

## Oral anticoagulation in atrial fibrillation: are the problems solved?

### *Atrial fibrilasyonda oral antikoagulan tedavi: Sorunlar çözüldü mü?*

The prevalence of atrial fibrillation (AF) is high and it is expected to increase in the near future (1). AF is a strong independent risk factor for ischemic stroke and systemic arterial embolisation (2). Oral anticoagulation (OAC) has been shown to decrease the risk of stroke. In a meta-analysis of 6 randomized trials including 2900 participants, the estimated relative risk reduction is reported as 64% (3). Despite the evident benefits, OAC is underused even in high-risk AF patients (4, 5).

The study by Elezi et al. (6) provides an interesting retrospective analysis of the prescription of OACs in patients with AF in a single tertiary centre in Kosovo. The main finding is the low percentage of OAC use in patients with AF when compared with the previous studies. It is reported that only less than 1/3 of patients with primary or secondary diagnosis of AF were discharged on anticoagulation therapy. Elder age, normal left atrial size, and preserved ejection fraction were the independent predictors of underprescription of anticoagulants.

In a very recent study in which the reasons for undertreatment with OAC therapy in a geriatric outpatient population has been evaluated, Tulner et al. reported that the patient age was the main determinant for not prescribing the OACs (7). This finding regarding the age for not prescribing the OACs is comparable with the results of the present study. Many physicians avoid using OACs in high-risk AF patients, especially for elderly individuals. The study of Poli et al. (8) reporting high bleeding rates in AF patients older than 85 years with a 4-6 score of CHADS2 seems to justify the avoidance from anticoagulation in elderly. However, in the Birmingham Atrial Fibrillation Treatment of the Aged (BAFTA) study, warfarin was reported to reduce the risk of ischemic and hemorrhagic strokes when compared with aspirin in AF patients those are older than 75 years with comparable rates for major bleeding (9). In the light of the findings of BAFTA study, clinicians should make every possible effort to start and keep on anticoagulation therapy in elderly patients and avoid switching to aspirin. Unfortunately, the authors mentioned particular difficulties including low incomes and poor transportation means, disrupting regular hospital visits and monitorisation of anticoagulation levels. Nevertheless, the role of physicians in the

quality measures of anticoagulation treatment can not be disregarded. There are substantial clinical differences among stroke risk classification schemes. This may lead to a confusion which causes a difficulty in deciding whether benefit of anticoagulation outweighs the increased risk of bleeding (10). Consensus on optimal scheme for anticoagulation prophylaxis, which may increase physicians' adherence to guidelines is still lacking.

Associated comorbid conditions like hypertension, diabetes mellitus and heart failure have particular significance since they are known to increase the risk of stroke in AF (11).

Elezi et al. (6) report that the percentages of comorbidities including heart failure are similar to the previous studies. The finding that the age distribution of the study population is younger than in other studies is remarkable. Whether this finding is attributable to the whole Kosovo population needs further evaluation and is an another epidemiologic research issue.

We believe that, although retrospective and single-centered, the study of Elezi et al. is a small representative sample of patients with AF visiting a tertiary centre in Kosovo. The contribution of the study to the literature would be the clinical characteristics of the patients with AF in a district which is different from other European countries reflecting the specific age distribution and devastating effects of war on health system. Also it has an additive role to emphasize the underuse of OAC in patients with AF and stimulates us to focus on our daily practice.

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