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

BY MITCHEL L. ZOLER
Philadelphia Bureau

Boston — Physicians must be more aggresive 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 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 Atrial Fibrillation 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.

In most of the 814 patients reviewed who met the criteria for having a high risk of stroke, 45% did not receive warfarin (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 neurospsychiatric 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 number of patients have recurrences following ablation, said Dr. Waldo. He recently sent a survey to 353 physicians who treat patients with atrial fibrillation; most of the physicians were members of the Heart Rhythm Society. He received 151 replies, of which 134 were from physicians who perform catheter ablation.

Virtually all respondents said they would eventually stop treatment with warfarin in patients with atrisk factors for stroke. The time frame for stopping treatment varied, but most respondents 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 Syncpe Statement Features Cardiac Diagnostic Flowchart

BY CHRISTINE KILGORE Contributing Writer

A new scientific statement from the cardiology community on the evaluation of syncope could either win nods of acceptance or raise eyebrows with the community on the evaluation of syncope.

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, the statement points out.

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The statement emphasizes the importance of prompt recognition and treatment of the adverse cardiovascular events that can result from syncope.

"The statement says that ‘neurally mediated’ syncope is an underrecognized cause of falls in up to 30% of falls in this population, due to orthostatic hypotension that is the cause of falls in up to a third of elderly patients.

Carotid sinus hypersensitivity is an unrecognized 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 ‘magnification’ 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 electrophysiology 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 patient may have ‘idiopathic syncope’ after a negative tilt table test ‘is still neurocardiogenic syncope.”