Manažment FP v špecifických klinických situáciách

Ďurčíková P., II. Klinika kardiológie a angiológie SZU, Oddelenie arytmií, SÚSCCH a.s., Banská Bystrica

Konflikt záujmov

Forma finančného prepojenia	Spoločnosť
Participácia na klinických sledovaniach/firemnom grante	nie
Nepeňažné plnenie (v zmysle zákona)	nie
Prednášajúci	nie
Akcionár	nie
Konzultant/odborný poradca	nie
Ostatné príjmy (špecifikovať)	nie

Manažment FP v špecifických klinických situáciách

1. FP u pacienta po KCH výkone a nekardiálnej OP
2. FP u onkologického pacienta
3. FP u pacienta po gastrointestinálnom krvácaní
4. FP u pacienta po iCMP a hemoragickej CMP
5. FP u fragilného pacienta

Odporúčania sa uvedeným klinickým situáciám takmer/ vôbec nevenujú...

FP u pacienta po KCH výkone a nekardiálnej OP

Odporúčania pre FP z r. 2020

Odporúčania	Trieda	Úroveň
Perioperačná liečba amiodarónom alebo betablokátormi sa odporúča na prevenciu pooperačnej FP po kardiochirurgickom zákroku.	I	A
Dlhodobá OAK na prevenciu TE príhod by sa mala zvážiť u pacientov s pooperačnou FP s rizikom CMP po nekardiálnej chirurgii vzhľadom na očakávaný klinický prínos OAK a pri preferencii pacienta.	IIa	B
Dlhodobá OAK na prevenciu TE príhod by sa mohla zvážiť u pacientov s pooperačnou FP s rizikom CMP po KCH operácii vzhľadom na očakávaný klinický prínos OAK a pri preferencii pacienta	IIb	B

Odporúčania nezohľadňujú:

1. Dĺžku trvania FP
2. Dilatáciu ĽP, štrukturálne ochorenie srdca
3. Typ KCH výkonu.

Zohľadňujú len riziko tromboembolizmu.

Odporúčania pre FP z r. 2024

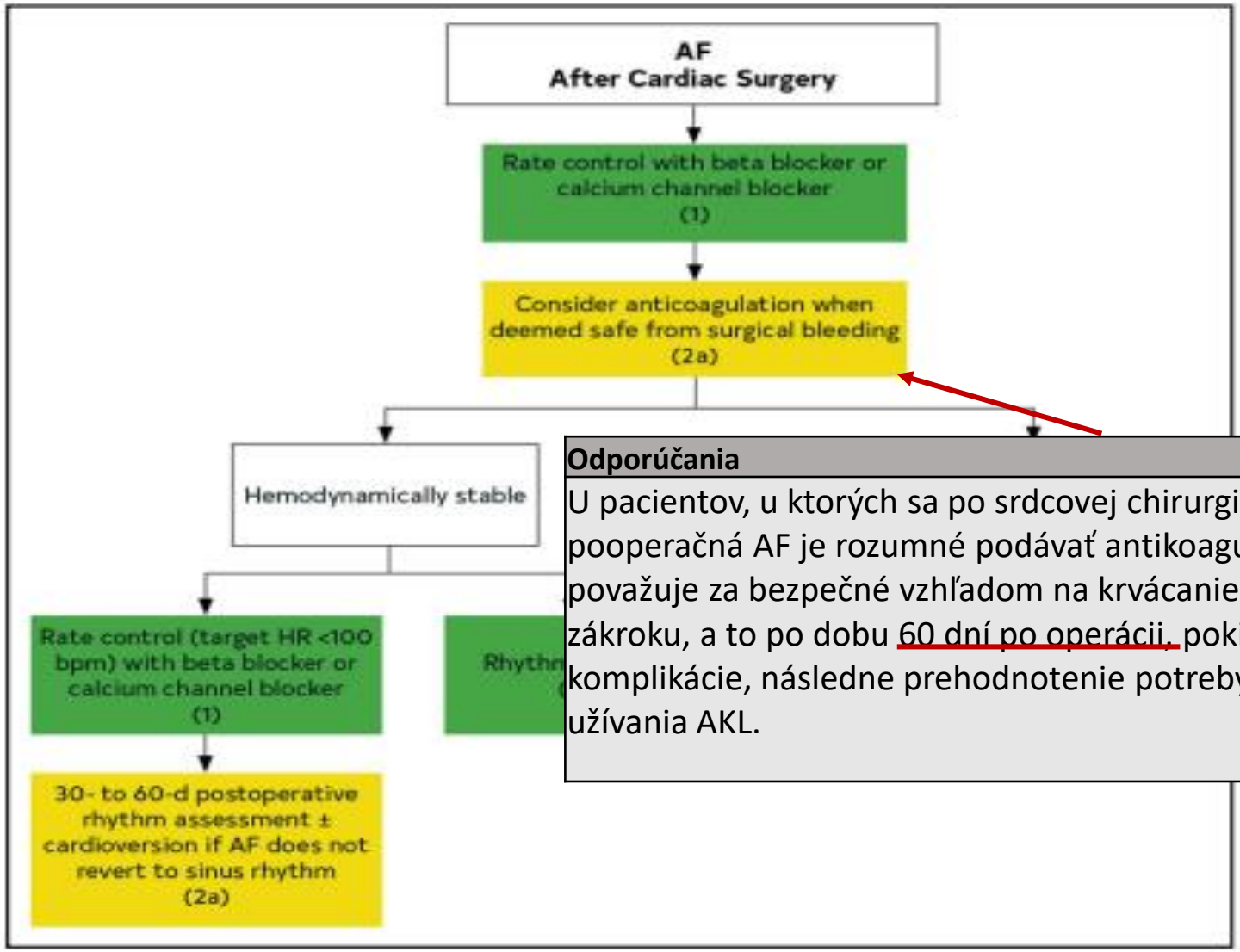
Odporúčania	Trieda	Úroveň
Perioperačná liečba amiodarónom sa odporúča k zabráneniu POAF po KCH OP*	I	A
K zabráneniu POAF by sa mala počas KCH výkonu vykonať sprievodná zadná perikardiotómia	IIa	B
Dlhodobú AKL je potrebné zvážiť u pacientov s POAF po KCH výkone a nekardiálnej chirurgii pri zvýšenom TE riziku	IIa	B
Rutinné používanie BB za účelom prevencie POAF po nekardiálnej OP sa neodporúča	III	B

* kumulatívna dávka 3000 mg

Odporúčania	Trieda	Úroveň
Skóre CHA2DS2-VA 2 alebo viac sa odporúča ako indikátor zvýšeného TE rizika pre rozhodnutie o začatí perorálnej antikoagulácie.	I	A
Skóre CHA2DS2-VA 1 by sa malo považovať za indikátor zvýšeného TE rizika pre rozhodnutie o začatí perorálnej antikoagulácie.	IIa	C

Upravené podľa Hindricks G et al. 2020 ESC Guidelines for the diagnosis and management of atrial fibrillation. Eur Heart J. 2021 Feb 1;42(5):373-498
Upravené podľa Gelder I.C.V. et al. 2024 ESC Guidelines for the management of atrial fibrillation. *European Heart Journal*, Volume 45, Issue 36, 21 September 2024, Pages 3314–3414

FP u pacienta po KCH výkone



Odporúčania	Trieda	Úroveň
U pacientov, u ktorých sa po srdcovej chirurgii rozvinie pooperačná AF je rozumné podávať antikoagulanciá, keď sa to považuje za bezpečné vzhľadom na krvácanie po chirurgickom zákroku, a to po dobu 60 dní po operácii, pokiaľ sa nevyvinú komplikácie, následne prehodnotenie potreby dlhodobého užívania AKL.	IIa	B

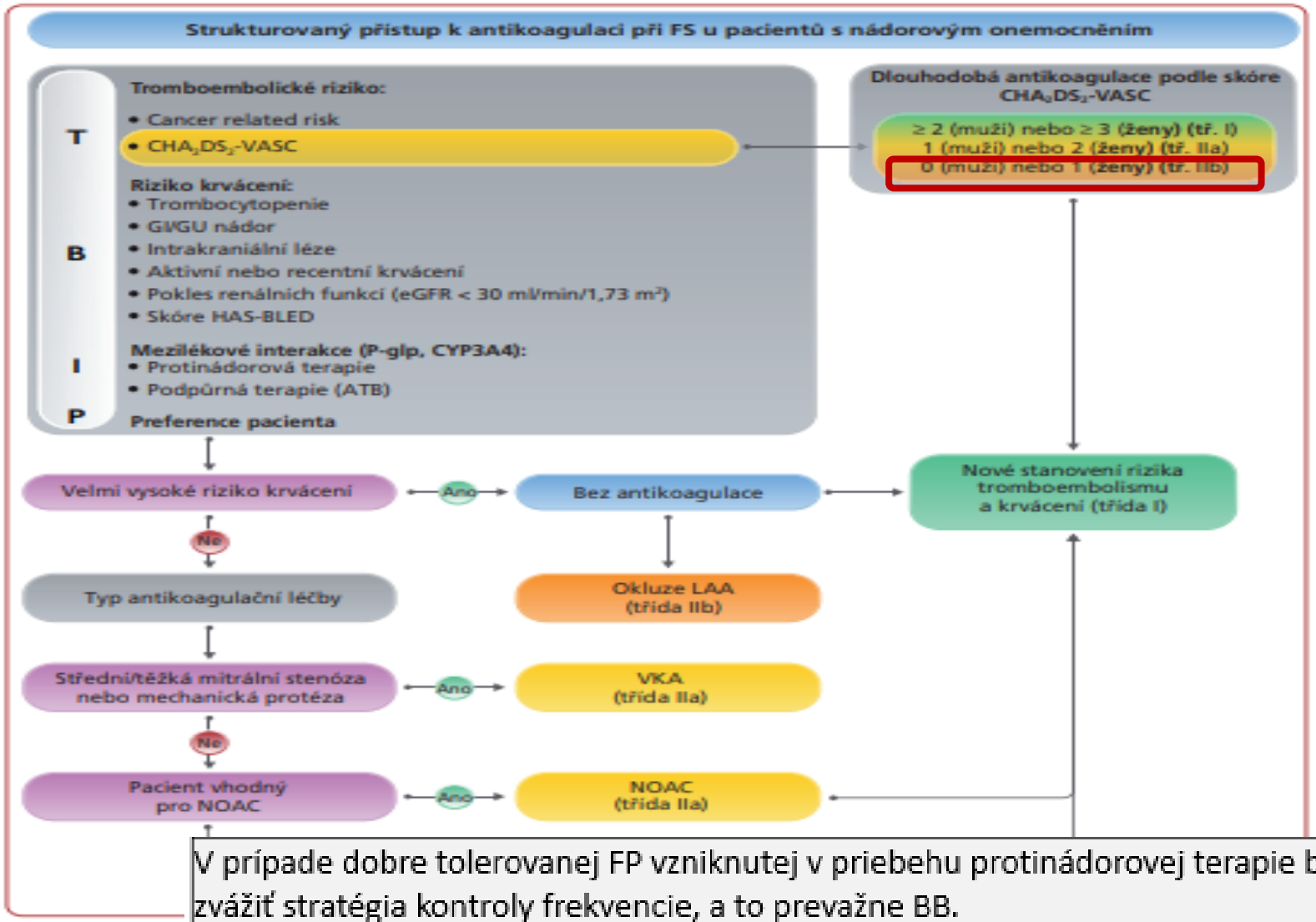
Joglat J.A. et al. 2023 ACC/AHA/ACCP/HRS Guideline for the Diagnosis and Management of Atrial Fibrillation, Circulation, 1/2O24

AKL u pacientov s POFP podľa odporúčaní

	• American Heart Association • American College of Cardiology • Heart Rhythm Society (2014, 2019)	• Society of Cardiovascular Anesthesiologists • European Association of Cardiothoracic Anesthetists (2019)	• European Society of Cardiology • European Association of Cardio-Thoracic Surgery • European Heart Rhythm Association (2016, 2020)	• Canadian Cardiovascular Society • Canadian Heart Rhythm Society (2020)
Long-term anticoagulation should be considered in patients with POAF on the basis of individual stroke and bleeding risk.	**2023 IIA (B)** **IIA (C)**	**IIA (B/C)**	**2024 IIA (B)** **IIB (B)** "the evidence on OAC in patients with POAF is not very robust."	Suggest anticoagulation be held for first 72 hours for individualized risk assessment of TE event and risk of postoperative bleeding **(Weak Recommendation, Low Quality of evidence)** Reassess need for OAC at 6-12 weeks **(Strong; Moderate)**

Chatterjee S. et al. Anticoagulation for atrial fibrillation after cardiac surgery: Do guidelines reflect the evidence? J Thorac Cardiovasc Surg. 2024 Feb;16

FP u onkologického pacienta



V prípade dobre tolerovanej FP vzniknutej v priebehu protinádorovej terapie by sa mala zvážiť stratégia kontroly frekvencie, a to prevažne BB.	IIa	C

Upravené podľa yon A.R. et al. 2022 ESC Guidelines on cardio-oncology, European Heart Journal, Volume 43, Issue 41, 2022, p4229–4361
2021 EHRA Practical Guide on the use of NOACs, Europace (2021) 23, 1612–1676

FP u onkologického pacienta

- u pacientov po prekonaní rakoviny v nedávnej dobe sa má systém TE CHA2DS2 VASc používať s opatrnosťou
- CHA2DS2-VASc skóre u onkologických pacientov pravdepodobne podhodnocuje ich tromboembolické riziko
- analýza súboru údajov dánskeho systému zdravotnej starostlivosti preukázala, že u pacientov s FA po prekonaní rakoviny v nedávnej dobe (< 5 rokov) s rizikom TE podľa CHA2DS2 VASc 0 – 1 bod sa počas 2 rokov preukázalo vyššie riziko iCMP a TE, než u pacientov bez rakoviny

Hu YF et al. Incident thromboembolism and heart failure associated with new-onset atrial fibrillation in cancer patients. Int J Cardiol 2013;165:355–357

Full research paper

European Journal of Preventive Cardiology

ESC European Society of Cardiology

European Journal of Preventive Cardiology
2018, Vol. 25(6) 651–658

DOI: 10.1177/2047487318759858
journals.sagepub.com/home/ejpc

SAGE

CHA_2DS_2-VASc score and risk of thromboembolism and bleeding in patients with atrial fibrillation and recent cancer

Maria D'Souza[1], Nicholas Carlson[2], Emil Fosbøl[3], Morten Lamberts[3], Lærke Smedegaard[1], Dorte Nielsen[4], Christian Torp-Pedersen[5], Gunnar Gislason[1,2,6] and Morten Schou[1]

Abstract

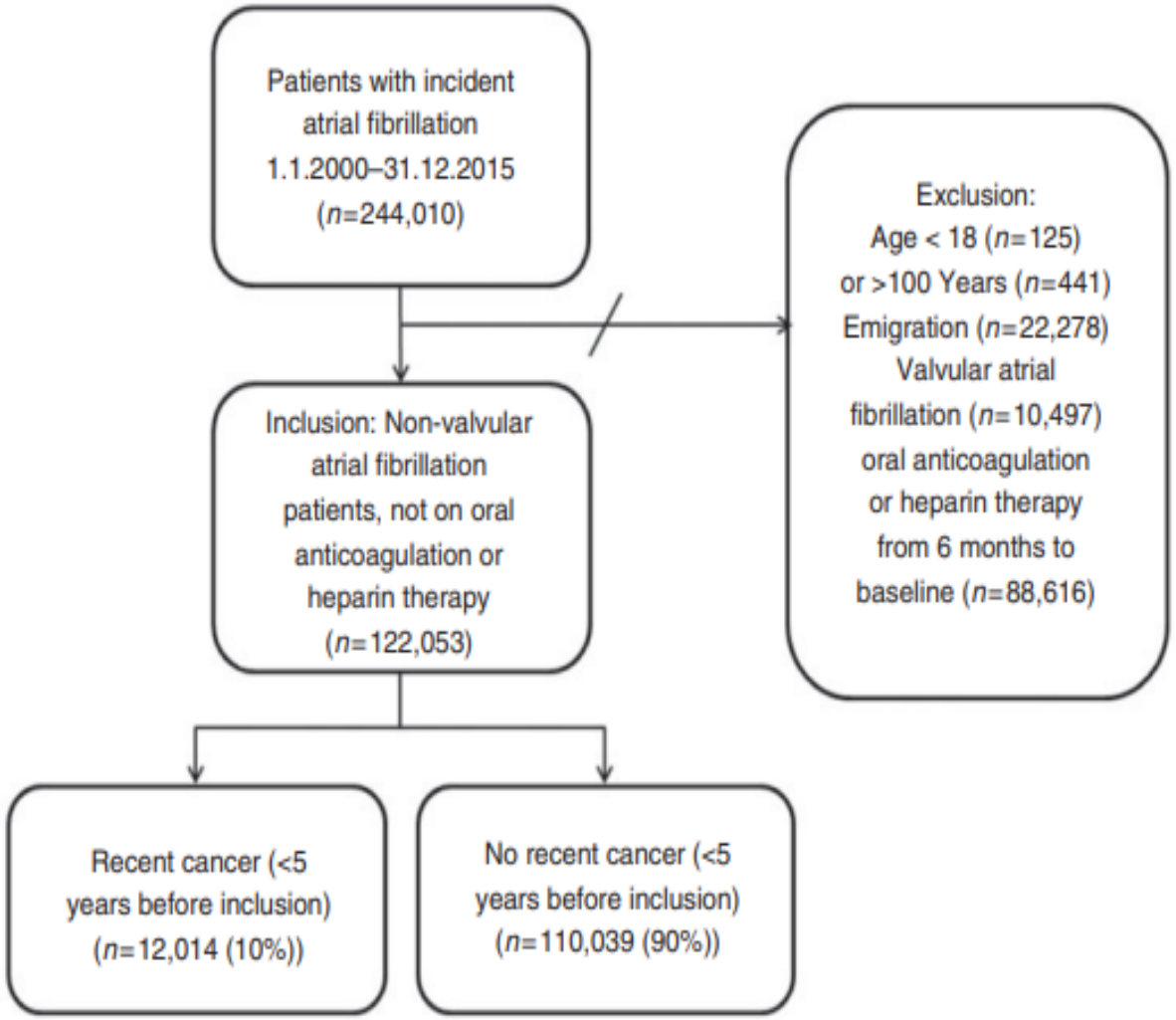
Background: Cancer may influence the risk of thromboembolism and bleeding associated with the CHA_2DS_2-VASc score. We examined the risk of thromboembolism and bleeding associated with the CHA_2DS_2-VASc score in atrial fibrillation patients with and without recent cancer.

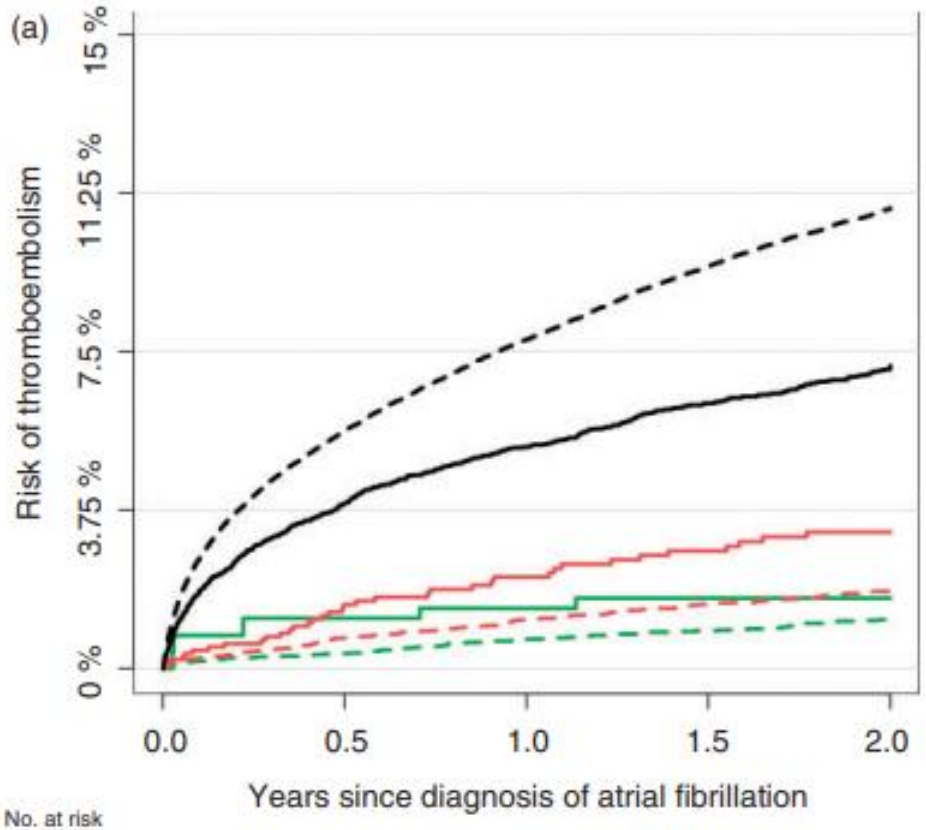
Methods and results: Using nationwide registers all patients diagnosed with atrial fibrillation from 2000 to 2015 and not on oral anticoagulation or heparin therapy were included and followed for 2 years. Recent cancer was defined by a cancer diagnosis 5 years or fewer earlier. Risks of thromboembolism and bleeding were estimated in cumulative incidence curves and Cox regression models. We included 122,053 patients with incident atrial fibrillation, 12,014 (10%) had recent cancer. The 2-year cumulative incidence of thromboembolism and bleeding in patients with versus without recent cancer was 1.7% (95% confidence interval (CI) 0.5–2.8) and 4.3% (95% CI 2.4–6.2) versus 1.2% (95% CI 0.9–1.5) and 1.7% (95% CI 1.4–2.0) for CHA_2DS_2-VASc score 0; 3.2% (95%CI 2.2-4.3) and 4.4% (95%CI 3.2-5.6) versus 1.8% (95%CI 1.6-2.1) and 3.0% (95% CI 2.7–3.3) for CHA_2DS_2-VASc score 1; and 7.1% (95% CI 6.6–7.7) and 6.8% (95% CI 6.3–7.2) versus 10.9% (95% CI 10.7–11.1) and 6.2% (95% CI 6.1–6.4) for CHA_2DS_2-VASc score 2 or greater. Although the CHA_2DS_2-VASc score was associated with thromboembolism and bleeding in both patients with and without cancer, the association differed between the groups for thromboembolism (test for interaction, $p < 0.001$) and bleeding (test for interaction, $p < 0.001$).

Conclusion: The association of the CHA_2DS_2-VASc score and risk of thromboembolism and bleeding differed between atrial fibrillation patients with and without recent cancer. Therefore, the CHA_2DS_2-VASc score should be used with caution in patients with recent cancer.

Maria D'Souza, et al., CHA_2DS_2-VASc score and risk of thromboembolism and bleeding in patients with atrial fibrillation and recent cancer, *European Journal of Preventive Cardiology*, Volume 25, Issue 6, 1 April 2018, Pages 651–658

Metodika štúdie a výsledky





No. at risk					
CHA_2DS_2-VASc 0, no recent cancer:	8595	7227	6571	6053	1368
CHA_2DS_2-VASc 0 and recent cancer:	513	303	223	185	36
CHA_2DS_2-VASc 1, no recent cancer:	12309	9725	8690	7890	1674
CHA_2DS_2-VASc 1, and recent cancer:	1419	763	562	456	86
CHA_2DS_2-VASc 2–9, no recent cancer:	89135	57494	46343	38462	6754
CHA_2DS_2-VASc 2–9 and recent cancer:	10082	4996	3627	2884	522

Maria D'Souza, et al., CHA_2DS_2-VASc score and risk of thromboembolism and bleeding in patients with atrial fibrillation and recent cancer
European Journal of Preventive Cardiology, Volume 25, Issue 6, 1 April 2018, Pages 651–658

FP u pacienta po gastrointestinálnom krvácaní

PROC (BAYL UNIV MED CENT)
2022;35(3):322–327

https://doi.org/10.1080/08998280.2022.2043707

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Management dilemmas in restarting anticoagulation after gastrointestinal bleeding

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Department of Internal Medicine, SUNY Upstate Medical University, Syracuse, New York

ABSTRACT

Systemic anticoagulants are widely prescribed to prevent and treat thromboembolism, among other indications. A common complication of using these agents is gastrointestinal bleeding. While early resumption of anticoagulants after the bleeding has resolved can increase the risk of rebleeding, delayed resumption puts the patient at increased risk of thromboembolic events and mortality. There is limited data on this topic to guide clinicians on resuming anticoagulation after hospitalization for gastrointestinal bleeding and to educate patients regarding the subsequent risks of recurrent gastrointestinal bleeding, thromboembolism, and mortality. The optimal time to resume anticoagulation is also unknown. This review summarizes the existing literature and available data on the commonly encountered dilemma of restarting anticoagulation therapy after hospitalization for gastrointestinal bleeding.

Jain H, Singh G, Kaul V, Gambhir HS. Management dilemmas in restarting anticoagulation after gastrointestinal bleeding. Proc (Bayl Univ Med Cent). 2022 Mar 9;35(3)

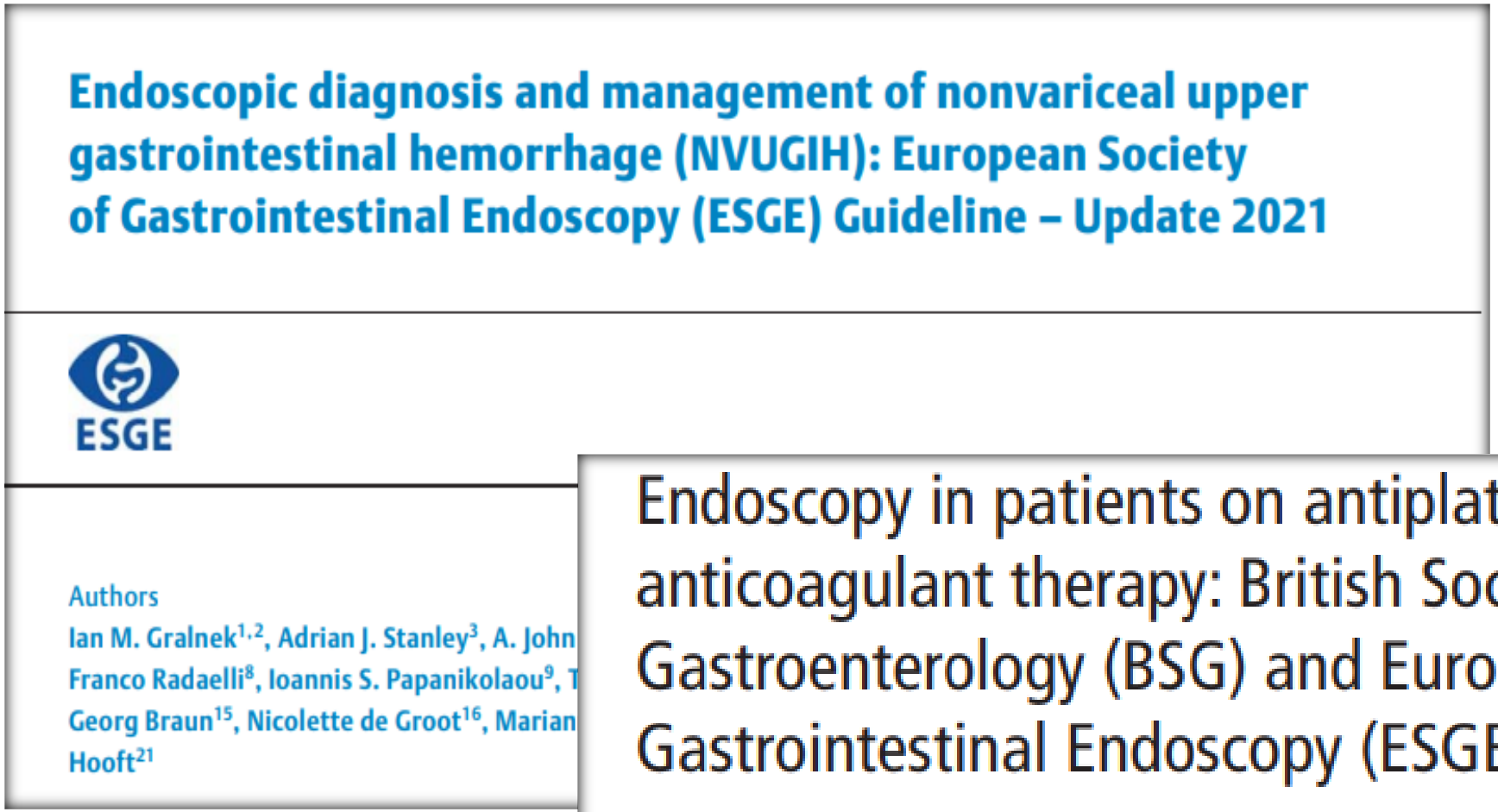
Study	Design	Indication	Anticoagulant	Resumed anticoagulation (n)		Follow-up months
				Yes	No	
Qureshi 2014[5]	Retrospective cohort	Nonvalvular AF	Warfarin	653	676	24
Witt 2012[2]	Retrospective cohort	AF, VTE, PV	Warfarin	260	182	3
Chen 2014[23]	Retrospective cohort	PV, AF, DVT, PE	Warfarin	22	12	n/a
Majeed 2017[4]	Retrospective cohort	AF, valvular heart disease, VTE	Warfarin	121	86	31
Sengupta 2018[24]	Retrospective cohort	Nonvalvular AF	DOAC	586	752	3

AF indicates atrial fibrillation; DOAC, direct oral anticoagulant; DVT, deep vein thrombosis; PE, pulmonary embolism; PV, prosthetic heart valves; VTE, venous thromboembolism.

Study	Recurrent GIB		Thromboembolism		Mortality	
	Resumed	Did not resume	Resumed	Did not resume	Resumed	Did not resume
Qureshi 2014[5]	61/653	29/676	90/653	131/676	187/653	276/676
Witt 2012[2]	26/260	10/182	1/260	10/182	15/260	37/182
Chen 2014[23]	6/22	0/12	0/22	2/12	Not available	
Majeed 2017[4]	39/121	17/86	5/121	16/86	51/121	52/86
Sengupta 2018[24]	21/586	28/752	16/586	17/752	Not available	

GIB indicates gastrointestinal bleeding.

Jain H, Singh G, Kaul V, Gambhir HS. Management dilemmas in restarting anticoagulation after gastrointestinal bleeding. Proc (Bayl Univ Med Cent). 2022 Mar 9;35(3)



Endoscopic diagnosis and management of nonvariceal upper gastrointestinal hemorrhage (NVUGIH): European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2021

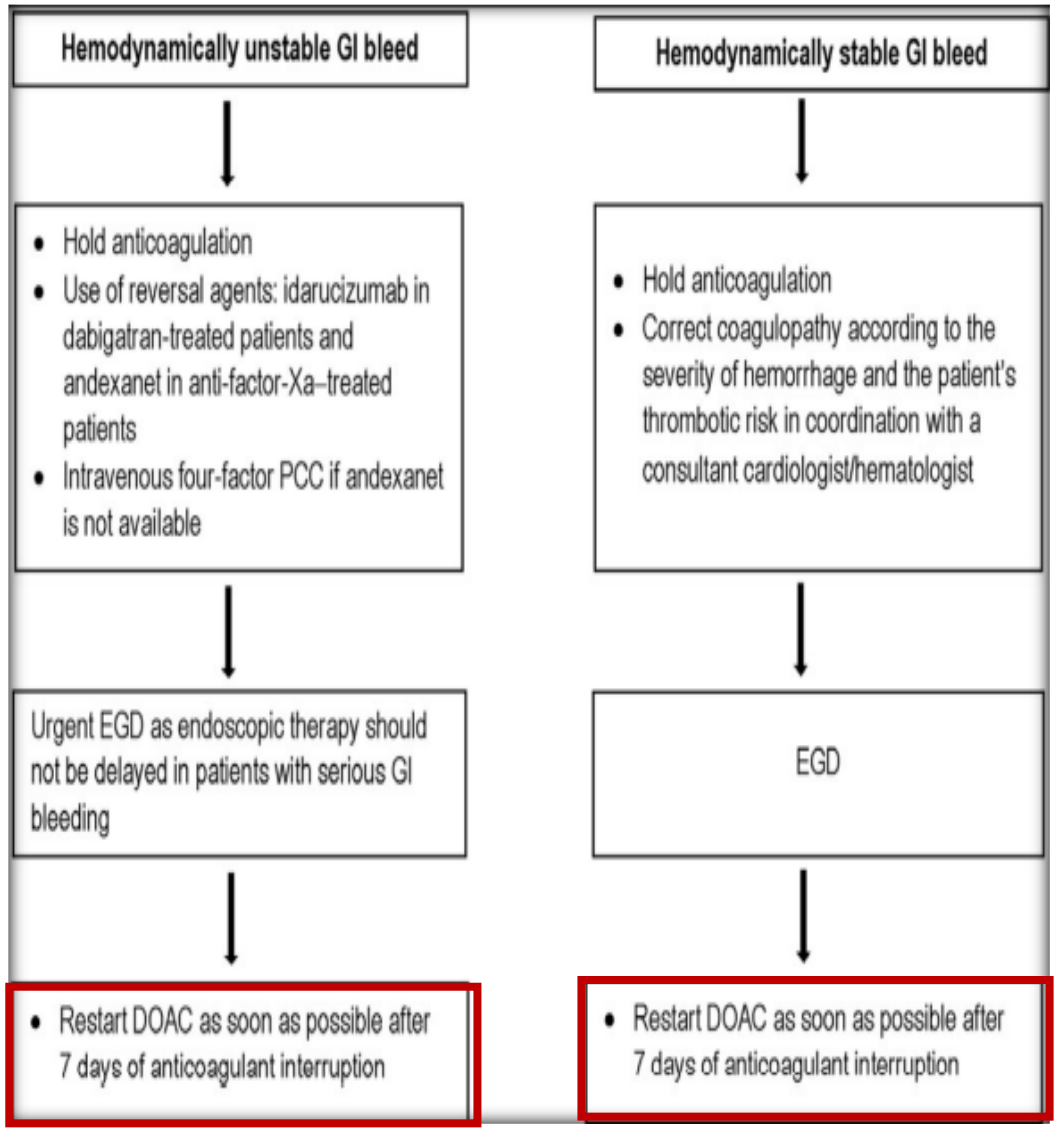
ESGE

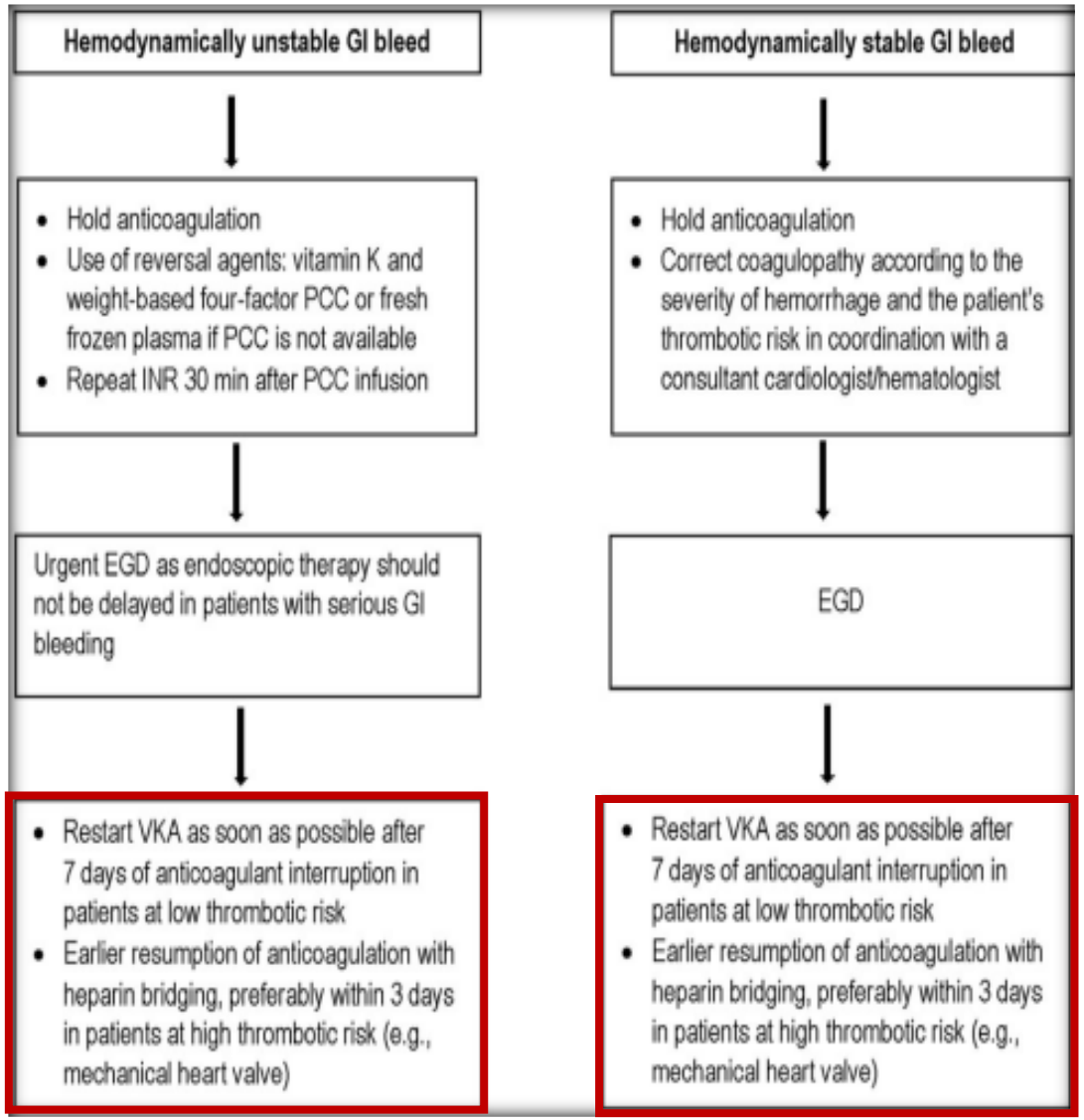
Authors
Ian M. Gralnek[1,2], Adrian J. Stanley[3], A. John
Franco Radaelli[8], Ioannis S. Papanikolaou[9], T
Georg Braun[15], Nicolette de Groot[16], Marian
Hooft[21]

Endoscopy in patients on antiplatelet or anticoagulant therapy: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guideline update

Andrew M Veitch ,[1] Franco Radaelli ,[2] Raza Alikhan,[3] Jean Marc Dumonceau,[4] Diane Eaton,[5] Jo Jerrome,[6] Will Lester,[7] David Nylander,[8] Mo Thoufeeq,[9] Geoffroy Vanbiervliet,[10] James R Wilkinson,[11] Jeanin E Van Hooft[12]

Gralnek IM et al. Endoscopic diagnosis and management of nonvariceal upper gastrointestinal hemorrhage (NVUGIH): European Society of Gastrointestinal Endoscopy (ESGE) Guideline - Update 2021. Endoscopy. 2021 Mar;53(3):300-332.
Veitch AM et al. Endoscopy in patients on antiplatelet or anticoagulant therapy: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guideline update. Gut. 2021 Sep;70(9):1611-1628.



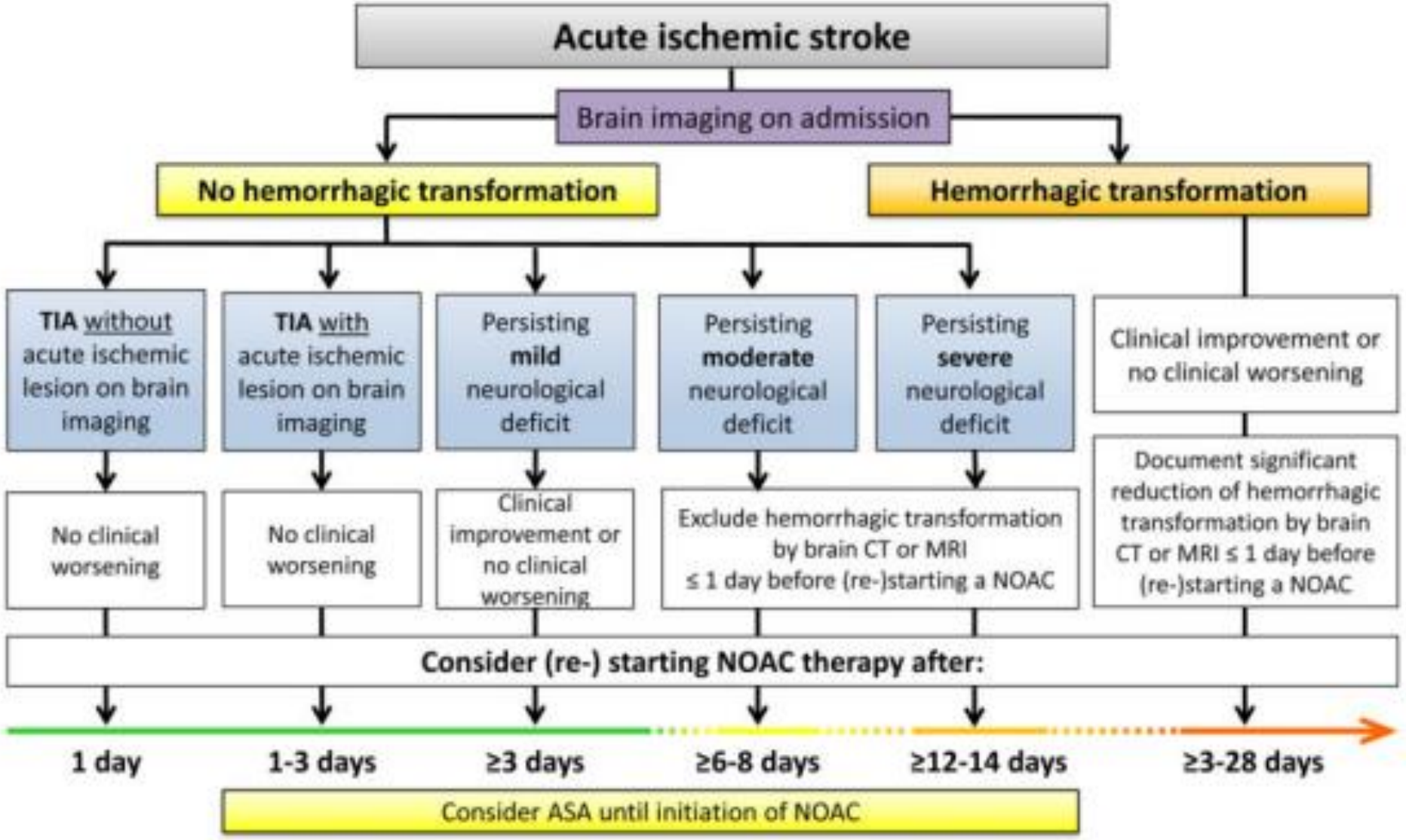


Gralnek IM et al. Endoscopic diagnosis and management of nonvariceal upper gastrointestinal hemorrhage (NVUGIH): European Society of Gastrointestinal Endoscopy (ESGE) Guideline - Update 2021. Endoscopy. 2021 Mar;53(3):300-332.
Veitch AM et al. Endoscopy in patients on antiplatelet or anticoagulant therapy: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guideline update. Gut. 2021 Sep;70(9):1611-1628.

FP u pacienta po iCMP a hemoragickej CMP

Odporúčania pre sekundárnu prevenciu iCMP u pacientov s FP po prekonaní akútnej iCMP	**Trieda**	**Úroveň**
U pacientov s FP s iCMP alebo TIA sa odporúča dlhodobá sekundárna prevencia CMP pomocou OAL, ak neexistuje prísna kontraindikácia použitia OAL s preferenciou NOAK pred VKA (u pacientov vhodných pre NOAK).	**I**	**A**
U pacientov s FP s akútnou iCMP sa skorá antikoagulácia (< 48 h) pomocou UFH, LMWH alebo VKA neodporúča.	**III**	**B**
Odporúčania pre prevenciu CMP u pacientov s AF po intrakraniálnom krvácaní		
U pacientov s FP s vysokým rizikom iCMP (opätovné) začatie OAL s preferenciou NOAK pred VKA v prípade vhodných pacientov na NOAK je potrebné zvážiť po konzultácii s neurológom • ICH v súvislosti s traumou • Akútna spontánna ICH (ktorá zahŕňa subdurálne, subarachnoidálne alebo intracerebrálne krvácanie) po starostlivom zvážení rizika a benefitu	**IIa**	**C**

Upravené podľa Hindricks G et al. 2020 ESC Guidelines for the diagnosis and management of atrial fibrillation. Eur Heart J. 2021 Feb 1;42(5):373-498



Based on expert opinion! No RCT data available yet

2021 EHRA Practical Guide on the use of NOACs, Europace (2021) 23, 1612–1676

FP u pacienta po iCMP a hemoragickej CMP

ANTICOAGULATION INDICATIONS, PREFERRED TYPE OF DOAC, AND RESUMPTION OR INITIATION TIMING

Indication	Type of Anticoagulation	Resumption or Initiation Timing[a]
Atrial fibrillation	DOAC (Eliquis) for nonvalvular AF; VKA for valvular AF	0 to 7 days for small ischemic stroke 8 to 14 days for large ischemic stroke After 2 weeks for ischemic stroke with parenchymal hematoma 2 to 6 weeks for ICH Consider LAAC for CAA
Cardiac thrombus	VKA	Within 1 week after ischemic stroke Within 2 weeks for ICH
Mechanical heart valve	VKA	Within 1 to 2 weeks after ischemic stroke Within 2 weeks for ICH
Venous thromboembolism	DOAC, VKA, or LMWH	Within 0 to 7 days for small ischemic stroke Within 8 to 14 days for large ischemic stroke Within 2 to 6 weeks for ICH IVC filter if immediate anticoagulation contraindicated
Antiphospholipid syndrome	VKA	Within 0 to 7 days for small ischemic stroke Within 8 to 14 days for large ischemic stroke Within 2 to 6 weeks for ICH
Cancer-related stroke	DOAC, LMWH	Within 0 to 7 days for small ischemic stroke Within 8 to 14 days for large ischemic stroke Within 2 to 6 weeks for ICH
Intraluminal thrombus	Heparin, DOAC, warfarin	Within 0 to 7 days for small ischemic stroke Within 8 to 14 days for large ischemic stroke
Cervical artery dissection	DOAC, warfarin, antiplatelet	Within 0 to 7 days for small ischemic stroke Within 8 to 14 days for large ischemic stroke

Abbreviations: DOAC, direct oral anticoagulation; ICH, intracranial hemorrhage; IVC, inferior vena cava; LAAC, left atrial appendage closure; LMWH, low-molecular-weight heparin; VKA, vitamin K antagonist.

- jedno z najťažších klinických rozhodnutí
- multidisciplinárny manažment: kardiológ + neurológ
- ak nemôže byť navrátená/iniciovaná AKL → zváženie LAAO

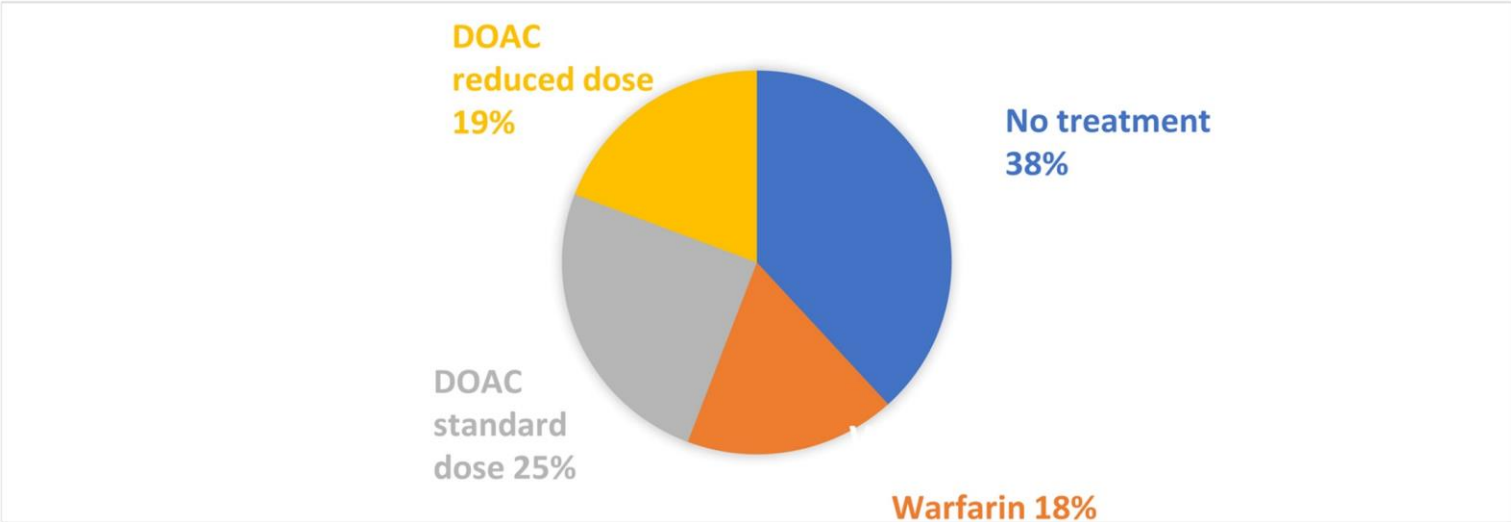
Liqi Shu et al. Resumption of Anticoagulant Therapy Following Ischemic and Hemorrhagic Strokes: Indications and Timing. Practical Neurology, 2023 január, 44 – 58.

FP u fragilného pacienta

Net Clinical Benefit of Oral Anticoagulation Among Frail Patients With Atrial Fibrillation: Nationwide Cohort Study

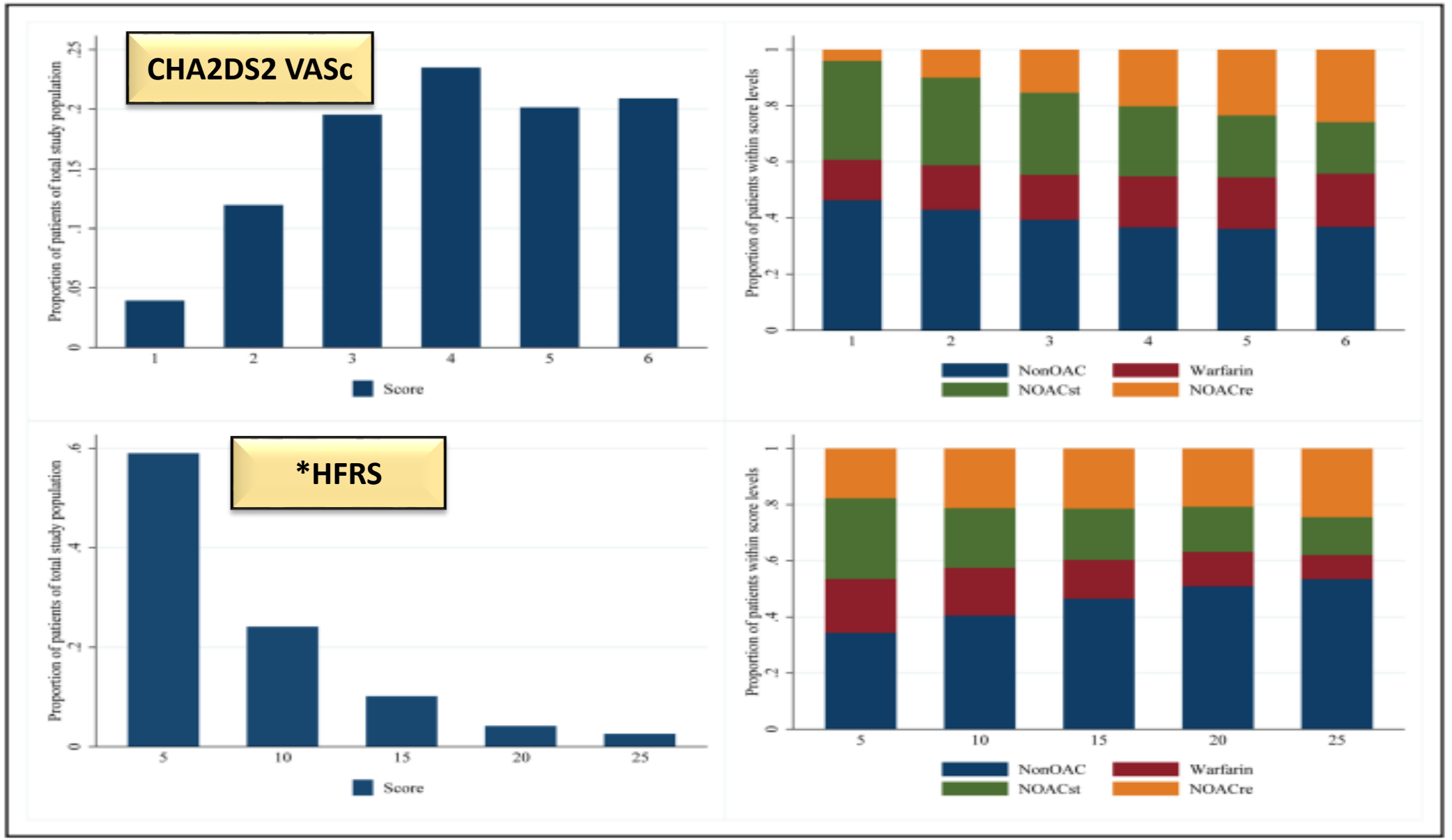
Mette Søgaard, PhD; Martin Jensen, MSc; Anette Arbjerg Højen, PhD; Torben Bjerregaard Larsen, MD, PhD; Gregory Y.H. Lip, MD; Anne Gulbech Ording, PhD; Peter Brønnum Nielsen, PhD

Study population of frail patients with AF
N = 36,223



- **vek:** medián 79 rokov
- 50,5 % žien
- **medián CHA2DS2 VASc:** 4
- **medián HAS BLED:** 4
- **medián skóre krehkosti:** 9,6 vs 8,5 (liečení vs neliečení)

Sogard M. et al. Net Clinical Benefit of Oral Anticoagulation Among Frail Patients With Atrial Fibrillation: Nationwide Cohort Study. AHA/ASA Journals. Stroke. Jan 2024,55(2)



* **Hospital Frailty Risk Score**

Sogard M. et al. Net Clinical Benefit of Oral Anticoagulation Among Frail Patients With Atrial Fibrillation: Nationwide Cohort Study. AHA/ASA Journals. Stroke. Jan 2024,55(2)

Characteristic, n (%)	No treatment	Warfarin/NOAC
Number	13 849	22 374
Female sex	50.9 (7055)	50.3 (11 250)
Age, y (IQR)	79.0 (71.0–86.0)	79.0 (72.0–86.0)
HFRS score, median (IQR)	9.6 (6.9–14.0)	8.5 (6.4–11.9)
CHA_2DS_2-VASc score, median (IQR)	4.0 (3.0–5.0)	4.0 (3.0–5.0)
HAS-BLED score, median (IQR)	3.0 (2.0–4.0)	3.0 (2.0–4.0)
Charlson score, median (IQR)	3.0 (1.0–4.0)	2.0 (1.0–4.0)
Prior stroke/SE	29.5 (4087)	31.1 (6951)
Prior major bleeding	23.8 (3294)	18.8 (4212)
Heart failure	32.0 (4431)	35.3 (7892)
Hypertension	66.9 (9269)	73.4 (16 425)
Diabetes	21.9 (3039)	21.6 (4829)
Vascular disease	22.9 (3169)	20.4 (4575)
Ischemic heart disease	33.9 (4689)	32.2 (7203)
COPD	21.2 (2935)	19.1 (4265)
Recent cancer (3 y)	19.5 (2694)	12.1 (2712)
Alcohol-related disease	9.5 (1315)	6.9 (1541)
Dementia	9.6 (1331)	6.4 (1429)

Characteristic, n (%)	No treatment	Warfarin/NOAC
eGFR, mean (SD)	63.9 (22.6)	66.1 (21.6)
eGFR 21–49	5.0 (695)	2.7 (604)
eGFR 50–90	38.4 (5316)	37.7 (8446)
eGFR >90	28.9 (4009)	30.7 (6861)
Missing	27.6 (3817)	28.9 (6460)
Medication		
Warfarin	0.0 (0)	28.4 (6355)
DOAC standard dose	0.0 (0)	40.5 (9053)
DOAC reduced dose	0.0 (0)	31.1 (6966)
Statins	43.6 (6045)	50.7 (11 343)
NSAID	20.4 (2824)	19.9 (4449)
β-Blockers	49.2 (6817)	67.1 (15 021)
Calcium	33.6 (4652)	36.6 (8183)
Loop diuretics	40.1 (5559)	44.6 (9976)
Nonloop diuretics	37.6 (5209)	41.8 (9356)
Vasodilators	5.4 (744)	5.5 (1229)
ACE inhibitor/ARB	48.5 (6720)	55.4 (12 388)

Sogard M. et al. Net Clinical Benefit of Oral Anticoagulation Among Frail Patients With Atrial Fibrillation: Nationwide Cohort Study. AHA/ASA Journals. Stroke. Jan 2024,55(2)

Výsledky

Strata	Thromboembolism, % (95% CI)		Major bleeding, % (95% CI)		Net clinical benefit,* % (95% CI)
	Non-users†	OAC users	Non-users†	OAC users	
Overall	2.1% (1.8% to 2.3%)	1.5% (1.4% to 1.7%)	3.2% (2.9% to 3.5%)	3.5% (3.2% to 3.8%)	0.70% (0.32% to 1.08%)
Age, y					
≤75	1.9% (1.4% to 2.4%)	1.2% (0.9% to 1.4%)	3.7% (3.0% to 4.3%)	2.8% (2.5% to 3.2%)	1.16% (0.57% to 1.73%)
>75	2.2% (1.9% to 2.5%)	1.7% (1.5% to 1.9%)	3.0% (2.6% to 3.4%)	3.8% (3.5% to 4.1%)	0.43% (−0.09% to 0.90%)
Frailty					
Intermediate (HFRS≤15)	2.0% (1.8% to 2.3%)	1.5% (1.3% to 1.6%)	3.1% (2.8% to 2.5%)	3.3% (3.1% to 3.6%)	0.76% (0.36% to 1.18%)
High (HFRS>15)	2.2% (1.7% to 2.8%)	1.9% (1.4% to 2.4%)	3.4% (2.7% to 4.1%)	4.3% (3.6% to 5.1%)	0.25% (−0.79% to 1.30%)

- **Riziko TE príhod a veľkého krvácania sa zvyšovalo s vekom a fragilitou pacienta.**
- **<u>Záver:</u> Dánska kohortová štúdia preukázala jednoznačný klinický benefit v prospech AKL, avšak ten klesal so zvyšujúcim sa vekom a krehkosťou pacienta.**

➢ **Aj fragilných pacientov je potrebné antikoagulovať, ich manažment si však vyžaduje väčšiu opatrnosť.**

Sogard M. et al. Net Clinical Benefit of Oral Anticoagulation Among Frail Patients With Atrial Fibrillation: Nationwide Cohort Study. AHA/ASA Journals. Stroke. Jan 2024,55(2)

Záver

- v uvedenej problematike sú odporúčania „skúpe“ a nejasné → problematický manažment v klinickej praxi
- manažment FP v špecifických klinických situáciách si vyžaduje **multidisciplinárny prístup**
- každého pacienta je dôležité manažovať s opatrnosťou, individuálne, s kladením dôrazu na klinický úsudok každého špecialistu

Ďakujem za pozornosť.