SHORT-TERM RISK OF BLEEDING DURING HEPARIN BRIDGING AT INITIATION OF VITAMIN K ANTAGONIST THERAPY IN MORE THAN 90,000 PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION MANAGED IN OUTPATIENT CARE

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BACKGROUND

- Few studies have investigated bridging risks during vitamin K antagonist (VKA) initiation, in particular in outpatient settings.
- There is overall consensus in favour of a bridging therapy prior to urgent cardioversion in patients with life-threatening haemodynamic instability caused by new-onset NVAF.
- The recommendation in guidelines is less clear for those with stable NVAF who do not require rapid anticoagulation.
- In real-life conditions, a bridging regimen is commonly used in those with a low stroke risk.1-3 This practice is not supported by evidence.

OBJECTIVES

To assess the safety and effectiveness of a bridging regimen during the initiation of VKA therapy in NVAF patients managed in outpatient care.

METHODS

Sources
- French health insurance claims databases [SNIIRAM]
- French hospital discharge database (PMSI)

Study population
Patients starting a VKA (warfarin, rivaroxaban, or acenocoumarol) dispensed from a community pharmacy between January 2010 and November 2014 for NVAF, aged 18 years or over.

Comparison groups
- Bridging therapy. SC bridging agent (LMWH, fondaparinux, UFH) + VKA
- Reference group: VKA only

Outcomes (ICD-10 codes)
- Bleeding: Intracranial, gastrointestinal, other
- Arterial thromboembolism: Ischemic stroke, systemic embolism (IS/SE)

Statistical analysis
- Multivariate adjusted hazard ratios (HR) with 95% confidence intervals (CI) were estimated using Cox models.
- Duration of follow-up: first and two following months of anticoagulation.
- Covariates: sex, age, INR, echocardiography index, type of VKA therapy, type of VKA prescribers, concomitant medications (CHA2DS2-VASc and HAS-BLED scores), etc.

RESULTS

Study population: 90,826 individuals (mean age of 72 years, 50% women), 30% with bridging therapy.

Figure 1. Multivariable adjusted association of bridging therapy with bleeding and IS/SE risks

- Table showing HRs and 95% CIs for bleeding and IS/SE risks with and without bridging therapy.

Figure 2. Multivariable adjusted association of bridging therapy with one-month bleeding risk according to sex

- Table showing HRs and 95% CIs for bleeding according to sex with and without bridging therapy.

CONCLUSION

At VKA initiation for NVAF, managed in ambulatory settings, bridging therapy is associated with a higher risk for bleeding and a similar risk for arterial thromboembolism as compared with no bridging therapy.

REFERENCES


Declaration of Interest: Authors have nothing to disclose.

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