Published in final edited form as:

Can J Cardiol. 2018 July ; 34(7): 945.e3. doi:10.1016/j.cjca.2018.03.016.

Stroke Prevention for High-Risk Atrial Fibrillation in the Emergency Setting: Differences Between Canada and the United States

Bory Kea, MD, MCR, FACEP, Benjamin C. Sun, MD, MPP, and David R. Vinson, MD

To the Editor:

We commend Dr Atzema for her excellent and highly relevant discussion of the role and barriers of ED physicians prescribing oral anticoagulants (OACs) at discharge to prevent strokes in patients with high-risk atrial fibrillation and flutter (AFF).¹ A recent US qualitative study of emergency physicians identified a similar list of prescribing barriers with 1 addition: the need for ED-specific AFF guidelines.² The rationale is that with certain acute conditions, such as AFF, both the ED patient population and the disease-management questions differ from those encountered by outpatient providers sufficiently to warrant ED-focused guidance. This would require the involvement of emergency physicians on the writing committees, as done by the Canadian Cardiovascular Society for their ED-management algorithm for AFF.³ We hope that their US and European counterparts will follow suit.

Another difference between US and Canadian practices regards follow-up after the ED encounter. The Canadian College of Physicians and Surgeons of Ontario “specifically states that if a physician initiates a prescription for a patient, they should reassess the patient at a later date, to confirm its safety and efficacy.”¹ No similar expectation is placed on US emergency physicians to re-evaluate patients for whom we start long-term medications.

On the follow-up question, Dr Atzema touted Kaiser Permanente Northern California as a role model, in which 85% of stroke-prone patients with AFF discharged home from the emergency department were evaluated within 30 days by another physician, usually the primary care provider.⁴ This high rate of follow-up may explain, in part, the relatively low frequency of ED OAC prescribing (27%) to high-risk patients who presented without OACs. In explaining their reasoning for withholding thromboprophylaxis, physicians often said they were deferring the decision to their outpatient colleagues. This sharing of mutual responsibility is fitting in an integrated care delivery system in which post-ED follow-up is easy to ensure, if not by primary care, then by an engaged phone-based pharmacy-led OAC service. In settings where post-ED follow-up is more difficult to obtain, deferring initiation

kea@ohsu.edu.

Disclosures

The authors have no conflicts of interest to disclose.

of OACs can expose patients to risk of stroke and has been associated with adverse outcomes, as Dr Atzema explains.

Many of the barriers that Dr Atzema explores can be addressed in a variety of care-delivery systems by bringing together the various stakeholders, including emergency physicians, cardiologists, outpatient providers, and pharmacists. As with many chronic conditions, optimal care requires multispecialty collaboration. Together, the barriers mentioned by Dr Atzema can be overcome.

References

1. Atzema CL. Stroke prevention for high-risk atrial fibrillation in the emergency setting: the emergency physician perspective. *Can J Cardiol* 2018;34:125–31. [PubMed: 29407006]
2. Kea B, Robinson C, Zhu A, Livingston J, Sun B. Barriers to prescribing stroke prophylaxis for atrial fibrillation in the emergency department: a qualitative provider perspective [abstract]. *Ann Emerg Med* 2017;70:S119.
3. Stiell IG, Macle L. Canadian Cardiovascular Society atrial fibrillation guidelines 2010: management of recent-onset atrial fibrillation and flutter in the emergency department. *Can J Cardiol* 2011;27:38–46. [PubMed: 21329861]
4. Vinson DR, Warton EM, Mark DG, et al. Thromboprophylaxis for patients with high-risk atrial fibrillation and flutter discharged from the emergency department. *West J Emerg Med* 2018;19:346–60. <https://doi.org/10.1016/j.cjca.2018.03.016> [PubMed: 29560065]