



Ger-E-News

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Anticoagulation in Older Adults

Q: An 84 yo M with newly diagnosed nonvalvular afib comes to the office for follow-up. History includes HTN, DMII, HLD, and CKD (estimated creatinine clearance of 20 mL/min). Medications include metformin, lisinopril, atorvastatin and aspirin. He broke his hip in a fall 3 years ago; he underwent repair and rehabilitation and has continued to live independently. He has fallen twice in the past 3 years, and uses a cane to assist in ambulation. No hx of stroke.

On examination, heart rate 86 bpm and irregularly irregular, and BP is 130/75 mmHg. He has decreased proximal muscle strength when he rises from a chair. His gait is stable with a cane. Recent TTE showed no atrial clot and normal systolic and diastolic function.

Which one of the following is the most appropriate management for reducing his risk of stroke?

- A. Continue aspirin
 - B. Stop aspirin, and begin warfarin
 - C. Stop aspirin and begin apixaban
 - D. Continue aspirin, and add warfarin
- (See answer on the next page.)

Anticoagulation and Older Adults

Risk of Bleeding and Thrombosis:

- A recent matched cohort study published in JAMA, Sept 2016, showed the bleeding risk with a VKA only mildly increased after the age of 80 years old, while in the same age group there is a sharp increase in the risk of thrombosis.
 - The event rate (per 100 patient years) of major bleeding was 0.9, 1.0, and 1.1 for patients in their 70's, 80's and 90's, respectively.
 - The event rate (per 100 patient years) of a thrombotic event was 0.8, 1.5, and 1.8 for patients in their 70's, 80's and 90's, respectively.
- In a study by Gage et al. 2005, they found that patients at high risk of falls on warfarin suffered 2.8 intracranial hemorrhages per 100 patient years, more than twice the 1.1 intracranial hemorrhages of other patients; however, prescribing warfarin in patients at high risk for falls with 2 or more CHADS2 points was associated with a 25% relative risk reduction (HR 0.75) in the composite outcome (out of hospital death or hospitalization for stroke, myocardial infarction, or hemorrhage)

Implications for daily practice

- Risk of thrombosis increases with age particularly in patients over the age of 90. This is also the population that is most often not started on anticoagulation due to concern for bleeding, particularly in the setting of a risk for falls.
- Risk of bleeding on a Vitamin K antagonist only mildly increases with age and is more pronounced in men than in women.
- High risk of falls should not be a contraindication to anticoagulation in an elderly patient and some studies would suggest it should not be an important factor when deciding whether a patient is a good candidate for anticoagulation or not.
- In AF, the CHADS2 score is a validated tool to assist with risk stratifying whether a patient would benefit from anticoagulation. Since many of the same risk factors for thrombosis are risk factors for bleeding, the HAS-BLED score can help estimate the 1 year risk of major bleeding. Of note, it still has not been externally validated in its original form.

The Bottom Line:

- Physicians are often hesitant to start anticoagulation in the very old based on age alone or fall risk.
- Risk of thrombosis increases with age and therefore anticoagulation, if indicated, should be considered in the eldest patients even if they are at risk for falls.

Answer: B, Stop aspirin, and begin warfarin

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