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Atrial Fib Dinner Talk

A couple of weeks ago we were treated to an exceptional presentation on the use of the newer anticoagulants in the treatment of atrial fibrillation (AF). Dr. Allan Bell, with Thrombosis Canada and a key member on multiple Canadian guideline committees, gave us an up to the minute look at how these drugs should be used, while focusing on our elderly patient population.

First some facts…AF related clots are very large and the strokes they cause can wipe out 1/3 of the brain's cells. AF related strokes carry double the mortality risk of non-AF strokes and a 70% greater risk of incapacity, if the victim does survive. AF stroke risk increases rapidly with age (23% risk for those 80-89 years of age). In spite of this awareness, only 35% of newly diagnosed, elderly (>85 years) AF patients are treated with anticoagulants, even though warfarin could prevent 2/3 of these strokes. The newer agents (NOACs – Pradaxa®, Xarelto® and Eliquis®) provide a further 19% stroke risk reduction, and are much safer (50% less likely to cause a brain bleed).

Why do physicians fail to treat their elderly AF patients so often? Dementia, short life expectancy and fear of bleeding (GI, cerebral, fall related, poor INR control) are the typical reasons, but these concerns are usually based on misunderstanding of the risks vs. benefits of treatment. For example, after an intracranial bleed there would be a natural reluctance to restart an anticoagulant. While the risk of a recurrent brain bleed is doubled, stroke risk increases eight times in this period, because of increased red blood cell "stickiness". After a GI bleed risk of recurrence does not increase upon restarting warfarin, while warfarin reduces mortality risk by 69%!

Physician's fears about re-bleeds can be reduced by taking a few simple steps. Stopping ASA and other NSAID meds, maintaining hydration and adding a PPI (Pantoloc®, Prevacid®, etc.) help on the GI side. Controlling BP, limiting alcohol and ensuring walking aids are used (to prevent falls), limit the risk of central bleeds. The newer agents are superior in efficacy, while carrying less risk. Xarelto® can be crushed without altering its activity. Warfarin is still preferred over the NOACs in severe renal or liver disease or in conjunction with artificial heart valves. Our consultant pharmacists would be happy to repeat the presentation in your facility, upon request.

It's Flu Time

Time to crank up those syringes and vaccinate everyone (staff included)! Our $75 prize for the bravest vaccine recipient in each facility is being offered again, so don't miss out on your chance to win big. Just let us know who the winner is and we will send along a cheque.

This year's vaccine includes just one strain from last year, the A/California (H1N1). The H3N2 strain A/Switzerland is new, as is the Influenza B strain, B/Phuket. I faced the music last week, receiving Fluviral®. Residents (and staff) over 65 will get Fluad®, which contains an adjuvant to enhance the immune response. Other brands may make their way into the system, if supplies run short.

Remember to have your GeriatRx adrenaline kit (or Epi-pen) on hand, in the unlikely event an anaphylactic reaction occurs. If you haven't sent in your latest weights and creatinines, please do so. Remember, before you swab, call GeriatRx. We want to get your Tamiflu® out early so you are ready in the event of a positive result. Good luck.

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