Profilaksa moždanog udara u bolesnika s fibrilacijom atrija u Općoj bolnici Zadar

Cerebrovascular insult prophylaxis in patients with atrial fibrillation in Zadar General Hospital

Aleksandar Knežević[1,2]*, Luka Markulin[3], Marijana Nadinić[2], Irena Užović Frakin[2]

[1]Sveučilište u Zadru, Zadar, Hrvatska
[2]Opća bolnica Zadar, Zadar, Hrvatska
[3]Psihijatrijska bolnica Ugljan, Ugljan, Hrvatska

[1]University of Zadar, Zadar, Croatia
[2]Zadar General Hospital, Zadar, Croatia
[3]Psyhiatric Hospital Ugljan, Ugljan, Croatia

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***ADDRESS FOR CORRESPONDENCE**: Aleksandar Knežević, Opća bolnica Zadar, Bože Peričića 5, HR-23000 Zadar, Croatia. / Phone: +385-91-519-2892 / E-mail: alknezevic@unizd.hr

Istraživanjem su obuhvaćeni bolesnici primljeni na bolničko liječenje u Općoj bolnici (OB) Zadar od 1. rujna 2016. do 31. kolovoza 2017. godine s dijagnozama (MKB–10) I63 i K92 te fibrilacijom atrija (FA) u trenutku prijema. U promatranom razdoblju od godine dana hospitalizirano je 378 bolesnika s cerebrovaskularnim inzultom (CVI) i 63 bolesnika s dijagnozom krvarenja iz gastrointestinalnog (GI) sustava. U istraživanje je uključeno 77 bolesnika s CVI. 1. skupina sastojala se od 3 (4%) bolesnika koji su u terapiji FA imali neki od novih oralnih antikoagulansa (NOAK), 2. skupina sastojala se od 22 (29%) bolesnika koji su u terapiji imali varfarin, 3. skupina sastojala se od 15 (19%) bolesnika koji su u terapiji imali acetilsalicilatnu kiselinu (ASK) dok se četvrta skupina sastojala od 37 (48%) bolesnika koji u terapiji nisu imali ništa od prethodno navedenih lijekova. Također, u promatranom razdoblju od godine dana hospitalizirano je 63 bolesnika s krvarenjem iz GI sustava. U istraživanje je uključeno 10 bolesnika s ovom dijagnozom. Dva (20%) bolesnika koja nisu imala FA u anamnezi u trenutku prijema su imali FA, 5 (50%) bolesnika je terapiji imalo NOAK i 3 (30%) varfarin. Nije hospitaliziran ni jedan bolesnik s FA koji bi u terapiji imao ASK. U skupini od 22 bolesnika koji su imala varfarin u terapiji dobro reguliranu antikoagulacijsku terapiju s vrijednostima INR-a od 2 do 3,5 imalo 4 bolesnika (18%). Kako je poznato da u Zadarskoj županiji u promatranom razdoblju je 2/3 bolesnika na antikoagulacijskoj terapiji uzimalo varfarin, a 1/3 NOAK, a iz objavljenih podataka je vidljivo da je omjer hospitaliziranih bolesnika s FA i CVI-om bio 1:8 u odnosu na one koji su uzimali NOAK prema varfarinu, a iz literaturnih podataka je poznato da je njihova učinkovitost u prevenciji CVI podjednaka, proizlazi da bolesnici liječeni varfarinom nisu bili optimalno antikoagulirani te time nisu mogli izbjeći nastanak tromboembolijskog CVI. U isto vrijeme u hospitaliziranih bolesnika s GI krvarenjem je bilo više onih koji su u terapiji uzimali NOAK što je u skladu s literaturnim podacima, ali i poznatim podacima o neoptimalnoj regulaciji INR u bolesnika koji uzimaju varfarin. Zaključno se može istaknuti da u uvjetima neoptimalne regulacije INR-a, bolesnicima s kroničnom FA ne treba primjenjivati varfarin, već će optimalnu prevenciju CVI imati primjenom NOAK-a, uz prihvatljiv rizik od gastrointestinalnog krvarenja.[1]

The study included patients receiving hospitalization in Zadar General Hospital from September 1st 2016 until August 31st 2017 with diagnoses (MKB-10) I63 and K92 and atrial fibrillation (FA) at the time of inoculation. In the observed period of the year, 378 patients with cerebrovascular insult (CV) and 63 patients with gastrointestinal (GI) bleeding were hospitalized. The study included 77 patients with CVI. The first group consisted of 3 (4%) of the patients who had some of the new oral anticoagulants (NOAC) therapy in the FA therapy. The second group consisted of 22 (29%) of the patients who had warfarin therapy, the third group consisted of 15 (19%) of patients receiving acetylsalicylic acid (ASA) while the fourth group consisted of 37 (48%) patients who did not have any of the aforementioned drugs in the therapy. Also, in the observed period of the year, 63 patients with GI bleeding were hospitalized. The study included 10 patients with this diagnosis. Two (20%) patients who did not have FA at the time of admission were FA. 5 (50%) patients had NOAC and 3 (30%) warfarin. No patient from the FA was hospitalized to have ASA therapy. In the group of 22 patients who had warfarin in therapy, well-regulated anticoagulation therapy with INR values ranging from 2 to 3.5 had 4 patients (18%). As it is known that in the Zadar County in the observed period, 2/3 of the patients taking anticoagulant therapy took warfarin and 1/3 of NOAC, and the published data show that the ratio of hospitalized patients with FA and CVI was 1: 8 compared to those who took NOAC against warfarin, and from the literature data it is known that their efficacy in preventing CVI alike, suggests that warfarin-treated patients were not optimally anticoagulated so they could not avoid the occurrence of thromboembolic CVI. At the same time, in hospitalized patients with GI bleeding, there were more those taking NOAC in therapy, which is consistent with the literature data, but also the known data on the nonoptimal INR regulation in patients taking warfarin. It can be concluded that, in conditions of non-optimal regulation of INR, patients with chronic FA do not need to use warfarin, but optimal CVI prevention will have NOAC, with an acceptable risk of gastrointestinal bleeding.[1]

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LITERATURE

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