

AFib Podcast - Fear of Bleeding

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Dr. Allred: Hello and welcome to today's episode of *The Four F's of Atrial Fibrillation*, where we address gaps and barriers to care for the diagnosed and undertreated atrial fibrillation patient, around four key areas of concern: frailty, falls, fear of bleeding and forgetfulness. In this episode, we will focus on answering key questions around fear of bleeding. I'm Dr. James Allred, a cardiologist specializing in electrophysiology with Cone Health in Greensboro, North Carolina.

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Dr. Allred: I'm your host for this podcast series. Today I'm joined by Ricky Fenton, who is the lead provider at Cone Health's Atrial Fibrillation Clinic. Ricky Fenton is a physician's assistant who has lots of experience in taking care of patients with atrial fibrillation. Ricky, welcome to the program today.

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Fenton: Hi, thanks for having me.

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Dr. Allred: Please tell us a little bit more about yourself.

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Fenton: Yeah, so I am actually from this area in Greensboro, and I did my undergraduate studies at Brigham Young University and then studied to become a PA at South University in Savannah, Georgia, and worked in cardiology there in Savannah at St. Joseph Hospital before moving back to Greensboro to work at the AFib Clinic here at Cone.

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Dr. Allred: And how long have you been in the AFib Clinic at Cone Health?

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Fenton: So, I've been here a little over two years now.

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Dr. Allred: So, for two years you've dedicated your time to management of patients with atrial fibrillation.

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Fenton: That's right, yeah.

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Dr. Allred: Very good. And so, I know you have lots of experience with anticoagulation. With that, what are the perceived versus actual barriers to appropriate anticoagulation?

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Fenton: You know, when thinking about the risk of bleeding on anticoagulation, there's both perceived and real barriers, and many providers worry about putting patients on medications that can cause harm. In looking back in 2012, there was a Medicare Part D study looking at patients with at least a moderate to high risk of stroke who had a diagnosis of AFib, and about 40 percent of those patients did not receive warfarin within the first year of diagnosis. And just thinking about the mentality of providers, I think that stems from a first "do no harm mentality" that providers can feel more responsible for an adverse event from prescribing a medicine rather than an adverse event from not prescribing; from omitting a therapy.

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Fenton: For example, if we prescribe anticoagulation and a patient has a major bleeding event, we may feel more culpable in that situation than if we omitted anticoagulation and the patient were to have an ischemic stroke. But really, looking forward, I think a lot of education, a lot of work has been done with providers to increase anticoagulation prescription. You know, looking at the Get With The Guidelines study and quality improvements, you know, this was across about 115 centers from 2013 to 2017, and the initial prescription of anticoagulation for AFib patients at discharge was about 80 percent.

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Fenton: But over the course of the program, anticoagulation prescription at discharge improved to over 96 percent. So I think many providers think the barrier of this perceived risk of bleeding is being addressed and being worked on. When you think about it from a patient's perspective, I hear almost daily that I'm trying to poison my patients, that I'm putting them on rat poison, which is part of how warfarin was originally discovered and utilized before it was adapted for use in humans. And so, when I tell them that I'm going to start them on a blood thinner, they have this idea.

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Fenton: They have their old uncle who was on warfarin for 20 years. And, you know, he's been a lifelong smoker. He has this horrible vascular disease and heart failure, and he had all these problems on warfarin. And so that's the picture that the patient has in their mind. As soon as I say we need to start a blood thinner. That's not the case anymore. With a lot of the direct oral anticoagulants, things have come a long way, as far as anticoagulation. But just addressing those concerns and being upfront with patients is important. So, those are really kind of the perceived barriers. And then thinking about the real barriers is that the bleeding risk is real.

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Fenton: It is there. It exists. So, it's something that we need to really talk to our patients about.

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Dr. Allred: And when you have conversations with family or caregivers, how do you approach the barriers of anticoagulation in those conversations?

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Fenton: You know, family members tend to have a lot of the same concerns that the patients do. Now, if a patient is unable to make decisions for themselves, those conversations with the family members and caregivers become very important to know if there is some dementia or something, but there is still a place for anticoagulation, even in those patients. And you're still preventing a stroke even in those patients.

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Dr. Allred: You know, when it comes to anticoagulation and talking to patients and their family, education is so valuable in helping them realize the reasons that we do what we do. When you think about the greatest risk and the greatest benefit of anticoagulation, what comes to mind and what data do you use with patients to tell that story?

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Fenton: I think with anticoagulation, the greatest risk for any anticoagulation is an increased risk of bleeding and really specifically, gastrointestinal bleeding. There is a real-world Danish study in 2017 looking at bleeding risk on anticoagulation and 4.5% of patients had a major bleeding event, and they defined a major bleeding event as a hospitalization for bleeding. And in those patients that were hospitalized for bleeding, just a little less than half, 42% of those were from gastrointestinal bleeds and then followed by urinary at 19 % and intracranial at 17 %. So really, being aware of the GI bleeding risk and educating patients about looking for black tarry stools, looking for frank blood in the stool, looking for dark urine, you know those kinds of things educating the patients on the front end when starting anticoagulation is really important. So that's really the greatest risk. Really, the greatest benefit for anticoagulation is ischemic stroke prevention. In a Swedish cohort study in 2012, looking at the net clinical benefit of warfarin, the investigators looked at a composite of all-cause mortality, ischemic strokes and intracranial hemorrhage, versus a patient's bleeding risk using the HAS-BLED Score, and what they found in that study is that even at a very high HAS-BLED Score, which would indicate a high bleeding risk, a high risk of intracranial hemorrhage, anticoagulating with warfarin was always favored. The survival rate was much higher in the anticoagulated group than with the non-anticoagulated group across all categories of stroke and bleeding risk. And so that's really what I like to tell patients is that there is this real risk of bleeding. It happens, and it's always unfortunate when it does, but anticoagulation is usually, almost always, favored to prevent all-cause mortality.

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Dr. Allred: I think it's really important that you have this data and that, as providers, we believe it. We share it. We use it. Because the reality is when you're busy in practice, patients don't come to your office saying, "Hey, Ricky Fenton, thanks for that stroke I didn't have today because I was on a blood thinner." They don't get that kind of feedback, but if your patient has a bleeding event, you absolutely get that feedback. And so, as you talked about earlier, some of the perceived barriers that we have as providers, part of it is the reinforcement of what you hear about the bleeds, but again, patients aren't sending you thank you notes for the stroke that they didn't have today. And so, recognizing the data and the importance of what you're doing, I think, helps us continue to do the right thing.

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Fenton: Mostly, you hear about how expensive the medicine is that usually the phone calls that you get.

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Dr. Allred: That's right. That's right.

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Dr. Allred: So, you mentioned HAS-BLED score already, but when we think of best practices and utilizing existing risk assessment tools, standardization, validated scales for bleeding, frailty, forgetfulness, falls, how do you use these type of scales and best practices in your practice?

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Fenton: Specifically for bleeding risk and assessing for stroke risk, The CHA₂DS₂-VASc score is kind of the gold standard right now for assessing that risk of stroke, and so patients get a point for having a

history of hypertension, diabetes, peripheral vascular disease, heart failure, female gender and being 65 or older. And they get an additional point for being 75 years old or older and then two points for a history of stroke or TIA. And the higher the CHA₂DS₂-VASc score, the higher the stroke risk. And so, I really like showing patients what their CHA₂DS₂-VASc score is and also the associated adjusted percent risk of stroke per year, because that's something that the patient can kind of wrap their head around. It's a tangible number, they can say, "OK, this is what my stroke risk is, and this is why my provider is recommending anticoagulation." So as far as stroke risk, the CHA₂DS₂-VASc score is kind of a gold standard. In assessing bleeding risk, the HAS-BLED score is a good one to use, and it has the best predictive ability for clinically relevant bleeding, moreso than other bleeding assessment tools like ATRIA, ORBIT, or HEMORR₂HAGES. So that's a good one to use. Now, a high HAS-BLED score does not exclude a patient from taking anticoagulation. What it does mean is that a patient should be monitored more closely and that risk factors for bleeding like hypertension, like alcohol consumption, should be treated aggressively in those type of patients.

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Dr. Allred: I think part of the problem with using scores like HAS-BLED is that HAS-BLED is just as predictive of a person's risk for stroke as it is their risk for bleeding. The higher your HAS-BLED score, the higher your likelihood of stroke is. And so, again, you're walking that tightrope with patients and trying to balance the risk for bleeding and the risk for stroke. End of the day, I think it's a conversation with patients, being willing to be open and honest with patients to say, "Hey, here's what we know, and here's what we don't know. Based on this information, I believe the best thing for you would be anticoagulation. Here's why." And then hearing from their end and what their thoughts are, right? It's a shared making-decision process that we have to go through with each patient.

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Fenton: You know, it really is a shared decision making, and many of my older patients sometimes struggle with that. You know, they're from a generation where medicine was a little bit more patriarchal. I'm going to tell you what to take, and you're going to take it. As opposed to now it's: Here's this medicine, this apixaban I want to prescribe for you. I think it will help you. The data shows that it is very likely to help you. You could have a bleed, but it's much less likely than your risk of stroke. What do you think about that? And I get this deer in the headlights: You're asking me what I think about this? But still engaging those patients and educating them, letting them see some of the data and you describing your thought process to them gives them a lot more buy-in into taking the medicine.

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Dr. Allred: Very good. Ricky Fenton, thank you so much for joining today. You are a real, world expert on atrial fibrillation management and anticoagulation care. And thanks for sharing your best practices and insights on fear of bleeding with us today.

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Fenton: Thank you. Great to be here.

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Dr. Allred: Thank you for joining us, and please come again to listen to the other episodes in our series *The Four F's of AFib*. This series was produced through the support of the BMS Pfizer Alliance. To learn more about the American Heart Association and its atrial fibrillation quality improvement efforts, visit heart.org/quality.