One-year outcomes in atrial fibrillation patients with versus without coronary artery disease. The prospective Global Anticoagulant Registry in the FIELD (GARFIELD)

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RESULTS

At least one-fifth of patients with atrial fibrillation (AF) also have coronary artery disease (CAD). The use of antithrombotic therapy for the prevention of thromboembolic events is indicated in both conditions.

While oral anticoagulation is more effective than antiplatelet therapy in preventing thromboembolic events associated with AF, antiplatelet drugs are preferable for patients with CAD, including those undergoing coronary artery stenting.

PURPOSE

To compare the baseline characteristics, antithrombotic treatments initiated at diagnosis, and associated 1-year clinical outcomes in patients with newly diagnosed non-valvular AF, with or without concomitant CAD, using data from the Global Anticoagulant Registry in the FIELD (GARFIELD).

METHODS

GARFIELD is an ongoing, international, observational study of consecutively recruited adults (≥18 years) with newly diagnosed non-valvular AF and ≥1 additional investigator-determined stroke risk factor(s). Such risk factors were not prespecified in the study protocol, nor were they limited to those in risk stratification schemes such as CHADSV2-LR or CHA2DS2-VASc.

Investigators sites were representative of the distribution of AF care settings in each country.

A total of 10,614 patients were recruited into cohort 1 at 540 randomly selected sites in 19 countries over a 2-year period; 5089 patients were recruited retrospectively as a validation cohort, and 5525 patients were recruited prospectively and comprise the study population for this analysis.

A Cox proportional hazards model was used to determine the effects of CAD on the outcomes of all-cause death, stroke/systemic embolism (SE) and acute coronary syndromes (ACS) at 1 year after AF diagnosis, adjusted for relevant components of the HAS-BLED score plus antithrombotic therapy initiated at AF diagnosis. The outcome of major bleed was adjusted for relevant components of the HAS-BLED score plus antithrombotic therapy initiated at AF diagnosis.

RESULTS

Of 5523 patients with available data, 1066 (19.3%) had CAD. Patients with CAD were on average older, more often male, and had higher prevalences of cardiovascular risk factors and higher risk scores than patients without CAD (Table 1).

Patients with CAD were much more likely to receive a combination of a vitamin K antagonist (VKA) and an antiplatelet drug than those without CAD (21.0% vs 8.1%; Figure 2).

Rates of all-cause death, stroke/SE, major bleed and ACS at 1 year were higher among patients with vs without CAD (Figure 2).

After adjustment, the risks of death, stroke/SE and major bleed were similar among those with and without CAD, while the risk of ACS at 1 year was significantly higher among patients with CAD (Figure 2).

CONCLUSIONS

In this multinational observational study, AF patients with CAD were older, more likely to be male, and had a higher risk profile than those without CAD. They were more likely to receive combination therapy with a VKA and an antiplatelet, AF patients with CAD had higher unadjusted rates of death, stroke/SE, ACS, and major bleeds, but only ACS remained significant after adjustment. These patients, irrespective of whether they undergo stenting, will have a more complex treatment over the follow-up.

These data are preliminary so the results should be interpreted with caution.

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REFERENCES


CONFLICTS OF INTEREST

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