POEMs

Patients with AF taking aspirin with anticoagulant at increased bleeding risk without clear benefit (ORBIT-AF)

**Bottom Line:**
Many patients with atrial fibrillation (AF) are receiving aspirin (A) in addition to an oral anticoagulant (OAC), despite the fact that 40 per cent of the patients in this study had no indication for aspirin (e.g., no known atherosclerotic disease). Concomitant use of aspirin increased the risk of bleeding over OAC alone (adjusted hazard ratio – aHR = 1.5) without any clear benefit regarding cardiovascular events. This practice persists despite lack of support from randomised trials (the lone potential exception is the group of patients with a mechanical heart valve). This is a case in which less may be more, and randomised trials comparing OAC with A+OAC are needed in this population. (LOE = 2b)

**Reference:**

**Study Design:** Cohort (retrospective)
**Funding:** Industry + government
**Setting:** Population based
**Allocation:** Unknown

**Synopsis:**
Most patients with AF are treated with an anticoagulant. Those who also have an indication for an antithrombotic, such as known coronary artery or cerebrovascular disease, may also be given aspirin. The benefit of this incremental therapy (A+OAC) is uncertain.

The authors used a registry of 10,126 adult outpatients being treated for AF; those with a reversible cause or short life expectancy were excluded. After also excluding those who were not taking an anticoagulant and those taking other antithrombotics, they were left with 4,804 patients who were taking OAC and 2,543 who were taking A+OAC.

Those using combination therapy were more likely to be male (53 per cent OAC, 66 per cent A+OAC) and more likely to smoke or have hyperlipidaemia, diabetes mellitus or heart failure.

A multivariate analysis found that those being given A+OAC had a higher likelihood of known coronary artery disease (adjusted odds ratio – aOR = 2.2), previous ablation (aOR = 1.6), previous stent placement (aOR = 1.5) or previous stroke or transient ischaemic attack (aOR = 1.5).

Older patients, those with long-standing or persistent AF, those living in the southern or western states, patients with liver or renal disease and those being cared for by a primary-care physician were less likely to be using combination therapy.

Using an adjusted propensity score analysis, the authors also looked at the likelihood of adverse outcomes at six months between groups. Major bleeding (aHR = 1.5; 95% CI 1.2–2.0) and bleeding resulting in hospitalisation (aHR = 1.5; 1.2–2.0) were both significantly more likely in patients receiving concomitant aspirin therapy.

When limiting the analysis to only those patients with previous MI (n=947) or stroke (n=1042), although the overall number of cardiovascular or bleeding events was small, there was no apparent difference in the likelihood of these events between groups.

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