International Journal of Cardiology 282 (2019) 66

Contents lists available at ScienceDirect

International Journal of Cardiology

journal homepage: www.elsevier.com/locate/ijcard

Letter to the Editor

Role of atrial cardiomyopathy in guiding choice of antithrombotic therapy

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ARTICLE INFO

Article history:
Received 25 December 2018
Accepted 2 January 2019

Keywords:
Cardiomyopathy
Rheumatic valvular atrial fibrillation
Anticoagulants

The clinical importance of atrial cardiomyopathy, recently explored in this journal [1], also has relevance in rheumatic valvular atrial fibrillation (RVAF), for the purpose of guiding choice of modality for thromboprophylaxis. Currently, the recommendation is that vitamin K antagonists should be the ones utilised in patients with moderate to severe mitral stenosis, without regard for the relevance of concomitant atrial cardiomyopathy [2]. Severity of atrial cardiomyopathy and its extent would be a more rational basis for choice of anticoagulant modality, if it could be shown that location of left atrial thrombi correlated with the site of maximum severity of left atrial cardiomyopathy. It is already recognised that 43% of RVAF patients have left atrial thrombi located solely in the left atrial appendage, the latter also being the sole location for left atrial thrombi in 91% of nonvalvular atrial fibrillation (NVAF) patients [3]. Accordingly, if direct acting oral anticoagulants (DOACs) work well for NVAF subjects (91% of whom have atrial thrombi exclusively located in the left atrial appendage) they should work equally well for RVAF patients with similar distribution of left atrial thrombi. Those RVAF patients who have left atrial thrombi which extend beyond the left atrial appendage should be the ones allocated to thromboprophylaxis with vitamin K antagonists (VKAs). The advantage of DOAC use is freedom from the burden and expense of lifelong monitoring for International Normalised Ratio, and reduction in risk of intracranial haemorrhage relative to the risk incurred by users of VKAs [4].

I have no funding and no conflict of interest.

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https://doi.org/10.1016/j.ijcard.2019.01.002
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