Anti-coagulation in Atrial Fibrillation: Warfarin *Vs* NOACs

I read with interest the editorial: "Paradigm Shift in Anti-Coagulating Patients with Non-Valvular Atrial Fibrillation" by Prof. Bushra Moiz in your prestigious journal.[1] Scientific literature about anti-coagulation in atrial fibrillation also resonates with the facts stated in the editorial. I wish to add to this topic by sharing some important points. Firstly, it is recommended to commence warfarin initially (whether for atrial fibrillation or venous thrombo-embolism) with unfractionated heparin or low molecular weight heparin (LMWH) until international normalized ratio (INR) becomes therapeutic,[2] which is also a reason some patients prefer novel oral anti-coagulents (NOACs) over warfarin. Secondly, if anti-coagulation in atrial fibrillation is contraindicated, then it is important to offer a combination of aspirin and clopidogrel.[3] Thirdly, there is limited data regarding the comparison between warfarin and NOACs, looking at effectiveness and safety, in Asians,[4] more so amongst the population of Indian subcontinent. So, it is imperative that a multi-centre national research effort is undertaken to bring out the facts regarding our population cohort.

CONFLICT OF INTEREST:
Author declared no conflict of interest.

AUTHOR'S CONTRIBUTION:
BHM: Conceived, written and submitted the manuscript.

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Author's Reply:

I thank the reader for taking interest in the editorial "Paradigm shift in anti-coagulating patients with non-valvular atrial fibrillation" published in JCPSP, January 2019 issue. The reader has raised several important issues regarding novel oral anticoagulants (NOACs) for which my response is as follows:

1. Vitamin K-antagonists (VKAs) take 48 to 72 hours for their onset of action and, therefore, require bridging with heparin for anticoagulating patients. Unlike VKAs, anticoagulation effect of NOACs is observed within 3 hours of their administration; hence, they are given directly without prior heparinization.[1]

2. We should be mindful of the fact that dual antiplatelet therapy (DAPT) and oral anticoagulation bear a comparable bleeding risk. Therefore, a patient who is not a candidate for oral anticoagulation because of bleeding risk cannot be a candidate for DAPT. DAPT may be a reasonable alternative to therapy with aspirin alone in the occasional high-risk patient with atrial fibrillation who cannot be treated with anti-coagulation because of patient or physician preferences.[2] With the availability of the NOAC agents, this condition should be extremely exceptional.

3. The three clinical trials for evaluating safety and efficacy of NOACs randomised a total of 44,563 subjects. The studies were global and multi-centric; for example, in dabigatran trial, patients were recruited from 951 clinical centres residing in 44 countries including India.[3] Similarly, 14,264 patients were enrolled in the double-blind multi-national study on rivaroxaban and included patients from Asian countries such as China, India, Turkey, Taiwan, Hong Kong, Thailand and so on.[4] These studies did not show differences in their endpoints for ethnicity. In light of these evidences and in my personal experience, NOACs are effective in our population.

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