Editor's Message

Individualized Care for Improved Outcomes in Patients With Atrial Fibrillation

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This supplement to JAOA—The Journal of the American Osteopathic Association includes a timely review1 and expert panel discussion2 of the most important goal for the treatment of patients with atrial fibrillation (AF): that is, the prevention of stroke.

With an aging population and the age-related prevalence of AF highlighted by the authors and discussants,1,2 all of us, whether we are primary care physicians or specialists, will be seeing more and more patients with AF. It may be that our patients have had singular AF episodes, multiple paroxysmal episodes, or multiple AF episodes that require intervention; or, our patients may have permanent AF. Regardless of the type of AF, and with few exceptions, all of these patients’ risk for thromboembolic complications is higher than that of similar patients without AF.

The care for these patients can be complex. Appropriate choices regarding either a rate-control strategy or a rhythm-control strategy can be challenging. These decisions are clearly individually specific and often require initial and then ongoing collaboration between primary care physicians and cardiologists. Antiarrhythmic drug regimens, cardioversion strategies, and percutaneous or surgical ablation options are available, but these treatments are designed to reduce AF-related symptoms. In most cases, these treatments do not mitigate the risk of stroke.

Stroke risk for patients with AF depends on the presence of concomitant clinical factors. The authors describe the 2 most commonly used scoring systems for thromboembolic risk for patients with nonvalvular AF. The CHADS2 score incorporates the risk associated with a history of congestive heart failure, hypertension, age, diabetes mellitus, and prior stroke.3 The CHA2DS2-VASc score adds the factors of gender, the presence of vascular disease, and a more stringent addressing of age-related risk.4

These scoring systems are summarized well in the following 2 articles,1,2 which highlight the required individualization of risk assessment balanced by the risk of bleeding associated with anticoagulation therapy.

In assessing risk, however, it needs to be emphasized that the scoring systems are based on statistical analyses of clinical studies of populations. As

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a reminder, a CHADS$_2$ score of 0 still renders an individual with AF a 1.9% per year risk of stroke. On the basis of the balance between benefit and risk of treatment, guidelines permit consideration of either no antithrombotic therapy or treatment with aspirin for patients with nonvalvular AF and a CHADS$_2$ score of 0. We may be reassuring by the fact that our elderly patient (let’s say with a CHADS$_2$ score of 3), for whom we felt anticoagulation therapy rendered him or her at too high a risk of a risk for bleeding, has not had a stroke while taking aspirin alone. But we can, at the next moment, be devastated by the younger patient with the CHADS$_2$ score of 0 who then has a stroke.

The devastation of such a patient’s negative experience can indeed unduly affect us. However, the authors and discussants in this supplement to the JAOA emphasize the importance of the systematic prospective application of these risk assessments and the opportunity for improving the care we provide. The data they cite remind us that there is much to be done to increase the number of patients with AF who receive the appropriate stroke-preventing medications.

With the addition of newer anticoagulants, prescribing and monitoring anticoagulation therapy may become easier. Warfarin’s advantages and challenges are well known. Our contributors describe some of the liabilities related to warfarin and patients’ associated difficulty with adherence to its related rigorous monitoring. Dabigatran, a direct thrombin inhibitor, and rivaroxaban, a factor Xa inhibitor, are now approved by the US Food and Drug Administration, and others are on the way. I recommend that readers study their advantages and disadvantages carefully.

For each patient with AF that is before us, we have an obligation to first assess his or her individual risk of stroke. Then, we need to discuss with him or her the potential hazards and benefits of the anticoagulation regimen indicated by the patient’s risk of stroke. The choices we have now are most appropriately implemented according to each and every patient’s particular set of clinical characteristics and his or her preferences. Our authors go a long way in helping us think about how we can hard wire these processes into our practices.

**References**


