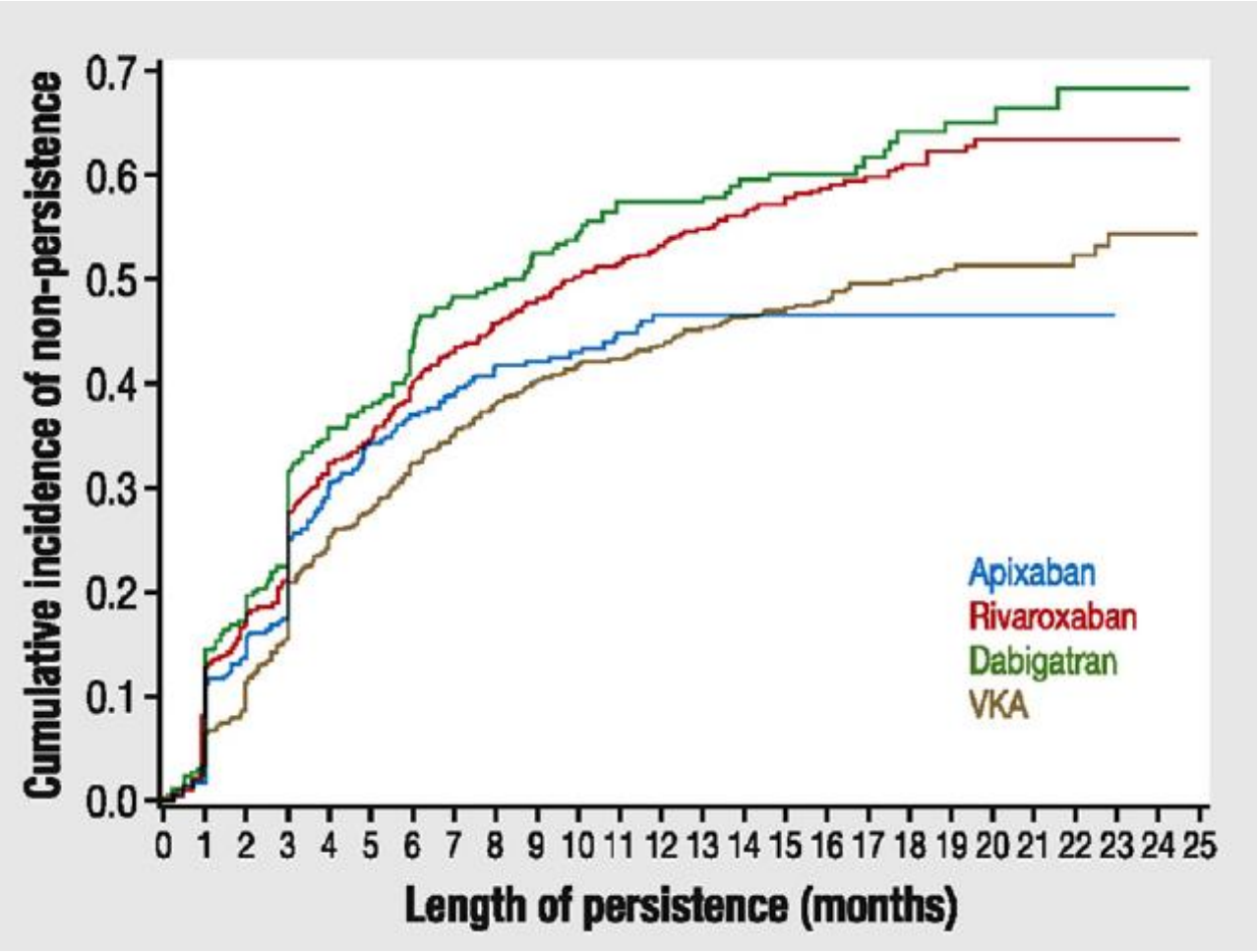
Management of antithrombotic therapy after non-major bleed with DOACs (declarative analysis)



Gauthier J et al. *ACVD suppl*, 2018

Initiation and continuation of OAC in AF : A cohort study in primary care in France

Results: Cumulative Incidence of Non-Persistence After Index Date by AC Treatment in AC-Naive Cohorts

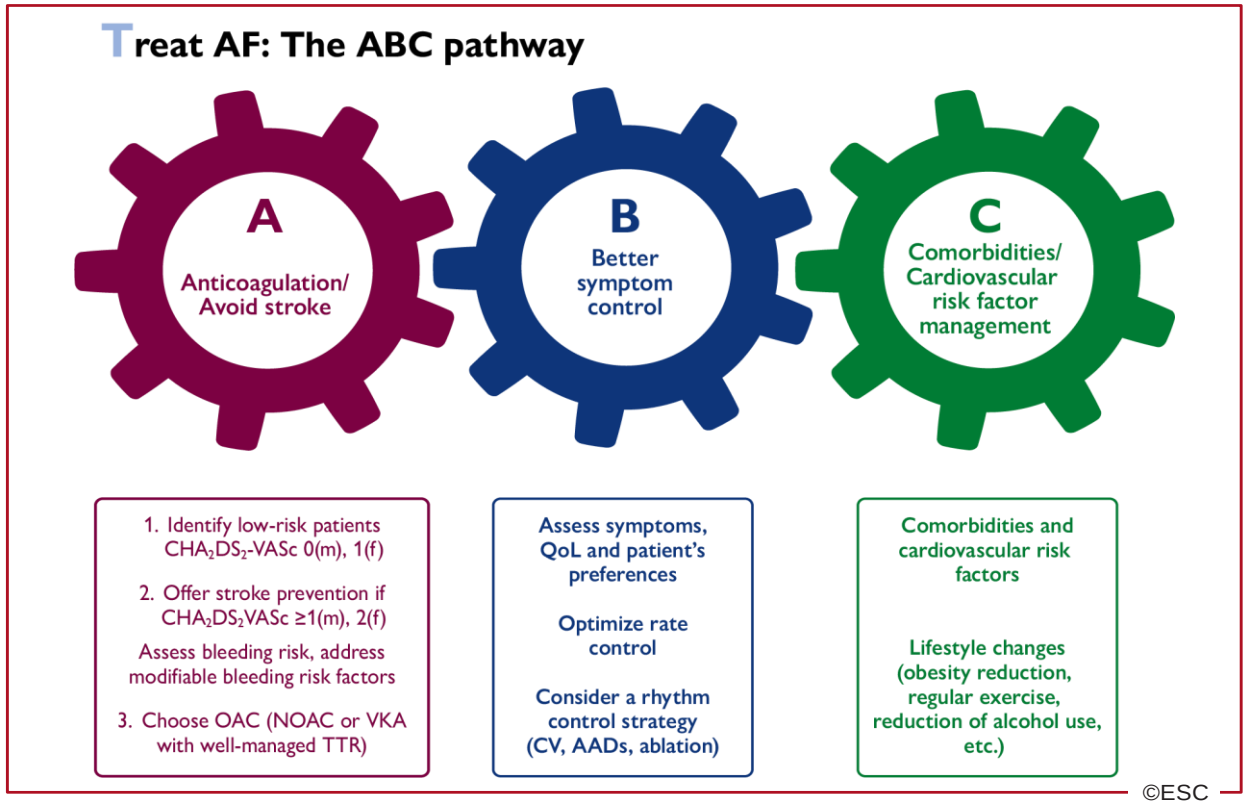


AC, anticoagulant; VKA, vitamin K antagonist.

S.-L. Collings et al. *Archives of Cardiovascular Disease* (2018) 111, 370—379.

Conclusion

- **ACO en cas de FA : un traitement à vie ?**
- Oui, dans la plupart des cas
- L'estimation du risque de saignement, en l'absence de contrindication absolue aux ACO ne doit pas en soi aboutir à une décision de ne pas (ou plus) utiliser un ACO.



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