Risks and Benefits of Anticoagulation in Atrial Fibrillation Insight From the Outcomes Registry for Better Informed Treatment of Atrial Fibrillation (ORBIT-AF) Registry

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Background—Patients with atrial fibrillation (AF) at the highest stroke risk derive the largest benefit from oral anticoagulation (OAC). Those with the highest stroke risk have been paradoxically less likely to receive OAC. This study assessed the association between stroke and bleeding risk on rates of OAC.

Methods and Results—We analyzed OAC use among 10 098 patients with AF from 174 community-based outpatient practices enrolled in 2010–2011 in the Outcomes Registry for Better Informed Treatment of Atrial Fibrillation (ORBIT-AF). OAC was defined as warfarin or dabigatran use at study enrollment. Stroke and bleeding risk were calculated using congestive heart failure, hypertension, age, diabetes mellitus, prior stroke (CHADS2), and anticoagulation and risk factors in AF (ATRIA) scores, respectively. The mean subject age was 73 years; 58% were men. Overall, 76% of patients received OAC (71% warfarin and 5% dabigatran). The use of OAC increased among those with higher CHADS2 scores, from 53% for CHADS2=0 to 80% for CHADS2≥2 (P<0.001). OAC use fell slightly with increasing ATRIA bleeding risk score, from 81% for ATRIA=3 to 73% for ATRIA≥5 (P<0.001). A significant interaction existed between ATRIA and CHADS2 scores (P=0.021). Among those with low bleeding risk, use of OAC increased significantly with increasing stroke risk. Among those with high bleeding risk, CHADS2 stroke risk had a smaller impact on use of OAC.

Conclusions—In community-based outpatients with AF, use of OAC was high and driven by not only predominantly stroke but also bleeding risk. Stroke risk significantly affects OAC use among those with low bleeding risk, whereas those with high bleeding risk demonstrate consistently lower use of OAC regardless of stroke risk. (Circ Cardiovasc Qual Outcomes. 2013;6:00-00.)

Key Words: anticoagulants • atrial fibrillation • hemorrhage • risk factors • stroke prevention

Atrial fibrillation (AF) is the most common cardiac arrhythmia.1 Guidelines strongly and uniformly recommend anticoagulation in patients with AF and risk factors for cardioembolic events to mitigate the likelihood of stroke or thromboembolism.2–4 The benefits of oral anticoagulant therapy are directly proportional to the underlying stroke risk as measured by the congestive heart failure, hypertension, age, diabetes mellitus, prior stroke (CHADS2) or congestive heart failure or left ventricular systolic dysfunction, hypertension, age, diabetes mellitus, prior stroke, vascular disease, and sex (CHA2DS2-VASc) scores.6 Despite the documented benefits of anticoagulation in high-risk patients, several prior studies have found that those with higher CHADS2 scores are less likely to receive anticoagulation compared with healthier patients at lower risk for thromboembolism. This risk-treatment paradox with AF has been described in patients after acute ischemic stroke or transient ischemic attack,7 in patients hospitalized for heart failure,8 and in patients with acute coronary syndromes.9,10

The reasons for these patterns remain unclear. One hypothesis suggests that providers may withhold anticoagulation from

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WHAT IS KNOWN

• Patients with atrial fibrillation at the highest risk of stroke derive the greatest benefit from anticoagulation with regard to reduction of thromboembolic risk.
• Prior work has demonstrated that patients at higher risk of stroke are paradoxically less likely to receive anticoagulation, but these studies have occurred in acutely ill patients and have not necessarily analyzed this phenomenon according to patients’ bleeding risk.

WHAT THE STUDY ADDS

• This study found that, in a population of stable outpatients with atrial fibrillation enrolled in the Outcomes Registry for Better Informed Treatment of Atrial Fibrillation rates of oral anticoagulation increased commensurate with patients’ stroke risk.
• Furthermore, although bleeding risk influenced decisions on anticoagulation, stroke risk demonstrated a larger effect on provision of anticoagulation than bleeding risk.
• These findings suggest that the risk-treatment paradox observed in hospitalized patients does not occur and that stroke risk drives decisions on anticoagulation more than bleeding risk in stable, community-based outpatients with atrial fibrillation.

The Outcomes Registry for Better Informed Treatment of AF (ORBIT-AF) is a prospective registry of community-based outpatient AF management.1 In this study, we used ORBIT-AF to assess use of OAC in community outpatients with AF. Our goals were to determine how the provision of OAC varied as a function of stroke risk, defined by the anticoagulation and risk factors in AF (ATRIA) score.12 We also sought to test the hypothesis that bleeding risk changes the effect of stroke risk on prescribed rates of OAC by assessing the interaction of these 2 competing risk dimensions on rates of OAC in the ORBIT-AF population.

Methods

Study Design

The rationale and study design of ORBIT-AF have been previously described.11 Briefly, ORBIT-AF is a prospective registry of 10098 patients enrolled from 174 heterogeneous centers throughout the United States. ORBIT-AF was designed to identify patterns in the characteristics and management of real-world community-based outpatients with AF. Inclusion criteria include adult patients with electrocardiographic evidence of AF. Patients with a life expectancy <6 months or transient AF because of a reversible condition, such as after cardiac surgery, were excluded. The study was approved by the institutional review board at all participating sites, and all participants provided informed consent for participation in ORBIT-AF.

Patient Population

This study included all patients in ORBIT-AF with complete baseline data. We excluded patients with moderate or severe mitral stenosis.

Outcome Measures

The primary outcome was OAC, defined as warfarin or dabigatran use at the time of study enrollment. During the enrollment period of June 2010 through August 2011, warfarin and dabigatran were the only available oral anticoagulants approved by the U.S. Food and Drug Administration. Patients were considered not receiving OAC if they were not taking either warfarin or dabigatran at the time of study enrollment. Secondary outcomes in this study included OAC use according to stroke and bleeding risk via the CHADS2 and ATRIA scores, respectively.

CHADS2, and CHA2DS2-VASc Scores

We calculated the CHÁDS2 score according to the formula CHADS2=age≥75 years+2 (history of stroke or transient ischemic attack)+heart failure+diabetes mellitus+hypertension.3 We defined heart failure as previous symptoms of heart failure or a prior hospital admission with a principle diagnosis of heart failure. We defined other components of the CHADS2 score according to the participants’ medical history. A subject received 1 point for the presence of ≥275 years of age, heart failure, diabetes mellitus, or hypertension and 2 points for the presence of a prior stroke or transient ischemic attack. The minimum CHADS2 score was 0 point, and the maximum CHADS2 score was 6 points.3 On the basis of guideline recommendations on thresholds for OAC, we defined a CHADS2 score of 0 to 1 as low and ≥2 as high.3

Among patients with a CHADS2 score of 0, we stratified their stroke risk according to 4 additional parameters in the CHA2DS2-VASc score that are not part of the CHADS2 score.4 These included (1) left ventricular dysfunction without heart failure, (2) female sex, (3) 65 to 74 years of age, and (4) history of peripheral vascular disease, coronary artery disease, or aortic plaque.

ATRIA Score

We calculated the ATRIA score according to the formula ATRIA=3×anemia+3×renal disease+2×age≥75 years+prior bleeding+hypertension.5 We defined anemia as a medical history of anemia. We defined renal disease as the estimated glomerular filtration rate<30 mL/min or dialysis dependent. We defined prior bleeding as a history of hemorrhagic stroke, any other intracranial bleeding, or clinically diagnosed gastrointestinal bleeding within the past 6 months. Subjects received 1 point for the presence and 0 points for the absence of each indicator variable, and we applied the multipliers on the basis of ATRIA score formula. The minimum ATRIA score was 0 points, and the maximum ATRIA score was 10 points.11 On the basis of thresholds of bleeding risk, we defined an ATRIA score of 0 to 3 as low and ≥4 as high.12

Statistical Analysis

Baseline characteristics were described as median (interquartile range) for continuous variables or percent for categorical variables. Baseline characteristics between those who did versus did not receive prescriptions for OAC were compared using Wilcoxon rank-sum tests for continuous variables or Pearson χ2 tests for categorical variables. Given our large sample size, some P values comparing baseline characteristics between groups were highly significant, despite a small magnitude of absolute differences. Therefore, we have discussed only differences that are both clinically and statistically significant. Percentages of OAC use are presented as a point estimate and corresponding 95% confidence interval (CI). Pearson χ2 tests compared associations among CHADS2, scores, CHA2DS2-VASc scores, ATRIA scores, and OAC use. A secondary sensitivity analysis excluded patients with contraindications to OAC who were included in the primary analysis. These contraindications included need for dual antiplatelet therapy, inability to adhere with or monitor OAC, high occupational

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risk, high bleeding risk, prior intracranial hemorrhage, comorbid medical conditions such as liver or renal disease, prior bleeding, allergy to OAC, patient refusal, frequent falls, and pregnancy. For this analysis, the definition of prior bleeding included any gastrointestinal bleeding, regardless of whether it occurred in the past 6 months or more remotely. All analyses performed for the initial study cohort were also performed for the sensitivity analysis. Logistic regression tested the interaction between stroke risk (ie, CHADS2 score) and bleeding risk (ie, ATRIA score) on rates of OAC in both the primary and secondary sensitivity analyses. We performed this test for interaction to determine whether bleeding risk changed the association between stroke risk and OAC in both the primary analysis and the secondary sensitivity analysis cohorts. The logistic regression accounted for site variability with generalized estimating equations. We used \( P < 0.05 \) as our threshold for statistical significance. All analyses were performed using SAS version 9.3 (SAS Institute, Cary, NC).

Results

Baseline Characteristics

In ORBIT-AF, 10,098 patients had complete baseline data. No patients were excluded for lack of data on OAC. We excluded 141 patients for moderate or severe mitral stenosis. The final study cohort included 9,957 patients.

Of the 9,957 study subjects, 7,563 subjects (76.0%) received OAC at baseline. Among the patients who received OAC, 7,070 (71.0%) received warfarin alone, 486 (4.9%) received dabigatran alone, and 7 (0.1%) received both warfarin and dabigatran. No patients received warfarin and dabigatran concomitantly. Overall, 58% of the study subjects were men, and 89% were white. As Table 1 shows, patients receiving OAC at baseline were older, less likely to have normal left ventricular systolic function, and more likely to have persistent or permanent AF (%).

<table>
<thead>
<tr>
<th>Variable</th>
<th>All Patients (n=9,957)</th>
<th>No OAC (n=2,394)</th>
<th>OAC (n=7,563)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y, median (IQR)</td>
<td>75 (67–82)</td>
<td>73 (63–82)</td>
<td>75 (68–82)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Men, %</td>
<td>58.0</td>
<td>57.6</td>
<td>58.1</td>
<td>0.65</td>
</tr>
<tr>
<td>White race, %</td>
<td>89.3</td>
<td>88.6</td>
<td>89.5</td>
<td>0.34</td>
</tr>
<tr>
<td>Heart rate, bpm, median (IQR)</td>
<td>70 (63–80)</td>
<td>70 (62–79)</td>
<td>70 (64–80)</td>
<td>0.008</td>
</tr>
<tr>
<td>Systolic blood pressure, mm Hg, median (IQR)</td>
<td>126 (116–138)</td>
<td>126 (118–138)</td>
<td>125 (116–138)</td>
<td>0.067</td>
</tr>
<tr>
<td>Body mass index, kg/m², median (IQR)</td>
<td>29 (25–34)</td>
<td>28 (25–33)</td>
<td>29 (26–34)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>LVEF≥50%, %</td>
<td>70.2</td>
<td>73.4</td>
<td>69.2</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Family history of atrial fibrillation, %</td>
<td>14.7</td>
<td>14.7</td>
<td>14.7</td>
<td>0.95</td>
</tr>
<tr>
<td>Type of atrial fibrillation</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>New onset, %</td>
<td>4.7</td>
<td>7.0</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Paroxysmal, %</td>
<td>50.7</td>
<td>64.9</td>
<td>46.2</td>
<td></td>
</tr>
<tr>
<td>Persistent or permanent, %</td>
<td>44.5</td>
<td>28.0</td>
<td>49.7</td>
<td></td>
</tr>
<tr>
<td>Medical history</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia, %</td>
<td>18.1</td>
<td>20.6</td>
<td>17.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Diabetes mellitus, %</td>
<td>29.4</td>
<td>25.9</td>
<td>30.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Cancer, %</td>
<td>23.7</td>
<td>23.4</td>
<td>23.8</td>
<td>0.67</td>
</tr>
<tr>
<td>Cognitive impairment or dementia, %</td>
<td>3.0</td>
<td>3.8</td>
<td>2.8</td>
<td>0.011</td>
</tr>
<tr>
<td>CHF, %</td>
<td>32.1</td>
<td>26.2</td>
<td>34.0</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

(Continued)
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Table 1.  Continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>All Patients (n=9957)</th>
<th>No OAC (n=2394)</th>
<th>OAC (n=7563)</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic cardiomyopathy, %</td>
<td>13.0</td>
<td>12.2</td>
<td>13.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospitalized for CHF in past year, %</td>
<td>5.6</td>
<td>5.4</td>
<td>5.7</td>
<td>0.58</td>
</tr>
<tr>
<td>Coronary artery disease†, %</td>
<td>31.9</td>
<td>31.7</td>
<td>32.0</td>
<td>0.78</td>
</tr>
<tr>
<td>COPD, %</td>
<td>16.3</td>
<td>16.7</td>
<td>16.2</td>
<td>0.57</td>
</tr>
<tr>
<td>Chronic kidney disease, %</td>
<td>34.1</td>
<td>32.0</td>
<td>34.8</td>
<td>0.025</td>
</tr>
<tr>
<td>Dialysis dependent, %</td>
<td>1.3</td>
<td>2.0</td>
<td>1.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gastrointestinal bleeding‡, %</td>
<td>9.1</td>
<td>12.7</td>
<td>8.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hyperlipidemia, %</td>
<td>71.9</td>
<td>67.4</td>
<td>73.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hypertension, %</td>
<td>83.0</td>
<td>77.2</td>
<td>84.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Implantable cardioverter-defibrillator, %</td>
<td>8.5</td>
<td>6.7</td>
<td>9.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Obstructive sleep apnea, %</td>
<td>18.2</td>
<td>16.1</td>
<td>18.9</td>
<td>0.002</td>
</tr>
<tr>
<td>Smoking history, %</td>
<td>48.5</td>
<td>47.0</td>
<td>48.9</td>
<td>0.099</td>
</tr>
<tr>
<td>Stroke or transient ischemic attack, %</td>
<td>15.0</td>
<td>10.8</td>
<td>16.3</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Laboratory data

| Serum creatinine, mg/dL, median (IQR) | 1.0 (0.9–1.3) | 1.0 (0.9–1.3) | 1.0 (0.9–1.3) | 0.058    |
| Hemoglobin, g/dL, median (IQR)       | 13.5 (12.3–14.6) | 13.4 (12.1–14.6) | 13.5 (12.3–14.7) | 0.002    |

Antithrombotic medications§

| None, %                        | 52.8              | 22.5            | 62.4          | <0.001   |
| Aspirin only, %                | 40.0              | 61.9            | 33.0          |         |
| Clopidogrel only, %            | 3.0               | 5.0             | 2.3           |         |
| Both aspirin and clopidogrel, %| 4.3               | 10.7            | 2.2           |         |

CHADS2 score

| Low (0–1), %                  | 28.5              | 40.7            | 25.1          | <0.001   |
| High (≥2), %                  | 71.2              | 59.3            | 74.9          |         |

ATRIA score

| Low (0–3), %                  | 73.7              | 70.9            | 74.6          | <0.001   |
| High (≥4), %                  | 26.3              | 29.0            | 25.4          |         |

Values are presented as % or median (IQR). ATRIA indicates anticoagulation and risk factors in atrial fibrillation; CHADS2, congestive heart failure, hypertension, age, diabetes mellitus, prior stroke; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; IQR, interquartile range; LVEF, left ventricular ejection fraction; and OAC, oral anticoagulation, defined as warfarin or dabigatran use at time of study enrollment.

*P values were calculated by comparing only nonmissing row values. P values are based on Pearson χ² tests for all categorical row variables. For all continuous or ordinal variables, P values are based on Wilcoxon rank-sum tests.

†Coronary artery disease was defined as history of prior myocardial infarction, coronary artery bypass grafting, percutaneous coronary intervention, or drug-eluting stent placement.

‡For the purposes of reporting baseline characteristics, gastrointestinal bleeding was defined as any clinical history of gastrointestinal bleeding, regardless of when it occurred. For the purposes of calculating the ATRIA score, the definition of prior bleeding included gastrointestinal bleeding in the past 6 mo. Of all subjects with any gastrointestinal bleeding, 16.1% had gastrointestinal bleeding within the past 6 mo.

§Aspirin only also includes patients treated with aspirin and dipyridamole (Aggrenox) with or without aspirin. Clopidogrel only includes patients treated with prasugrel or clopidogrel without aspirin. Both aspirin and clopidogrel also includes patients treated with aspirin and prasugrel.

(95% CI, 79.1–81.9) among those with an ATRIA score of 3% to 63.8% (95% CI, 58.1–69.4) among those with an ATRIA score ≥7 (Figure 2B; P<0.001).

OAC Use According to Stroke and Bleeding Risk

Comparing rates of OAC across levels of stroke and bleeding risk found highest rates of OAC among patients with high CHADS2 and low ATRIA scores (82.1%; 95% CI, 81.1–83.2; Table 2). Conversely, rates of OAC were lowest among patients with low CHADS2 and high ATRIA scores (63.8%; 95% CI, 58.1–69.4; Table 2). Among patients with a low bleeding risk, rates of OAC increased commensurate with stroke risk (Figure 1). Higher bleeding risk tended to decrease rates of OAC among patients with increasing stroke risk (Figure 1). Tests for interaction between low versus high CHADS2 and ATRIA scores found a significant relationship between bleeding and stroke risk on rates of OAC (Table 2; P=0.021). This suggests that differences in rates of OAC between those with low and high CHADS2 scores differ by ATRIA score. In patients with low ATRIA scores, rates of OAC increase more moving from low to high CHADS2 scores than they do in patients with high ATRIA scores.

Sensitivity Analysis

We performed a secondary sensitivity analysis to assess the impact of excluding those with contraindications to OAC. This analysis included all patients in the primary analysis.
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(n=9957) less those with contraindications to OAC (n=1393). The sensitivity analysis included 8564 subjects.

In this group, 7097 subjects (82.9%) received OAC at baseline. Rates of OAC increased across the spectrum of CHADS₂ scores, from 56.9% (95% CI, 52.9–60.9) among subjects with a CHADS₂ score of 0 to 91.4% (95% CI, 88.9–93.9) among those with a CHADS₂ score of 5 to 6 (P<0.001). Rates of OAC increased slightly with increasing ATRIA scores, from 82.3% (95% CI, 81.4–83.3) among those with a low ATRIA score ≤3 to 84.6% (95% CI, 83.1–86.2) among those with an ATRIA score ≥4 (P=0.037). Tests for interaction between low versus high CHADS₂ and ATRIA scores did not find a significant relationship between bleeding and stroke risk on rates of OAC (P=0.090; Table 4).

Discussion

In this analysis of outpatients with AF, we found an overall rate of OAC of 76%. Rates of OAC increased with increasing stroke risk in patients with both high and low bleeding risks. This suggests, in this population of stable outpatients, that the risk-treatment paradox does not exist and that stroke risk primarily drives clinical decisions on provision of OAC.

Overall Rates of OAC

This study found a 76% rate of OAC among all patients and an 83% rate of OAC among those without contraindications to anticoagulation. Previous studies have documented a rate of anticoagulation of 50% to 65% in appropriate patients. Many reasons may account for the higher rates of OAC in the current study. Earlier studies documenting lower rates of anticoagulation enrolled patients in the 1990s, shortly after publication of trials supporting its efficacy and before widespread adoption of anticoagulation into clinical practice. Many of these studies focused on underserved populations, including Medicaid beneficiaries, who may receive less medical care. In contrast, few members of the ORBIT-AF cohort come from traditionally underserved populations. Those studies investigating patients in health maintenance organizations or other managed care settings documented rates of anticoagulation closer to those in the ORBIT-AF cohort.

Table 2. Rates of Anticoagulation According to Stroke and Bleeding Risk*

<table>
<thead>
<tr>
<th>ATRIA Score</th>
<th>CHADS₂ Score, n/N (%)</th>
<th>Total, n/N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (0–3)</td>
<td>1633/2458 (66.4)</td>
<td>5644/7342 (76.9)</td>
</tr>
<tr>
<td>High (≥4)</td>
<td>261/409 (63.8)</td>
<td>1917/2611 (73.4)</td>
</tr>
<tr>
<td>Total</td>
<td>1894/2867 (66.1)</td>
<td>7561/9953 (76.0)†</td>
</tr>
</tbody>
</table>

ATRIA indicates anticoagulation and risk factors in atrial fibrillation; and CHADS₂, congestive heart failure, hypertension, age, diabetes mellitus, prior stroke.

*P value=0.021 for the interaction between CHADS₂ and ATRIA scores.
†This calculation excludes 4 subjects without ATRIA or CHADS₂ scores.

Figure 1. Rates of oral anticoagulation (OAC) according to congestive heart failure, hypertension, age, diabetes mellitus, prior stroke (CHADS₂), and anticoagulation and risk factors in atrial fibrillation (ATRIA) scores. The table below the chart represents the total number of subjects in each group. CHADS₂ score was missing on 1 patient, and ATRIA score was missing on 4 patients. OAC defined as warfarin or dabigatran use at time of study enrollment.
For example, 73% of all patients received warfarin or aspirin in a population-based study of patients with newly detected AF in a large health plan. It is also possible that OAC use has improved as a result of quality control measures and publication of American College of Cardiology/American Heart Association performance measures for AF. More recent studies focusing on outpatients with AF have documented higher rates of anticoagulation. For example, a study from the AFFECTS (Atrial Fibrillation: Focus on Effective Clinical Treatment Strategies) Registry, enrolling patients from 2005 to 2007, documented that 64% of eligible patients received warfarin and 83% received warfarin or aspirin.

ORBIT-AF enrolled patients from anticoagulation, cardiology, and electrophysiology clinics. Previous studies have shown lower rates of OAC among patients who do not see cardiologists. It is possible that sites voluntarily participating in ORBIT-AF may reflect providers at those sites who are more aware of guideline recommendations and quality measures. Therefore, some degree of selection bias could explain the higher rates of OAC observed in this study.

Figure 2. Rate of oral anticoagulation (OAC) according to congestive heart failure, hypertension, age, diabetes mellitus, prior stroke (CHADS2) stroke score (A) and anticoagulation and risk factors in atrial fibrillation bleeding score (B). *P values <0.001 for the relationship of CHADS2 and ATRIA scores, respectively, to rates of OAC. OAC defined as warfarin or dabigatran use at time of study enrollment.
For example, rates of OAC decreased from 76.9% to 73.4% among all subjects with low versus high ATRIA scores, for a marginal difference of 3.5% (Table 2). In contrast, rates of OAC increased from 66.1% to 80.0% among all subjects with low versus high CHADS2 scores, for a marginal difference of 21.9% (Table 2). Our sensitivity analysis excluding those with contraindications to OAC demonstrated similar marginal differences (Table 4). Furthermore, the test for interaction demonstrated that rates of OAC increase more moving from low to high CHADS2 scores among patients with low bleeding risk than they do in patients with high bleeding risk (Table 2). The large difference in magnitude of effect and significant interaction between stroke and bleeding risk demonstrates that stroke risk drives decisions on OAC more than bleeding risk in the ORBIT-AF population of stable outpatients with AF.

Despite the importance of stroke risk, bleeding risk still influenced OAC decisions. In the primary analysis, bleeding risk impacted OAC use the most in patients with high stroke risk. In patients with a CHADS2 score ≥2, rates of OAC were 66.4% in those with low versus 63.8% in those with high ATRIA scores. In contrast, among those with a CHADS2 score ≤1, rates of OAC were 71.9% in those with low ATRIA scores to 75.2% in those with high ATRIA scores (Table 2).

It is possible that investigators rationalized a decision not to treat patients with OAC by justifying high bleeding risk as a contraindication to OAC regardless of the potential net benefit of OAC. This underscores the phenomenon that those who benefit the most from OAC are still less likely to receive OAC if their bleeding risk is high. Although withholding OAC in those at high risk for bleeding may seem intuitive, several potential downsides exist to such an approach. First, stroke risk and bleeding risk are highly correlated. Patients at high risk of bleeding are often at the highest risk of stroke. Furthermore, a clear positive correlation exists between stroke risk and the absolute benefit derived from OAC.27,28 Although it would seem logical to withhold OAC from patients with AF at high bleeding risk, current data suggest that most patients with high bleeding or stroke scores derive clinical benefit from OAC through reduced stroke risk.29–32 No prospective studies have ever tested whether withholding OAC in those at high risk of bleeding results in net clinical benefit. Future prospective studies are necessary to determine if a combined bleeding and stroke-score–guided approach to OAC results in improved survival. Future work must also assess the degree to which bleeding risk should impact decisions on OAC.
the limited data available, data from this study suggest that clinicians caring for stable outpatients with AF are withholding OAC from the patients at highest stroke and bleeding risk without prospective data demonstrating a benefit from that approach.

**Differences Between Inpatient and Outpatient Populations**

Recent studies have clearly documented a negative correlation between stroke risk and provision of OAC. This phenomenon has been observed most prominently in acutely ill inpatients. This study, in contrast, describes a positive correlation between stroke scores and provision of OAC in a large cohort of community outpatients. It is possible that the findings documented in the studies of inpatients occurred because clinicians withheld OAC in the context of concurrent acute illnesses or use of other antithrombotic medications, such as aspirin or clopidogrel. Other data would suggest that the risk-treatment paradox in these studies may be isolated to the inpatient setting. For instance, studies of outpatients have documented a positive correlation between rates of OAC and stroke risk. These findings imply a need for prospective studies to assess uptake of OAC among acutely ill inpatients as they transfer to stable outpatient care.

**Limitations**

Several limitations exist in this analysis. Participation in ORBIT-AF was voluntary, and it is possible that subject enrollment or site participation in ORBIT-AF could alter local clinical practice. The patient population in this study was also a largely white and male population, suggesting that the data may be less applicable to minority or female populations. Selection bias may also have influenced the results, as it is possible that including patients from specialty clinics, such as electrophysiology or thrombophilia practices, may have led to higher rates of OAC than observed in primary care settings. We did not include other available methods of calculating bleeding risk in our analysis. In particular, we did not use the hypertension, abnormal renal/liver function, stroke, bleeding history or predisposition, labile international normalized ratio, elderly, drugs/alcohol concomitantly score because we do not have baseline data on international normalized ratio lability, one of the hypertension, abnormal renal/liver function, stroke, bleeding history or predisposition, labile international normalized ratio, elderly, drugs/alcohol concomitantly (ie, HAS-BLED) score components, on patients in ORBIT-AF. Finally, this study did not assess the impact of stroke and bleeding risk on provision of newer anticoagulants. Although overall rates of OAC remain unchanged, despite rising use of dabigatran, it is possible that provision of OAC may increase as rivaroxaban and apixaban permeate clinical practice.

**Conclusions**

In this analysis of outpatients with AF, we found that rates of OAC exceed those reported in previous studies, perhaps reflecting wider adoption of stroke prophylaxis guidelines in contemporary community practice. In contrast to prior studies, we found that use of OAC rose appropriately with increasing stroke risk, as defined by the CHADS2 score. This rise in the use of OAC occurred in patients at both high and low bleeding risks. However, in the highest risk patients, rates of OAC were driven predominantly by stroke risk.

Despite these improvements, quality initiatives remain necessary to improve overall stroke prevention treatment in patients with AF. Prospective studies must test the benefit of a combined bleeding and stroke score approach to anticoagulation.

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