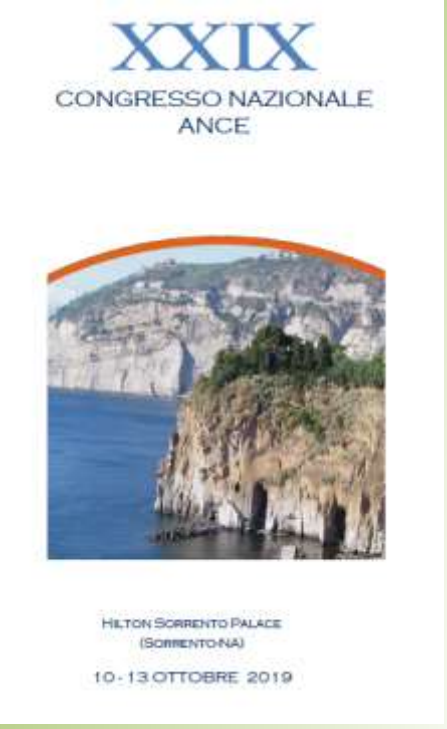
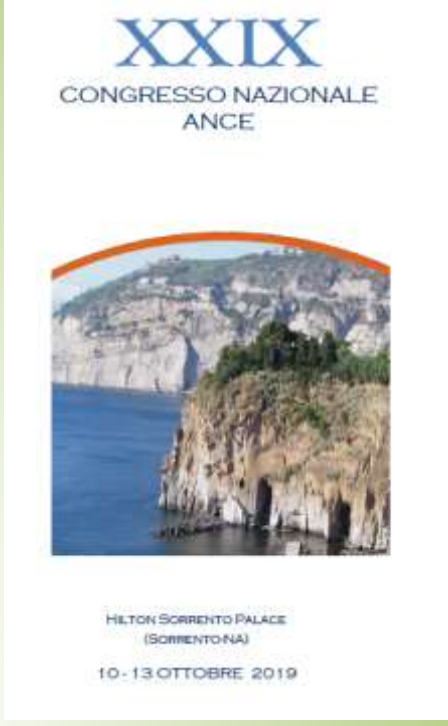




FIBRILLAZIONE NELL'ANZIANO, AL DI LA' DI UNA SEMPLICE ARITMIA

Andrea Ungar, MD, PhD, FESC

Syncope Unit – Centro Ipertensione
Geriatria e Terapia intensiva Geriatrica
Firenze

Syncope Unit Florence

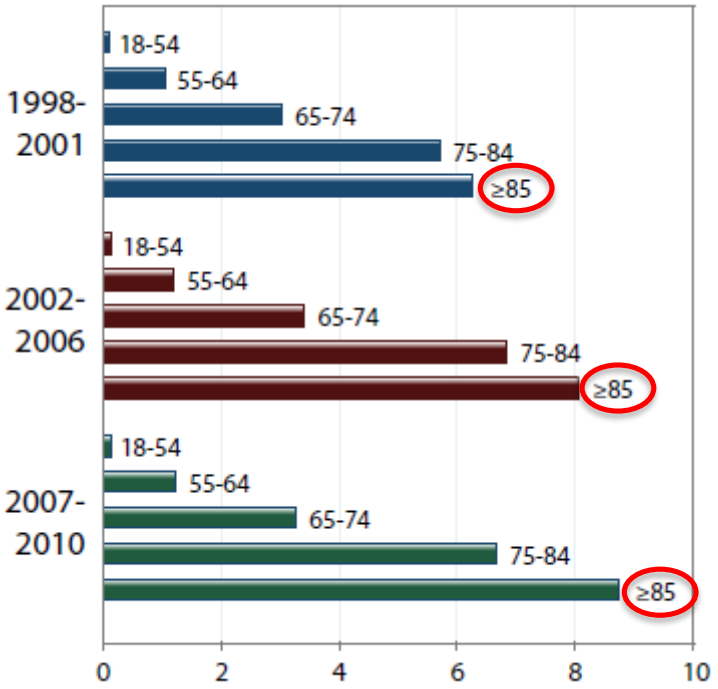
Syncope Unit Florence

Table 8 Cardiovascular and other conditions independently associated with atrial fibrillation

Characteristic/comorbidity	Association with AF
Genetic predisposition (based on multiple common gene variants associated with AF)[64]	HR range 0.4–3.2
Older age[19] 50–59 years 60–69 years 70–79 years 80–89 years	HR: 1.00 (reference) 4.98 (95% CI 3.49–7.10) 7.35 (95% CI 5.28–10.2) 9.33 (95% CI 6.68–13.0)

Temporal Trends in Incidence, Prevalence, and Mortality of Atrial Fibrillation in Primary Care

Incidence rate of AF by age-group and year of diagnosis (the UK Clinical Practice Research Datalink, a primary care database – GOLD – N=57 818 patients with incident AF)



Lane DA, JAHA 2017

2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

The Task Force for the management of atrial fibrillation of the European Society of Cardiology (ESC)

Recommendations for screening for atrial fibrillation

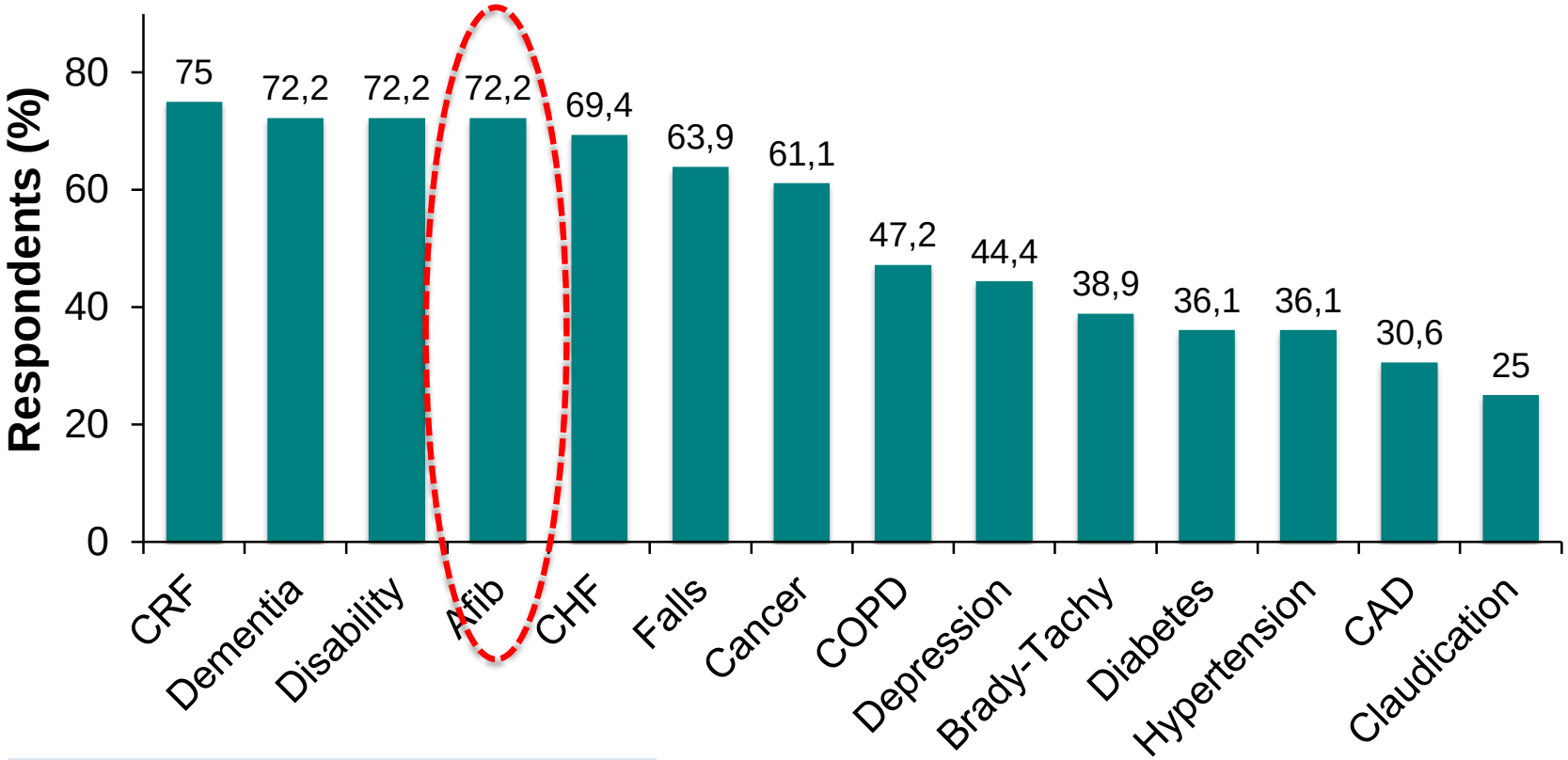
Recommendations	Class[a]	Level[b]	Ref[c]
Opportunistic screening for AF is recommended by pulse taking or ECG rhythm strip in patients >65 years of age.	I	B	130, 134, 155
Systematic ECG screening may be considered to detect AF in patients aged >75 years, or those at high stroke risk.	IIb	B	130, 135, 157

Recommendations for screening for atrial fibrillation

			130, 134, 155
			27, 127
(AHRE). Patients with AHRE should undergo further ECG monitoring to document AF before initiating AF therapy.	I	B	141, 156
aged >75 years, or those at high stroke risk.	IIb	B	30, 135, 157

Frailty syndrome: an emerging clinical problem in the everyday management of clinical arrhythmias: results of the European Heart Rhythm Association survey

Comorbidities most frequently associated to the frailty syndrome



Afib: atrial fibrillation; **Brady-Tachy:** bradycardia tachycardia syndrome; **CAD:** coronary artery disease; **CRF:** chronic renal failure

Fumagalli S et Al.,
EP Europace 2017

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FIBRILLAZIONE NELL'ANZIANO, AL DI LA' DI UNA SEMPLICE ARITMIA

Ma chi è l'anziano fragile ?

Syncope Unit Florence

Syncope Unit Florence

Definitions

Comorbidity definition

the presence of one or more additional diseases or disorders co-occurring with a primary disease (eg. HF) or disorder.

Disability definition

the loss of autonomy and the consequent dependence in one or more global activities of daily living.

Frailty definition

Definitions

Comorbidity definition

the presence of one or more additional diseases or disorders co-occurring with a primary disease (eg. HF) or disorder.

Disability definition

the loss of autonomy and the consequent dependence in one or more global activities of daily living.

Frailty definition

? ?

Fragilità: definizione

- Sindrome multifattoriale, determinata dalla riduzione della fisiologica riserva funzionale e della capacità di resistere a eventi stressanti ambientali (capacità di omeostasi)
- Comporta un aumentato rischio di eventi clinici: disabilità, ospedalizzazione, istituzionalizzazione, morte
- Condizione complessa e dinamica, della quale si sono proposti numerosi modelli

Definizione operativa di fragilità in popolazione anziana generale: Cardiovascular Health Study

1. Forza (handgrip) nel quintile inferiore
2. Velocità del cammino nel quintile inferiore
3. Perdita di peso non intenzionale ≥4,5 kg nell'ultimo anno
4. Facile esauribilità
5. Livello di attività fisica nel quartile inferiore

PHENOTYPE FRAILTY INDEX

Fragile: ≥3 componenti

Intermedio (prefragile): 1 o 2 componenti

Non fragile (robusto): 0 componenti

Fried L, et al. *J Gerontol* 2001

Short Physical Performance Battery (SPPB)

Test dell'equilibrio

Posizione piedi uniti
per 10 sec → 1 punto

NO → tempo:____ sec
<10 secondi → 0 punti

SI

Posizione semitandem
per 10 sec → 1 punto

NO → tempo:____ sec
<10 secondi → 0 punti

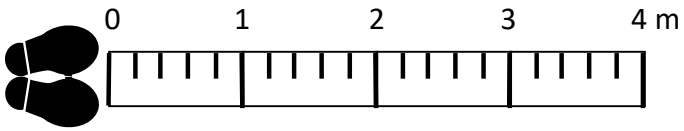
SI

Posizione tandem
tempo:____ sec
per 10 sec → 2 punti
3-9.9 sec → 1 punto
<3 sec → 0 punti

Test della marcia

Tempo per percorrere 4 metri di passo normale: ____sec
(tempo migliore di 2 prove)

<4.8 sec	→ 4 punti
4.8-6.2 sec	→ 3 punti
6.3-8.7 sec	→ 2 punti
>8.7 sec	→ 1 punto
incapace	→ 0 punti



Test della sedia

Capace

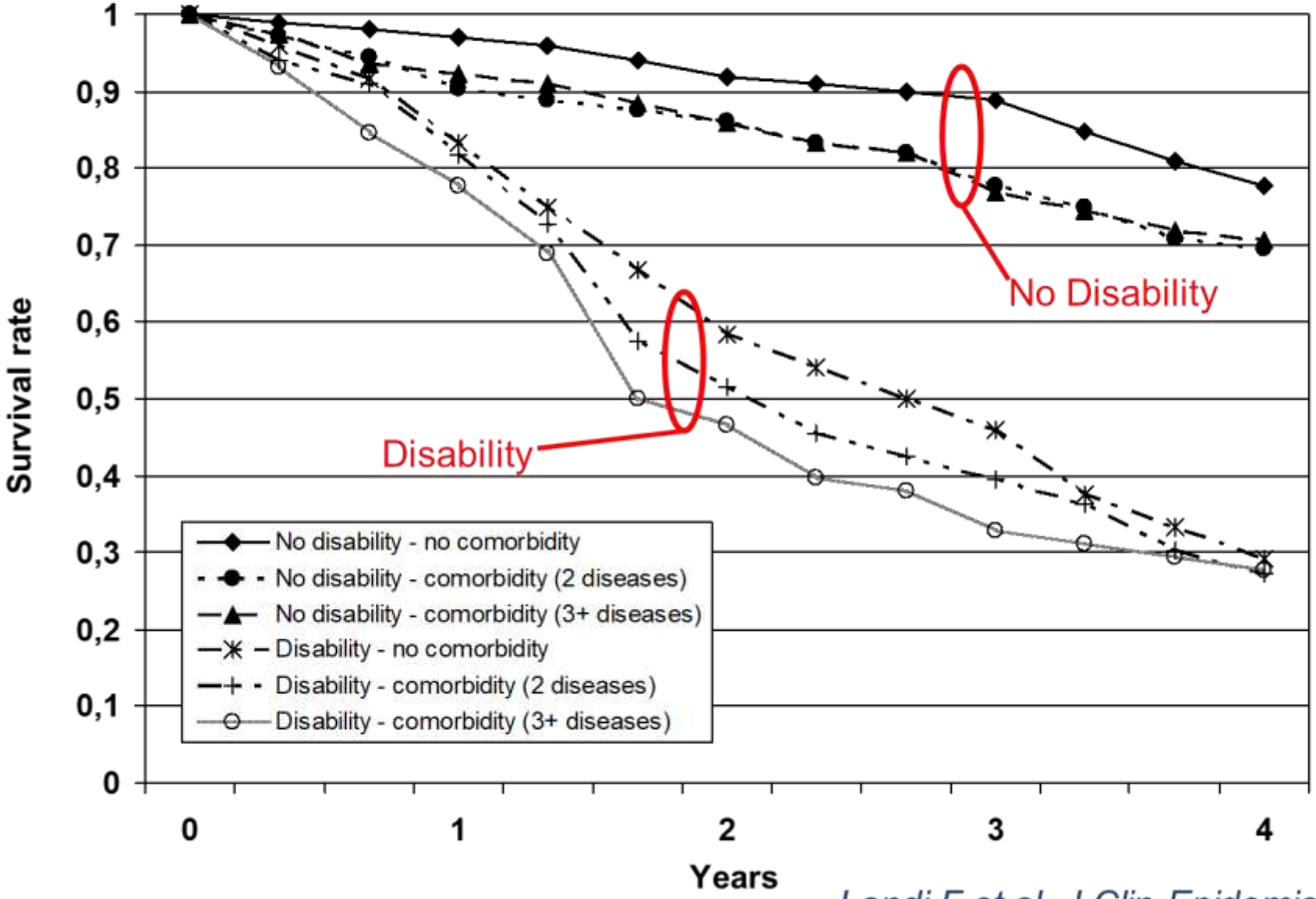
Alzarsi e sedersi per 5 volte più velocemente possibile a braccia incrociate

<11.2 sec	→ 4 punti
11.2-13.7 sec	→ 3 punti
13.8-16.7 sec	→ 2 punti
16.8-60 sec	→ 1 punto
>60 sec o incapace	→ 0 punti

Punteggio totale: 0-12

Guralnik et al, *J Gerontol 1994*

Disability, more than multimorbidity, was predictive of mortality among older persons aged 80 years and older



Landi F et al. J Clin Epidemiol. 2010

EDITORIAL COMMENTARY

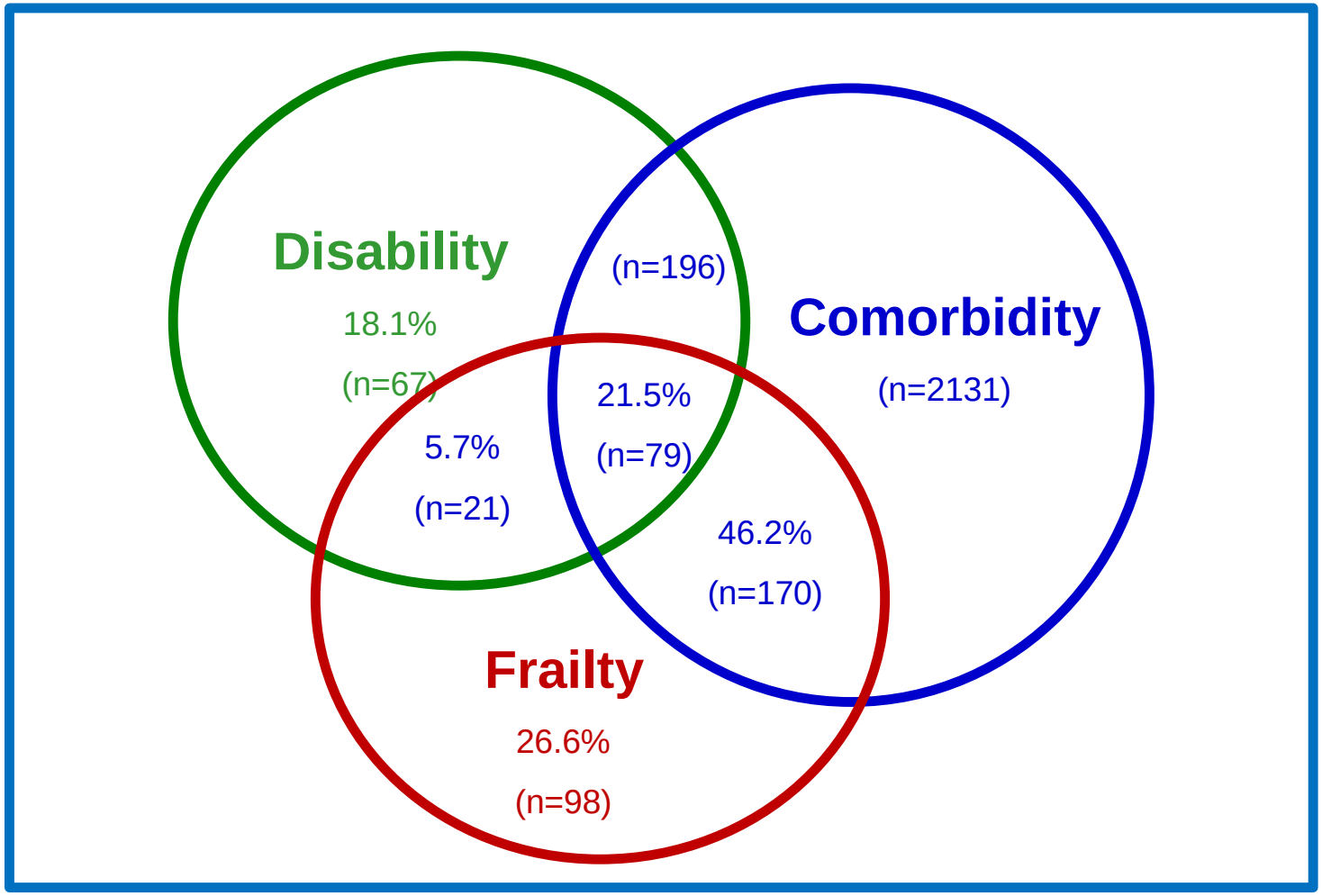
Frailty: It's hard to define, but you know it when you see it

Keith B. Allen, MD

J Thorac Cardiovasc Surg. 2014;148:3117-8

Frailty concept: two 78-year-old patients with severe degenerative mitral valve regurgitation and **comparable Logistic Euro-Score (12%)**

Relationship between comorbidity, disability and frailty according to the Phenotype Frailty Index

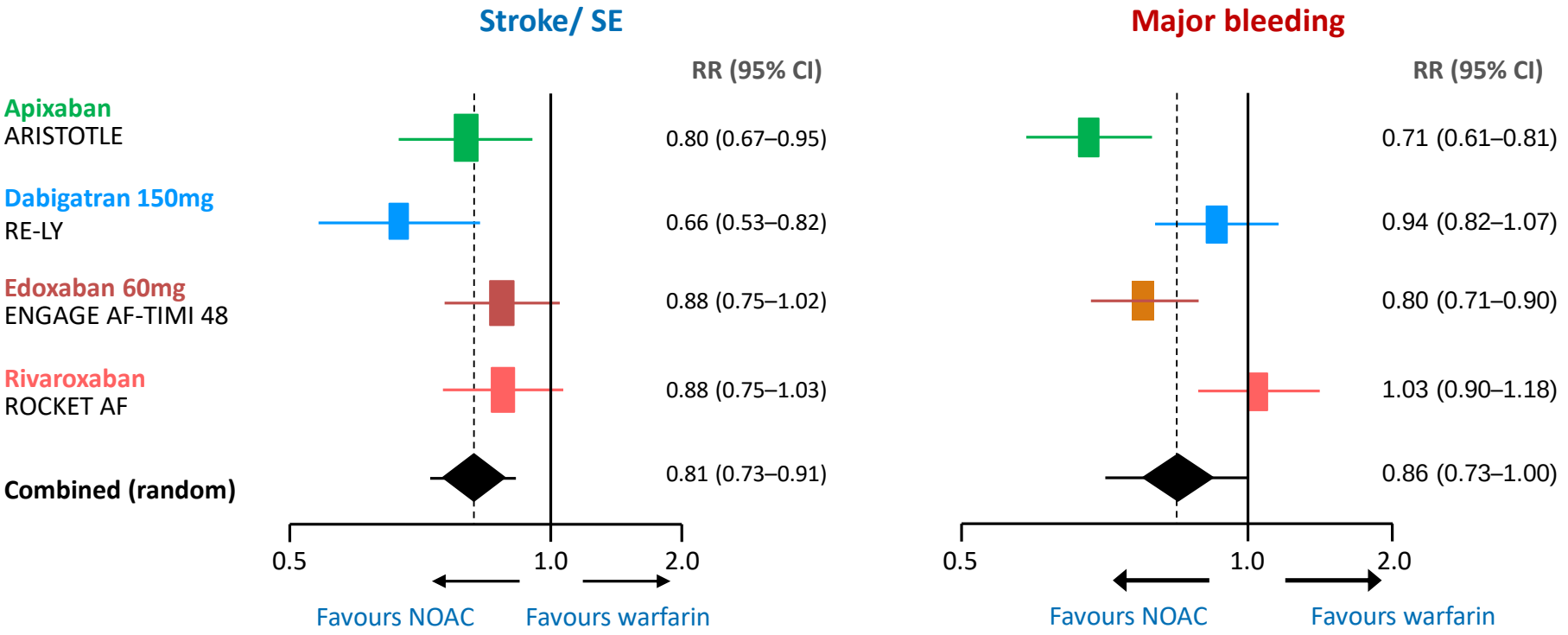


Fried L, et al. *J Gerontol* 2001

Winter 1507-1508

…. MS, 96 aa; Non assume farmaci
Dal 1948 non perde un angelus….

NOACs: main outcomes in AF



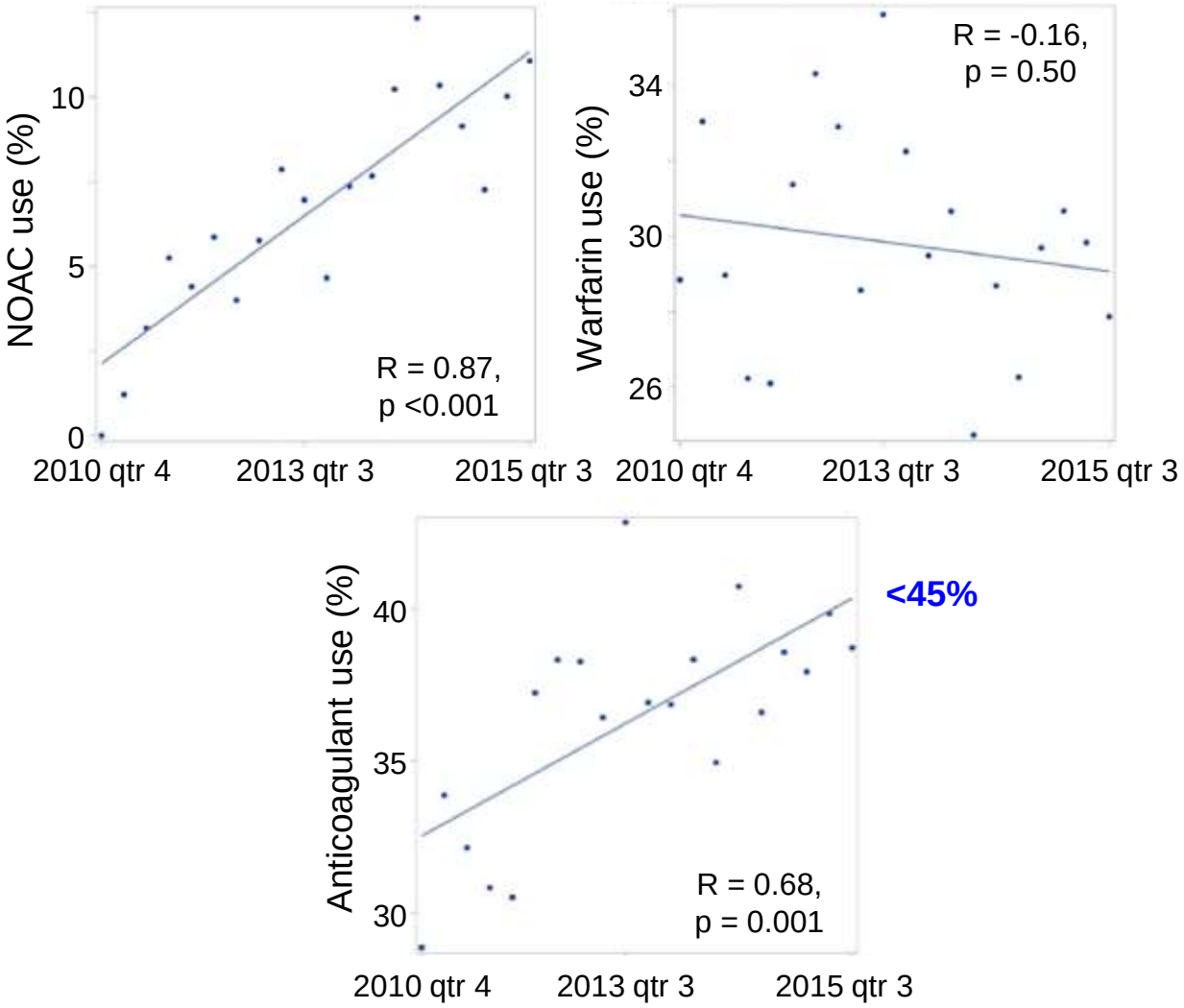
Modified from Ruff *et al. Lancet* 2014;383:955-62

Ruff *et al. Lancet* 2014;383:955-62

Effect of New Oral Anticoagulants on Prescribing Practices for Atrial Fibrillation in Older Adults

Quarterly trend in anticoagulants use (N=6568; age ≥75 years)

(the Clinical Investigation Data Exploration Repository - CIDER, Washington University)



<45%

Fohtung RB et Al, JAGS 2017

2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

The Task Force for the management of atrial fibrillation of the European Society of Cardiology (ESC)

13. Specific situations

13.1 Frail and 'elderly' patients

- ✓ Many AF patients present at older age (e.g. >75 or >80 years)
- ✓ There are no studies suggesting that cardiovascular risk reduction is less effective in these 'elderly' AF patients than in younger patients
- ✓ Rather, age is one of the strongest predictors/risk factors for ischaemic stroke in AF
- ✓ Good data are available to support the use of anticoagulants in older patients
- ✓ Elderly AF patients are at higher risk of stroke and, thus, are more likely to benefit from OAC than younger patients, and yet OAC is still underutilized in the elderly

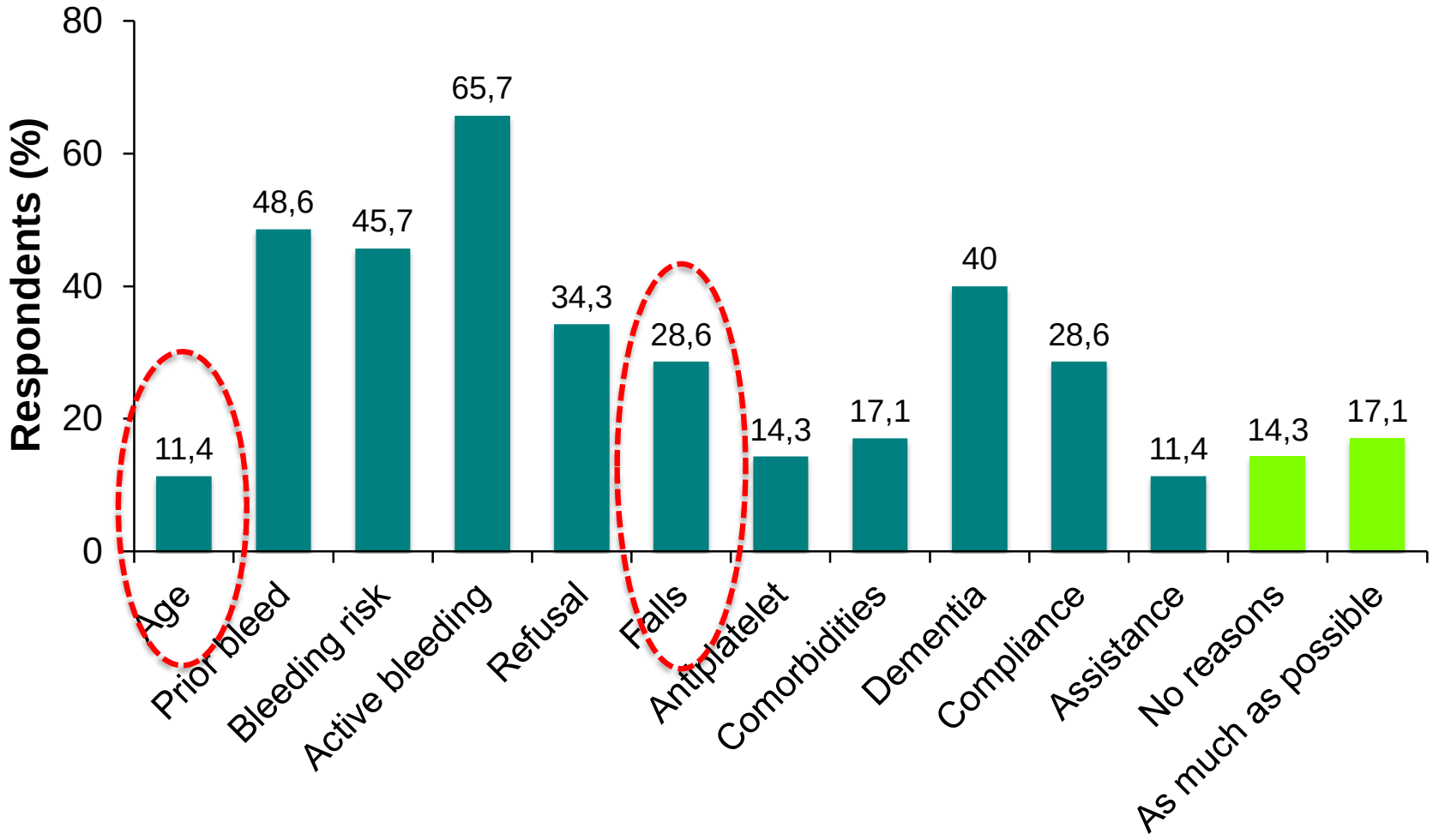
Kirchhof P, Eur Heart J 2016

Frailty syndrome: an emerging clinical problem in the everyday management of clinical arrhythmias: results of the European Heart Rhythm Association survey

Fumagalli S et Al.,
EP Europace 2017

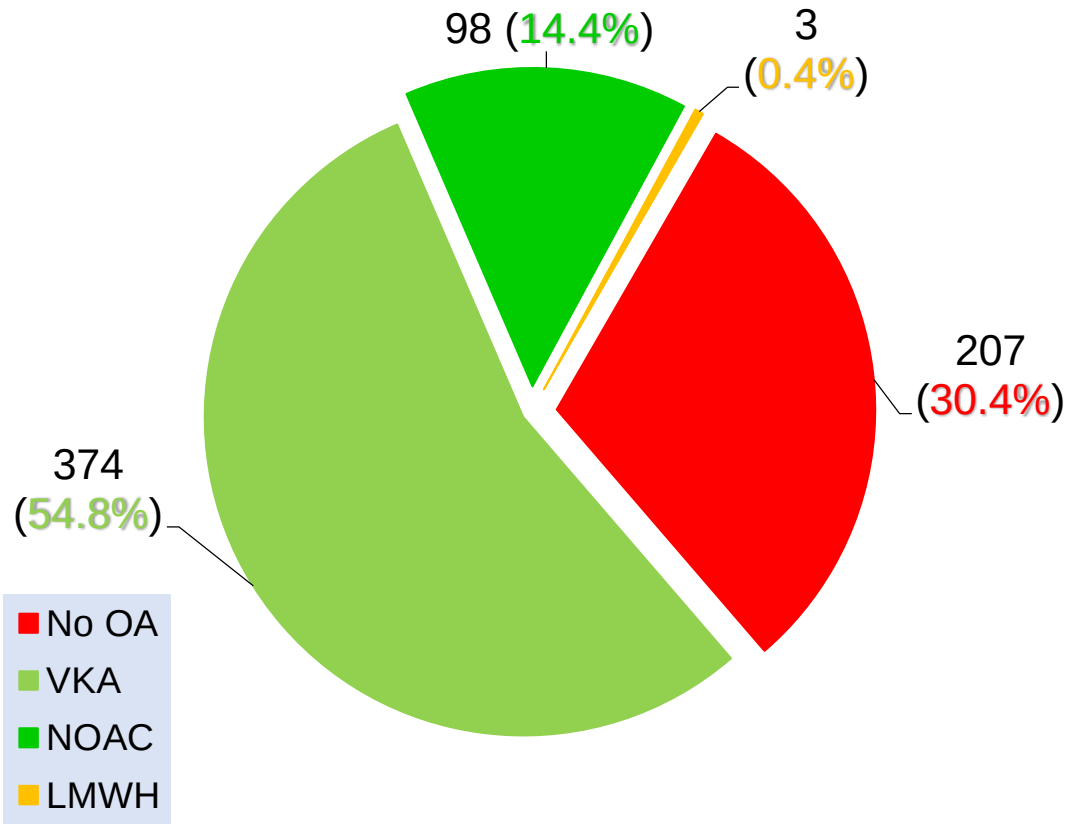
Reasons not to prescribe OAs to a frail patient with AF

(light green bars indicate responses that are in favour of the use of Oas)



The Effect of Bleeding Risk and Frailty Status on Anticoagulation Patterns in Octogenarians With Atrial Fibrillation: The FRAIL-AF Study

Anticoagulant use in 682 hospitalized patients ≥80 years with AF/AFl (Age: 85.9; 3 academic hospitals; Montreal, Quebec; 2012-2013)



The most common reasons for not prescribing an OA:

1. Hx of bleeding (15.5%)
2. Active bleeding (15.5%)
3. Risk of falls (14%)
4. Patient refusal (8.7%)
5. No justification provided (15%)

Lefebvre MCD, 2016

Arrhythmias in elderly and frailty syndrome

AF Antithrombotic management – Consensus statements

All AF patients with non-sex-related CHA_2DS_2-VASc stroke risk factor should be considered for OAC therapy, irrespective of their frailty status

Frail AF patients require a detailed assessment of their baseline stroke /bleeding risk profile and consideration of their personal values / preferences with regards to AF management

Frail AF patients taking OAC need a frequent, regular clinical follow-up for treatment effects monitoring and stroke / bleeding risk re-assessment

The advantages of NOACs relative to VKAs are likely consistent in frail and non-frail AF patients, but frail AF patients may have a greater benefit from NOACs owing to a higher absolute risk of TE events

Aspirin should not be used for stroke prevention in frail AF patients, since it is essentially ineffective and associated to similar risk of bleeding compared to NOACs / VKAs

2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

The Task Force for the management of atrial fibrillation of the European Society of Cardiology (ESC)

13. Specific situations

13.1 Frail and 'elderly' patients

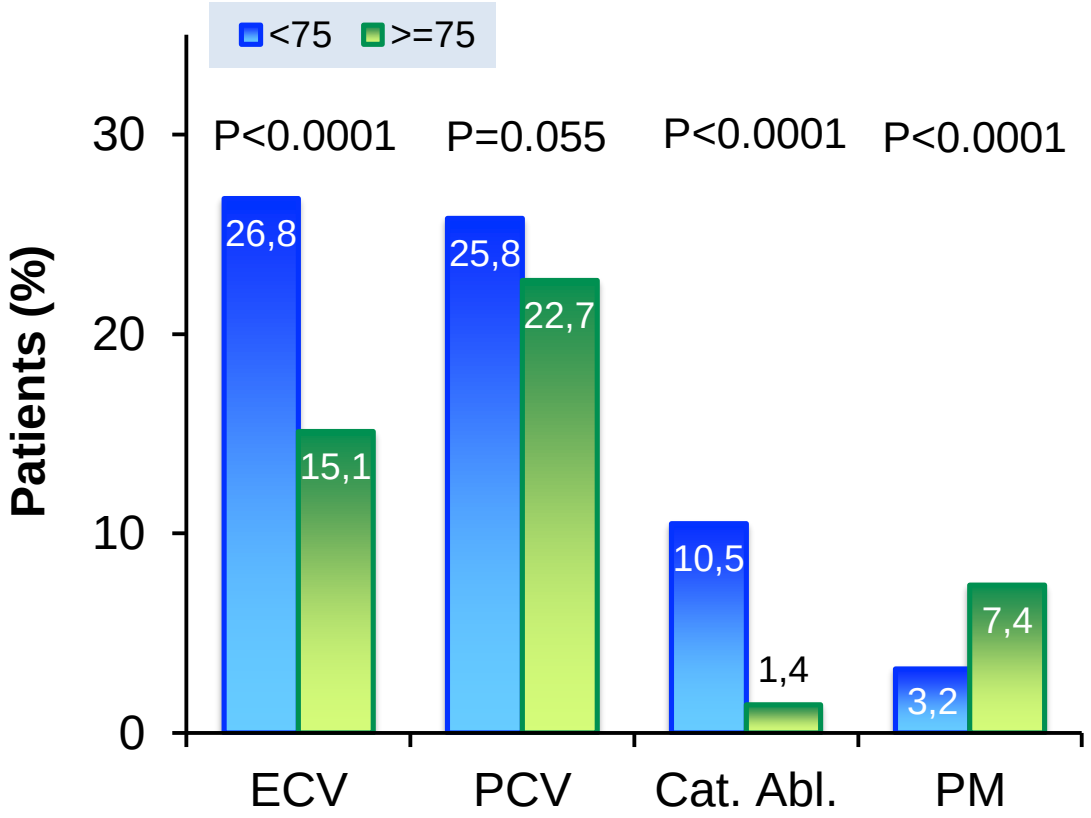
- ✓ The available data support the use of rate and rhythm control interventions, including PMs and catheter ablation, without justification to discriminate by age group
- ✓ Patients at older age may present with multiple comorbidities. Such conditions may limit HRQL more than AF
- ✓ Impairment of renal and hepatic function, and polypharmacy make drug interactions and ADRs more likely
- ✓ Integrated AF management and careful adaptation of drug dosing seem reasonable to reduce the complications of AF therapy in such patients

Kirchhof P, Eur Heart J 2016

Age-Related Differences in Presentation, Treatment, and Outcome of Patients With Atrial Fibrillation in Europe

Interventions Performed or Planned at Enrollment by Age Group in the EORP-AF General Pilot Registry

(<75 years - N=2068; age: 63±9 y; ≥75 years - N=1051; age: 81±5 y)



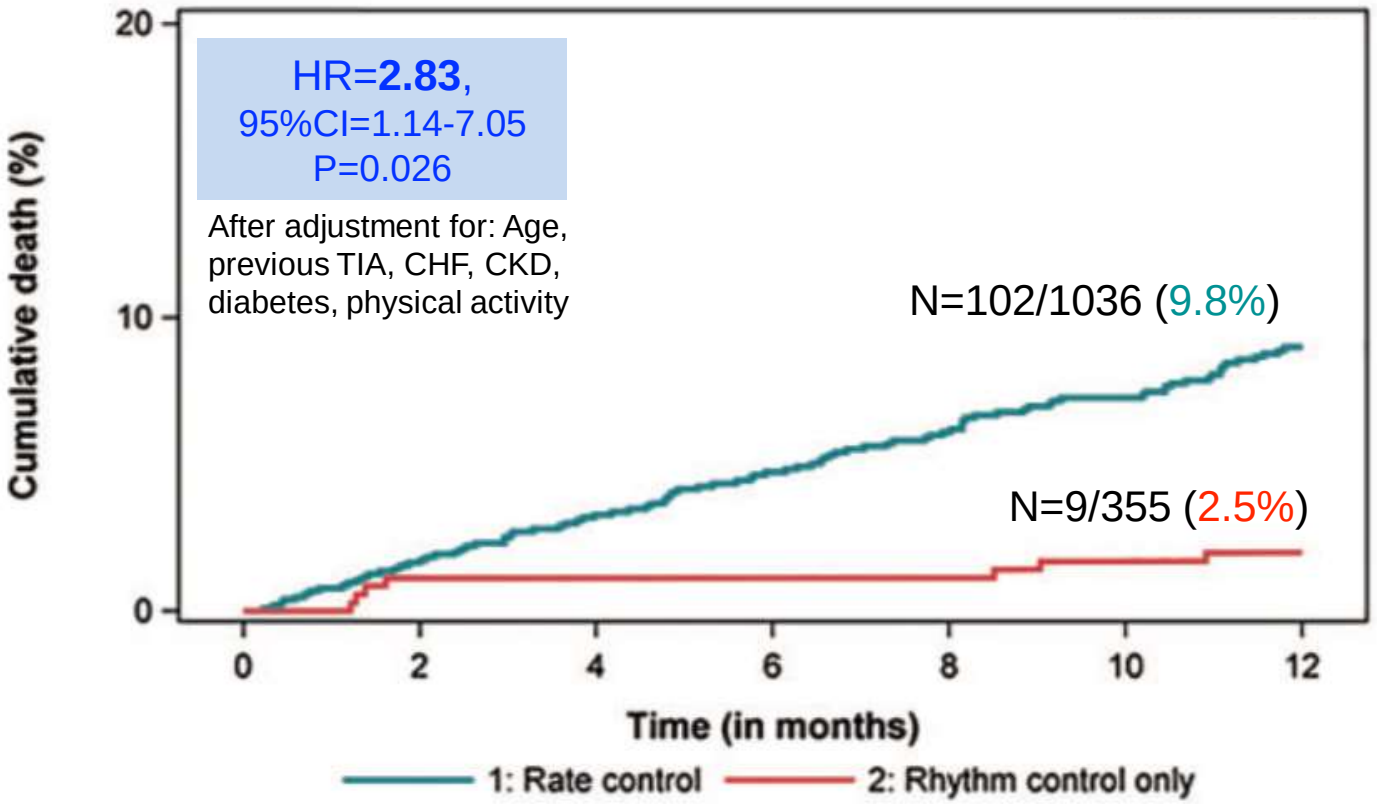
ECV / PCV: External / Pharmacological CV
Cat. Abl.: catheter ablation of AF
PM: pacemaker implantation

Fumagalli S, JACC: CE 2015

Rate vs. rhythm control and adverse outcomes among European patients with atrial fibrillation

the EORP-AF General Pilot Registry Investigators

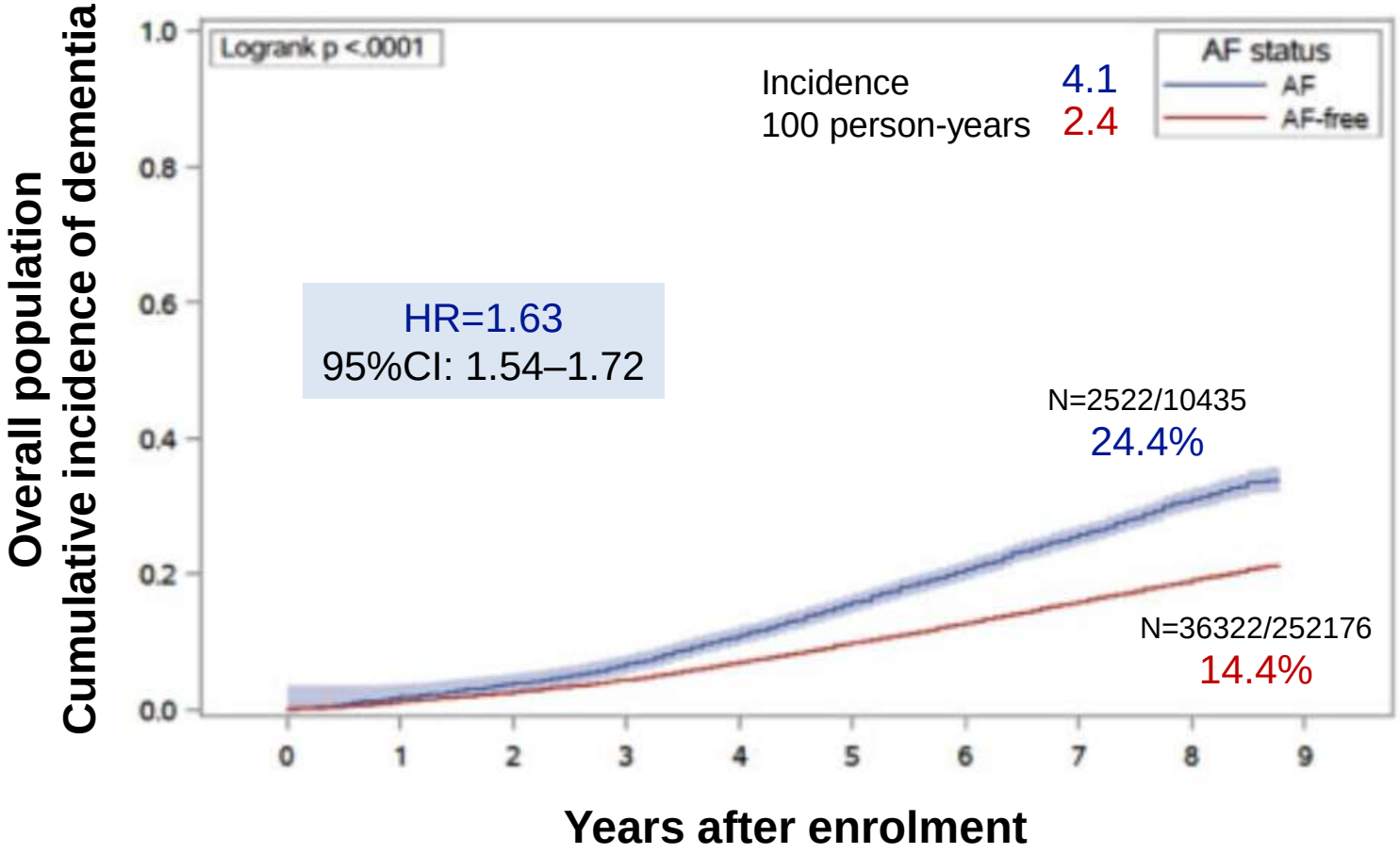
Kaplan–Meier curves for all-cause death according to baseline strategy (Rate control – 73 y, women: 40%; Rhythm control – 66 y, women: 34%)



Purmah Y, Europace 2018

Risk of dementia in stroke-free patients diagnosed with atrial fibrillation: data from a population-based cohort

The cumulative incidence of dementia in the overall population of the Korean NHIS-Senior (2005-13; AF-free - 71 years, FU: 85 m; AF - 72 years; FU: 86 m)

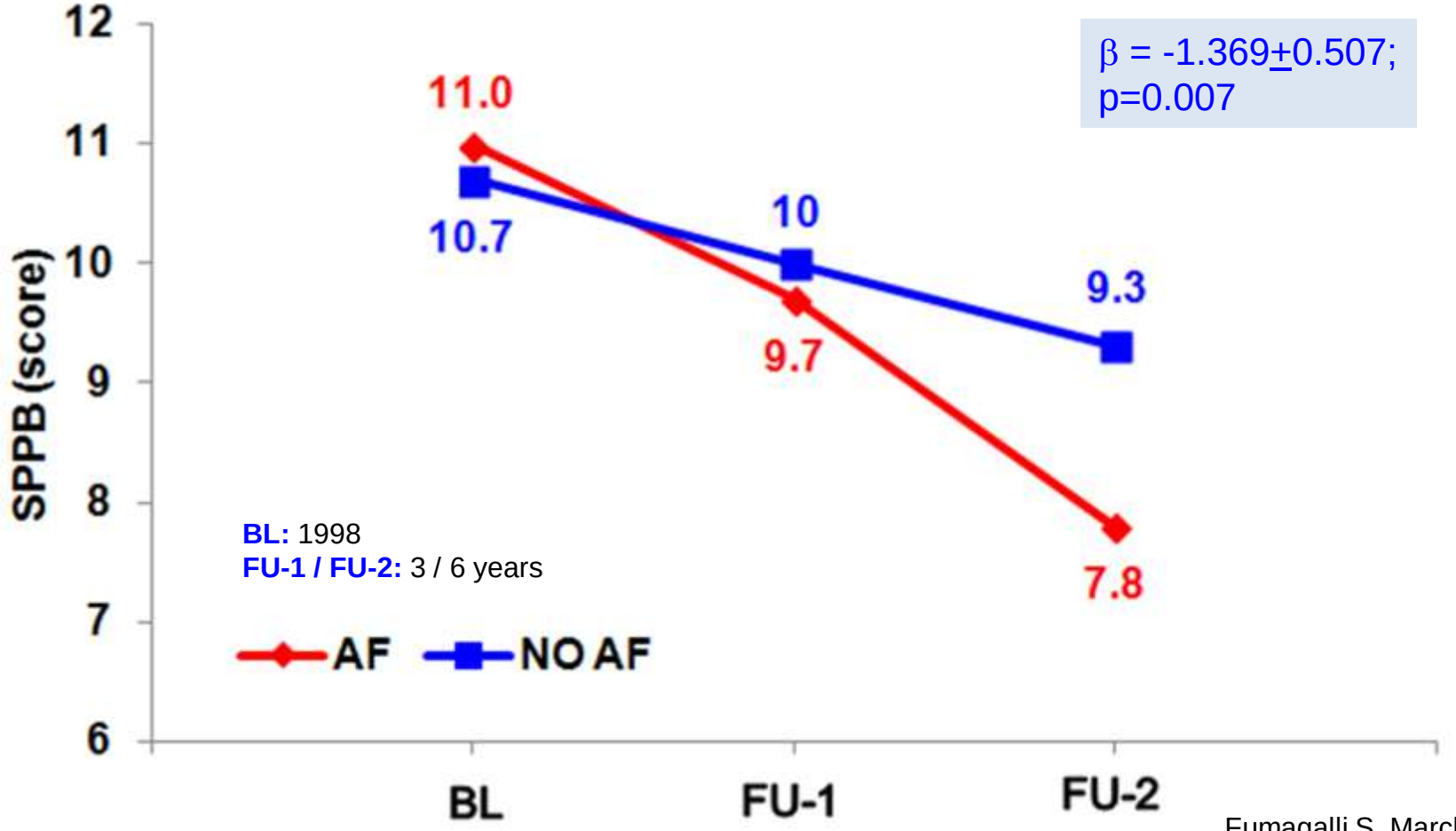


Kim D, EHJ 2019

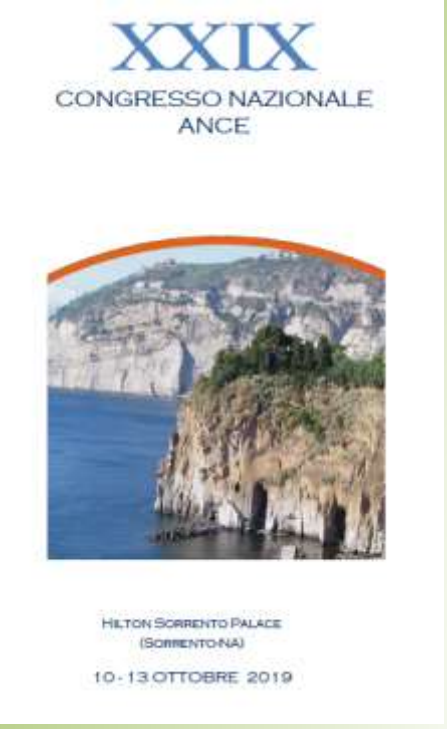
Atrial fibrillation and physical function decline in an Italian elderly population: the InCHIANTI Study experience

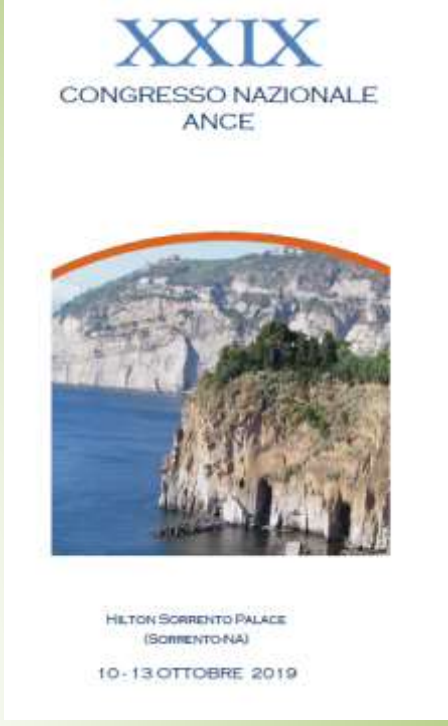
SPPB trends by presence of AF

(N=267; AF prevalence: 4.9%; age - AF: 81±6 vs. NO AF: 77±6 years, p<0.01)



Fumagalli S, Marchionni N, Ferrucci L, EHRA 2017





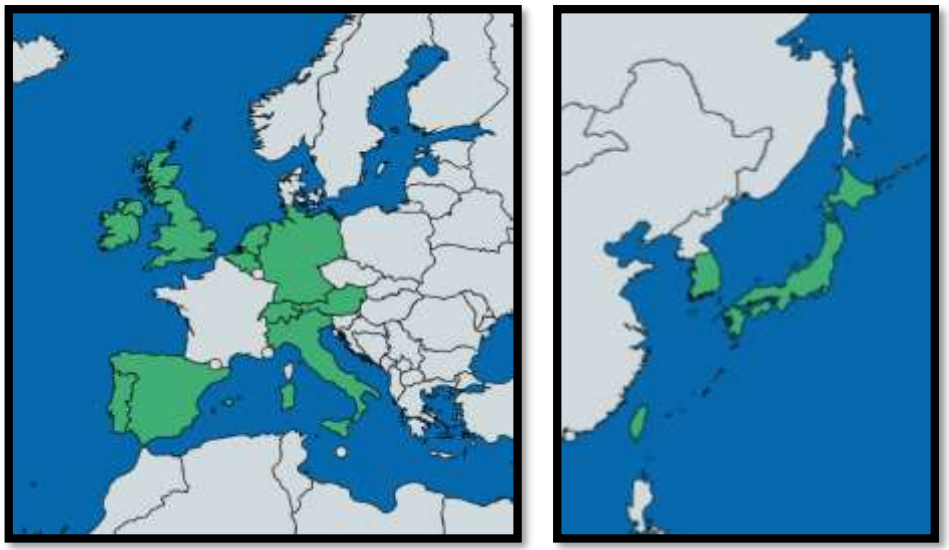
FIBRILLAZIONE NELL'ANZIANO, AL DI LA' DI UNA SEMPLICE ARITMIA

Perchè I DOAC nell'anziano fragile?

Syncope Unit Florence

Syncope Unit Florence

Programma ETNA-AF Global (Edoxaban Treatment in routiNe clinical prActice for patients with nonvalvular Atrial Fibrillation)



- **L'ETNA-AF Global è il più ampio Registro con un singolo DOAC**
- **analizzerà l'utilizzo, la sicurezza e l'efficacia di edoxaban nella normale pratica clinica**

ETNA-AF Europe

De Caterina R et al. JCM 2019;20:97–104

Obiettivo primario: valutare la sicurezza di edoxaban

- **L'ETNA-AF è stato disegnato per valutare in un periodo di 4 anni l'insorgenza, la durata e la severità di:**
  - **Sanguinamenti, incluse le emorragie intracraniche**
  - **Eventi avversi correlati al farmaco**
  - **Mortalità cardiovascolare e mortalità per tutte le cause**

- **Obiettivi secondari:**
  - **Ictus, TIA, eventi embolici sistemici, eventi cardiovascolari maggiori (MACE)**
  - **Eventi tromboembolici venosi**
  - **SCA, ospedalizzazioni per patologie cardiovascolari, *compliance* al trattamento**

First 1-year follow-up snapshot analysis of over 12,500 AF patients treated with edoxaban in routine clinical practice: ETNA-AF-Europe

De Caterina R, et al. ESC 2019. Poster presentation P1257.

Introduction

- Evidence from real-world studies has demonstrated the safety of different NOACs in routine care; moreover, real-world data are currently emerging for edoxaban and will complement the findings from the randomised trials[1-3]

- ETNA-AF-Europe (clinicaltrials.gov: NCT02944019) aims to evaluate the risk-benefit profile of edoxaban in unselected AF patients in routine clinical practice[4]

[1]Steinberg BA, et al. Am J Cardiol 2017;119:1590–5.
[2]Eikelboom JW, Weitz JI. Thromb Haemost 2015;113:1159–61.
[3]Pottegard A, et al. Pharmacoepidemiol Drug Saf 2018;27:174–81.
[4]De Caterina R, et al. J Cardiovasc Med (Hagerstown) 2019;20:97–104.

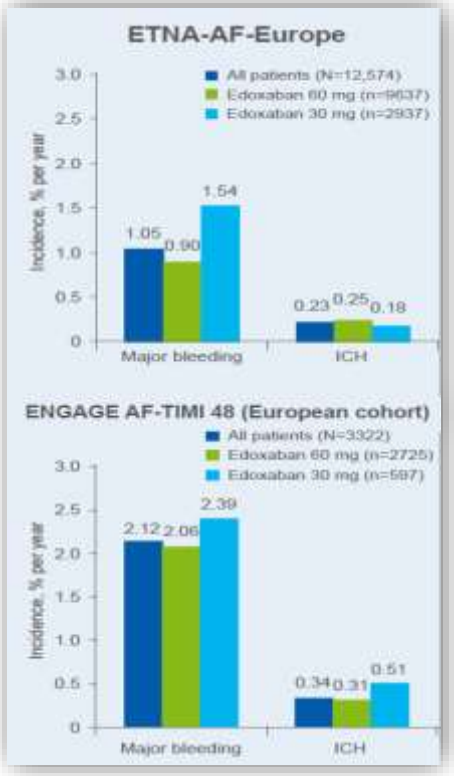
Methods

- ETNA-AF-Europe is a multinational, multicentre, observational, post-authorisation, safety study conducted in 825 sites in 10 European countries (Austria, Belgium, Germany, Ireland, Italy, The Netherlands, Portugal, Spain, Switzerland and United Kingdom)
- A total of 13,980 patients were enrolled, and will be followed for up to 4 years
- The ETNA-AF-Europe snapshot that was used for this analysis was executed on 22 April 2019

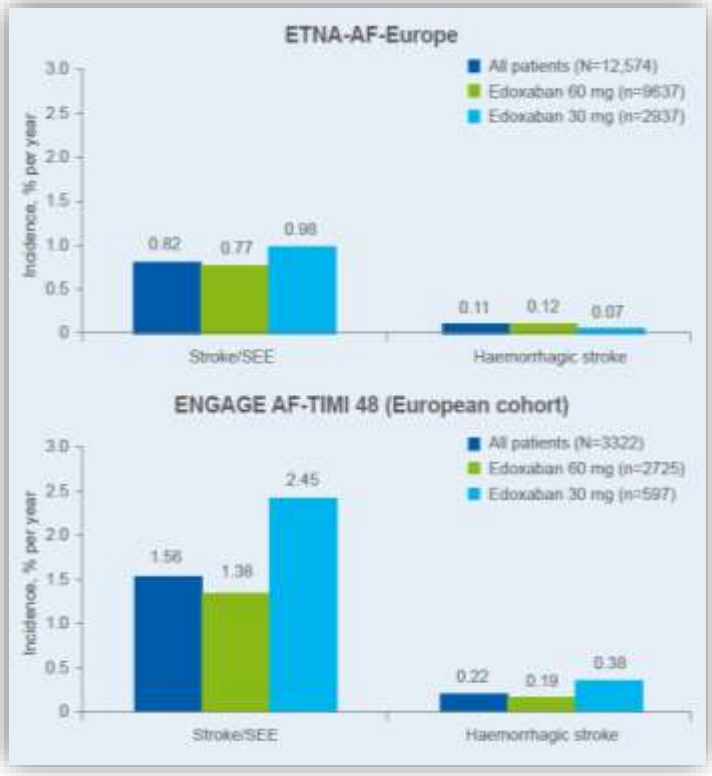
De Caterina R, et al. ESC 2019. Poster presentation P1257.

ETNA-AF Europe : Risultati al primo anno di follow up

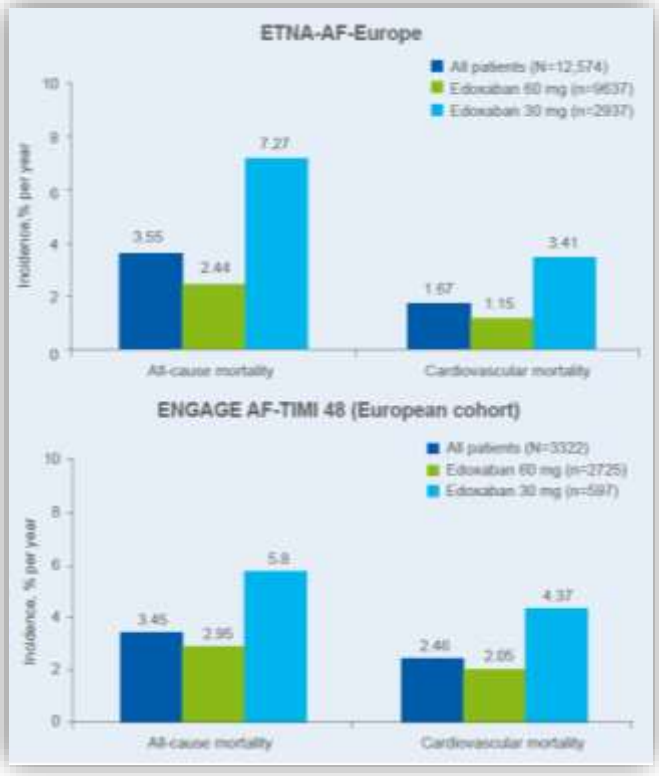
Safety events



Stroke events



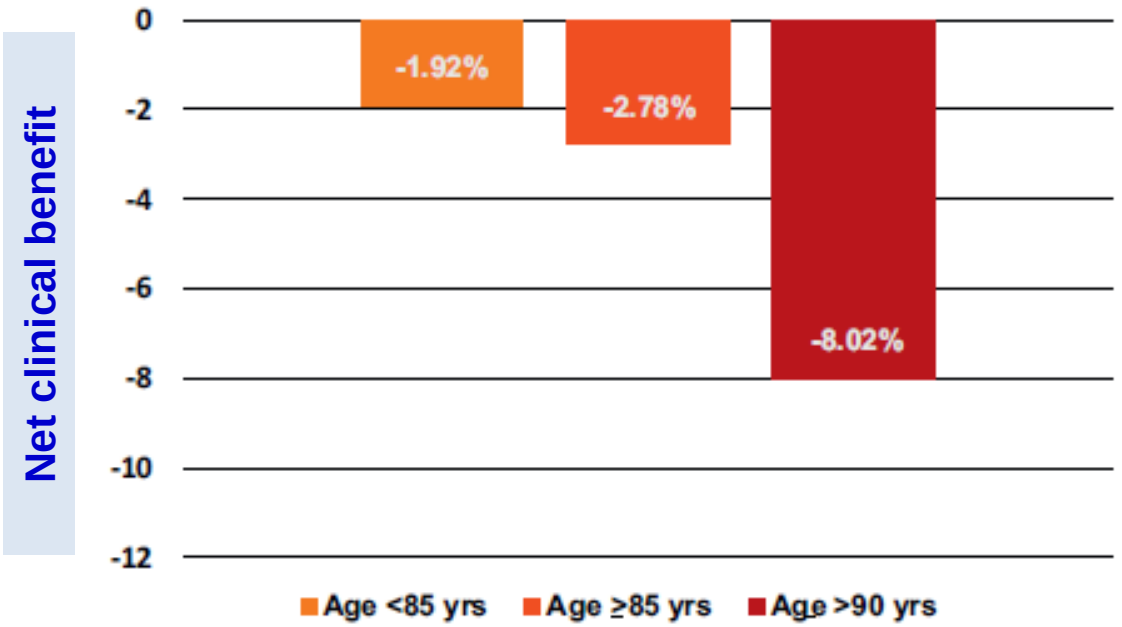
Mortality



De Caterina et al. Poster presented at ESC Congress 2019.

The safety and efficacy of non-vitamin K antagonist oral anticoagulants in atrial fibrillation in the elderly

Net clinical benefit, adjusted for the risk of subsequent death, of OACs vs no OACs according to different age groups (the PREFER in AF)



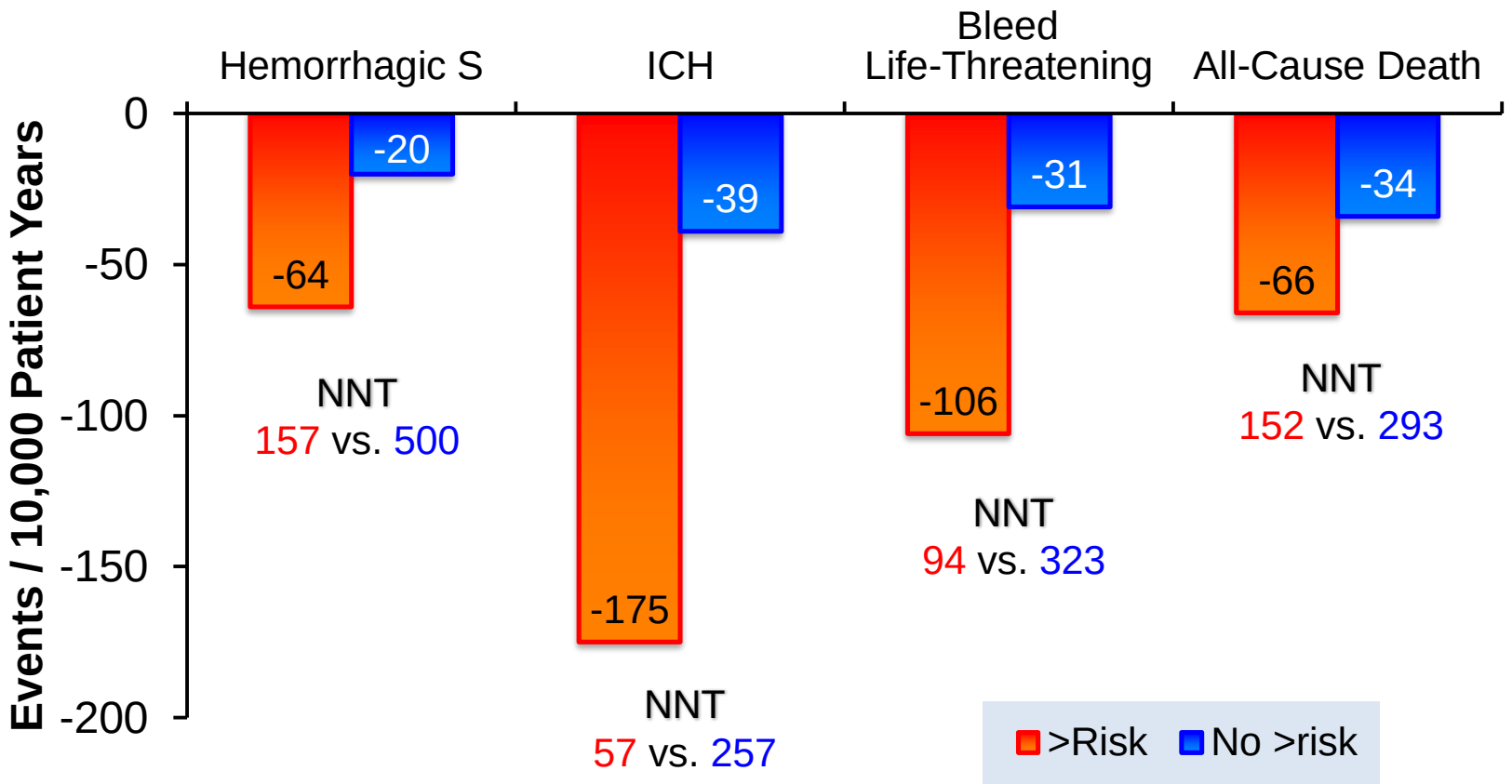
VKAs or **NOACs** led to a **36%** risk reduction of TE events vs. antiplatelet or no treatment; **notably**, OACs **did not increase** the risk of major bleeding compared to antiplatelet therapy

Patti G
Int J Cardiol 2018

Edoxaban Versus Warfarin in Atrial Fibrillation Patients at Risk of Falling

ENGAGE AF–TIMI 48 Analysis

Absolute Risk Reduction of HD Edoxaban Regimen Compared With Warfarin in Patients at Increased Versus Not at Increased Fall Risk



Steffel J, 2016

Clinical Outcomes and History of Fall in Patients with Atrial Fibrillation Treated with Oral Anticoagulation: Insights From the ARISTOTLE Trial

THE AMERICAN JOURNAL of MEDICINE®

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753 patients **with** vs **15738** **without** **history of falling**

Characteristics	Fall(s) Within 1 Year		*P*-Value
	Yes (n = 753)	No (n = 15,738)	
Age, median (25th, 75th), years	75 (67, 79)	70 (63, 76)	< .0001
Age ≥75 years, n (%)	379 (50.3%)	4787 (30.4%)	< .0001
Female sex, n (%)	357 (47.4%)	5438 (34.6%)	< .0001
BMI, median (25th, 75th), kg/m²	29.1 (25.6, 33.8)	28.4 (25.2, 32.4)	< .001
CHA2DS2-VASC score, mean (SD)	**4.19** (1.65)	**3.43** (1.51)	<.001
Prior stroke, TIA, SE	**28.3%**	**20.9%**	<.001
Prior bleeding	**35.1%**	**16.0%**	<.001

Clinical Outcomes and History of Fall in Patients with Atrial Fibrillation Treated with Oral Anticoagulation: Insights From the ARISTOTLE Trial

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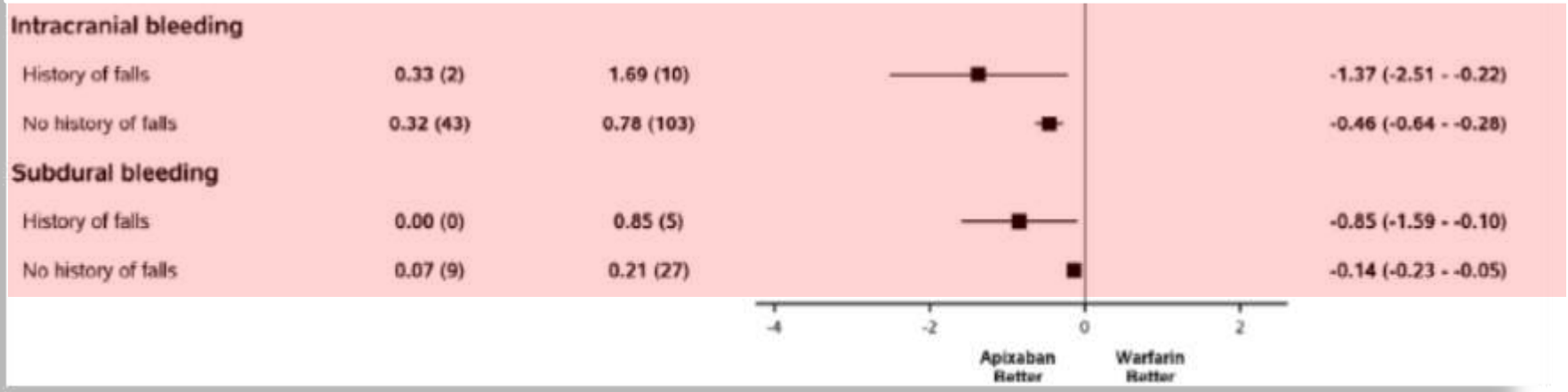
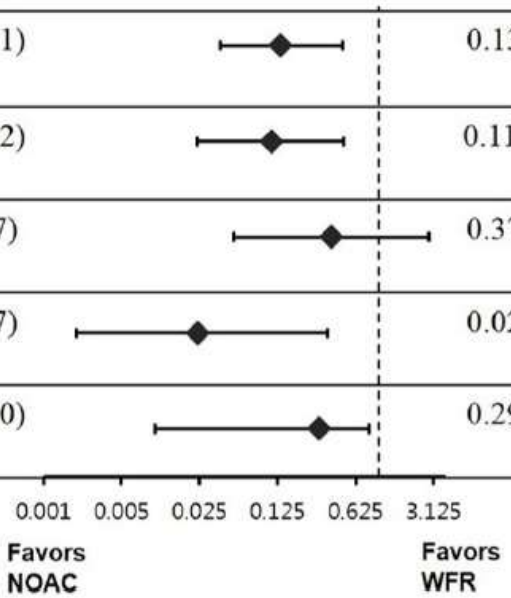


Effectiveness and safety of non-vitamin K antagonist oral anticoagulants in octogenarian patients with non-valvular atrial fibrillation

PLOS ONE | https://doi.org/10.1371/journal.pone.0211766 March 7, 2019

Hyue Mee Kim[1,2], Eue-Keun Choi[1]*, Chan Soon Park[1], Myung-Jin Cha[1], Seo-Young Lee[1], Joon-Myung Kwon[3], Seil Oh[1]

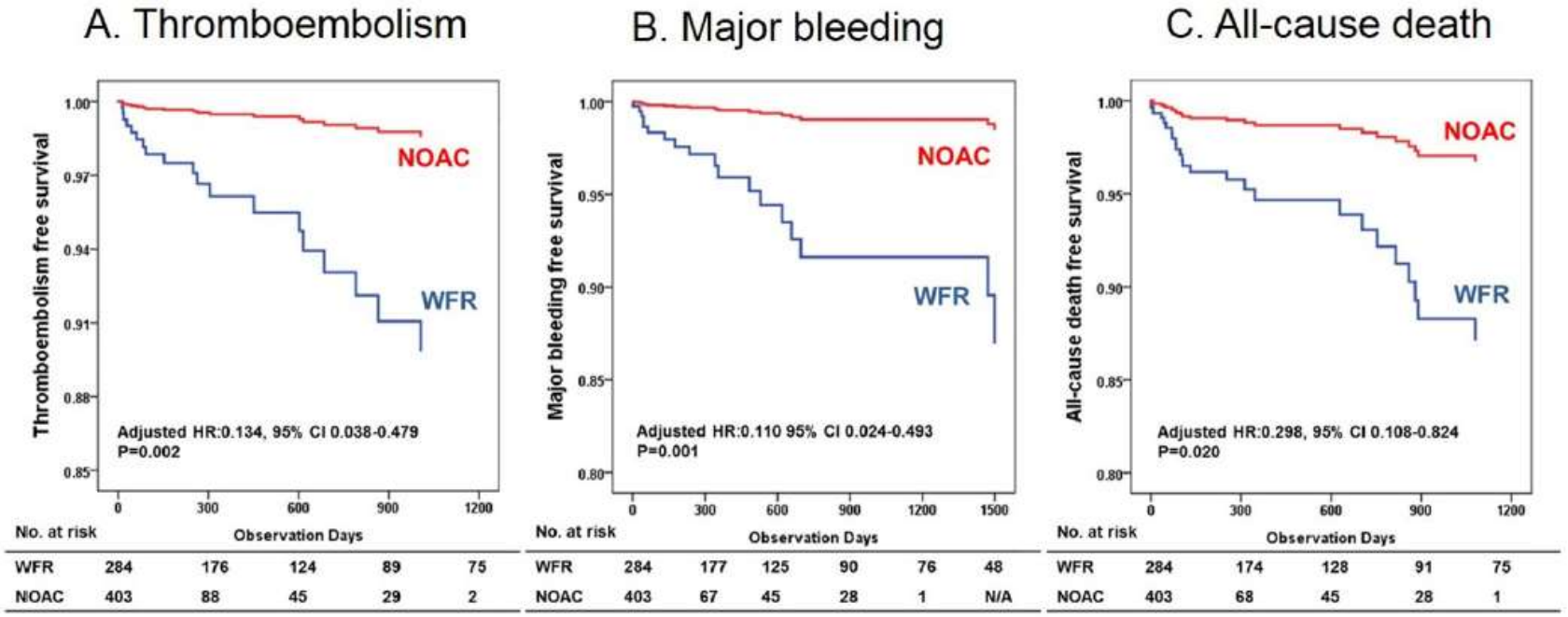
	No. of patients	NOACs (100 person-years)	WFR (100 person-years)	Hazard ratio* (95% CI)	P value
Thromboembolism	687	5 (1.84)	14 (2.71)	0.134 (0.038-0.479)	0.002
Major bleeding	687	4 (1.48)	14 (2.72)	0.110 (0.024-0.493)	0.001
GI bleeding	687	3 (1.1)	6 (1.17)	0.374 (0.047-2.949)	0.347
ICH	687	1 (0.37)	5 (0.97)	0.024 (0.002-0.350)	0.006
All-cause death	687	7 (2.57)	18 (3.50)	0.298 (0.108-0.824)	0.020



Effectiveness and safety of non-vitamin K antagonist oral anticoagulants in octogenarian patients with non-valvular atrial fibrillation

PLOS ONE | https://doi.org/10.1371/journal.pone.0211766 March 7, 2019

Hyue Mee Kim[1,2], Eue-Keun Choi[1]*, Chan Soon Park[1], Myung-Jin Cha[1], Seo-Young Lee[1], Joon-Myung Kwon[3], Seil Oh[1]



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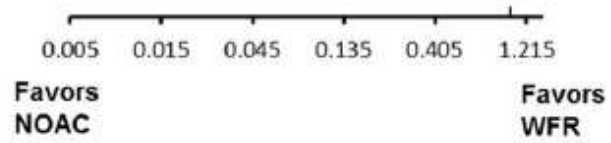
Conclusion

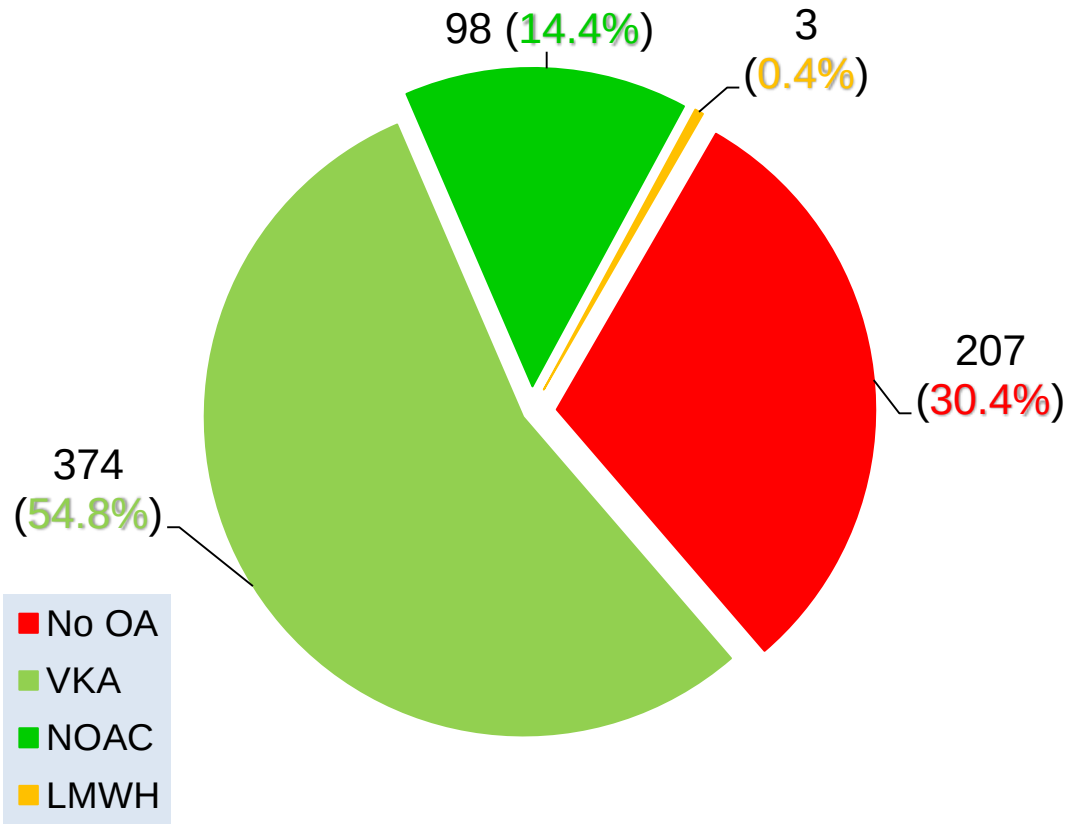
In octogenarian patients with AF, NOACs showed better outcomes in reducing the risk of TE, major bleeding events, and all-cause deaths when compared with warfarin. Although most patients had been prescribed a reduced dose, on-label use of NOACs was effective and safe in this patient population. It would be reasonable to prescribe NOACs rather than warfarin in octogenarian patients with non-valvular AF.

	NOACs	WFR	Hazard ratio*	P value
Thromboembolism				
On-label use			.627)	0.002
Under-dosed use	1 (1.08)	14 (2.72)	0.173 (0.021-1.455)	0.106
Major bleeding				
On-label use	3 (1.82)	14 (2.72)	0.169 (0.034-0.833)	0.029
Under-dosed use	1 (1.08)	14 (2.72)	0.144 (0.017-1.205)	0.074
All-cause death				
On-label use	6 (3.59)	18 (3.50)	0.427 (0.146-1.243)	0.119
Under-dosed use	1 (1.08)	18 (3.50)	0.126 (0.015-1.036)	0.054



The Effect of Bleeding Risk and Frailty Status on Anticoagulation Patterns in Octogenarians With Atrial Fibrillation: The FRAIL-AF Study

Anticoagulant use in 682 hospitalized patients ≥80 years with AF/AFl (Age: 85.9; 3 academic hospitals; Montreal, Quebec; 2012-2013)



The most common reasons for not prescribing an OA:

1. Hx of bleeding (15.5%)
2. Active bleeding (15.5%)
3. Risk of falls (14%)
4. Patient refusal (8.7%)
5. No justification provided (15%)

Lefebvre MCD, 2016

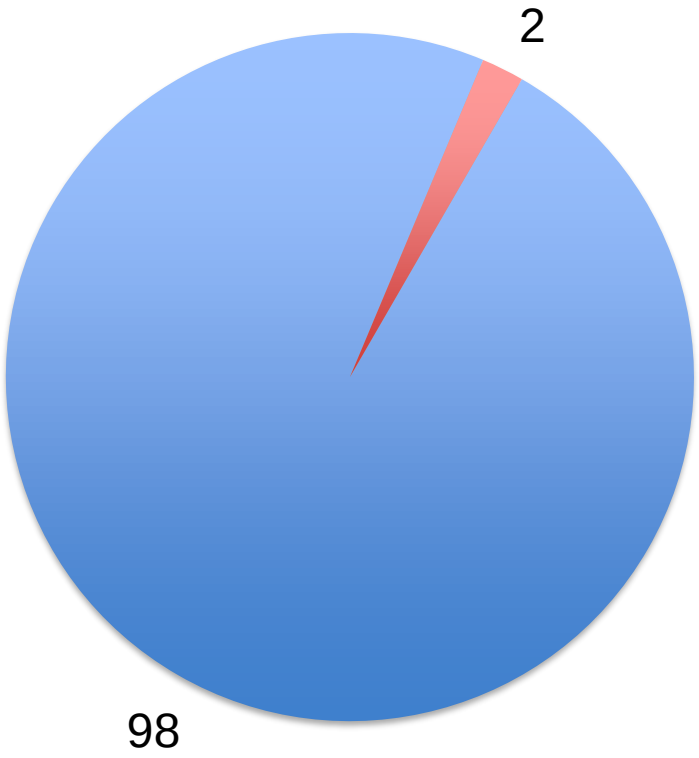
Bleeding related to non-vitamin K antagonist oral anticoagulants in emergency department: A “Real-world” snapshot from Southern Italy

On behalf of MIRC-NOAC study group

Salzano A,
Eur J Intern Med 2017

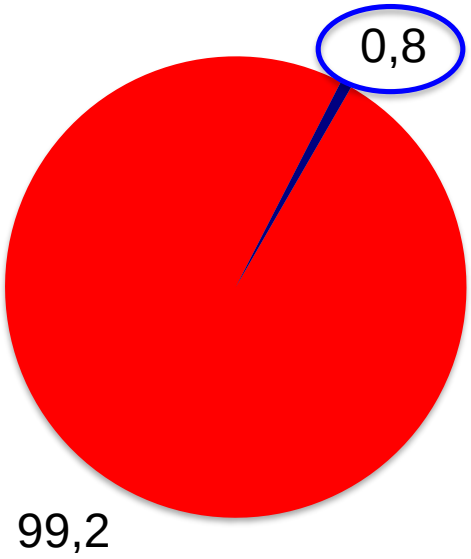
Clinical characteristics of patients with bleeding (year 2015; people potentially referring to the ED: N=3.000.000)

All bleeding –
N=1977



All other accesses –
N=95993

Bleeding due to NOAC –
N=15



All other bleeding –
N=1962

Bleeding
Genitourinary: **5**
Gatrointestinal: **2**
ICH: **5**
Mixed: **3**

Age: 77±11 years
CHA_2DS_2-VASc: 4
HAS-BLED: 2

Hospitalization – N=11/15 (73%)
Mortality – 3/15 (20%)

Risk of Intracranial Hemorrhage in Ground-level Fall With Antiplatelet or Anticoagulant Agents

Authors: Michael Ganetsky, MD, Gregory Lopez, Tara Coreanu, BSc, Victor Novack, MD, PhD, Steven Horng, MD, Nathan I. Shapiro, MD, MPH, and Kenneth A. Bauer, MD

GLF = ground-level fall and tICH = traumatic intracranial hemorrhage and taking and antiplatelet or anticoagulants.

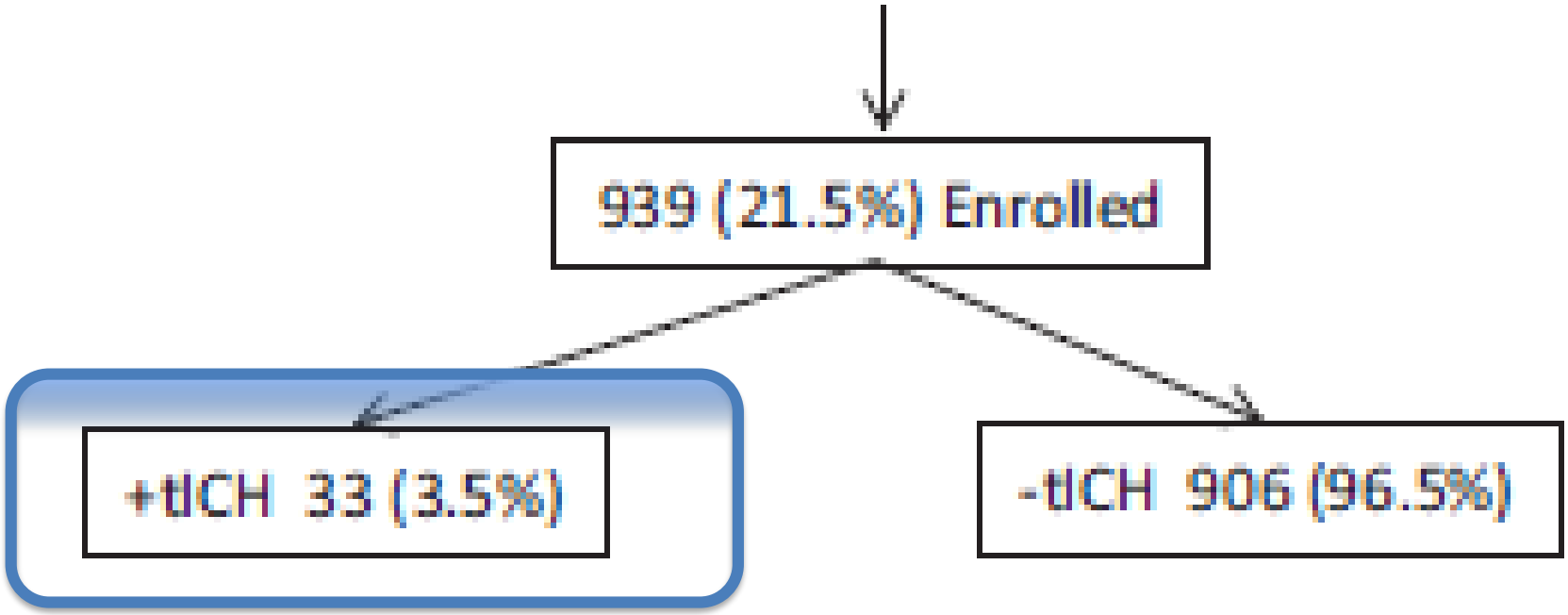


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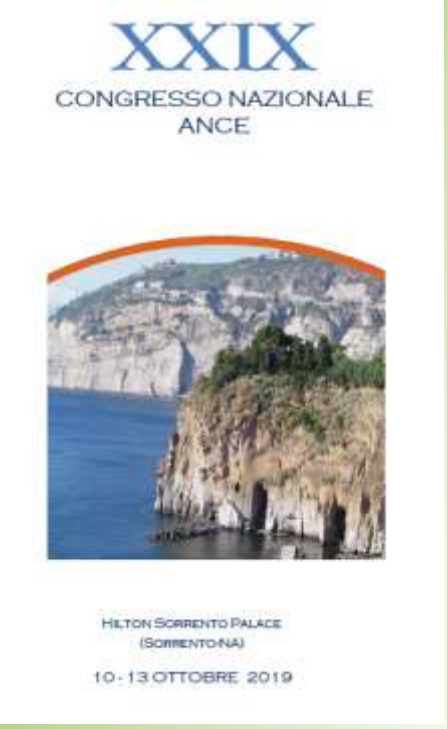
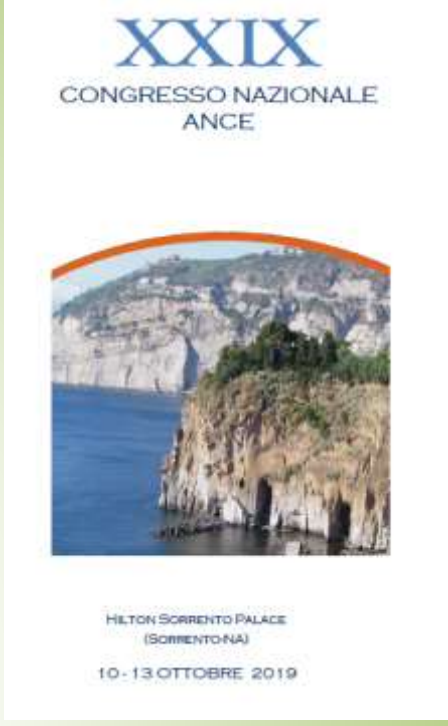
Table 2
Subject Findings and Outcomes

Finding and Outcome	Antiplatelet Treatment, *n* = 668 (71.1%)	Anticoagulation Treatment, *n* = 180 (19.2%)	Combined Treatment. *n* = 91 (9.7%)	p-value*
Head strike recorded	407 (60.9)	102 (56.7)	62 (68.1)	0.19
LOC	120 (18.0)	18 (10.0)	3 (3.3)	<0.001
External signs of head trauma	277 (41.5)	62 (34.4)	28 (30.8)	0.05
Deaths				
Within 7 days	8 (1.2)	0	0	0.34
Within 30 days	23 (3.4)	3 (1.7)	4 (4.4)	0.35
tICH on CT	29 (4.3)	3 (1.7)	1 (1.1)	0.13

Data are reported as *n* (%).
ICU = intensive care unit; LOC = loss of consciousness; tICH = traumatic intracranial hemorrhage.
*Chi-square or exact test analysis.

Conclusion: There is a low incidence of clinically significant tICH with a ground-level fall in head trauma in patients taking an anticoagulant or antiplatelet medication. There was no statistical difference in rate of tICH between antiplatelet and anticoagulants, which is unanticipated and counterintuitive as most literature and teaching suggests a higher rate with anticoagulants. A larger data set is needed to determine if small differences between the groups exist.





FIBRILLAZIONE NELL'ANZIANO, AL DI LA' DI UNA SEMPLICE ARITMIA

Come ci comportiamo?

Syncope Unit Florence

Syncope Unit Florence

Appropriateness of oral anticoagulant therapy prescription and its associated factors in hospitalized older people with atrial fibrillation

Carlotta Franchi[1,†], Stefania Antoniazzi[2,3,†], Marco Proietti[4], Alessandro Nobili[4], Pier Mannuccio Mannucc
and on behalf of the SIM-AF Collaborators*

	Patients with OAC *N* (%)	Patients without OAC *N* (%)
Overall	221	107
APPROPRIATE	153 (69.2)	19 (18)
a) CHA_2DS_2-VASc ≥1 (men) and ≥2 (women) but with contraindication for OAC	–	19
b) Dose	153	–
Dabigatran	11	–
Rivaroxaban	13	–
Apixaban	22	–
Edoxaban	8	–
Warfarin	93	–
Acenocoumarol	6	–

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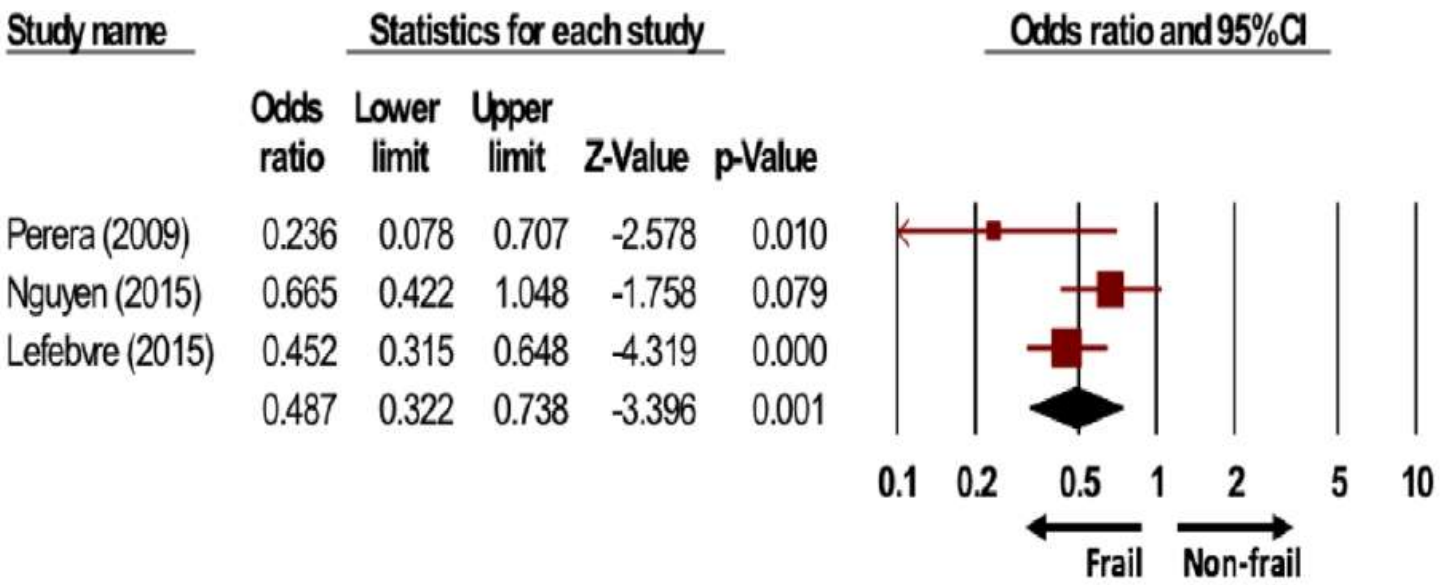
Table 3

Results from univariate and multivariable logistic regression analyses for the appropriateness of oral anticoagulant prescribing

	OR	95% CI	*P*-value
Univariate analysis			
Age (year)	0.97	0.94–1.00	0.030
History of falls	0.50	0.28–0.89	0.018
BMI (kg m^{-2})	1.07	1.01–1.12	0.020
BMI categories			
Underweight	0.29	0.06–1.47	0.136
Normal weight (ref.)	–	–	–
Overweight	1.69	1.02–2.82	0.043
Obesity	1.79	0.87–3.66	0.114

What is the Impact of Frailty on Prescription of Anticoagulation in Elderly Patients with Atrial Fibrillation? A Systematic Review and Meta-Analysis

Zardasht Oqab[1], Payam Pournazari[1], Robert S Sheldon[1]

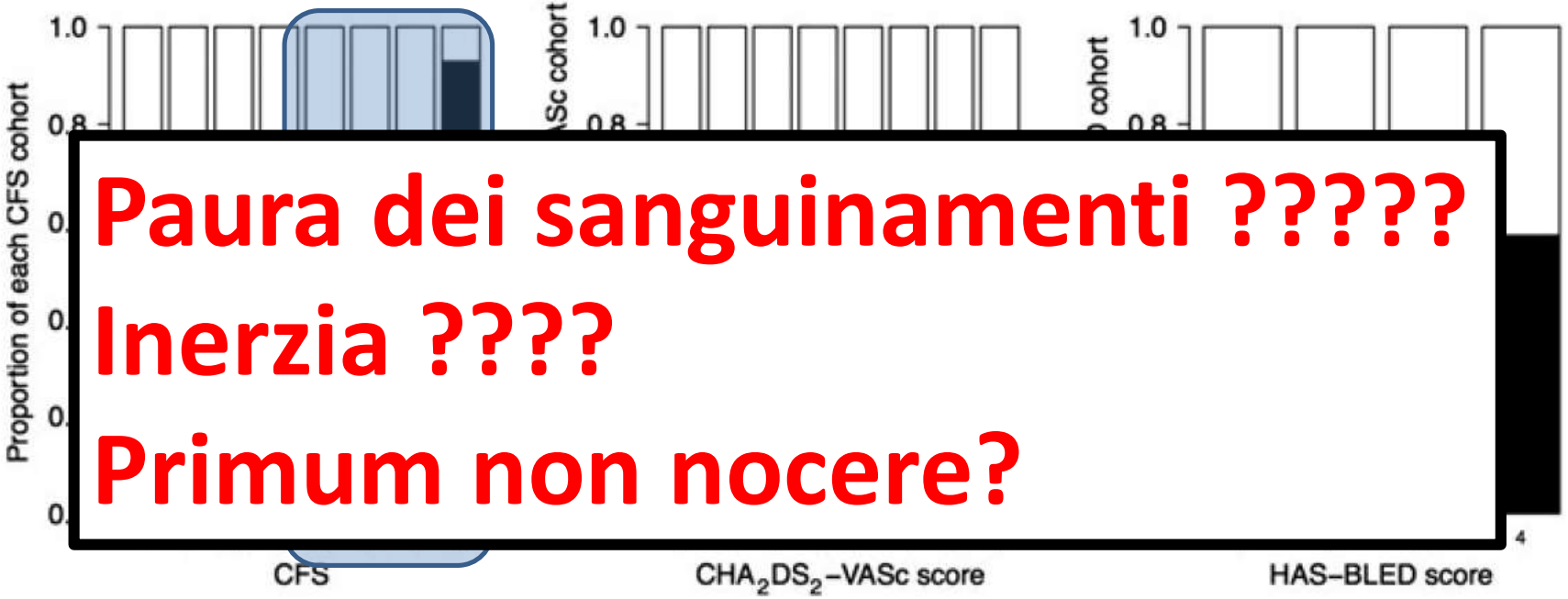


Conclusions: The **prevalence** of **frailty** in hospitalized elderly patients with AF **is high**, and the **use** of OAC **is low** in these patients. Frail elderly are significantly less likely to receive OAC.

Clinical frailty is independently associated with non-prescription of anticoagulants in older patients with atrial fibrillation

Induruwa I et Al,
Geriatr Gerontol Int 2017

The proportion of individuals not taking anticoagulants (*black*) compared with those taking anticoagulants (*white*), by Clinical Frailty Scale, CHA_2DS_2-VASc and HAS-BLED scores (N=419; anticoagulated No/Yes: 215/204)



Paura dei sanguinamenti ?????

Inerzia ????

Primum non nocere?

Anticoagulated
Yes – Frailty: 52.5%
No – Frailty: 81.4%
P<0.001

Anticoagulated
Yes – CHA_2DS_2-VASc: 5
No – CHA_2DS_2-VASc: 4
P<0.001

Anticoagulated
Yes – Age: 83
No – Age: 87
P<0.001

Multivariate predictors
$OR_{Frailty} = 0.77$, p<0.001
$OR_{Bleeding\ Risk} = 0.85$, p=0.02
$OR_{Age} = 0.98$, p<0.001

QUESTIONI APERTE

Efficacia e sicurezza degli anticoagulanti orali nell'anziano fragile con fibrillazione atriale: problema ancora aperto

Paolo Alboni[1], Nicola Stucci[2], Elena Cojocaru[2], Andrea Ungar[3]

[1]*Sezione di Cardiologia, Ospedale Privato Quisisana, Ferrara*
[2]*U.O. Medicina, Ospedale Privato Quisisana, Ferrara*
[3]*S.O.D. Geriatria e Terapia Intensiva Geriatrica, AOU Careggi e Università degli Studi, Firenze*

G ITAL CARDIOL | VOL 18 | MARZO 2017

Documento di consenso di Esperti con Metodo Delphi
GIMSI-AcEMC

Utilizzo degli anticoagulanti orali nei pazienti anziani a rischio di caduta sincopale o non sincopale

Steering Commitee:
Ivo Casagranda, Andrea Ungar, Michele Brignole

Membri del Delphi

Medicina di emergenza-urgenza	Roberto Lerza, Pier Michele Diamanti
Geriatr	
Cardiol	
FCSA	
Medici	
Tossico	
Neurologia	Alessandra Fanciulli
Medicina generale	Sergio Baglioni
Syncope Unit	Pasquale Abete, Attilio Del Rosso, Filippo Numeroso, Marco Tomaino

Si agli anticoagulanti, in particolare si ai DOACs

Grazie per la vostra attenzione