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Job Harenberg
Department of Clinical Pharmacology, Medical Faculty Mannheim, Ruprecht-Karls-University Heidelberg, Mannheim, Germany
email: job.harenberg@medma.uni-heidelberg.de

Gregory Y.H. Lip
Centre for Cardiovascular Sciences, University of Birmingham, City Hospital, Birmingham, UK

References


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The new era of oral anticoagulation: the ‘finger pointing to the moon is not the moon’
Reply to: Differences between indirect comparison studies of the oral anticoagulants for stroke prevention in atrial fibrillation: where do we go next? By Job Harenberg, Gregory Y.H. Lip

Sir,

The new era of oral anticoagulation has begun, at least for those patients requiring anticoagulation but showing a suboptimal international normalized ratio control. The comments from Drs Harenberg and Lip suggest a different interpretation of available information but actually highlight the difficulty of discriminating the truth among a huge amount of data.

The same amount of data they successfully contributed to provide, as being part of several trials published over the last years in some major international journals. Of note, the majority of these trials came out as fully sponsored randomized controlled trials. A PubMed search with the query ‘Dabigatran OR Apixaban OR Rivaroxaban’ would nowadays retrieve ~1409 citations; among these publications there are only very few independent studies, none of them in major international journals.

Moreover, all the analyses done by means of meta-analytic tools share the same limitations which have been correctly mentioned by Harenberg, i.e. the ‘open label’ warfarin treatment in the RE-LY study vs. double dummy in the two other studies; the differences in time in therapeutic range of the international nationalized ratio between the studies; the differences in biographic data of the patients across the studies, such as gender, CHADS2 score (congestive heart failure (C), high blood pressure (H), age 75 or older (A), diabetes (D), and previous stroke (S2)), creatinine clearance and concomitant use of aspirin.

It is obvious that these limitations have to be recognized by the researchers who try to summarize such a complex scenario. We actually provided an entire ‘Limitations’ section within our manuscript,1 with the purpose of being open to criticisms and honestly declaring that we were suggesting an interpretation, a point of view rather than the truth.
Thus, we believe that a different point of view, on the basis of the same scenario, with the same evidences and shadows, must be regarded as a different understanding, basically as a different possible way to the truth. Unfortunately, these limitations cannot be eliminated by anyone and the confusion that Harenberg and Lip were afraid of is perhaps fuelled by those who fail to accept a different, independent and unbiased interpretation.

We all look at the moon pointing a finger, but the ‘finger pointing to the moon is not the moon’.

Luca Testa
Stefania Lanotte
Samuele Pizzocri
Matteo Casavecchia

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