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Outlook Better When Warfarin Restarted After Major Bleed

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By Todd Neale, Senior Staff Writer, MedPage Today
Reviewed by Robert Jasmer, MD; Associate Clinical Professor of Medicine, University of California, San Francisco

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Among patients with atrial fibrillation who stopped taking warfarin because of a major gastrointestinal bleed, restarting anticoagulation was associated with improved outcomes, a retrospective study showed.

Action Points

- Among patients with atrial fibrillation who stopped taking warfarin because of a major gastrointestinal bleed, restarting anticoagulation was associated with improved outcomes.
- Point out that restarting warfarin within 60 days of the bleed -- versus restarting later or not at all -- was associated with a lower risk of death and was not associated with a significantly greater risk of recurrent GI bleeding.

Restarting warfarin within 60 days of the bleed -- versus restarting later or not at all -- was associated with lower risks of thromboembolism (hazard ratio 0.71, 95% CI 0.54-0.93) and death (HR 0.67, 95% CI 0.56-0.81) during follow-up, according to Waqas Qureshi, MD, of Wake Forest University in Winston-Salem, N.C., and colleagues.

It was not, however, associated with a significantly greater risk of recurrent GI bleeding (HR 1.18, 95% CI 0.94-1.10), they reported online in the American Journal of Cardiology.

The findings "may have clinical implications, especially if further research shows that early resumption of warfarin leads to better outcomes," they wrote.

The researchers retrospectively analyzed data from 1,329 patients (mean age 75) who had nonvalvular atrial fibrillation, were being treated with warfarin and monitored through the anticoagulation clinic at Henry Ford Health System in Detroit, and developed a major GI bleed that resolved from 2005 to 2010. All patients had at least 2 years of follow-up data available.

Slightly less than half of the cohort (49.1%) restarted warfarin within 6 months of the bleed; the median duration of interruption was 50 days.

The major reasons for not re-initiating anticoagulation were an inability of the patient to attend follow-up at the anticoagulation clinic (19%) and physician preference (18%).

"The study is not large enough to be generalizable to the rest of the country; however, the cohort had adequate diversity to provide an idea of this practice gap," Qureshi and colleagues noted.

Overall, 34.8% of the patients died within 2 years, 16.6% had a thromboembolic episode within 1 year, and 6.8% had a recurrent GI bleed within 90 days.

Of the deaths, four were from thromboembolism; all occurred in the patients who did not

restart warfarin. One death was related to a "massive GI hemorrhage," and occurred in a patient who had restarted warfarin.

The researchers looked into whether there were differences between restarting warfarin earlier rather than later. They found that compared with restarting after a 30-day interruption, restarting within the first 7 days after the major bleed was associated with a significantly lower risk of dying (HR 0.56, 95% CI 0.33-0.93), a nonsignificantly lower risk of thromboembolism (HR 0.76, 95% CI 0.37-1.59), and a greater risk of recurrent bleeding (HR 3.27, 95% CI 1.82-5.91).

Re-initiating warfarin treatment from 7 to 30 days after the major bleed was not, however, associated with an increase in recurrent bleeding.

"Even though there are many other variables that physicians take into account while making a decision of resuming warfarin in these patients, we have provided the risks versus benefits of these treatment decisions that might have clinical implications," the authors wrote.

They acknowledged some limitations of the study, including the retrospective design; possible bias in the detection of thromboembolism stemming from differences in healthcare use between those who did and did not restart warfarin; the exclusion of individuals who died within 2 days after the first major bleed; and the fact that those who were restarted on warfarin had fewer comorbidities compared with those who were not.

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They did not report any conflicts of interest.

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