Management of Atrial Fibrillation (AF)–Related Stroke Risk: A Healthcare Imperative

AF leads to a substantial number of strokes
AF is responsible for at least 15% to 20% of all ischemic strokes and 36% of strokes in those 80 to 89 years of age

AF-related stroke is typically more severe, more likely to recur, and leads to more deaths
• More impairment* at 30 days, 3 months, and 1 year
• Greater dependency† for severe strokes at 3, 6, and 12 months
• 1.7 times more likely to be bedridden
• More than 2 times higher recurrence rates at 6 months and 1 year after first stroke
• 2 times as likely to be fatal

AF prevalence is growing as the population ages
• Approximately 82% of people with AF are ≥65 years of age

AF-related stroke risk increases with common comorbidities
• Along with age, additional risk factors for stroke in patients with AF include a history of hypertension, diabetes mellitus, prior stroke or transient ischemic attack (TIA), and heart failure

<table>
<thead>
<tr>
<th>Comorbid Conditions of Patients With AF</th>
<th>Hypertension</th>
<th>Congestive heart failure</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected Range</td>
<td>62%</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>Patients (millions)</td>
<td>4.6</td>
<td>4.6</td>
<td>4.6</td>
</tr>
<tr>
<td>2010</td>
<td>2.7</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>2050</td>
<td>5.6</td>
<td>5.6</td>
<td>5.6</td>
</tr>
</tbody>
</table>

*Impairment determined by scores on modified Rankin Scale.
†Dependence measured on the Barthel Index.

Projected US Adults With AF

Retrospective database analysis from Medicare and commercial health insurance plans (July 2004-Dec 2005).
Guidelines Recommend Thromboprophylaxis for Most Patients With AF

### ACC/AHA/HRS Guidelines for Managing Patients With AF

For patients with NVAF and prior stroke, TIA or CHA\(_2\)DS\(_2\)-VASc score of ≥2 oral anticoagulants are recommended.

For patients with NVAF and a CHA\(_2\)DS\(_2\)-VASc score of 1, no antithrombotic therapy or treatment with an oral anticoagulant or aspirin may be considered.

For patients with NVAF and CHA\(_2\)DS\(_2\)-VASc of 0, it is reasonable to omit antithrombotic therapy.

Selection of antithrombotic agent should be based on risks of thromboembolism, shared decision-making, discussion of risks of stroke and bleeding, and the patient’s preferences.

Adapted from January CT, et al.

**Nearly half of at-risk patients with AF may not be receiving thromboprophylaxis in accordance with guideline recommendations—regardless of care setting\(^\text{11-17}\)**

**Barriers to more effective stroke risk management in patients with AF include:**

- Incomplete knowledge of guidelines among HCPs\(^\text{18}\)
- Complexities of stroke-risk stratification\(^\text{12,19,20}\)
- Patients’ problems with adherence to thromboprophylaxis\(^\text{18,21,22}\)
- Limited patient knowledge about AF and stroke risk; thromboprophylaxis risks and benefits\(^\text{17,22}\)

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Abbreviations: ACC, American College of Cardiology; AHA, American Heart Association; HCP, healthcare professional; HRS, Heart Rhythm Society.