DISAGREEMENT BETWEEN PHYSICIAN-REPORTED AND SCORING SYSTEM-BASED STROKE AND BLEEDING RISKS IN PATIENTS WITH ATRIAL FIBRILLATION: INSIGHTS FROM THE STROKE PREVENTION AND RHYTHM INTERVENTIONS IN ATRIAL FIBRILLATION (SPRINT-AF) REGISTRY

Poster Contributions
Hall C
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Session Title: Arrhythmias and Clinical EP: New Observations Affecting Clinical Management
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Background: Oral anticoagulation (OAC) for stroke prevention is an important treatment in the management of atrial fibrillation (AF). Accurate assessment of stroke and bleeding risk is critical when evaluating the risk/benefits of OAC therapy. From a contemporary, national, real-world observational registry, we compared the stroke and bleeding risks reported by physicians vs. those derived from validated scoring schemes.

Methods: From December 2012 to July 2013, a cross-sectional analysis of 850 consecutive AF patients from 101 practices in 10 Canadian provinces was performed. Physicians categorized patients as low, moderate, or high risk for bleeding and stroke based on either: overall clinical judgment, individual patient factors, or existing scoring schemes. For each patient, we then centrally calculated the CHADS2 score (low: 0; moderate: ≥2) and the HAS-BLED score (low: 0; moderate: 1-2, high: ≥3). Agreement between physician-reported and score-derived risks was reported by the weighted kappa with 95% confidence intervals (CI).

Results: Data were available in 843 (99%) patients for the present analysis. The weighted kappa between physician-reported stroke risk and CHADS2 was 0.42 (95% CI: 0.35 to 0.50). The greatest area of disagreement occurred in CHADS2 ≥ 2, as 220 (40%) patients in this risk category were deemed to be at low/moderate risk for stroke by physicians. The weighted kappa between physician-reported bleeding risk and the HAS-BLED score was 0.14 (95% CI: 0.07 to 0.21). The greatest area of disagreement occurred at HAS-BLED 1-2 (moderate bleeding risk), as 293 (45%) of patients in this category were considered low risk for bleeding by physicians.

Conclusions: In this contemporary, national, real-world registry of AF patients, we observed very modest agreement between physician-reported stroke risk and CHADS2. There was poor correlation between physician-reported bleeding risk and HAS-BLED. There are sizeable disparities between score-derived stroke and bleeding risks vs. those reported by physicians. This was mainly due to under-estimation of score-derived risks by physicians. Further work is needed to understand the reasons which account for this discrepancy.