Atrial fibrillation (AF) is the commonest cardiac arrhythmia, with an increasing prevalence with age. However, AF is often asymptomatic and/or intermittent, and very often, its ‘how hard one looks’ to find AF particularly amongst high-risk groups. Indeed, newly developed AF may be present in 30% of patients with cardiovascular risk factors at 1 year, and if undiagnosed, this may sadly result in the first presentation (or confirmed diagnosis) of AF in the context of a devastating stroke.1

In this issue of QJM, Frewen et al describe the demographics of the Irish population with AF in a nationally representative sample aged >50, from The Irish Longitudinal Study on Ageing (TILDA) cohort. Consistent with other studies, they found that the overall prevalence of AF was 3%, being higher in men overall and with advancing age. Although, 68% had a high risk of stroke (CHADS2VASc ≥2), only 40.7% of these were on oral anticoagulation (OAC), as recommended by current guidelines. Conversely, 36% of those at low risk of stroke were inappropriately treated with OAC. Interestingly, frail subjects were more likely to be treated, whilst high CHADS2VASc or HAS-BLED scores were not predictive.

One reason for the low OAC uptake is perhaps the continuing focus (or obsession?) on identifying ‘high risk’ individuals who can then be targeted for OAC, which—until recently—was an ‘inconvenient’ drug, warfarin. The reality is that stroke risk is a continuum, and that the patient’s risk profile changes over time.2 Thus, the 2012 focused update of the European Society of Cardiology (ESC) guidelines3 advocates a major clinical practice shift towards the initial identification of ‘truly low risk’ subjects [essentially ‘age <65 and lone AF (male and female) or a CHA2DS2VASc score = 0] as the first decision-making step. Such ‘truly low risk’ AF patients do not need any antithrombotic therapy.

Subsequent to this initial step, all other AF patients with ≥1 stroke risk factors can be offered effective stroke prevention, which is OAC, whether as well-controlled warfarin or one of the novel OAC drugs. Of note, a CHADS2 score = 0 is not low risk, as such patients can have a stroke/thromboembolism rate ranging between 0.8 to 3.2% per year.4

In their study, Frewen et al. found that awareness of AF was low (38% unaware), and less than half were aware of their diagnosis, which they suggest was due to poor screening for AF. I would suggest that perhaps more attention should also be directed towards patient values and preferences per se, especially as many patients with AF possess very limited knowledge of AF as well as its consequences and therapy.5 In a survey of anticoagulated AF patients, we have also shown significant differences between different ethnic groups in terms of their knowledge of the risks, actions and benefits of warfarin as well as of AF itself.5

The cohort design of the TILDA ageing population is also important, as much attention has been directed to incident comorbidities that become more prevalent in the elderly, such as renal (dys)function. The latter predisposes to an increased risk of AF, and when AF is associated with renal impairment, there is an increased risk of stroke, death, myocardial infarction and bleeding.6

Thus, should renal (dys)function be added as one extra point to the CHADS2 or CHA2DS2VASc scores? Notwithstanding the fact that such patients are very high risk overall, renal impairment per se is associated with the risk factors making up the CHADS2 or CHA2DS2VASc scores. Indeed, one recent large ‘real world’ analysis renal impairment was not an independent predictor of stroke/thromboembolism in patients with AF and did not significantly improve the predictive ability of the CHADS2 or CHA2DS2VASc scores.7

In summary, Frewen et al. show that awareness of AF remains worryingly low, and thromboprophylaxis is inadequate. The clinical practice shift towards initial identification of ‘low risk’ and better detection of AF in high-risk groups merits urgent attention, as does patient centred research into patient...
values and preferences. The cohort design of TILDA may also provide important insights into this common arrhythmia, and its associated risks. Things can only get better.

Gregory Y.H. Lip
University of Birmingham Centre for Cardiovascular Sciences
City Hospital
Birmingham B18 7QH, UK
email: g.y.h.lip@bham.ac.uk

References


