Submission to Review of Anticoagulation Therapies in Atrial Fibrillation

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Introduction

I am a General Practitioner and have been working in Toowoomba for the past 9 years. As such, I have had extensive experience treating patients with atrial fibrillation. This submission is not a detailed scientific or economic one, but one based on clinical experience and written from the view of both GP and patient.

Why anticoagulate?

The answer is simple. People with Atrial Fibrillation (AF) are at a higher risk of having a stroke (CVA). Some people with AF are at higher risk than others with AF due to other clinical factors such as heart disease or age.

Strokes are bad for two main reasons. Strokes either cause death or permanent disability. People don't like the idea of death, but they probably fear permanent disability much more. The permanent disability from a CVA ranges from mild (slurred speech or weakness of arms or legs) to severe (bed bound due to paralysis of one side, not able to swallow, not able to communicate).

In a sense patients have no real choice. They either accept anticoagulation treatment or they take a risk in having a stroke and being permanently disabled.

From the GP perspective it is like waving a big stick at patients. It is like saying: "If you don't take this medication, you'll either die or be permanently disabled and not be able to live independently."

Choices, Side Effects and Lifestyle

There are two main PBS-subsidised options for anti-coagulation in AF.

1. **Aspirin**. This reduces the risk of stroke by a small amount. There is one dose for all patients, no monitoring required, no real lifestyle modification is required, and generally the treatment is well tolerated.

2. **Warfarin.** This reduces the risk of stroked by a much greater degree than aspirin. However, this greater efficacy comes at a greater cost. Dosage is different for all patients, and is affected by genetic and lifestyle factors. Blood tests have to performed regularly, at least monthly or even more, to check the INR is in the right range. If the INR is too low, then the patient is at risk of stroke, but if the INR is too high, the patient is at risk of bleeding, which can be life threatening. There is a real

risk for patients taking warfarin, that their level is ineffective or dangerous. Patients have to be very careful with their diet and other medications otherwise the INR can become too high or too low. There are life and death issues here, as well as the everyday issues like choices of diet.

I think it is clear that the two options available currently are not ideal. One is not effective enough, and the other is dangerous at worst or very difficult to live with at best. For the above reasons, patients generally dislike taking warfarin, and GPs generally don't like it either. Another option is required.

Another option

There is no anticoagulant without risk or side-effect. By definition, an anti-coagulant will cause an extra risk of bleeding.

However, an ideal alternative to warfarin would have the following features:

1. One dose for all patients
2. Efficacy comparable with warfarin
3. Risk of bleeding comparable or better than warfarin
4. General tolerability comparable with warfarin
5. Minimal interactions with other medications
6. No interaction with diet

I believe the new anti-coagulants do possess all these features.

Opinion

I will leave the detailed scientific and economic arguments to others, though I believe there are strong arguments to support the use of the newer agents. I treat patients one by one. I know what patients want.

1. They want the security of knowing their stroke risk is reduced
2. They want to be able to eat what they want when they want
3. They want to be free from worrying about whether their level of anti-coagulation is too low or too high
4. They want to be free from regular blood tests
5. They want to know the side effects are not worse than the condition being treated/prevented

Patient's quality of life is very important, especially when we are treating people who don't feel sick. Patients genuinely dislike or hate taking warfarin. As a GP, I am very excited at the prospect of being able to give patients a choice - and I believe a better choice. I urge the review committee and the Government to approve the PBS-listing of these medications for patients with AF.