

offered the benefits of this treatment as younger subjects are.

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GPs not prepared for monitoring anticoagulation

EDITOR,—Philip M W Bath and colleagues suggest that, with the expected increase in patients taking warfarin for non-rheumatic atrial fibrillation, the management of long term anticoagulant treatment could be devolved into the community.¹ The haematology audit committee in North West Thames region is auditing the management of such treatment. As part of this audit we surveyed the general practitioners of 10 consecutive patients referred to each of 13 anticoagulant clinics throughout the region. We excluded three doctors from the same practices as others already recruited, and so a postal questionnaire was sent to general practitioners from 127 practices; 99 (78%) responded.

The 99 practices had a total of 1431 patients receiving anticoagulant treatment on their lists, with a median of 21 (range 1-50) patients per practice. The general practitioners reported that they were responsible for regulating the dose of warfarin for only 121 of the patients, and only 149 of the patients had blood specimens taken in the surgery. Eighty four of the general practitioners were satisfied with the service received from the hospital anticoagulant clinic. When asked about taking more control of their patients receiving anticoagulant treatment, 93 of the general practitioners did not want to run their own anticoagulant clinic—reasons given included insufficient time, knowledge, and training; lack of facilities; and a need for more finance. Although only three of the general practitioners had written guidelines on anticoagulation, 63 said that they would find such guidelines useful.

Our findings show that few patients receiving anticoagulant treatment in our region are managed by their general practitioner and few general practitioners are keen to take on this extra task. Before the management of anticoagulant treatment is devolved to primary care a substantial programme of education and guidance for general practitioners is probably required. In addition, the initiation and early management of warfarin treatment, during the period when patients are most at risk from bleeding,² may need to remain the responsibility of hospitals. We agree with Bath and colleagues that more resources are required to prevent strokes in patients with non-rheumatic atrial fibrillation. Prevention of the embolic complications of atrial fibrillation should release such resources,³ and flexible approaches to the management of anticoagulation in primary and secondary care need to be evaluated.

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No consensus among doctors

EDITOR,—Philip M W Bath and colleagues state that "many patients with atrial fibrillation are not prescribed warfarin despite the absence of contraindications."¹

Their finding from a retrospective study that there continues to be a low rate of introducing anticoagulation is not new. Our recent prospective survey of patients admitted as emergencies with atrial fibrillation to a district general hospital also showed a surprisingly low rate of introducing antithrombotic treatment.² Over six months only 20 of the 102 patients who had had atrial fibrillation were taking warfarin; 17 were taking aspirin.² Anticoagulation was given to only seven of the 150 patients who had not previously been given warfarin.² Consensus on treatment therefore continues to be lacking among physicians for the introduction of anticoagulant treatment, despite evidence from five randomised controlled trials.²

Despite the suggestion that warfarin should be used even in patients with paroxysmal atrial fibrillation¹ the risk-benefit profile for warfarin treatment has not been established in such patients (and the profile may be quite different from that in patients with chronic atrial fibrillation).³ Therefore warfarin should be reserved for patients with paroxysmal atrial fibrillation who are at highest thromboembolic risk—including those with the sick sinus syndrome, frequent paroxysms of the arrhythmia, a previous thromboembolic event, or structural heart disease.³ Aspirin, by contrast, has less potential for major adverse reactions and should provide sufficient prophylaxis for most other patients with paroxysmal atrial fibrillation.³ Many patients with paroxysmal atrial fibrillation also have concomitant underlying ischaemic heart disease, which may benefit from the use of aspirin.

Although aspirin has been advocated as prophylaxis against thromboembolic events, in some patients with chronic atrial fibrillation its use has not been fully substantiated by the recent large studies. Aspirin would be preferable to warfarin if it were equally effective, if only for its ease of administration. The results, however, remain inconsistent. For example, the Copenhagen atrial fibrillation aspirin anticoagulation study showed no benefit from aspirin 75 mg daily, but this study was in an older population.⁴ The stroke prevention in atrial fibrillation study reported that aspirin 325 mg daily had some beneficial effect, but not in patients over 75; it also did not prevent severe strokes.⁵ Sadly, the use of aspirin remains controversial.

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Use of warfarin dependent on local services

EDITOR,—The observation of Philip M W Bath and colleagues that many patients with atrial fibrillation were not given long term warfarin or aspirin as prophylaxis against stroke is not surprising.¹ Previous studies have shown that despite the proved efficacy of warfarin in primary stroke prevention in atrial fibrillation, doctors remain reluctant to prescribe oral anticoagulant treatment for their elderly patients.²

The Veterans Affairs stroke prevention in non-rheumatic atrial fibrillation study was a randomised study of 228 patients aged over 70, 88 of them being over 75.³ It confirmed that the benefits of warfarin applied to people over 70, with a 79% reduction in the risk of first stroke, and that the rate of bleeding complications was not increased in older people.

The use of anticoagulation in atrial fibrillation is dependent on local clinical services achieving complication rates comparable with those in the published trials. If warfarin is to be widely used in older patients, in whom there is clear and proved benefit, local anticoagulation services must be able to deliver care to them. If, as Bath and colleagues suggest, the unpublished results of the European atrial fibrillation trial show a beneficial effect for warfarin in secondary stroke prevention the matter is further complicated. Patients with atrial fibrillation and recurrent stroke are likely to be more frail; to have coexistent disease; to be receiving concomitant drug treatment, which increases the risk of interaction with anticoagulants; and to be less able to attend hospital outpatient clinics.

Physicians have understandable concerns about prescribing warfarin for elderly patients because of fears about haemorrhage or drug compliance. The usual contraindications to anticoagulant treatment apply to elderly patients, just as to younger people, and dose requirements for warfarin decrease with age.⁴ Studies have shown, however, that when prothrombin time is monitored regularly haemorrhagic complications from warfarin treatment can be avoided in elderly people.⁵

If government firmly believes that it can achieve the targets stated in *The Health of the Nation* there should be a case for introducing anticoagulation in atrial fibrillation as a health promotion strategy in general practice.

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Don't deny treatment to elderly people

EDITOR,—In the paper surveying the use of anticoagulation in patients with atrial fibrillation, Philip M W Bath and colleagues recommended that patients over the age of 80 should not be given anticoagulant drugs because the risks are high.¹ This statement is unsupported by evidence. The benefits of anticoagulation are now well accepted.^{2,3} Since a stroke at any age is catastrophic, any therapy which reduces the incidence