

# Wider Warfarin Use Advocated in Atrial Fib Cases

*Patients at risk for stroke need anticoagulants since even short fibrillation episodes can produce a clot.*

BY MITCHEL L. ZOLER  
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BOSTON — Physicians must be more aggressive in the way they use warfarin to treat patients with atrial fibrillation, even if most fibrillation episodes are of relatively short duration.

"If a patient with atrial fibrillation has risk factors for stroke, I recommend that they take warfarin unless there is a strong reason not to" and even when the fibrillation episodes are short duration, Dr. Albert L. Waldo said at an international symposium on atrial fibrillation sponsored by Massachusetts General Hospital.

Patients who usually have fibrillation episodes of just a few minutes can also have episodes that sometimes last several hours, he noted, and even short episodes can produce a clot.

"How long does it take blood to clot?" said Dr. Waldo, professor of cardiology and medicine at Case Western Reserve University in Cleveland.

Despite the importance of oral anticoagulation for patients with atrial fibrillation, many patients never get warfarin treatment.

Dr. Waldo cited evidence that he and his associates recently compiled by reviewing

the records of 945 atrial fibrillation patients who were treated at 38 hospitals in 28 states.

All hospitals participated in the National Anticoagulation Benchmark and Outcomes Report program.

Patients were seen during 2002 at 37 hospitals and during July 2000–December 2002 at one hospital. In 2001, the most recent guidelines for management of atrial fibrillation were published by the American College of Cardiology, the American Heart Association, and the European Society of Cardiology; these guidelines highlighted the need for warfarin treatment in virtually all atrial fibrillation patients, especially those at high stroke risk.

Among the 814 patients reviewed who met the criteria for having a high risk of stroke, 45% did not receive warfarin (and 25% received aspirin but no warfarin). Warfarin was also withheld from 46% of the moderate-risk patients and from 60% of low-risk patients.

The records were also reviewed for reasons these patients were considered to have high bleeding risk and therefore did not get warfarin. No explanation was found in the records of 43% of the patients not on warfarin. A risk for falls was cited for 42%—"not a good reason to withhold

warfarin," according to Dr. Waldo. Other reasons were neuropsychiatric impairment, a past bleeding episode, or peptic ulcer disease.

The patients with the highest risk of stroke were those with a history of stroke, transient ischemic attack, or systemic embolic event. Of the 196 patients in this group, 39% received no warfarin (21% received aspirin but no warfarin).

Age is another risk factor for stroke. In the analysis, 48% of patients aged 75 or older did not get warfarin, a striking divergence from the treatment guidelines, which call for warfarin for all patients in this age group.

"Many physicians base warfarin treatment on their own impressions and intuition rather than on the guidelines," Dr. Waldo said at the symposium, also sponsored by the Academy of Health Care Education.

Significant predictors of warfarin use were assessed in a logistic-regression model. In this analysis, a perceived or actual bleeding risk reduced the likelihood that a patient would get warfarin by about 28%, and age older than 80 years reduced use of warfarin by about 34%.

Patients with persistent or permanent

atrial fibrillation were 80% more likely to get warfarin, and those with a history of a stroke, transient ischemic attack, or embolic event were 59% more likely to get warfarin.

Catheter ablation of atrial fibrillation cannot be presumed to eliminate a patient's risk of stroke and need for oral anticoagulation, because a significant number of patients have recurrences following ablation, said Dr. Waldo. He recently sent a survey to 353 physicians who treat patients with atrial fibrillation;

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most of the physicians were members of the Heart Rhythm Society. He received 151 replies, of which 134 were from physicians who perform catheter ablations.

Virtually all responders said they would eventually stop treatment with warfarin in patients with no other risk factors for stroke. The time frame for stopping treatment varied, but most responders said they would halt warfarin if no recurrences appeared by 6 months after treatment.

But for patients at high risk for stroke because of their age or clinical history, most responders said they would not stop warfarin treatment, Dr. Waldo said. ■

## New Syncope Statement Features Cardiac Diagnostic Flowchart

BY CHRISTINE KILGORE  
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A new scientific statement from the cardiology community on the evaluation of syncope could either win nods of acceptance or raise eyebrows with its support for echocardiograms and stress tests and its caution against tilt table testing.

The American Heart Association/American College of Cardiology Foundation Scientific Statement on the Evaluation of Syncope—the first such statement on syncope issued by the organizations—reiterates some well-established findings, chiefly that most cases of the often-vexing problem have a cardiovascular cause.

It emphasizes the importance of promptly ruling out structural heart disease and ischemia, as well as less common causes associated with sudden death.

The statement lays out a diminished role, however, for tilt table testing, saying that "serious questions about the sensitivity, specificity, diagnostic yield, and day-to-day reproducibility of tilt table testing exist."

Tilt table testing has traditionally been used as an aid in establishing the diagnosis of neu-

rocardiogenic syncope, and according to lead author Dr. S. Adam Strickberger, "Some ... may feel the tilt table test was devalued" in the new statement.

"But in general, I think there are a lot fewer tilt table tests ordered by electrophysiologists today ... and it's fair to say there is a smaller role for the tests than there would have been 10-15 years ago," Dr. Strickberger said in an interview.

The 11-page statement, which the AHA and ACC Foundation issued in collaboration with the Heart Rhythm Society and which was endorsed by the American Autonomic Society, was published last month (J. Am. Coll. Cardiol. 2006;47:473-84).

Although the document does not offer guidelines per se, it features a simple flowchart for the "diagnostic approach" to patients with syncope as well as comments on the role of various tests.

Its creation was driven by the recognition that syncope "can herald life-threatening diseases" and that "there are patients who are not managed appropriately,"

said Dr. Strickberger, director of arrhythmia research and professor of medicine at Georgetown University, Washington. "We wanted a practical document."

Most important, the statement says, the evaluation of syncope should include a front-line assessment for structural heart disease and ischemia. Less common causes that are associated with sudden death, including Wolff-Parkinson-White syn-

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drome and inherited cardiac ion channel abnormalities, should be excluded early.

"The primary purpose of the evaluation ... is to determine whether the patient is at increased risk for death," the statement says.

In most patients, the cause of syncope can be determined "with great accuracy" from a careful history, physical exam, and ECG. Echocardiograms, exercise tests, and ischemic evaluations fall on the next tier.

The statement says that "an

echocardiogram is a helpful screening test if the history, physical examination, and ECG do not provide a diagnosis or if underlying heart disease is suspected."

"Most of the people on the writing group have a fairly low threshold for the echocardiogram and stress test, which may represent some shift (in thinking)," Dr. Strickberger said.

The statement includes a section on the elderly, mentioning that up to 30% of falls in this population may be due to syncope, and that orthostatic hypotension is the cause of falls in up to a third of elderly patients.

Carotid sinus hypersensitivity is an underrecognized cause of syncope in the elderly, the statement says, and "neurally mediated causes remain a frequent mechanism of syncope in the elderly and may be underestimated because of an atypical presentation."

The statement furthermore states that "particular emphasis (in the elderly) should be given to the impact of polypharmacy, orthostatic intolerance, autonomic dysfunction, and carotid

sinus hypersensitivity."

The greatest challenges with syncope evaluation can lie with the patient, of any age, who has a normal general work-up and cardiac examination.

Here, Dr. Strickberger said, the key lies in determining the "malignancy" of the episode and adjusting the intensity of the evaluation accordingly.

Episodes that occur with little or no warning and that result in a significant injury may warrant other tests such as electrophysiologic testing—which has a low yield and is not routinely recommended—and the tilt table test, he said.

In general, though, the tilt table test provides little information, the statement says.

In patients with no evidence of ischemia and a structurally normal heart, "the pretest probability that the diagnosis is neurocardiogenic syncope is high, so heads-up tilt table testing contributes little to establishing the diagnosis," according to the statement.

In a patient with an otherwise normal evaluation, the statement explains, "the most likely diagnosis" after a negative tilt table test "is still neurocardiogenic syncope." ■