There’s a new choice for preventing stroke these days for patients who have atrial fibrillation, which is the most common heart-rhythm disorder in patients over the age of 60. It causes the heart to beat erratically and can lead to a stroke in susceptible people.

Who are those at risk for stroke due to atrial fibrillation? Anyone over age 75 or people with high-blood pressure (treated or untreated), diabetes or heart failure are at significant risk. People ages 65 to 74 with a prior history of heart attack and women are at moderate risk. Without question of course, those who have had a prior stroke are at highest risk for another one.

Traditionally, we have always recommended warfarin (also called Coumadin) for people at risk for stroke due to atrial fibrillation. However, this has been a “hard pill to swallow” for most. For one thing, warfarin interacts with many other medications and foods, creating a situation where the blood can swing from being “too thick” to “too thin.” As a result, many people are forced to have frequent blood tests to check how warfarin affects their blood. This is done by measuring the “International Normalized Ratio” (INR), which we want to be between the values of 2 and 3.

However, in the last two years there are finally new choices to substitute for warfarin for most patients with atrial fibrillation. Two drugs that are currently approved by the FDA, and hopefully a third will join the ranks in the next few months, work on a different part of the clotting pathway and in a far more predictable way than warfarin. Dabigatran (also called pradaxa) works on a protein called “thrombin,” while rivaroxaban (also called xarelto) works on a protein called “Xa.” These proteins are critical for making the blood clot, and by inhibiting their action, these drugs keep the blood thin.

These drugs have been studied in three major trials, each including about 15,000 to 18,000 patients with atrial fibrillation, with half taking warfarin and half taking the new drug. The first new drug, Dabigatran (pradaxa), showed itself to be superior to warfarin for preventing stroke, with about the same risk for major overall bleeding as warfarin though with a slight increase in gastrointestinal bleeding. Importantly, dabigatran showed less risk for a bleeding
stroke ("hemorrhagic stroke"), which is the most deadly type. Dabigatran was approved by the FDA in 2010, and generally is prescribed as 150 mg twice daily.

The next drug to receive FDA approval was rivaroxaban (xarelto) in 2011. It was studied in the ROCKET-AF trial and found to be equal to warfarin in preventing stroke with a similar risk for major overall bleeding and, like dabigatran, had less risk for a bleeding stroke. Rivaroxaban is generally prescribed as 20 mg once daily.

Finally, apixaban, studied in the ARISTOTLE trial, is still awaiting approval from the FDA, and was demonstrated not only to be superior to warfarin to prevent stroke, but also to be superior to warfarin for major bleeding.

These are exciting new choices for prevention of stroke for patients with atrial fibrillation, but this does not mean that we should abandon warfarin. Patients who have taken warfarin successfully should continue to do so. In other words, "if it ain’t broke, don’t fix it." Also, some medical conditions, such as very severe kidney failure, still warrant the use of warfarin. And, cost is an issue, too. Not all insurance companies cover these drugs or at a level that makes them affordable. In the end though, it’s a choice to be made between the patient and physician.

Dr. Indik is an associate professor of medicine and director of the Cardiovascular Disease Fellowship Program at the UA College of Medicine, Section of Cardiology; and holds the Flinn Foundation and American Heart Association Endowed Chair in Electrophysiology in the UA Sarver Heart Center.

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