ESISTE UN VANTAGGIO REALE SCEGLIENDO UN NAO PITTOSTO CHE IL DICUMEROLICO NELLA GESTIONE DEI PAZIENTI CON FIBRILLAZIONE ATRIALE?

Come decidere tra una terapia consolidata con il disagio del controllo dell'INR ed una terapia nuova con il disagio del carico burogratico che comporta

Milano 9-10 aprile 2015

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Unità Operativa di Cardiologia
Ospedale Valduce – Como

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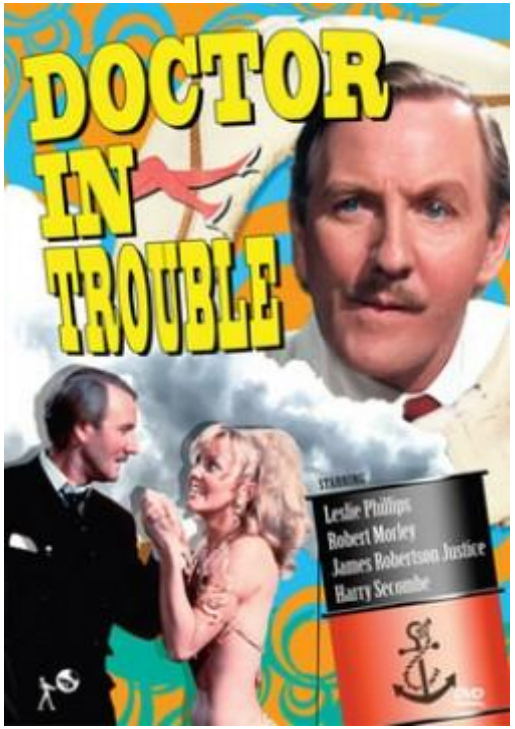
CONFLITTI DI INTERESSI : NESSUNO

SCILLA E CARIDDI



LE FONTI

European Heart Journal
doi:10.1093/eurheartj/ehs253

ESC GUIDELINES

Eur Heart J August 2012

2012 focused update of the ESC Guidelines for the management of atrial fibrillation

An update of the 2010 ESC Guidelines for the management of atrial fibrillation
Developed with the special contribution of the European Heart Rhythm Association

Authors/Task Force Members: A. John Camm (Chairperson) (UK)*, Gregory Y.H. Lip (UK), Raffaele De Caterina (Italy), Irene Savelieva (UK), Dan Atar (Norway), Stefan H. Hohnloser (Germany), Gerhard Hindricks (Germany), Paulus Kirchhof (UK)

Linee guida AIAC per la gestione e il trattamento della fibrillazione atriale. Aggiornamento 2013

Antonio Raviele (Chairman)[1], Marcello Disertori[2] (Co-Chairman), Paolo Alboni[3], Emanuele Bertaglia[4], Gianluca Botto[5], Michele Brignole[6], Riccardo Cappato[7], Alessandro Capucci[8], Maurizio Del Greco[2], Roberto De Ponti[9], Matteo Di Biase[10], Giuseppe Di Pasquale[11], Michele Gulizia[12], Federico Lombardi[13], Sakis Themistoclakis[14], Massimo Tritto[15]

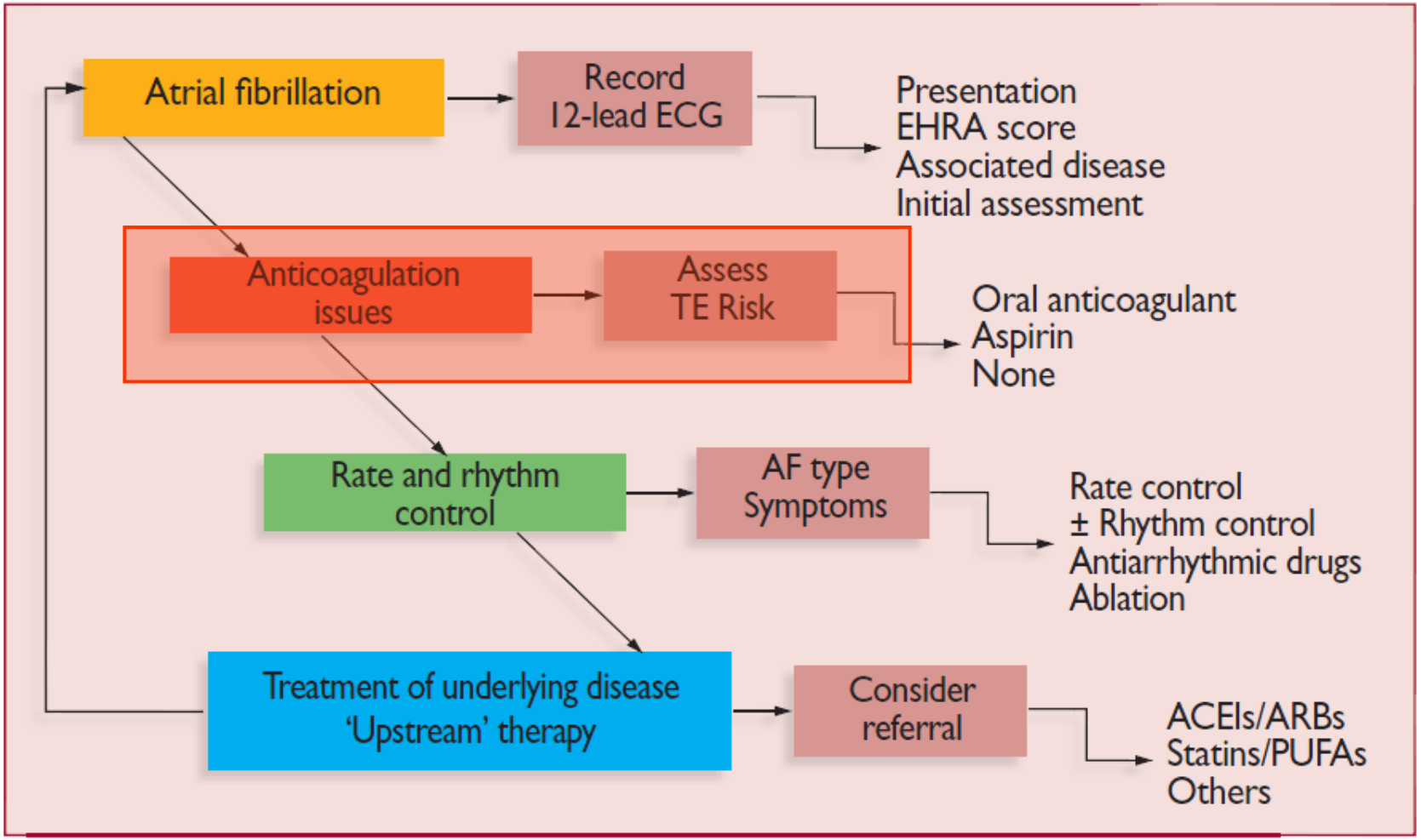
G Ital Cardiol 2013; 14: 215-40

LA STRATIFICAZIONE DEL RISCHIO

The Risk of
Systemic Thromboembolism
in Patients With AF
IS NOT
Homogenous

AFIB: The Management Cascade

ESC/EHRA Guidelines 2010



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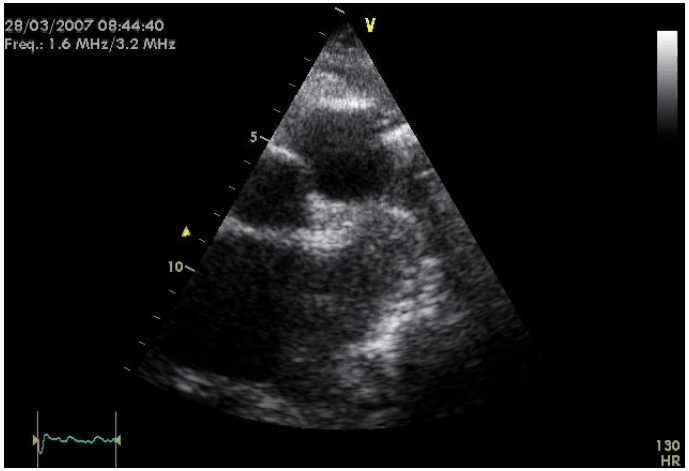
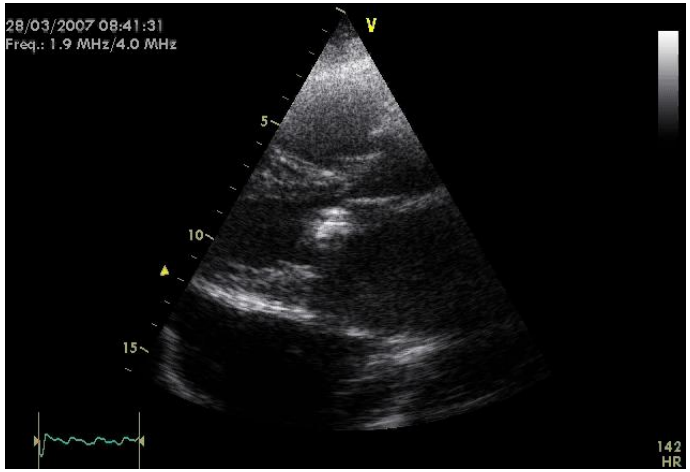
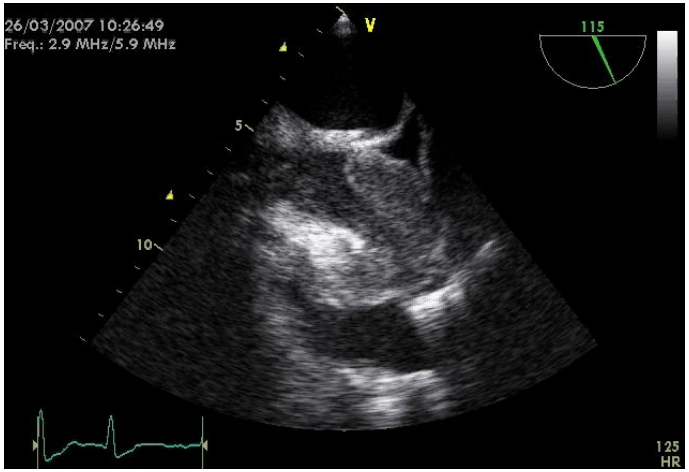
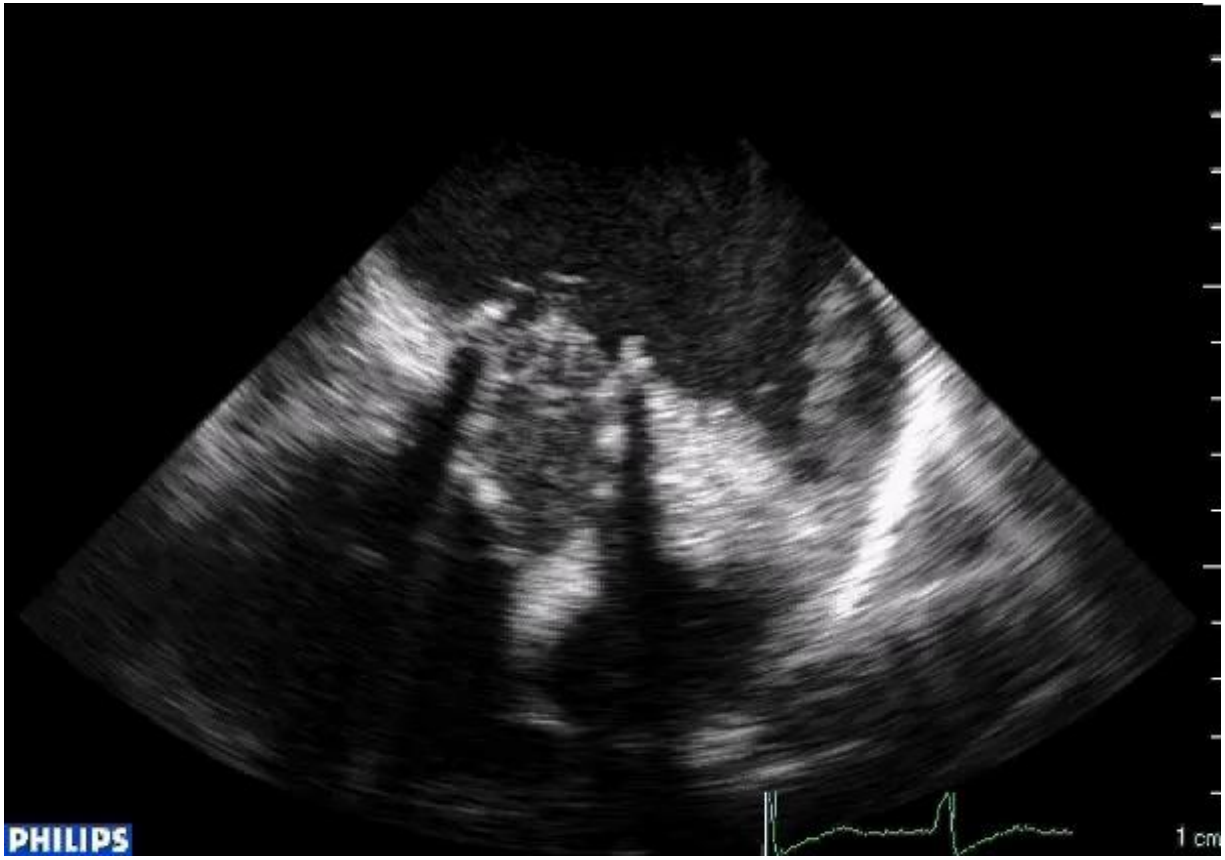






LA STRATIFICAZIONE DEL RISCHIO



LA STRATIFICAZIONE DEL RISCHIO

$CHADS_2$ score	Patients (n = 1733)	Adjuste stroke rate (%/y)* (95% confidence interval)
0	120	1.9 (1.2 - 3.0)
1	463	2.8 (2.0 - 3.8)
2	523	4.0 (3.1 - 5.1)
3	337	5.9 (4.6 - 7.3)
4	220	8.5 (6.3 - 11.1)
5	65	12.5 (8.2 - 17.5)
6	5	18.2 (10.5 - 27.4)

*The adjusted stroke rate was derived from the multivariable analysis assuming no aspirin usage; these stroke rates are based on data from a cohort of hospitalised AF patients, published in 2001, with low numbers in those with a **$CHADS_2$ score** of 5 and 6 to allow an accurate judgement of the risk in these patients. Given that stroke rates are declining overall, actual stroke rates in contemporary non-hospitalised cohorts may also vary from these estimates. Adapted from Gage BF et al.

AF = atrial fibrillation; $CHADS_2$ = cardiac failure, hypertension, age, diabetes, stroke (doubled).

www.escardio.org/guidelines

European Heart Journal (2010) 31, 2369-2429

EUROPEAN SOCIETY OF CARDIOLOGY®

$CHADS_2$ score and stroke rate

LA STRATIFICAZIONE DEL RISCHIO

Major risk factors
Previous stroke
TIA or systemic embolism
Age ≥ 75 years

Clinically relevant non-major risk factors
CHF or moderate to severe LV systolic dysfunction [e.g. LV EF ≤ 40%]
Hypertension
Diabetes mellitus
Age 65-74 years
Female sex
Vascular disease

Risk factor	Score
Congestive heart failure/LV dysfunction	1
Hypertension	1
Age ≥ 75 ans	2
Diabetes mellitus	1
Stroke/TIA/thrombo-embolism	2
Vascular disease*	1
Age 65-74	1
Sex category [i.e. femal sex]	1
Maximum score	**9**

*Prior myocardial infarction, peripheral artery disease, aortic plaque. Actual rates of stroke in contemporary cohorts may vary from these estimates.

www.escardio.org/guidelines

European Heart Journal (2010) 31, 2369-2429

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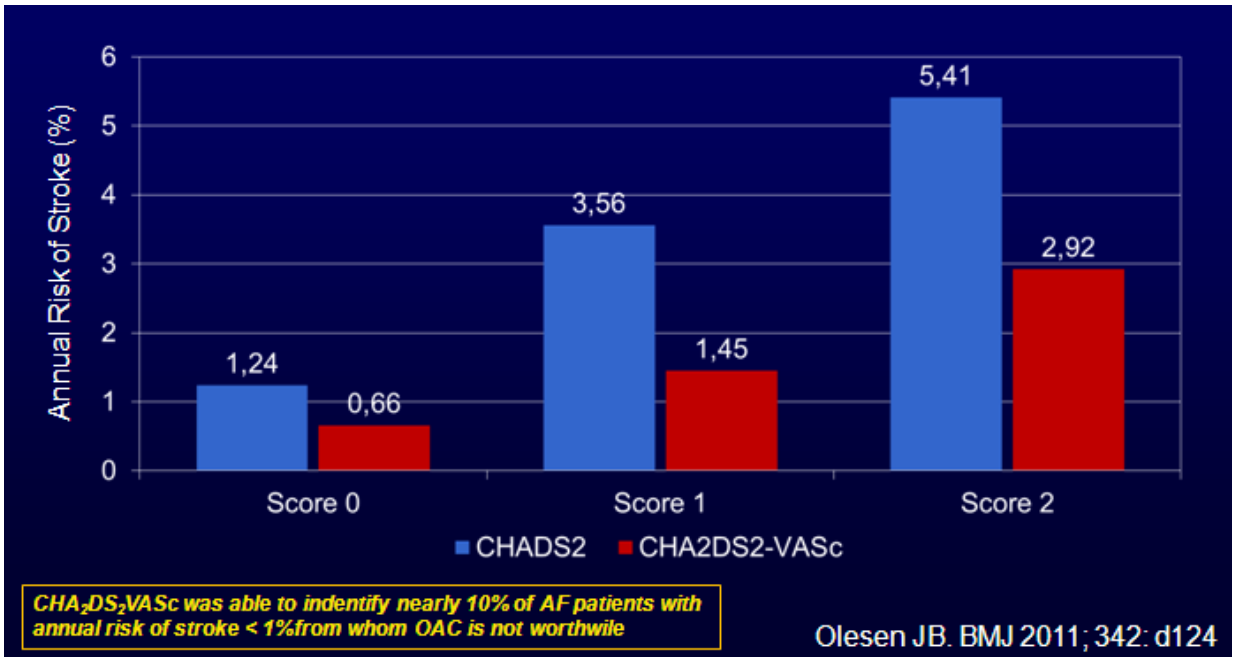
LA STRATIFICAZIONE DEL RISCHIO



BMJ

RESEARCH

Validation of risk stratification schemes for predicting stroke and thromboembolism in patients with atrial fibrillation: nationwide cohort study

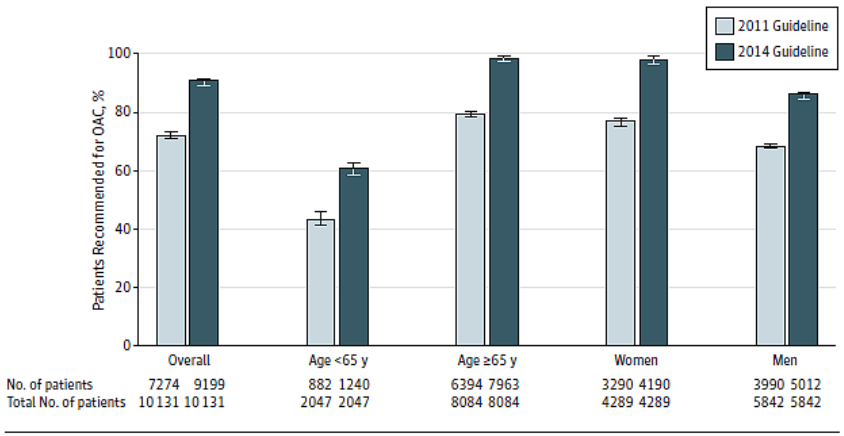
Jonas Bjerring Olesen, research fellow,[1] Gregory Y H Lip, professor,[2] Morten Lock Hansen, research fellow,[1] Peter Riis Hansen, research director,[1] Janne Schurmann Tolstrup, research director,[3] Jesper Lindhardsen, research fellow,[1] Christian Selmer, research fellow,[1] Ole Ahlehoff, research fellow,[1] Anne-Marie Schjerning Olsen, research fellow,[1] Gunnar Hilmar Gislason, research director,[1] Christian Torp-Pedersen, professor[1]

Conclusions The risk associated with a specific risk stratification score depended on the risk factors composing the score. CHA_2DS_2-VASc performed better than $CHADS_2$ in predicting patients at high risk, and those categorised as low risk by CHA_2DS_2-VASc were truly at low risk for thromboembolism.

LA STRATIFICAZIONE DEL RISCHIO

In summary, the implication of using the recently updated guideline is to encourage oral anticoagulation for more patients at intermediate to low risk of stroke. Lacking evidence that this approach leads to overall improved outcomes for patients, we must be aware that the likely consequence is increased bleeding risk and uncertain benefit.

Figure. Change in the Percentage of Patients Recommended for Oral Anticoagulation (OAC) Under New vs Old Atrial Fibrillation Treatment Guidelines



The figure displays the proportion of patients in the entire Outcomes Registry for Better Informed Treatment of Atrial Fibrillation study population who were recommended for OAC under the 2011 and 2014 guidelines.[1,2] Error bars indicate 95% CIs of the proportions.

jamainternalmedicine.com JAMA Internal Medicine Published online March 2, 2015

Letters

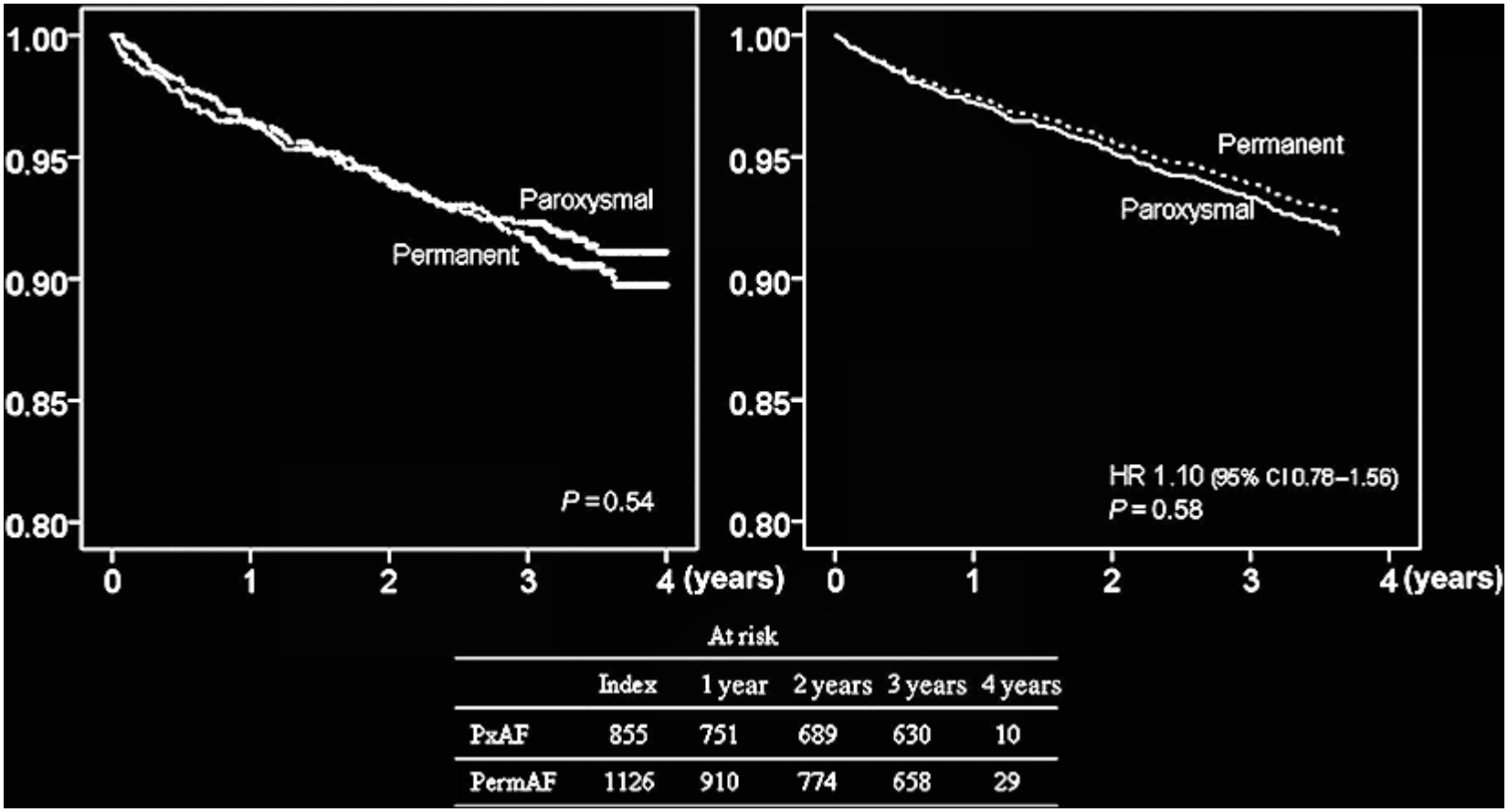
RESEARCH LETTER

Effect of the 2014 Atrial Fibrillation Guideline Revisions on the Proportion of Patients Recommended for Oral Anticoagulation

Invited Commentary

In 2014, the American Heart Association, American College of Cardiology, and Heart Rhythm Society published a revised guideline for atrial fibrillation (AF) treatment recommending use of a refined stroke risk score and revised threshold for oral anticoagulation (OAC) initiation.[1] We assessed the potential effect of this new guideline by comparing the proportion of patients with AF recommended for OAC under the 2011 and 2014 guidelines.[1,2]

TIPI DI FA E RISCHIO EMBOLICO



At risk

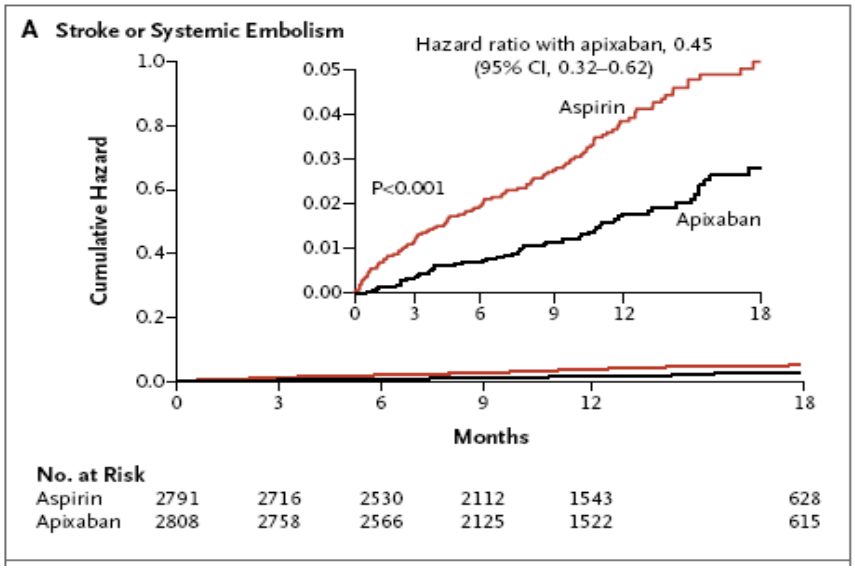
	Index	1 year	2 years	3 years	4 years
PxAF	855	751	689	630	10
PermAF	1126	910	774	658	29

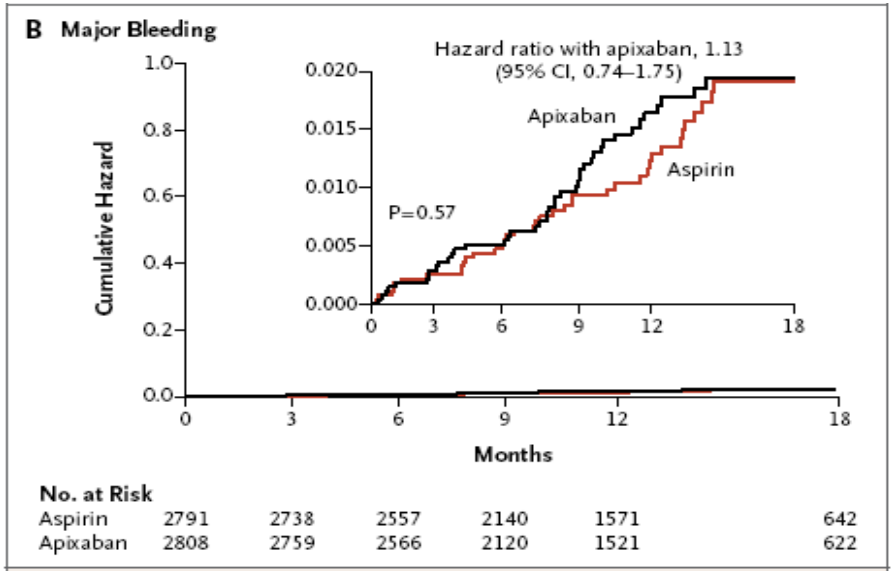
Survival free from ischaemic stroke in paraoxysmal atrial fibrillation (AF) and permanent AF. Unadjusted incidence to the left, multivariably adjusted to the right

European Heart Journal

Friberg L et al. Eur Heart J 2010;31:967-975

QUALE TRATTAMENTO ANTITROMBOTICO ?





The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

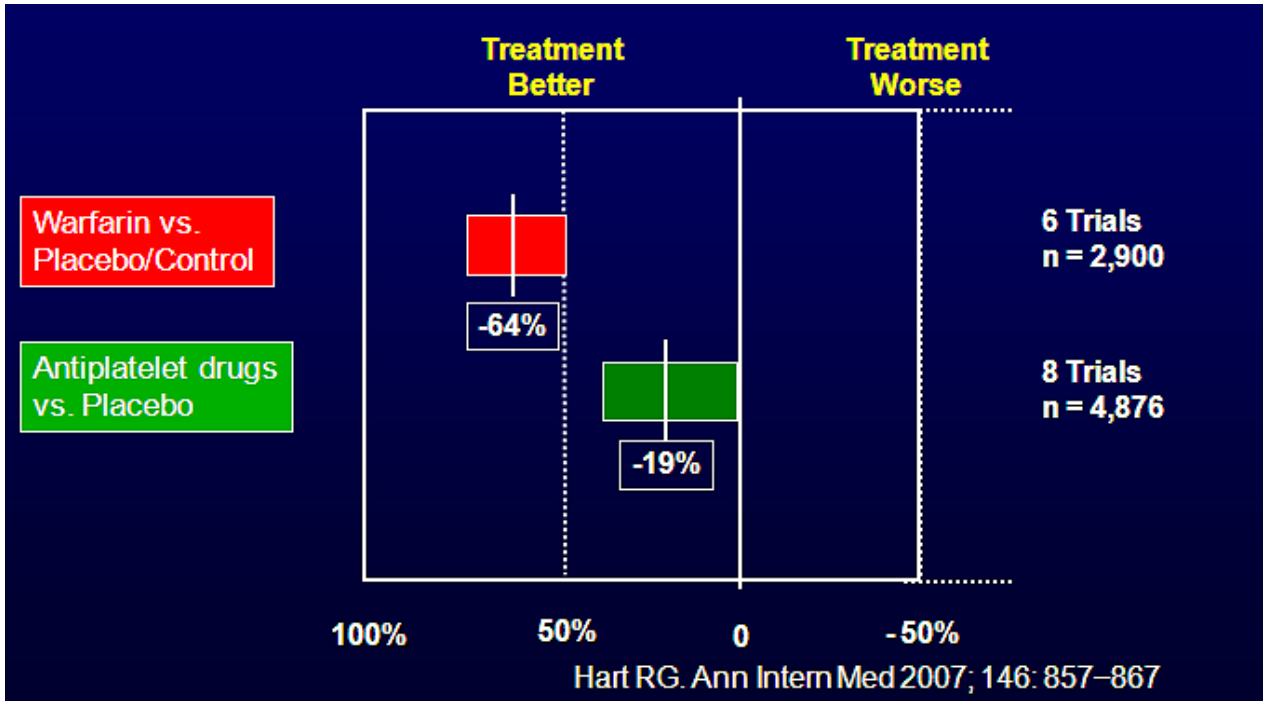
Apixaban in Patients with Atrial Fibrillation

Stuart J. Connolly, M.D., John Eikelboom, M.B., B.S., Campbell Joyner, M.D., Hans-Christoph Diener, M.D., Ph.D., Robert Hart, M.D., Sergey Golitsyn, M.D., Ph.D., Greg Flaker, M.D., Alvaro Avezum, M.D., Ph.D., Stefan H. Hohnloser, M.D., Rafael Diaz, M.D., Mario Talajic, M.D., Jun Zhu, M.D., Prem Pais, M.B., B.S., M.D., Andrzej Budaj, M.D., Ph.D., Alexander Parkhomenko, M.D., Ph.D., Petr Jansky, M.D., Patrick Commerford, M.B., Ch.B., Ru San Tan, M.B., B.S., Kui-Hian Sim, M.B., B.S., Basil S. Lewis, M.D., Walter Van Mieghem, M.D., Gregory Y.H. Lip, M.D., Jae Hyung Kim, M.D., Ph.D., Fernando Lanas-Zanetti, M.D., Antonio Gonzalez-Hermosillo, M.D., Antonio L. Dans, M.D., Muhammad Munawar, M.D., Ph.D., Martin O'Donnell, M.B., Ph.D., John Lawrence, M.D., Gayle Lewis, Rizwan Afzal, M.Sc., and Salim Yusuf, M.B., B.S., D.Phil., for the AVERROES Steering Committee and Investigators*

ASA

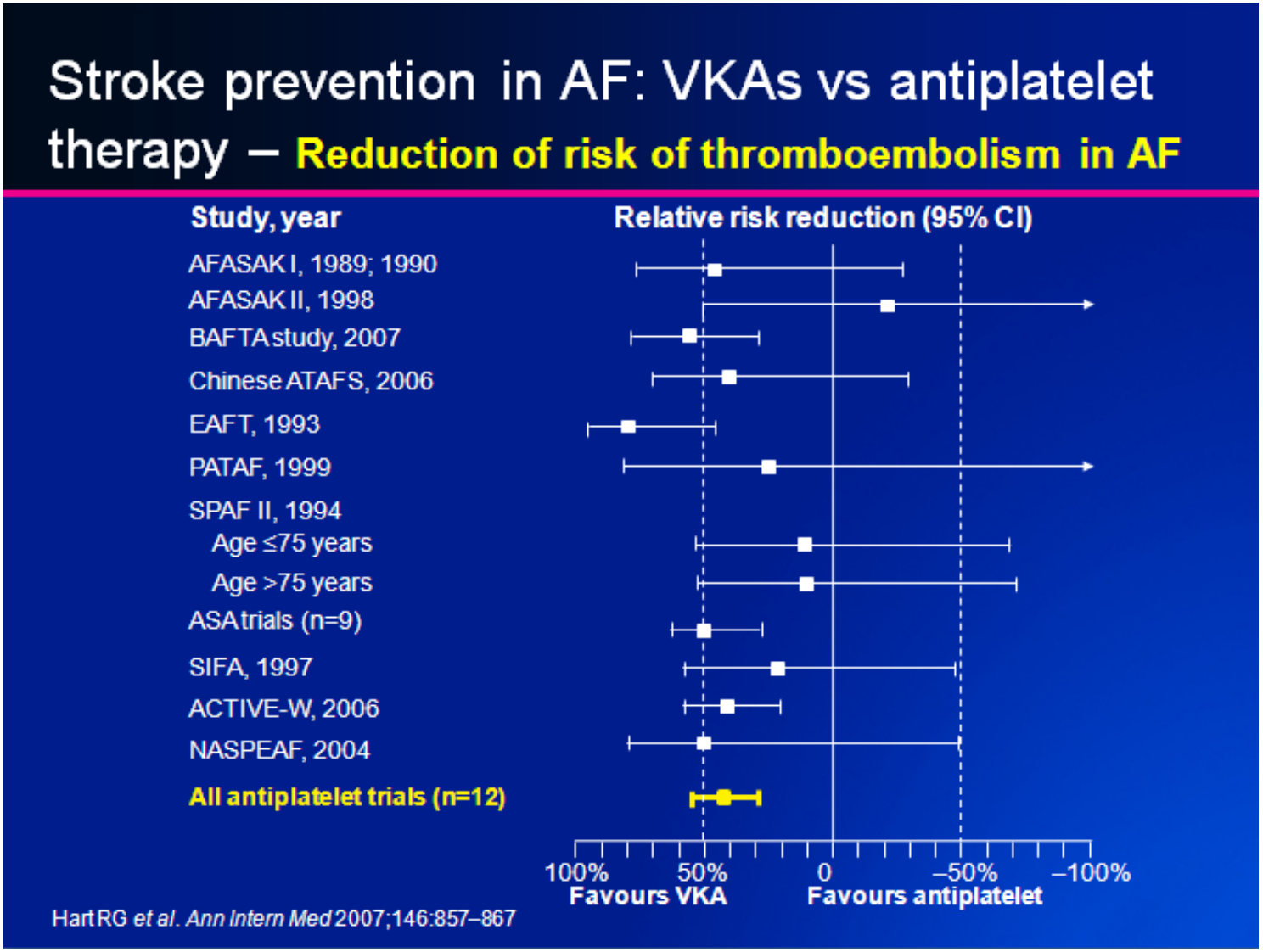
QUALE TRATTAMENTO ANTITROMBOTICO ?

Conclusions: Adjusted-dose warfarin and antiplatelet agents reduce stroke by approximately 60% and by approximately 20%, respectively, in patients who have atrial fibrillation. Warfarin is substantially more efficacious (by approximately 40%) than antiplatelet therapy. Absolute increases in major extracranial hemorrhage associated with antithrombotic therapy in participants from the trials included in this meta-analysis were less than the absolute reductions in stroke. Judicious use of antithrombotic therapy importantly reduces stroke for most patients who have atrial fibrillation



Annals of Internal Medicine
Established in 1927 by the American College of Physicians

WARFARIN: EFFETTI



PERCHE' LA TAO FUNZIONA NELLA FA

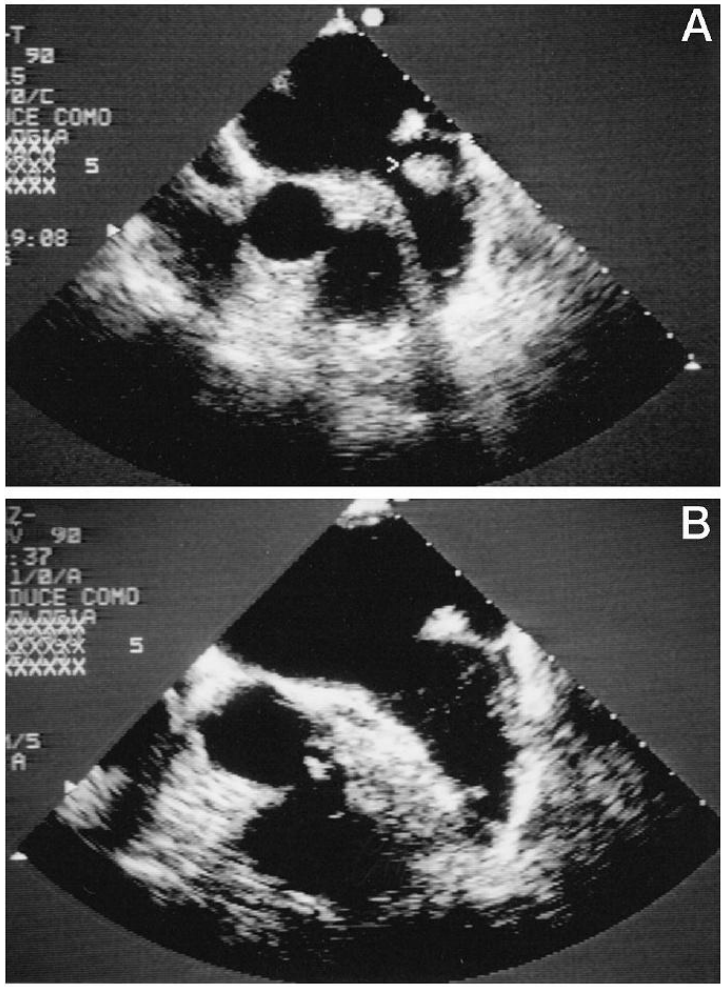


FIGURE 1. TEEs (horizontal plane) of the left atrium and left atrial appendage (patient No. 4 of the table). Panel A shows the left atrium and appendage in a 60-year-old woman affected by mitral stenosis and aortic regurgitation. The duration of atrial fibrillation was unknown. Note the pedunculated thrombus (white arrow) at the mouth of left atrial appendage. Panel B shows the same patient after 4 weeks of warfarin. The thrombus had completely resolved. Scant spontaneous echocontrast can be seen in left atrial appendage.

Atrial Thrombi Resolution After Prolonged Anticoagulation in Patients With Atrial Fibrillation*

A Transesophageal Echocardiographic Study

Giovanni Corrado, MD; Giorgio Tadeo, MD; Sandro Beretta, MD; Luca Mario Tagliagambe, MD; Giovanni Foglia Manzillo, MD; Manuela Spata, MD; and Mauro Santarone, MD

Background: **Cardioversion of atrial fibrillation in nonanticoagulated patients may be associated with clinical thromboembolism. Prolonged anticoagulation with warfarin before cardioversion of atrial fibrillation produces a marked reduction of cardioversion-related thromboembolism. The benefit of anticoagulant therapy is generally believed to be due to atrial thrombi organization.**
Patients and methods: **Transesophageal echocardiography (TEE) is highly accurate for diagnosis of atrial thrombi and gives the possibility to serially evaluate the effects of anticoagulant therapy. One hundred twenty-three patients with atrial fibrillation lasting longer than 2 days underwent TEE before cardioversion. An atrial thrombus was identified in 11 patients (9%), and was always confined to the left atrial appendage. TEE was repeated after a median of 4 weeks of oral warfarin. Atrial thrombus had completely resolved in 9 of 11 patients (81.8%; 95% CI, 48.2 to 97.7%); in two patients, clot was still present. No patient had clinical thromboembolism between the two TEE studies.**
Conclusions: **In the population of our study, a prolonged course of warfarin therapy was associated with resolution of atrial thrombi in the majority of patients. According to these data, the mechanism of thromboembolism reduction with 4 weeks of anticoagulation before cardioversion in patients with atrial fibrillation seems to be related mainly to thrombus lysis rather than organization. Due to the possibility of thrombus persistence even after prolonged anticoagulation, follow-up with TEE before cardioversion is necessary to document thrombus resolution.**
(CHEST 1999; 115:140–143)

Key words: anticoagulation; echocardiography; fibrillation

Abbreviations: AF = atrial fibrillation; TEE = transesophageal echocardiography; TTE = transthoracic echocardiography

WARFARIN: LIMITI

The limitations of VKA therapy

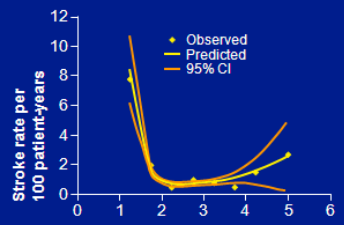
- Significant inter- and intra-patient variability in dose–response,[1] due to:
  - Co-morbid conditions
  - Genetic polymorphisms
  - Numerous interactions with food and concomitant drugs
  - Unpredictable pharmacology
- Narrow therapeutic window[1]
  - Regular coagulation monitoring and dose adjustments required
  - Failure to stay within the therapeutic range increases the risk of stroke or adverse bleeding events[2]
- Underuse[2–4]
  - Fear of haemorrhage; intracranial haemorrhage is the most devastating bleeding event[5]
  - Particularly in elderly patients because of high perceived risk of bleeding versus possible benefits[5]

1. Ansell J *et al. Chest* 2008;133:160S–198S; 2. Nieuwlaat R *et al. Am Heart J* 2007;153:1006–1012;
3. Ogilvie IM *et al. Am J Med* 2010;123:638–645; 4. Nieuwlaat R *et al. Eur Heart J* 2005;26:2422–2434;
5. Waldo A *et al. J Am Coll Cardiol* 2005;46:1729–1736

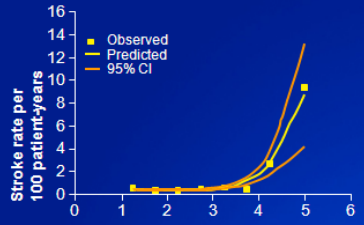
WARFARIN: LIMITI

VKAs have a narrow therapeutic window

Ischaemic stroke[1]



Haemorrhagic stroke[1]



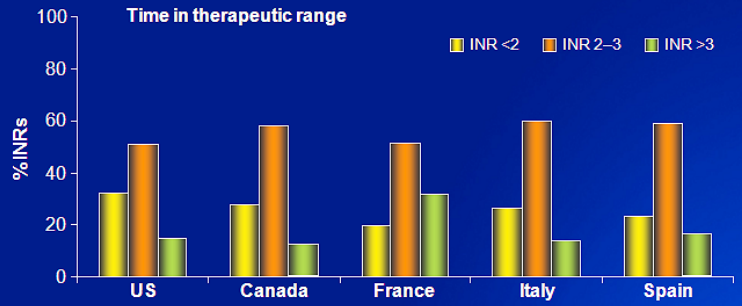
- INR below 2 is associated with an increased risk of ischaemia
- INR above 3 is associated with an increased risk of haemorrhagic stroke

VKA-related haemorrhage is the leading cause of iatrogenic hospitalization, accounting for 13% of hospitalizations due to drug-related adverse events[2]

1. Amouyel P *et al. Eur J Intern Med* 2009;20:63–69; 2. Pouyanne P *et al. BMJ* 2000;320:1036

INR control in routine practice is suboptimal (2)

Retrospective, multicentre cohort study (ISAM)



Ansell J *et al. J Thromb Thrombolysis* 2007;23:83–91

VKAs have many drug–drug interactions

Increased INR response

Specific Drugs Reported		
acetaminophen	fenofibrate	oxymetholone
alcohol[a]	fenoprofen	pantoprazole
allopurinol	fluconazole	paroxetine
aminosalicylic acid	fluorouracil	penicillin G, intravenous
amiodarone HCl	fluoxetine	pentoxifylline
argatroban	flutamide	phenylbutazone
aspirin	fluvastatin	phenytoin[a]
atenolol	fluvoxamine	piperacillin
atorvastatin[a]	gemfibrozil	piroxicam
azithromycin	glucagon	pravastatin[a]
bexlinodin	halothane	prednisone[a]
capecitabine	heparin	propafenone
carbamazepine	ibuprofen	propoxyphene
cefazolin	ifosfamide	propranolol
cefoperazone	indomethacin	propylthiouracil[a]
cefotetan	influenza virus vaccine	quinidine
cefoxitin	irbesartan	quinine
ceftriaxone	isoniazid	rabeprazole
cefuroxime	ketoprofen	ranitidine[a]
cephalothin	ketorolac	rofecoxib
cimetidine	lansoprazole	salicylates
chloramphenicol	leflunomide	simvastatin
chloral hydrate[a]	levamisole	sorafenib
chlorpromazine	levofloxacin	streptokinase
cholestyramine[a]	levothyroxine	sulfamethizole
cinnarizine	lisinopril	sulfamethoxazole
ciprofloxacin	lovastatin	sulfinpyrazone
cisapride	mefenamic acid	sulfisoxazole
clarithromycin	methimazole[a]	sulindac
clofibrate	methyldopa	tamoxifen
COUMADIN overdose	methylphenidate	tetracycline
cyclophosphamide[a]	methylsalicylate ointment (topical)	thyroid
danazol	metronidazole	ticarcillin
dextran	miconazole (intravaginal, oral, systemic)	ticlopidine
dextrothyroxine	moricizine hydrochloride[a]	tissue plasminogen activator (t-PA)
diazoxide	nalidixic acid	tolbutamide
diclofenac	naproxen	tramadol
dicumarol	neomycin	trimethoprim/sulfamethoxazole
diflunisal	norfloxacin	ursodiol
disulfiram	ofloxacin	valproate
doxycycline	olsalazine	vitamin E
erythromycin	omeprazole	zafirlukast
esomeprazole	oxandrolone	zileuton
ethacrynic acid	oxaprozin	

Decreased INR response

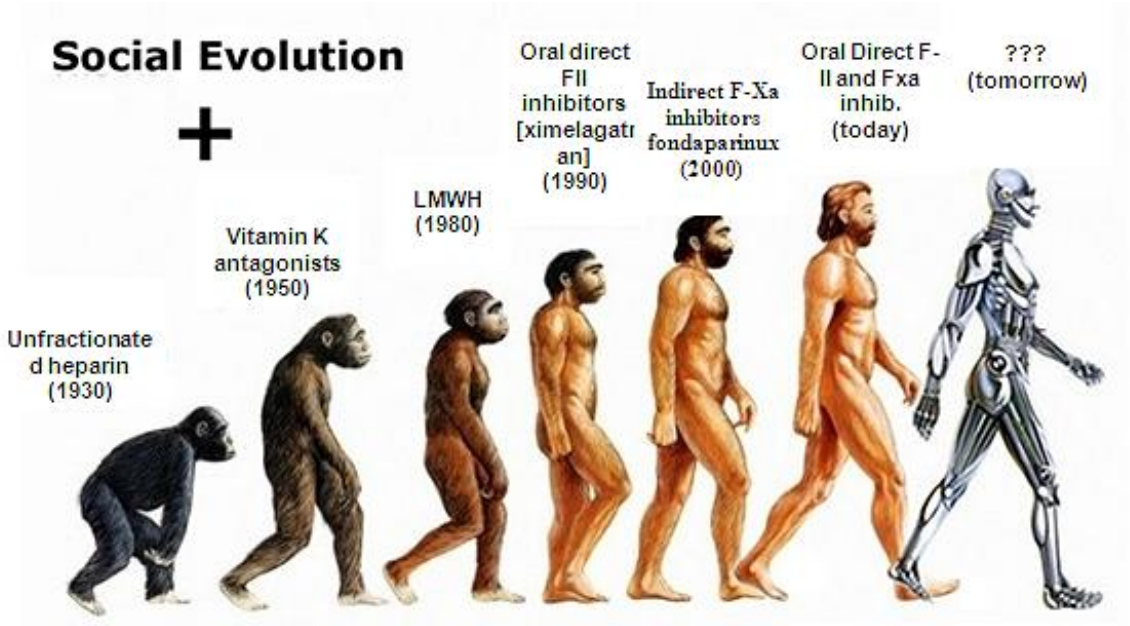
Specific Drugs Reported		
alcohol[a]	COUMADIN underdosage	phenytoin[a]
aminoglutethimide	cyclophosphamide[a]	pravastatin[a]
amobarbital	dicloxacillin	prednisone[a]
atorvastatin[a]	ethchlorvynol	primidone
azathioprine	glutethimide	propylthiouracil[a]
butabarbital	griseofulvin	raloxifene
butalbital	haloperidol	ranitidine[a]
carbamazepine	meprobamate	rifampin
chloral hydrate[a]	6-mercaptopurine	secobarbital
chlordiazepoxide	methimazole[a]	spironolactone
chlorthalidone	moricizine hydrochloride[a]	sucralfate
cholestyramine[a]	nafcillin	trazodone
clozapine	paraldehyde	vitamin C (high dose)
corticotropin	pentobarbital	vitamin K
cortisone	phenobarbital	

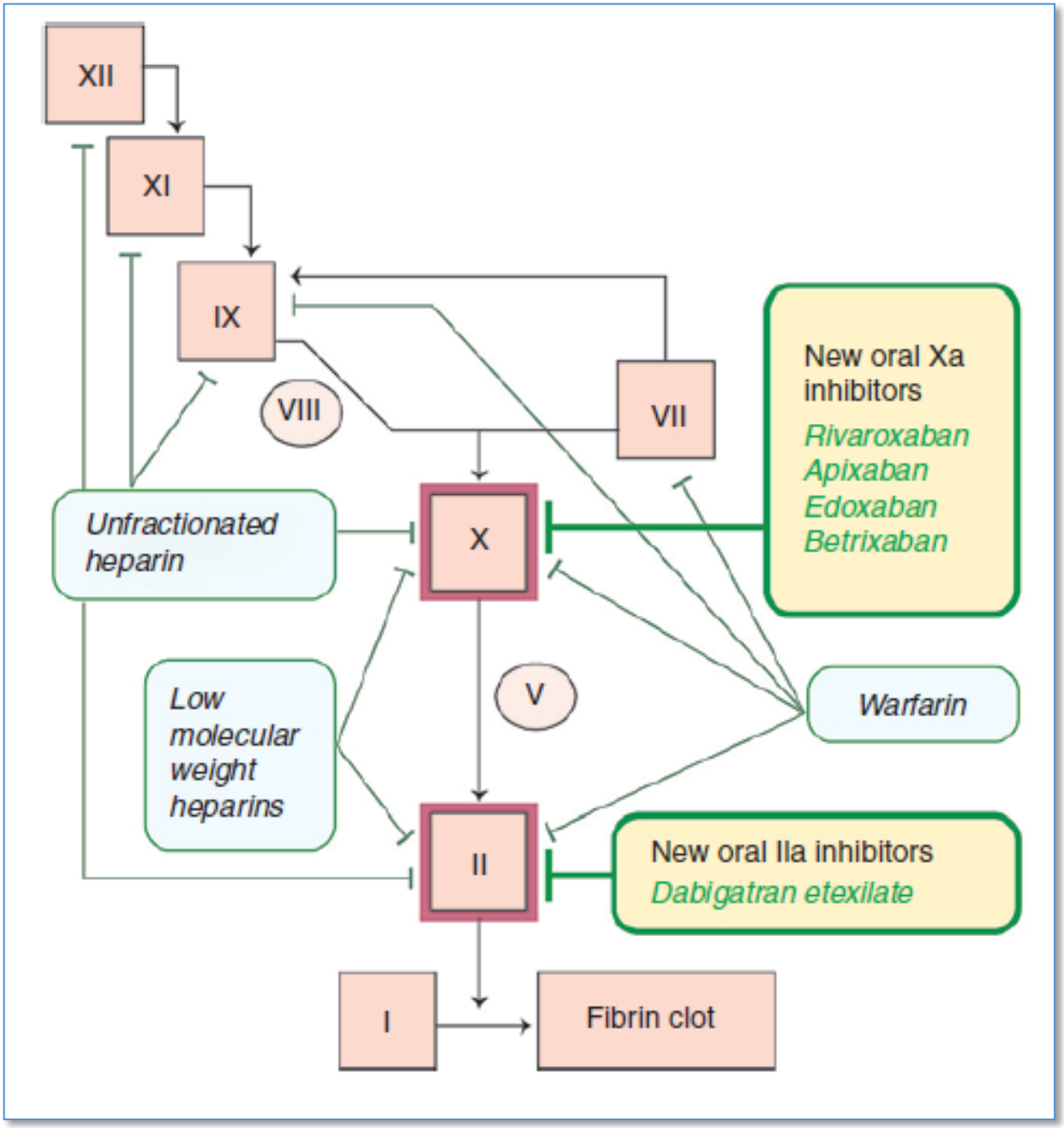
also: diet high in vitamin K
unreliable PT/INR determinations

Coumadin Package Insert US revised January 2010

L'ANTICOAGULANTE IDEALE

- High efficacy to safety index
- Predictable dose-response (no lab monitoring)
- Oral administration
- Rapid onset and offset of action
- Availability of a safe antidote
- No non-anticoagulant side effects
- Minimal interaction with food and other drugs





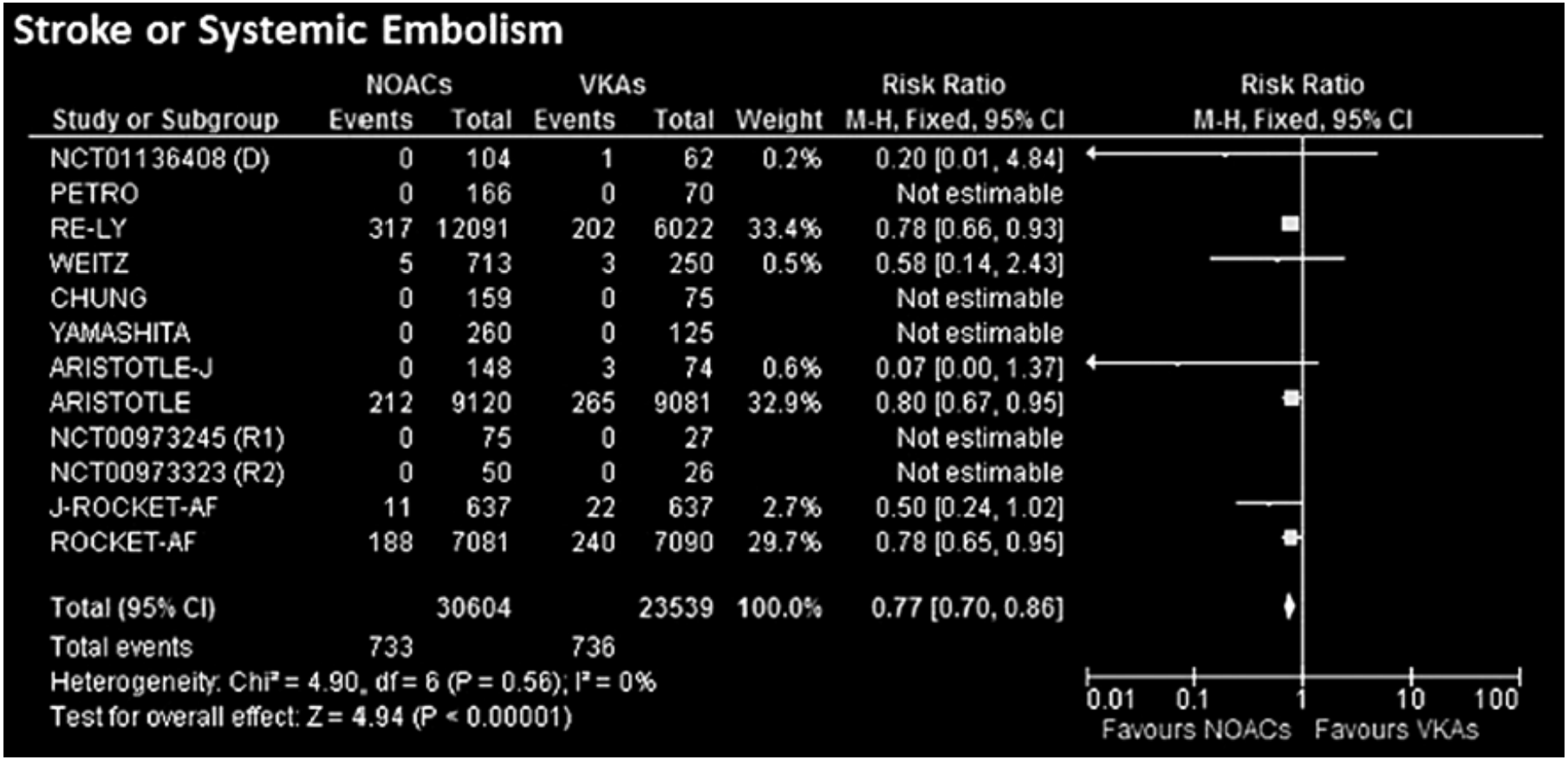
I BERSAGLI

Mantha, S., Cabral, K. and Ansell, J. (2013), New Avenues for Anticoagulation in Atrial Fibrillation. Clinical Pharmacology & Therapeutics, 93: 68–77. doi: 10.1038/clpt.2012.197

NOACs

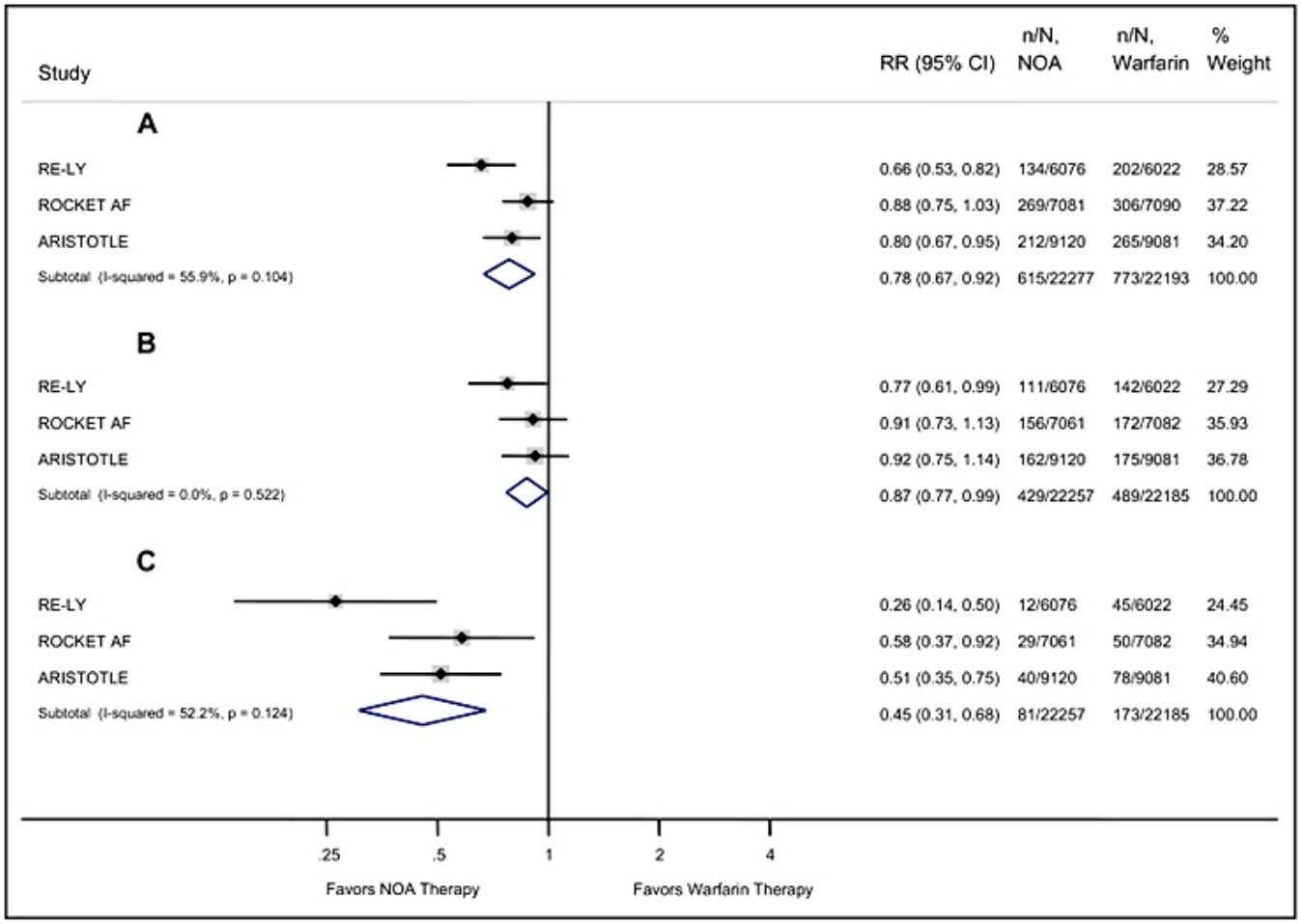
	Dabigatran (RE-LY)[70, 71]	Rivaroxaban (ROCKET-AF)[3]	Apixaban (ARISTOTLE)[4]
Drug characteristics			
Mechanism	Oral direct thrombin inhibitor	Oral direct factor Xa inhibitor	Oral direct factor Xa inhibitor
Bioavailability, %	6	60–80	50
Time to peak levels, h	3	3	3
Half-life, h	12–17	5–13	9–14
Excretion	80% renal	2/3 liver, 1/3 renal	25% renal, 75% faecal
Dose	150 mg b.i.d.	20 mg o.d.	5 mg b.i.d.
Dose in renal impairment	110 mg b.i.d.	15 mg o.d. (if CrCl 30-49 mL/min)	2.5 mg b.i.d.
Special considerations	Intestinal absorption is pH-dependent and is reduced in patients taking proton pump inhibitors	Higher levels expected in patients with renal or hepatic failure	
	Increased risk of bleeding in patients taking verapamil/amiodarone/quinidine/ketoconazole	Activity lower in fasted patients so should be taken after food	
Study characteristics			
Study design	Randomized, open-label	Randomized, double-blind	Randomized, double-blind
Number of patients	18 111	14 264	18 201
Follow-up period, years	2	1.9	1.8
Randomized groups	Dose-adjusted warfarin vs. blinded doses of dabigatran (150 mg b.i.d., 110 mg b.i.d.)	Dose-adjusted warfarin vs. rivaroxaban 20 mg o.d.	Dose-adjusted warfarin vs. apixaban 5 mg b.i.d.

AF: NOACs vs Warfarin



Dentali f et al. Efficacy and safety of the novel oral anticoagulants in atrial fibrillation: a systematic review and meta-analysis of the literature. *Circulation* 2012;126(20):2381-91

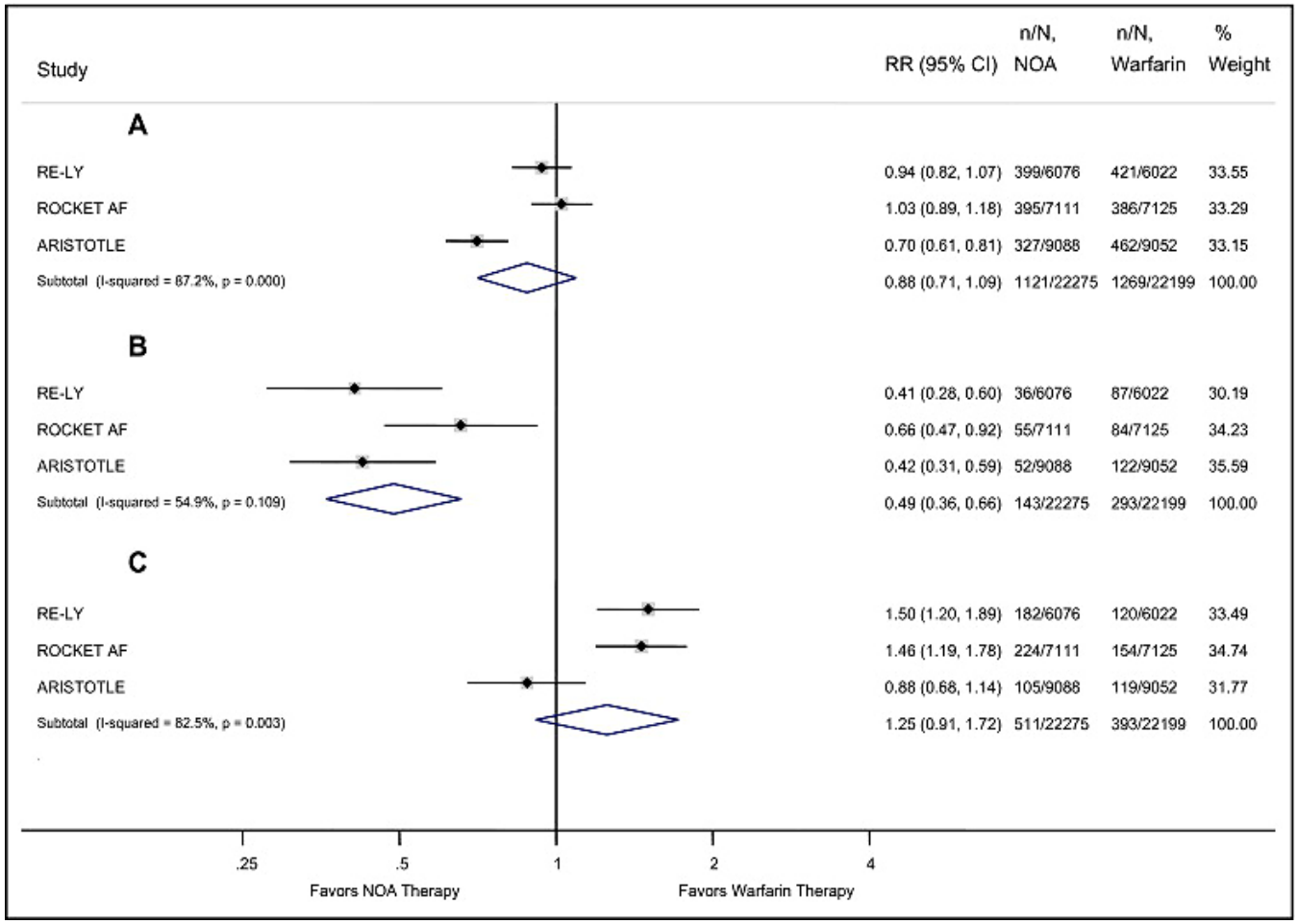
AF: NOACs vs Warfarin



Forest plot for (A) all-cause stroke and systemic embolism, (B) ischemic and unspecified stroke, and (C) hemorrhagic stroke, new oral anticoagulants (NOA) versus warfarin in patients with AF.

Corey S et al. meta-analysis of efficacy and safety of new oral anticoagulants (dabigatran , rivaroxaban , apixaban) versus warfarin in patients with atrial fibrillation .*Am J Cardiol* 2012;110:453-460

AF: NOACs vs Warfarin



Forest plot for *(A)* major bleeding, *(B)* intracranial bleeding, and *(C)* gastrointestinal bleeding, new oral anticoagulants (NOA) versus warfarin in patients with AF.

Corey S et al. meta-analysis of efficacy and safety of new oral anticoagulants (dabigatran , rivaroxaban , apixaban) versus warfarin in patients with atrial fibrillation .*Am J Cardiol* 2012;110:453-460

COSTO-EFFICACIA

Amanda R. et al. Cost-effectiveness of apixaban, dabigatran, rivaroxaban, and warfarin for stroke prevention in atrial fibrillation. *Stroke* 2013;44.1676-1681

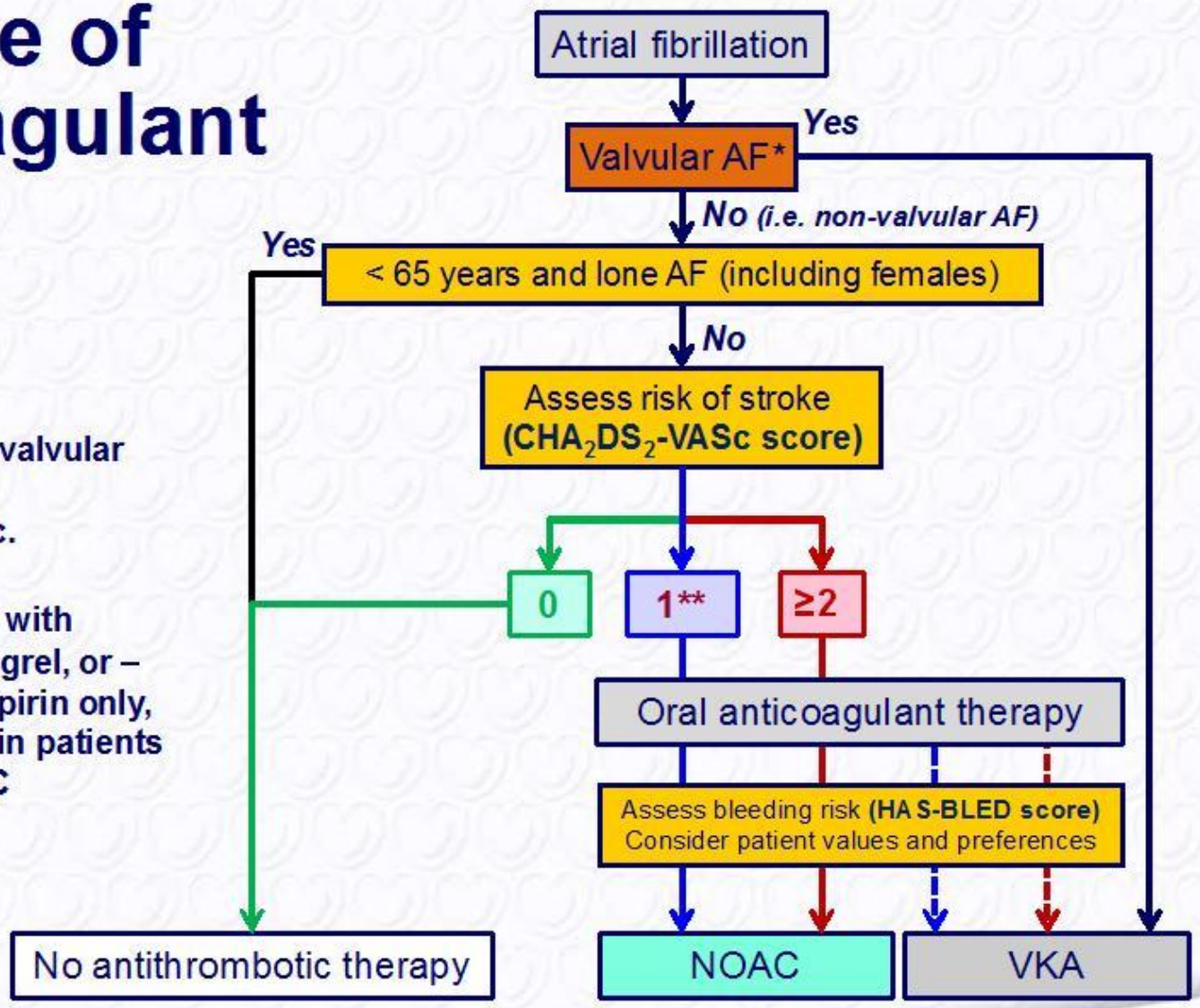
Table. Projected Costs, QALYs, and ICERs for Patients With Nonvalvular Atrial Fibrillation Receiving Anticoagulation Therapy

	Base Case			Probabilistic Sensitivity Analysis		
	Total Cost	QALY	ICER	Total Cost (SD)	QALY (SD)	ICER
Warfarin	$77 813	7.97	…*	$77 772 ($2223)	7.97 (0.04)	…*
Rivaroxaban, 20 mg	$78 738	8.26	$3190/QALY	$78 719 ($1852)	8.26 (0.06)	$3266/QALY
Dabigatran, 150 mg	$82 719	8.41	$11 150/QALY	$82 705 ($1959)	8.41 (0.07)	$11 211/QALY
Apixaban, 5 mg	$85 326	8.47	$15 026/QALY	$85 337 ($1512)	8.47 (0.06)	$15 130/QALY

ICER indicates incremental cost-effectiveness ratio; QALY, quality-adjusted life-year; and SD, standard deviation.
*Warfarin is the reference therapy for the ICER calculation.

Conclusions—In patients with nonvalvular atrial fibrillation and an increased risk of stroke prophylaxis, apixaban 5 mg, dabigatran 150 mg, and rivaroxaban 20 mg were all cost-effective alternatives to warfarin

Choice of Anti-coagulant



- Includes rheumatic valvular AF, hypertrophic cardiomyopathy, etc.

** Antiplatelet therapy with aspirin plus clopidogrel, or – less effectively – aspirin only, may be considered in patients who refuse any OAC

www.escardio.org/guidelines

European Heart Journal 2012;33:2719-2747 - doi:10.1093/eurheartj/ehs253

EUROPEAN SOCIETY OF CARDIOLOGY®

Anticoagulation - NOACs

Recommendations for prevention of thromboembolism in non-valvular AF - NOACs		
Recommendations	**Class**	**Level**
When adjusted-dose VKA (INR 2–3) cannot be used in a patient with AF where an OAC is recommended, due to difficulties in keeping within therapeutic anticoagulation, experiencing side effects of VKAs, or inability to attend or undertake INR monitoring, one of the NOACs, either: • a direct thrombin inhibitor (dabigatran); or • an oral factor Xa inhibitor (e.g., rivaroxaban, apixaban)[d] … is recommended.	I	B
Where OAC is recommended, one of the NOACs, either: • a direct thrombin inhibitor (dabigatran); or • an oral factor Xa inhibitor (e.g., rivaroxaban, apixaban)[d] … should be considered rather than adjusted-dose VKA (INR 2–3) for most patients with non-valvular AF, based on their net clinical benefit.	IIa	A

[d]Apixaban (pending approval EMA and FDA approval): prescribing information is awaited.

European Heart Journal 2012;33:2719-2747 - doi:10.1093/eurheartj/ehs253

Recommendations	Class	Level
Where dabigatran is prescribed, a dose of 150 mg b.i.d. should be considered for most patients in preference to 110 mg b.i.d., with the latter dose recommended in: • elderly patients, age ≥ 80 • concomitant use of interacting drugs (e.g. verapamil) • high bleeding risk (HAS-BLED score ≥3) • moderate renal impairment (CrCl 30–49 mL/min).	IIa	B
Where rivaroxaban is being considered, a dose of 20 mg o.d. should be considered for most patients in preference to 15 mg o.d., with the latter dose recommended in: • high bleeding risk (HAS-BLED score ≥3) • moderate renal impairment (CrCl 30–49 mL/min).	IIa	C
Baseline and subsequent regular assessment of renal function (by CrCl) is recommended in patients following initiation of any NOAC, which should be done annually but more frequently in those with moderate renal impairment where CrCl should be assessed 2–3 times per year.	IIa	B
NOACs (dabigatran, rivaroxaban, and apixaban) are not recommended in patients with severe renal impairment (CrCl <30 mL/min).	III	A

European Heart Journal 2012;33:2719-2747 - doi:10.1093/eurheartj/ehs253

Quando mantenere anti Vit-K?

- Buon livello dei controlli (TTR)
- Insuff. renale severa
- Protesi valvolari meccaniche (Eichelboom JW et al, *N Eng J Med*, 2013)
- Pregresso sanguinamento GI
- Scarsa aderenza ai DOA
- Costi

La noia della compilazione del piano terapeutico AIFA non è contemplata nelle linee guida

Quando preferire i NOACs?

- TTR basso
- Interazioni tra farmaci
- Storia di sanguinamento intracranico
- Problemi logistici
- Nuovi pazienti

Perchè preferire i NOACs?

- Rapida insorgenza d’azione
- Effetto dose risposta prevedibile
- Emivita relativamente breve

CAVEATS NOACs

- Emivita relativamente breve : se scarsa aderenza , aumento di rischio di ictus o embolia sistemica
- Non necessità di monitoraggio : può favorire una scarsa aderenza alla terapia?
- Test di coagulazione ?
- Antidoti?
- Associabilità ad antiaggreganti?

ITER DELLA FA

- Diagnosticare la fibrillazione atriale
- Stratificare il rischio tromboembolico
- Applicare le linee guida al mondo reale

≠

PRESCRIZIONE NOACS: UN PERCORSO A OSTACOLI

Agenzia Italiana del Farmaco
AIFA

Registri Farmaci sottoposti a Monitoraggio

ATTENZIONE

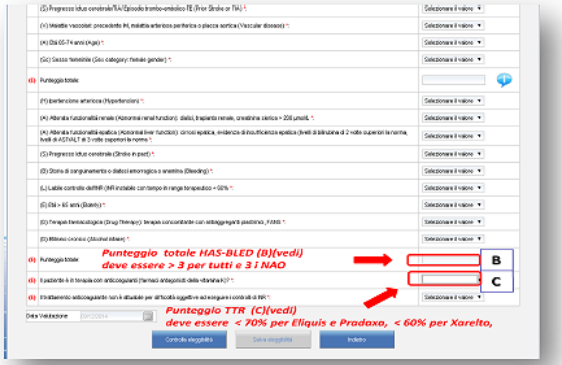
Le immagini che seguono potrebbero urtare la vostra sensibilità

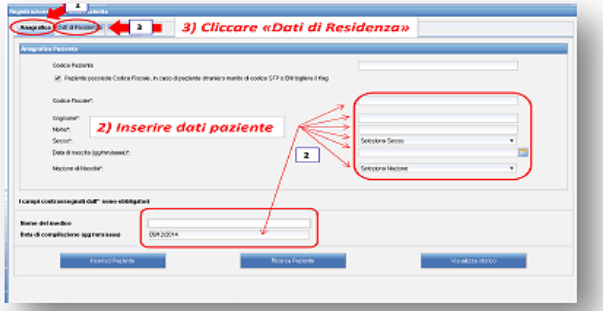
Per visualizzare la lista aggiornata dei Registri pubblicati nella nuova piattaforma si prega di consultare le pagine dedicate ai Registri Farmaci sottoposti a Monitoraggio nel portale istituzionale dell'AIFA

SUL WEB ESISTONO PROGRAMMI MIGLIORI…

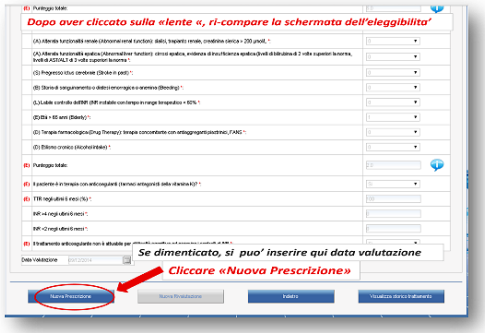
Inserimento Paziente con i dati anagrafici

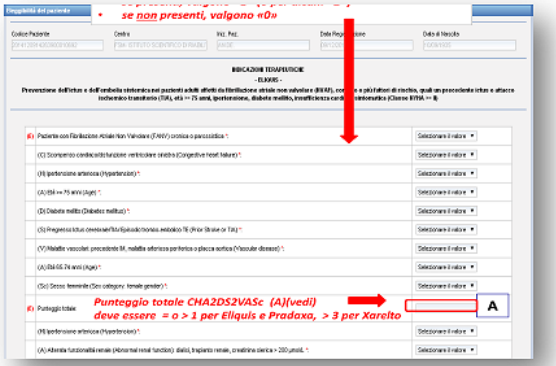
Inserire i criteri di eleggibilità CHA2DS2- VASc SCORE e HAS – BLED SCORE





Nuova prescrizione





IL MONDO REALE

	Anno 2011			Anno 2012			Anno 2013			Anno 2014 (Gen - Ottobre)		
Fascia età	Femmine	Maschi	**Totale**	Femmine	Maschi	**Totale**	Femmine	Maschi	**Totale**	Femmine	Maschi	**Totale**
0 - 54 anni	3	3	6	1	7	8	5	4	9	4	12	16
55 -64 anni	3	4	7	8	7	15	19	24	43	24	28	52
65 - 74 anni	7	5	12	14	5	19	33	47	80	33	64	97
75 - 84 anni	3	1	4	6	4	10	59	54	113	88	74	162
85 - ed oltre	0	0	0	2	1	3	25	13	38	31	19	50
TOTALE	16	13	**29**	31	24	**55**	141	142	**283**	180	197	**377**

pz in anti Vit K 10.079

PRESCRIZIONE NOACs IN PROVINCIA DI COMO

THE REAL WORLD

CLINICAL SIGNIFICANCE

- The EURObservational Research Programme on Atrial Fibrillation (EORP-AF) Pilot Survey provides contemporary data on oral anticoagulation prescribing by European cardiologists.
- When oral anticoagulation was used, vitamin K antagonists were prescribed in the majority of patients (72.2%). Novel oral anticoagulants were used in the minority (7.7%) of patients. In addition, 80.5% of patients with a Congestive heart failure, Hypertension, Age $\geq$75 [Doubled], Diabetes, Stroke [Doubled]-Vascular disease, Age 65-74, and Sex category [female] (CHA_2DS_2-VASc) score $\geq$1 received oral anticoagulation.
- Antiplatelet therapy is still over-prescribed, with or without oral anticoagulation, whereas elderly patients are commonly undertreated with oral anticoagulation.

CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE®

'Real-World' Antithrombotic Treatment in Atrial Fibrillation: The EORP-AF Pilot Survey

Gregory Y.H. Lip, MD,[a] Cécile Laroche, MSc,[b] Gheorghe-Andrei Dan, MD,[c] Massimo Santini, MD,[d] Zbigniew Kalarus, MD,[e] Lars Hvilsted Rasmussen, MD,[f,g] Popescu Mircea Ioachim, MD,[h] Otilia Tica, MD,[h] Giuseppe Boriani, MD,[i] Paolo Cimaglia, MD,[i] Igor Diemberger, MD,[i] Camilla Fragtrup Hellum, MD,[f,g] Bettina Mortensen, MD,[f,g] Aldo P. Maggioni, MD[b]

ESISTE UN VANTAGGIO REALE SCEGLIENDO UN NAO PITTOSTO CHE IL DICUMEROLICO NELLA GESTIONE DEI PAZIENTI CON FIBRILLAZIONE ATRIALE?

Come decidere tra una terapia consolidata con il disagio del controllo dell'INR ed una terapia nuova con il disagio del carico burogratico che comporta

Milano 9-10 aprile 2015

Giovanni Corrado, FESC

GRAZIE PER LA VOSTRA ATTENZIONE