One-year clinical outcomes and management of patients with ischaemic vs non-ischaemic cardiomyopathy and newly diagnosed atrial fibrillation: results from GARFIELD-AF

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BACKGROUND

Atrial fibrillation (AF) is commonly associated with congestive heart failure (CHF) and their combined presentation in patients is associated with a worse prognosis than either condition alone.

There are few data on how many AF patients with or without CHF receive appropriate antithrombotic therapy in routine clinical practice, or whether the rates of stroke/systemic embolism (SE), major bleeding, and all-cause mortality are different.

There is particularly relevant in patients with AF and ischaemic or non-ischaemic cardiomyopathy since the prescription of antithrombotic therapies might be different and could affect outcomes.

There is also evidence to suggest that AF is associated with higher rates of stroke/systemic embolism (SE), major bleeding, and all-cause mortality compared to patients with non-ischaemic heart disease but not those with non-ischaemic heart disease.

PURPOSE

To assess antithrombotic therapy and 1-year outcome in patients with newly diagnosed AF and CHF stratified by aetiology (ischaemic vs non-ischaemic).

METHODS

GARFIELD-AF is an ongoing, international, non-interventional registry evaluating treatment and outcomes of AF and CHF. Patients with ischaemic cardiomyopathy were defined as having a history of coronary artery disease, whereas patients with non-ischaemic cardiomyopathy were included if they did not have any of the following: a history of ischaemic heart disease, diabetes mellitus, or hypertension.

RESULTS

A total of 14,952 patients with newly diagnosed AF and CHF were included in GARFIELD-AF. Patients with ischaemic cardiomyopathy were more likely to receive anticoagulant therapy at diagnosis, whereas patients with non-ischaemic cardiomyopathy were less likely to receive anticoagulant therapy (25.3% vs 31.1% vs 14.7%, respectively).

CONGESTIVE HEART FAILURE FAILURE TREATMENTS

The proportion of patients prescribed at least one CHF medication was lower in the group with non-ischaemic cardiomyopathy than those with non-ischaemic cardiomyopathy.

CONCLUSIONS

A third of patients with CHF had ischaemic cardiomyopathy. These patients had worse outcomes compared to patients with non-ischaemic cardiomyopathy; they were less frequently anticoagulated and more often received antiplatelet therapy, alone or in combination with AC therapy.

They were also less likely to receive CHF medications that patients with non-ischaemic cardiomyopathy.

CLINICAL IMPLICATIONS

Poor progression is linked to the onset of AF.

Suboptimal treatment may have an impact on outcomes.

We speculate that polypolypharmacy may explain the inadequacy of treatment in ischaemic cardiomyopathy (therapies for AF and CHF).

REFERENCES


DECLARATION OF INTEREST

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AC, acetyl salicylic acid; AC + AP, antiplatelet + anticoagulant; AF, atrial fibrillation; AHA, Antithrombotic Work Group; ATR, antithrombotic recommendations; BMI, body mass index; CHF, congestive heart failure; CKD, chronic kidney disease; IQR, interquartile range; LVEF, left ventricular ejection fraction; MCS, medical centre Study Group; NCH, new or worsening congestive heart failure; NS, not significant; PCI, percutaneous coronary intervention; ROC, receiver operating characteristic; SE, systemic embolism; TIA, transient ischaemic attack; WDC, World Heart Federation Council on Clinical Affairs; WHO, World Health Organization.