Use of oral anticoagulants in African-American and Caucasian patients with atrial fibrillation: is there a treatment disparity?

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Abstract: Atrial fibrillation (AF) is a very common cardiac arrhythmia, and its prevalence is increasing along with aging in the developed world. This review discusses racial differences in the epidemiology and treatment of AF between African-American and Caucasian patients. Additionally, the effect of race on warfarin and novel oral anticoagulant use is discussed, as well as the role that physicians and patients play in achieving optimal treatment outcomes. Despite having a lower prevalence of AF compared with Caucasians, African-Americans suffer disproportionately from stroke and its sequelae. The possible reasons for this paradox include poorer access to health care, lower health literacy, and a higher prevalence of other stroke-risk factors among African-Americans. Consequently, it is important for providers to evaluate the effects of race, health literacy, access to health care, and cultural barriers on the use of anticoagulation in the management of AF. Warfarin-dose requirements vary across racial groups, with African-American patients requiring a higher dose than Caucasians to maintain a therapeutic international normalized ratio; the novel oral anticoagulants (dabigatran, rivaroxaban, and apixaban) seem to differ in this regard, although data are currently limited. Minority racial groups are not proportionally represented in either real-world studies or clinical trials, but as more information becomes available and other social issues are addressed, the treatment disparities between African-American and Caucasian patients should decrease.

Keywords: antithrombotic, atrial fibrillation, stroke, warfarin, race

Introduction
Atrial fibrillation (AF) is highly prevalent in the US, and with the incidence of AF continuing to grow, the costs of treatment are also increasing.1 Stroke is a serious but preventable complication of AF, but therapeutic anticoagulation for the prevention of stroke can lead to an increased risk of bleeding;2,3 therefore, clinicians must be aware of the optimum benefit:risk ratio for the treatment of these patients. Despite African-Americans having a lower incidence of AF than Caucasians, the burden remains high, with one in nine African-Americans receiving a diagnosis before 80 years of age.4

The objectives of this review are: 1) to provide clinicians with an overview of AF and the importance of stroke prevention; 2) to discuss stroke prevention in underrepresented patient populations, particularly African-American patients; 3) to highlight knowledge gaps related to stroke prevention in underrepresented patient populations; 4) to discuss racial differences in the prevalence of AF and response to anticoagulants; and 5) to discuss the role clinicians may play in the care of patients with AF.
Description, prevalence, and consequences of atrial fibrillation and stroke

AF, defined as an abnormal rate or rhythm of the heart, is the most common type of arrhythmia. In patients with AF, multiple disorganized electrical impulses lead to rapid and chaotic contractions that prevent the atria from contracting properly, and as a result blood does not travel normally through the heart and vasculature. Although many patients with AF do not experience any symptoms, some patients can experience heart palpitations, lack of energy, dizziness, or shortness of breath. Additionally, AF can lead to an increase in the risk of stroke by allowing clots to form within the heart, which may travel to the brain. Nonvalvular AF (NVAF), defined as AF in the absence of rheumatic mitral valve disease, a prosthetic heart valve, or mitral valve repair, is the most common type of AF.3,5

The prevalence of AF is increasing along with aging in the developed world, and AF is associated with a fivefold-increased risk of stroke, with a fifth of all strokes associated with AF.6,7 Strokes are classified by the type of brain injury (eg, ischemic, hemorrhagic) and the type and location of the vascular lesion.8 Ischemic strokes are by far the more common type, causing over 80% of all strokes, and 20% of all ischemic strokes result directly from AF.9,10 The absolute risk of stroke in patients with AF can vary 20-fold, and this risk is dependent on the number of additional risk factors that a patient may have, such as heart failure, hypertension, older age, diabetes, prior stroke, vascular disease, and female sex.2,11,12 Strokes related to AF tend to be associated with greater morbidity and mortality compared with non-AF-related strokes;13,14 however, the risk of stroke can be reduced with anticoagulant treatment.2,3,6,15

The total health care cost of all strokes in the US was $53.9 billion in 2010, and of that figure, the cost of AF-related strokes was estimated to range from $3.2 billion to nearly $13 billion. By 2050, the economic burden of strokes related to AF in the US is estimated to approach $30 billion.16

Are there racial/ethnic differences in the epidemiology of AF?

The incidence of AF is lower in African-Americans than in Caucasians; the reasons for this remain unclear.17,21 It has been suggested that the incidence of AF in African-Americans may be underreported, and that the number of African-Americans with AF might be higher if more sensitive methods for detection were used.18,20,22 A study investigating racial differences in the incidence of AF examines that for all associations examined, risk factors were similar in African-Americans and Caucasians, except for left ventricular posterior-wall thickness, which was more strongly associated with AF in African-Americans.23

Conversely, the relative rate of stroke is higher in African-Americans than in Caucasians,21 which appears to contradict the strong association between stroke and AF. One possible reason for the higher incidence and mortality rate of stroke in African-Americans may be the higher prevalence of other stroke-risk factors, including hypertension, obesity, and diabetes, in this population.17,19

In general, cryptogenic stroke (defined as ischemic stroke without a well-defined etiology) accounts for 34%–54% of ischemic strokes in most modern stroke registries and databases.24–29 Additionally, a population-based study showed that the rate of cryptogenic stroke in African-Americans was approximately double the rate observed in Caucasians (risk ratio 1.9, 95% confidence interval 1.5–2.3).28 Use of sophisticated heart-monitoring techniques like implanted loop recorders might detect unrecognized paroxysmal AF as the cause of some cryptogenic strokes in African-Americans.30 This suggestion is further supported by results from the REGARDS (REasons for Geographic And Racial Differences in Stroke) study, a national, population-based, longitudinal study of African-American and Caucasian adults aged at least 45 years in the US, which found that the odds of an association of stroke with race (African-American versus Caucasian) and AF progressively decreased with increasing test sensitivity.22

Treatment of AF: reducing the risk of stroke with oral anticoagulants

There are many treatment options for patients with AF that aim to control irregular heart rate or prevent stroke.31 Options include cardioversion, ablation, and pharmacological agents, which may be used for rate or rhythm control.32 Additionally, antithrombotic therapy can be used to reduce the risk of stroke in patients with AF, and that is the focus of this article.

Antithrombotic therapy to prevent thromboembolism is recommended for all patients with AF, except those with lone AF or contraindications, and the selection of an antithrombotic agent should be based on absolute risks of stroke and bleeding and the relative risk and benefit for a given patient.31

Guidelines for oral anticoagulant use in patients with AF in both the US and Europe are summarized in Table 1;2,3,6,33,34
Table 1: Guideline recommendations on the use of warfarin and novel oral anticoagulants for the prevention of stroke in patients with nonvalvular atrial fibrillation

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guidance by risk</th>
<th>Guidance by agent</th>
<th>Guidance by renal function</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHA/ACC/HRS</td>
<td>CHA$<em>2$DS$</em>{-}$vASc score</td>
<td>Warfarin-treated: determine INR weekly, then monthly when stable</td>
<td>Evaluate prior to NOAC initiation and annually thereafter (or when clinically indicated)</td>
</tr>
<tr>
<td>AHA/ASA</td>
<td>• Warfarin (INR 2.0–3.0) in all patients at high risk and many at moderate risk of stroke</td>
<td>Warfarin, dabigatran, apixaban and rivaroxaban indicated for first and recurrent stroke prevention in NVAF patients</td>
<td>Use warfarin in patients with NVAF with CHA$<em>2$DS$</em>{-}$vASc $\geq 2$ and end-stage CKD (CrCl $&lt; 15$ mL/min) or undergoing hemodialysis</td>
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<tr>
<td></td>
<td>• Aspirin in patients at low risk and some moderate risk, based on patient preference, bleeding risk, and access to monitoring</td>
<td>Dabigatran useful alternative to warfarin in patients with AF and risk factors for stroke or SE who do not have prosthetic heart valve or hemodynamically significant valve disease, severe renal failure (CrCl $&lt; 15$ mL/min), or advanced liver disease</td>
<td>Consider reduced NOAC dose in patients with NVAF with moderate-to-severe CKD and CHA$<em>2$DS$</em>{-}$vASc $\geq 2$ (safety and efficacy not established)</td>
</tr>
<tr>
<td></td>
<td>• If VKA cannot be used in patients with AF when recommended, use dabigatran, rivaroxaban, or apixaban</td>
<td>Apixaban 5 mg BID is an alternative to warfarin (or aspirin in patients unable to take a VKA), in patients with NVAF who have $\geq 1$ additional risk factor and $\geq 1$ of the following characteristics: age $\geq 80$ years, weight $\leq 60$ kg, serum creatinine $\leq 1.5$ mg/dL</td>
<td>Can use dabigatran 150 mg BID instead of warfarin for the prevention of first and recurrent stroke in NVAF patients with $\geq 1$ additional risk factor who have CrCl $&gt; 30$ mL/min</td>
</tr>
<tr>
<td></td>
<td>• Apixaban 2.5 mg BID is an alternative to warfarin (or aspirin in patients unable to take a VKA) in patients with NVAF who have $\geq 1$ additional risk factor and $\geq 2$ of the following criteria: age $\geq 80$ years, weight $\leq 60$ kg, and serum creatinine $\leq 1.5$ mg/dL</td>
<td>Rivaroxaban (20 mg/day) is reasonable in NVAF patients at moderate-to-high risk of stroke (prior history of TIA, stroke, or SE, or $\geq 2$ additional risk factors)</td>
<td>On the basis of PK data, the use of dabigatran 75 mg BID in patients with NVAF and $\geq 1$ additional risk factor who have a low CrCl (15–30 mL/min) (based on PK data only; safety and efficacy not established)</td>
</tr>
<tr>
<td></td>
<td>• Rivaroxaban, 20 mg QD, or lower dose (15 mg QD) in patients with a high bleeding risk (HAS-BLED $\geq 3$) or moderate renal impairment (CrCl 30–49 mL/min)</td>
<td>• NOACs not recommended in patients with severe renal impairment (CrCl $&lt; 30$ mL/min)</td>
<td></td>
</tr>
<tr>
<td>ESC</td>
<td>CHA$<em>2$DS$</em>{-}$vASc score</td>
<td>If unable to maintain INR, use dabigatran, rivaroxaban, or apixaban</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $\geq 2$: use VKA (INR 2.0–3.0), dabigatran, rivaroxaban, or apixaban, unless contraindicated</td>
<td>Where OAC recommended, use an NOAC rather than VKA for most NVAF patients, based on net clinical benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $\leq 1$: consider VKA (INR 2.0–3.0), dabigatran, rivaroxaban, or apixaban, based on bleeding risk and patient preference</td>
<td>Use dabigatran 150 mg BID, or lower 110 mg BID dose (in Europe) in patients aged $\geq 80$ years, using concomitant interacting drugs (eg, verapamil), with a high bleeding risk (HAS-BLED $\geq 3$) or moderate renal impairment (CrCl 30–49 mL/min)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If VKA cannot be used in patients with AF when recommended, use dabigatran, rivaroxaban, or apixaban</td>
<td>Use rivaroxaban 20 mg QD, or lower dose (15 mg QD) in patients with a high bleeding risk (HAS-BLED $\geq 3$) or moderate renal impairment (CrCl 30–49 mL/min)</td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
Table 1 (Continued)

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guidance by risk</th>
<th>Guidance by agent</th>
<th>Guidance by renal function</th>
</tr>
</thead>
</table>
| ACCP<sup>a</sup> | CHADS<sub>2</sub> score  
  ○ 0: no therapy rather than antithrombotic therapy; for those who choose therapy, use aspirin (75–325 mg QD)  
  ○ 1: OAC rather than no therapy, or aspirin; in patients unable to take OACs, use combination therapy with aspirin and clopidogrel  
  ○ ≥2: OAC rather than no therapy, or combination therapy; for patients unsuitable for OACs, use combination therapy rather than aspirin | When OACs recommended, dabigatran 150 mg BID suggested rather than VKA (INR 2.0–3.0) | No recommendation provided by renal function |
| ASA/AHA<sup>b</sup> | Patients with valvular AF with CHA<sub>DS</sub><sup>2</sup>-vASc ≥2 and acceptably low risk of hemorrhage: use long-term VKA (INR 2.0–3.0)  
  ○ NVAF: CHA<sub>DS</sub><sup>2</sup>-vASc score  
  ○ ≥2 OACs recommended, including warfarin, dabigatran, apixaban, and rivaroxaban  
  ○ 1: no antithrombotic therapy, anticoagulant therapy, or aspirin may be considered  
  ○ 0: no antithrombotic therapy | Selection of OAC should be based on individual risk factors, cost, tolerability, patient preference, potential drug interactions, and other clinical characteristics | No recommendation provided by renal function |

Note: *Guidelines reflect the fact that apixaban had not been approved at the time of publication.

Abbreviations: AF, atrial fibrillation; ACC, American College of Cardiology; ACCP, American College of Chest Physicians; AHA, American Heart Association; ASA, American Stroke Association; BID, bis in die (twice daily); CKD, chronic kidney disease; CrCl, creatinine clearance; ESC, European Society of Cardiology; HRS, Heart Rhythm Society; INR, international normalized ratio; NVAF, nonvalvular atrial fibrillation; OAC, oral anticoagulant; PK, pharmacokinetic; QD, quaque die (once daily); SE, systemic embolism; TIA, transient ischemic attack; NOAC, novel oral anticoagulant; VKA, vitamin K antagonist.
however, it should be noted that some of these were published prior to the approval of apixaban and edoxaban.

**Differences in treatment by race/ethnicity**

A treatment disparity exists between African-American and Caucasian patients; however, none of the current guidelines for the prevention of stroke in patients with AF states whether any amendments to treatment should be made based on racial differences.\(^2\,\,3\,\,5\,\,6\,\,15\,\,35\)

African-Americans are undertreated, and thus are at an increased risk of stroke.\(^18\,\,36\,\,37\) Differences in access to health care may account in part for lower rates of AF detection in African-Americans than in Caucasians. In the REGARDS study, race and income were both found to be independent predictors of patients being aware that they had AF, with African-Americans being less than a third as likely as Caucasians to be aware.\(^18\) Additionally, this study found that race was an independent predictor of warfarin treatment, with the odds of African-American patients being treated with warfarin only a quarter as great as the odds for Caucasians.\(^18\) A study using a multiethnic stroke-free cohort of hospitalized patients with nonrheumatic AF found that although the percentage of time on warfarin did not differ by race/ethnicity, the median percentage of time that patients spent within the therapeutic range (international normalized ratio [INR] 2.0–3.0) was lower in African-American than Caucasian patients (47.8% versus 55.2%).\(^38\) Additionally, an analysis of the AFFIRM (Atrial Fibrillation Follow-up Investigation of Rhythm Management) study population found that ethnic minority status was an independent predictor of poor INR control, and race was subsequently included in a scoring system used to predict poor INR control in patients with AF treated with warfarin (SAMe-\(TT\)\(_2\), female sex, age <60 years, medical history [more than two comorbidities], treatment [with interacting drugs], tobacco use [doubled], and race [doubled]).\(^39\)

Results from the Cardiovascular Health Study, a prospective, US-based cohort study of risk factors for cardiovascular disease in community-dwelling adults aged over 65 years, found that African-Americans have poorer access to health care than Caucasians, and were more likely to have no supplemental insurance coverage.\(^40\) A study investigating the differences in the type of hospital where minorities and low-income patients received care found that African-American patients and those living in low-income areas more frequently received care in teaching and safety-net hospitals and hospitals with higher bed counts, more intensive care unit beds, and emergency department volume, compared with Caucasians and those living in high-income areas.\(^41\) Crude inpatient-mortality rates for patients hospitalized with acute ischemic stroke were significantly lower in African-American than Caucasian patients across all three socioeconomic status cohorts (low, medium, and high income); however, African-American patients were younger, and fewer had any form of AF.\(^41\) When adjusted for risk, inpatient mortality was similar in African-American and Caucasian patients, but was significantly higher in low-income-area patients than in high-income-area patients.\(^41\) Caucasian patients were more likely than African-American patients to arrive by emergency medical services, to be evaluated by a stroke team, and to have a documented National Institutes of Health Scale score.\(^42\) Additionally, African-Americans were less likely to have visited a physician 1 year after their stroke than Caucasians.\(^43\) Together, these results highlight the socioeconomic differences between African-American and Caucasian patients, and suggest that there is a need for better access to health care and improvements to education programs for African-American patients.

**Warfarin**

For over 50 years, warfarin has been the standard of care for the prevention of stroke in patients with AF, and remains the most commonly used anticoagulant in this population. A meta-analysis of six randomized controlled trials showed that warfarin reduced the risk of all strokes (ischemic and hemorrhagic) by 64% versus placebo.\(^44\) Although highly efficacious for the prevention of stroke in patients with AF, warfarin has many limitations, including an increased risk of bleeding, multiple drug and food interactions, and the need for regular monitoring and dose adjustment to maintain treatment within the narrow therapeutic range (INR 2.0–3.0).\(^45\) These limitations can result in the underuse of warfarin.\(^46\)

It has been shown that warfarin-dose requirements vary across racial/ethnic groups, with African-American patients requiring a higher dose than Caucasian patients to maintain an INR between 2.0 and 3.0.\(^47\) A chart review comparing older African-American and Caucasian patients found that although the dose of warfarin required to maintain a therapeutic INR decreased with age, African-Americans required a higher maintenance dose than Caucasians.\(^48\) Therefore, strategies for initiating warfarin therapy based on studies of patients of European ancestry could result in insufficient anticoagulation of older African-American patients, thereby potentially increasing their risk of thromboembolism.\(^48\)

Several studies have investigated the treatment disparity between African-American and Caucasian patients.\(^49\,\,51\)
A cohort study of Medicare beneficiaries with AF found that the use, monitoring, and effectiveness of warfarin therapy were suboptimal, especially in African-American patients. One possible effect of this is that African-American patients with AF are at greater risk of warfarin-related intracranial hemorrhage. Additionally, African-American patients were significantly less likely than Caucasians to fill a warfarin prescription for newly incident NVAF or to receive a warfarin prescription at hospital discharge.

Several genetic factors have recently been identified as possible reasons why African-American patients require a higher dose of warfarin. Dose variability is affected by

Table 2 Comparison of pharmacokinetic/pharmacodynamic interactions and dosing of warfarin and novel oral anticoagulants

<table>
<thead>
<tr>
<th>Warfarin&lt;sup&gt;®&lt;/sup&gt;</th>
<th>Dabigatran&lt;sup&gt;®&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mode of action</strong></td>
<td>Inhibitor of factors II, VII, IX, and X, and the anticoagulant proteins C and S</td>
</tr>
<tr>
<td><strong>Route of administration</strong></td>
<td>Oral or IV</td>
</tr>
<tr>
<td><strong>Approved dose (US)</strong></td>
<td>Target INR 2.0–3.0</td>
</tr>
<tr>
<td><strong>Half-life</strong></td>
<td>40 hours</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Daily INR determination upon initiation until stable INR 2.0–3.0 achieved; INR every 1–4 weeks thereafter</td>
</tr>
<tr>
<td><strong>Reversal</strong></td>
<td>• Vitamin K</td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reasons for dose reductions</strong></td>
<td>Dose and administration individualized to each patient</td>
</tr>
<tr>
<td><strong>Food interactions</strong></td>
<td>Foods high in vitamin K (eg, kale, spinach, turnip greens, scallions, brussels sprouts, raw broccoli, grapefruit juice, prunes, asparagus, avocado, beef liver)</td>
</tr>
<tr>
<td><strong>Drug interactions</strong></td>
<td>Monitor INR closely if used concurrently with inhibitors or inducers of: CYP3A4, CYP2C9, or CYP1A2; Closely monitor concurrent use with drugs that can increase bleeding risk</td>
</tr>
<tr>
<td><strong>Effect of race on treatment</strong></td>
<td>Asian patients may require lower initiation and maintenance doses of warfarin</td>
</tr>
</tbody>
</table>

Abbreviations: aPPCs, activated prothrombin complex concentrate; anti-FXa, anti-factor Xa; aPTT, activated partial thromboplastin time; BID, bis in die (twice daily); CrCl, creatinine clearance; ECT, ecaril clotting time; INR, international normalized ratio; IV, intravenous; NSAID, nonsteroidal anti-inflammatory drug; rFVIIa, recombinant factor VIIa; PCC, prothrombin complex concentrate; P-gp, p-glycoprotein; PK, pharmacokinetic; PT, prothrombin time; QD, qua die (once daily); SNP, single-nucleotide polymorphism; TT, thrombin time.
single-nucleotide polymorphisms (SNPs) in genes encoding cytochrome P450 (CYP)-2C9, which metabolizes the S-enantiomer of warfarin, and vitamin K epoxide reductase complex 1, which is the target enzyme for warfarin. These genotypes explain up to 30% of total variability in warfarin-dose requirements in people of European or Asian origin; however, they explain substantially less genetic variability in African-Americans (10%). A genome-wide association study identified a novel association between an SNP in CYP2C9 (rs12777823) and warfarin-dose variability in African-American patients. Patients carrying this SNP require a significantly lower stable dose of warfarin than those without the variant.

### Rivaroxaban

**Factor Xa inhibitor**

- Oral (tablet or nasal gastric tube) taken with food
- 5–9 hours

**Cannot be monitored using standard laboratory tests; PT, aPTT, and Hemtest (Hemtest Laboratories, St Louis, MO, USA) are prolonged dose-dependently; anti-FXa activity is also influenced by rivaroxaban**

- **A specific antidote for rivaroxaban is not available**
- **Because of high plasma protein binding, rivaroxaban is not expected to be dialyzable**
- **Protamine sulfate and vitamin K are not expected to affect the anticoagulant activity of rivaroxaban**
- **Partial reversal of PT prolongation has been seen after administration of PCCs in healthy volunteers**
- **The use of other procoagulant reversal agents like aPPC or rFVIIa has not been evaluated**

**Patients with CrCl 15–50 mL/min should take reduced dose (15 mg QD)**

**Should be taken with the evening meal; bioavailability decreases if not taken with food**

**Avoid concomitant use with combined P-gp and strong CYP3A4 inhibitors**

**Avoid concomitant use with combined P-gp and strong CYP3A4 inducers**

**Increase monitoring if used concomitantly with NSAIDs or aspirin**

**Avoid concurrent use with other platelet-aggregation inhibitors or antithrombotic agents**

**Healthy Japanese subjects were found to have on average 20%–40% higher exposure compared with other ethnicities, including Chinese**

### Apixaban

**Factor Xa inhibitor**

- Oral (tablet or nasal gastric tube) taken with food
- 5 mg BID
- 60 hours

**Cannot be monitored using standard laboratory tests; PT, aPTT, and Hemtest (Hemtest Laboratories, St Louis, MO, USA) are prolonged dose-dependently; anti-FXa activity is also influenced by rivaroxaban**

- **A specific antidote for apixaban is not available**
- **Hemodialysis does not appear to have a substantial impact on apixaban exposure**
- **Protamine sulfate and vitamin K would not be expected to affect the anticoagulant effect of apixaban**
- **There is no experience with antifibrinolytic agents in patients receiving apixaban**
- **There is neither scientific rationale for reversal nor experience with systemic hemostasis in patients receiving apixaban**
- **PCCs, aPCC, or rFVIIa may be considered, but have not been evaluated in clinical trials**
- **Activated charcoal reduces absorption of apixaban, thereby lowering apixaban plasma concentration**

**Patients with CrCl 15 to 50 mL/min**

**None**

### Edoxaban

**Factor Xa inhibitor**

- Oral (solution or tablet)
- 60 mg QD (30 mg QD for patients with CrCl 15 to 50 mL/min)
- 12–17 hours

**Cannot be monitored using standard laboratory tests; PT, aPTT, and Hemtest (Hemtest Laboratories, St Louis, MO, USA) are prolonged dose-dependently; anti-FXa activity is also influenced by rivaroxaban**

- **A specific antidote for edoxaban is not available**
- **Hemodialysis does not significantly contribute to edoxaban clearance**
- **Protamine sulfate, vitamin K, and tranexamic acid are not expected to reverse the anticoagulant activity of edoxaban**

**Patients with CrCl >95 mL/min**

**None**
Table 3: Phase III clinical trial results for the novel oral anticoagulants

<table>
<thead>
<tr>
<th></th>
<th>RE-LY (dabigatran 110 mg)</th>
<th>RE-LY (dabigatran 150 mg)</th>
<th>ROCKET AF (rivaroxaban 20 mg)</th>
<th>ARISTOTLE (apixaban, 5 mg)</th>
<th>ENGAGE AF-TIMI 48 (edoxaban 60 mg)</th>
<th>ENGAGE AF-TIMI 48 (edoxaban, 30 mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke or</td>
<td>RR 0.90 (95% CI 0.74–1.10)</td>
<td>RR 0.65 (95% CI 0.52–0.81)</td>
<td>HR 0.88 (95% CI 0.75–1.03)</td>
<td>HR 0.79 (95% CI 0.66–0.95)</td>
<td>HR 0.79 (97.5% CI 0.63–0.99)ızı̈</td>
<td>HR 1.07 (97.5% CI 0.87–1.31)ızı̈</td>
</tr>
<tr>
<td>systemic</td>
<td>P&lt;0.001 (noninferiority)</td>
<td>P&lt;0.001 (noninferiority)</td>
<td>P&lt;0.001 (noninferiority)</td>
<td>P&lt;0.001 (noninferiority)</td>
<td>P&lt;0.001 (noninferiority)</td>
<td>P&lt;0.001 (noninferiority)</td>
</tr>
<tr>
<td>embolism</td>
<td>P=0.30</td>
<td>P=0.01</td>
<td>P=0.12</td>
<td>P=0.01</td>
<td>P=0.08</td>
<td>P=0.10</td>
</tr>
<tr>
<td>Hemorrhagic</td>
<td>RR 0.31 (95% CI 0.17–0.56)</td>
<td>RR 0.26 (95% CI 0.14–0.49)</td>
<td>HR 0.59 (95% CI 0.37–0.93)</td>
<td>HR 0.51 (95% CI 0.35–0.75)</td>
<td>HR 0.54 (95% CI 0.38–0.77)</td>
<td>HR 0.33 (95% CI 0.22–0.50)</td>
</tr>
<tr>
<td>stroke</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
<td>P&lt;0.01</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Intracranial</td>
<td>RR 0.30 (95% CI 0.19–0.45)</td>
<td>RR 0.41 (95% CI 0.28–0.60)</td>
<td>HR 0.67 (95% CI 0.47–0.93)</td>
<td>HR 0.42 (95% CI 0.30–0.58)</td>
<td>HR 0.47 (95% CI 0.34–0.63)</td>
<td>HR 0.30 (95% CI 0.21–0.43)</td>
</tr>
<tr>
<td>hemorrhage</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Myocardial</td>
<td>RR 1.29 (95% CI 0.96–1.75)</td>
<td>RR 1.27 (95% CI 0.94–1.71)</td>
<td>HR 0.81 (95% CI 0.63–1.06)</td>
<td>HR 0.88 (95% CI 0.66–1.17)</td>
<td>HR 0.94 (95% CI 0.74–1.19)</td>
<td>HR 1.19 (95% CI 0.95–1.49)</td>
</tr>
<tr>
<td>infarction</td>
<td>P=0.09</td>
<td>P=0.12</td>
<td>P=0.37</td>
<td>P=0.37</td>
<td>P=0.60</td>
<td>P=0.13</td>
</tr>
<tr>
<td>All-cause</td>
<td>RR 0.91 (95% CI 0.80–1.03)</td>
<td>RR 0.88 (95% CI 0.77–1.00)</td>
<td>HR 0.92 (95% CI 0.82–1.03)</td>
<td>HR 0.89 (95% CI 0.80–0.99)</td>
<td>HR 0.92 (95% CI 0.83–1.01)</td>
<td>HR 0.87 (95% CI 0.79–0.96)</td>
</tr>
<tr>
<td>mortality</td>
<td>P=0.13</td>
<td>P=0.05</td>
<td>P=0.15</td>
<td>P=0.04</td>
<td>P=0.08</td>
<td>P=0.006</td>
</tr>
<tr>
<td>Major</td>
<td>RR 0.90 (95% CI 0.70–0.93)</td>
<td>RR 0.93 (95% CI 0.81–1.07)</td>
<td>HR 1.04 (95% CI 0.90–1.20)</td>
<td>HR 0.69 (95% CI 0.60–0.80)</td>
<td>HR 0.80 (95% CI 0.71–0.91)</td>
<td>HR 0.47 (95% CI 0.41–0.55)</td>
</tr>
<tr>
<td>bleeding</td>
<td>P=0.003</td>
<td>P=0.32</td>
<td>P=0.58</td>
<td>P=0.001</td>
<td>P=0.001</td>
<td>P=0.001</td>
</tr>
</tbody>
</table>

Notes: 1The primary end point for ROCKET-AF used the per-protocol population. In the per-protocol analysis, the RR for stroke or SE with rivaroxaban versus warfarin was 0.79 (95% CI 0.66–0.96, P<0.001 for noninferiority); 2modified intention-to-treat population in the treatment period; 3safety on-treatment population. All values are for the intention-to-treat populations unless otherwise stated. All P-values are for superiority unless otherwise stated.
interaction 0.16 and 0.34 for edoxaban 60 mg and 30 mg BID, respectively). No subgroup analyses by race have been published for the RE-LY (Randomized Evaluation of Long-term anticoagulant therapy) or ARISTOTLE (Apixaban for Reduction In STroke and Other Thromboembolic Events in atrial fibrillation) trials, and no real-world data are currently available comparing the treatment effects of NOACs by race.

The prescribing information for dabigatran and rivaroxaban does not state whether any dose adjustments are needed for race; however, based on the results of a PK study in healthy subjects that showed no difference in apixaban PK among Caucasians, Asians, and African-Americans, the apixaban prescribing information states that no dose adjustment is required based on race/ethnicity.

Role of physicians and patients in stroke prevention in patients with AF

There are disparities in stroke awareness between minority groups compared with Caucasians, including lack of awareness of stroke symptoms and signs and lack of knowledge about the need for urgent treatment and the causal role of risk factors. The Centers for Disease Control and Prevention analyzed data from an optional module of the 2005 Behavioral Risk Factor Surveillance System that had used data from 13 US states and the District of Columbia to assess public awareness of stroke warning symptoms and the importance of seeking emergency care. The results showed that the proportion of respondents who were able to identify all five stroke warning signs and recognized the need to call emergency services was lower in African-Americans than in Caucasians (29.5% versus 41.3%). This and other similar studies emphasize the need for educational efforts to improve knowledge about stroke symptoms among African-Americans.

There are differences in attitudes, beliefs, and compliance among minority groups, including denial of disease, concern for potential or experienced side effects of medications, absence of symptoms, hierarchy of need, burden of filling prescriptions, attending doctor visits, and lower health literacy, all of which influence compliance with treatment.

Studies have shown that literacy decreases with age, and that this is more pronounced in African-American than Caucasian patients. Older patients receiving oral anticoagulants must become active participants in their own care, in that they and their families must read and comprehend written information.
regarding their treatment. It is also important to ensure that the reading materials supplied to patients with NVAF are sufficiently comprehensible to older adults. This may in part be easier with NOAC than with warfarin use, due to fewer food and drug interactions associated with NOACs.

Conclusion

AF is less common in African-Americans than in Caucasians; however, African-Americans have a higher risk of stroke. This could be due to African-Americans having a higher prevalence of other stroke-risk factors compared with Caucasians, although this may be an oversimplified view, as there are a number of other reasons why this disparity may occur. These include a need for more sensitive methods of detecting AF and a need for better access to health care and patient education for African-Americans. Warfarin-dose requirements vary across racial/ethnic groups, with African-American patients requiring a higher dose than Caucasians to maintain a therapeutic INR: the NOACs seem to differ in this regard, although data are currently limited. Minority racial groups are not proportionally represented in either real-world studies or clinical trials, and as more information becomes available and other social issues are addressed, the treatment disparities between African-American and Caucasian patients should decrease.

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