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Enlisting Emergency Medicine Clinicians to Help Reduce Strokes in High-Risk Patients With Atrial Fibrillation and Flutter

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Dear Editor,

We applaud Drs. Hsu and Freeman for their excellent up-to-date review of the voluminous literature on the prevalence, benefits, risks, and obstacles to thromboprophylaxis for patients with atrial fibrillation (AF) at high risk for stroke.¹ This will assist clinicians at the bedside as well as multidisciplinary panels in designing guidelines for their medical center or medical group.

We have two additions that could make this review even better. The first is an expansion of their educational efforts to include clinicians working in the emergency department (ED).²

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SUPPORTING INFORMATION

Supplementary information accompanies this paper on the Clinical Pharmacology & Therapeutics website (<http://www.cpt-journal.com>)

CONFLICT OF INTEREST

The authors declared no competing interests for this work.

The continued underprescribing of oral anticoagulants (OACs) described by Hsu and Freeman indicates that improvements in stroke prevention will require concerted efforts from all providers who contribute to AF care. Patients with AF frequent the ED for rhythm-related complaints, where they often receive rate reduction and cardioversion interventions.³ Providing this level of care for patients with AF creates a natural opportunity for the emergency medicine clinician to discuss stroke prevention with those who are at high risk and are not already receiving OACs. The ED experience itself might serve as a sentinel event for the patient with AF, facilitating needed changes in healthcare behaviors.⁴ There are many ways emergency medicine clinicians can contribute to stroke reduction, ranging from simply introducing the topic with eligible patients to prescribing OACs on discharge (Table 1).^{3–5} Approximately 20–50% of actionable high-risk patients with AF receive a prescription of OACs on ED discharge, with higher prescribing for patients who were in the ED primarily for AF-related complaints⁴ (see Appendix S1). Initiating anticoagulation at the time of discharge for stroke-prone patients with AF does not increase bleeding rates and contributes to decreased mortality.² The most appropriate course of action in each situation, however, will vary by clinician, patient, shift, practice setting, and resource availability.

Our second recommendation is to expand the need for stroke prevention to patients with high-risk atrial flutter. The American Heart Association and other leading cardiology societies recommend prescribing antithrombotic therapy to patients with atrial flutter, according to the same risk profile used for AF. Although the absolute risk for ischemic stroke from atrial flutter is not as high as that associated with AF, the risk is sufficient to warrant anticoagulation, as recommended by society guidelines (see Appendix S1).

Stroke is the most feared and devastating complication that accompanies AF and atrial flutter. To increase our odds of successful stroke prevention, the medical community will need to enlist the participation of emergency medicine clinicians and expand the targeted population to include those with high-risk atrial flutter.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Methods for emergency medicine clinicians to contribute to multidisciplinary efforts to prevent strokes in patients with high-risk atrial fibrillation and flutter

Table 1

Category	Intervention
Discussion and education	Introduce the topic of stroke prevention, stress its importance, and urge continued conversation with an outpatient provider
	Explain the benefits and risks of treatment and nontreatment
	Include personalized stroke-risk information in the discharge instructions
Consultation and shared care	Arrange a follow-up appointment with a primary care provider, cardiologist, or outpatient atrial fibrillation clinic to address stroke prevention
	Consult an available oral anticoagulation service to contact the patient to continue education and, if appropriate, facilitate initiation of anticoagulation. These services are often telephone based and pharmacy led
Pharmacotherapy	Prescribe an appropriate oral anticoagulant medication on discharge (and, if help is needed, consult a cardiologist)
	Adopt a policy of “default short-term anticoagulation therapy” to provide all high-risk patients lacking contraindications a protective tail of stroke prevention for a limited duration until they can follow up in an outpatient setting to decide on a more definitive treatment plan ⁵