Two-year outcomes of patients with newly diagnosed atrial fibrillation: results from GARFIELD-AF

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Two-year outcomes of patients with newly diagnosed atrial fibrillation: results from GARFIELD-AF

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Aims

The relationship between outcomes and time after diagnosis for patients with non-valvular atrial fibrillation (NVAF) is poorly defined, especially beyond the first year.

Methods and results

GARFIELD-AF is an ongoing, global observational study of adults with newly diagnosed NVAF. Two-year outcomes of 17162 patients prospectively enrolled in GARFIELD-AF were analysed in light of baseline characteristics, risk profiles for stroke/systemic embolism (SE), and antithrombotic therapy. The mean (standard deviation) age was 69.8 (11.4) years, 43.8% were women, and the mean CHA2DS2-VASc score was 3.3 (1.6); 60.8% of patients were prescribed anticoagulant therapy with/without antiplatelet (AP) therapy, 27.4% AP monotherapy, and 11.8% no antithrombotic therapy. At 2-year follow-up, all-cause mortality, stroke/SE, and major bleeding had occurred at a rate (95% confidence interval) of 3.83 (3.62; 4.05), 1.25 (1.13; 1.38), and 0.70 (0.62; 0.81) per 100 person-years, respectively. Rates for all three major events were highest during the first 4 months. Congestive heart failure, acute coronary syndromes, sudden/unwitnessed death, malignancy, respiratory failure, and infection/sepsis accounted for 65% of all known causes of death and strokes for <10%. Anticoagulant treatment was associated with a 35% lower risk of death.

Conclusion

The most frequent of the three major outcome measures was death, whose most common causes are not known to be significantly influenced by anticoagulation. This suggests that a more comprehensive approach to the management of NVAF may be needed to improve outcome. This could include, in addition to anticoagulation, interventions targeting modifiable, cause-specific risk factors for death.

Clinical Trial Registration


Keywords

Atrial fibrillation • Anticoagulation • Stroke prevention • Stroke • Bleeding

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† A complete list of investigators is given in Appendix.
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Introduction

Atrial fibrillation (AF), the most frequent of all cardiac arrhythmias, is associated with an increased risk of stroke, systemic embolism (SE), and heart failure. Patients with AF have a two-fold increased risk of death compared with those without AF.1−3 Anticoagulation reduces the risk of stroke/SE and of death at the cost of an increased risk of bleeding. Anticoagulation with vitamin K antagonists (VKAs) or with the newer non-vitamin K antagonist oral anticoagulants (NOACs) is recommended for patients with AF and at least one additional risk factor for stroke, whereas antiplatelet (AP) therapy, either as monotherapy or with concomitant anticoagulation, is indicated in a specific subset of patients.1−4 Currently, there are very limited data on the extended time course of events after diagnosis of non-valvular atrial fibrillation (NVAF) in large multinational populations.

The Global Anticoagulant Registry in the FIELD—Atrial Fibrillation (GARFIELD-AF) is an ongoing, observational, worldwide study of adults with newly diagnosed NVAF, which is governed by the highest academic and ethical standards in the generation, dissemination, and communication of its research findings.5 The registry plans to prospectively recruit ~52 000 patients representing all ethnicities and care settings in five consecutive cohorts from randomly selected centres in 35 countries.

Here, we report 2-year event rates for all-cause mortality, stroke/SE, and major bleeding for the first two cohorts (in 17 162 patients) and the factors that have contributed to these events, namely baseline characteristics and treatment.

Methods

Study design and participants

Men and women aged ≥18 years with NVAF diagnosed according to standard local procedures within the previous 6 weeks, and with at least one additional risk factor for stroke as judged by the investigator, are eligible for inclusion. Risk factors are not prespecified in the protocol nor are they limited to the components of existing risk stratification schemes. The study excludes patients with a transient reversible cause of NVAF and those for whom follow-up is not envisaged or possible.7 Consecutive patients are enrolled prospectively into five sequential cohorts, with the aim of recruiting up to 52 000 patients. Investigator sites have been selected randomly and represent the different care settings. Data collection/quality control/auditing

GARFIELD-AF data are captured using an electronic case report form (eCRF) designed by Dendrite Clinical Systems Ltd (Henley-on-Thames, UK). Oversight of operations and data management are managed by the sponsor and coordinating centre (TRI), with support from Quintiles (Durham, NC, USA), The University of Birmingham Department of Primary Care Clinical Sciences (Birmingham, UK), Thrombosis Research Group—Brigham and Women’s Hospital (Boston, MA, USA), and AXIAL (Paris, France). The GARFIELD-AF protocol requires that 20% of all eCRFs are monitored against source documentation, that there is an electronic audit trail for all data modifications, and that critical variables are subjected to additional audit.5 Data for the analysis in this report were extracted from the study database on 3 August 2015.

Statistical analysis

Continuous variables are expressed as mean ± SD and categorical variables as frequency and percentage. Use of antithrombotic therapy at baseline was analysed by CHA2DS2-VASc and ‘modified’ HAS-BLED (excluding fluctuations in the international normalized ratio) scores, calculated retrospectively from the data collected. Patients with missing values were not removed from the study.

Occurrence of major clinical outcomes is described using the number of events, the proportion of patients with the event divided by the population at risk at the beginning of the follow-up period, person-time event rate (per 100 person-years), and 95% confidence interval (CI). We estimated person-year rates using a Poisson model, with the number of events as the dependent variable and the log of time as an offset, i.e. a covariate with a known coefficient of 1. Only the first occurrence of each event was taken into account. The 4-monthly event rates were compared with the overall rates using the ratio between the observed and expected numbers of events (applying the overall rate to assess expected rates for that period). The Poisson trend statistic was used to assess the trends over time. Hazard ratios (HRs) were estimated using a proportional hazards Cox model after multiple imputation by the Multiple Imputation by Chained Equations (MICE) algorithm.7,8 We used the MICE algorithm to fill in missing values, creating five complete datasets. Data analysis was performed at the TRI with SAS version 9.4 (SAS Institute Inc., Cary, NC, USA) and Stata Statistical Software: Release 13 (StataCorp, College Station, TX, USA).
Results

Study population

A total of 17,162 patients with NVAF were prospectively enrolled in the first and second GARFIELD-AF cohorts between March 2010 and June 2013 and are included in this analysis. Patients in these cohorts were recruited from 858 randomly selected study sites representative of routine practice in each of 30 countries. Two-year follow-up was achieved in 97% of patients.

At baseline, mean (SD) age was 69.8 (11.4) years, and 43.8% of patients were female. The mean (SD) CHA\_2DS\_2-VASc and HAS-BLED scores were 3.3 (1.6) and 1.5 (0.9), respectively. Other baseline characteristics are shown in Table 1. At diagnosis of AF, 60.8% of patients were prescribed AC therapy (50.0% VKAs...
and 10.8% NOACs, with or without AP), 27.4% received AP monotherapy, and 11.8% received no AC or AP therapy. The proportion of patients receiving AC therapy (with or without AP) increased with CHA\textsubscript{2}DS\textsubscript{2}-VASc score, being lowest for patients with a score of 0 (41.6%) and highest for patients with a score of 5 (67.5%; Cuzick test, \( P < 0.001 \); Figure 1A). The use of AC (with or without AP) decreased with increasing HAS-BLED score, from 76.5 to 49.8% for patients with scores of 0 and \( \geq 4 \), respectively (Cuzick test, \( P < 0.001 \); Figure 1B). Anticoagulant therapy was not prescribed in 36.9% of patients with CHA\textsubscript{2}DS\textsubscript{2}-VASc \( \geq 2 \). Patients not receiving AC therapy tended to be younger (mean [SD] age 68.6 [12.3] vs. 70.6 [10.8] years; \( P < 0.001 \)), were more likely to have paroxysmal AF (29.6 vs. 22.3%; \( P < 0.001 \)), and had a lower mean (SD) CHA\textsubscript{2}DS\textsubscript{2}-VASc score (3.0 [1.6] vs. 3.4 [1.6]; \( P < 0.001 \)) but a higher mean (SD) HAS-BLED score (1.7 [0.9] vs. 1.5 [1.0]; \( P < 0.001 \)) than patients receiving AC therapy.

### Clinical outcomes

During the 2-year follow-up, the rates (95% CI) of all-cause mortality, stroke/SE, and major bleeding (first occurrences) were 3.83 (3.62; 4.05), 1.25 (1.13; 1.38), and 0.70 (0.62; 0.81) per 100 person-years, respectively (Table 2). The rates of all three major events were significantly higher during the first 4 months of follow-up (mortality +29%; stroke/SE +35%; major bleeding +56%) compared with the overall event rates (Figure 2 and see Supplementary material online, Table S1). Beyond the first 4 months, the rates of events were lower and modestly declined over the course of follow-up (\( \chi^2 \) test for trend, \( P = 0.001 \) for mortality and stroke/SE, \( P = 0.001 \) for major bleeding). The early higher risk of death was observed irrespective of AF pattern, but was higher with new (newly diagnosed/new onset) AF than with other patterns of AF (standardized mortality rate 1.41 [95% CI 1.19; 1.66] vs. 1.19 [1.00; 1.41], respectively). The same was also true for major bleeding, with standardized incidence rates of 1.70 (95% CI 1.19; 2.44) vs. 1.43 (1.01; 2.03), respectively, for new AF compared with other AF patterns. No difference in early excess of risk was observed for stroke/SE.

The rate of death due to cardiovascular causes including fatal bleeds was 1.55 (1.42; 1.70) per 100 person-years (Table 2). The most frequent causes of cardiovascular death were congestive heart failure (CHF), sudden or unwitnessed death, ACS, and ischaemic stroke (Table 3). The rate of non-cardiovascular causes of death was lower (1.37 [1.25; 1.51] per 100 person-years) and mainly due to malignancy, respiratory failure, and infection/sepsis (Table 3). The primary cause of death could not be identified in 280 of 1181 deaths. By multivariate analysis, the baseline variables significantly associated with a higher risk of death were older age, diabetes mellitus, CHF, vascular disease, history of stroke/SE, history of bleeding, chronic kidney disease (CKD), smoking, and non-paroxysmal forms of AF. Anticoagulation was associated with a significantly lower risk of death (Figure 3).

<table>
<thead>
<tr>
<th>Event</th>
<th>Rate (95% CI)</th>
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<tbody>
<tr>
<td>Death</td>
<td>3.83 (3.62; 4.05)</td>
</tr>
<tr>
<td>Cardiovascular death</td>
<td>1.55 (1.42; 1.70)</td>
</tr>
<tr>
<td>Non-cardiovascular death</td>
<td>1.37 (1.25; 1.51)</td>
</tr>
<tr>
<td>Undetermined cause</td>
<td>0.91 (0.81; 1.02)</td>
</tr>
<tr>
<td>Stroke/SE</td>
<td>1.25 (1.13; 1.38)</td>
</tr>
<tr>
<td>Major bleeding</td>
<td>0.70 (0.62; 0.81)</td>
</tr>
<tr>
<td>Acute coronary syndromes</td>
<td>0.63 (0.55; 0.73)</td>
</tr>
<tr>
<td>Congestive heart failure(^b)</td>
<td>2.41 (2.24; 2.59)</td>
</tr>
</tbody>
</table>

\(^a\)Only the first occurrence of each event was taken into account.
\(^b\)Occurrence of new CHF or worsening of pre-existing CHF.

Table 2 Event rates (per 100 person-years) for selected clinical outcomes at 2 years of follow-up

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Figure 1 Antithrombotic treatment at baseline stratified by CHA\textsubscript{2}DS\textsubscript{2}-VASc score (A) and by HAS-BLED score (B).
The rates of different types of stroke are detailed in Table 3, along with the rates of bleeding events of different severity. Strokes were predominantly ischaemic, and primary haemorrhagic strokes were very uncommon. Sixty patients died from ischaemic stroke, 5 from haemorrhagic stroke, and 89 patients who survived a stroke died over the course of follow-up. The most frequent site for bleeding events was the gastrointestinal tract (occurring in 1.47% of the total population). Bleeds in a critical organ (intra-ocular/retinal, intra-spinal, haemo-pericardium, haemothorax, retroperitoneal) and intracranial bleeding (epidural/subdural haematomas) each occurred in 0.22% of the population.

At 2-year follow-up, the rates of ACS and CHF were 0.63 (95% CI 0.55; 0.73) and 2.41 (2.24; 2.59) per 100 person-years, respectively (Table 2).

The rates of death, stroke/SE, and major bleeding increased progressively with increasing grades of the CHA2DS2-VASc and HAS-BLED scoring schemes (Cuzick test, \( P < 0.001 \); see Supplementary material online, Figure S1) and correspondingly, the HRs for death, stroke/SE, and major bleeding correlated with the CHA2DS2-VASc and HAS-BLED scores (Figure 4).

**Discussion**

Analyses of event rates from the GARFIELD-AF registry have identified that death was the most frequent major adverse clinical event over 2 years of follow-up in patients with NVAF. The rate of death was three-fold higher than the rate of stroke/SE and more than five-fold higher than the rate of major bleeding. The highest frequency of events (for each major outcome measure) occurred during the first 4 months of follow-up. The early risks of death and major bleeding (but not stroke/SE) were higher with new (newly diagnosed/new onset) NVAF than with the other patterns of NVAF. These data suggest that incident NVAF may occur as a complication of a chronic or acute cardiovascular or non-cardiovascular underlying disease that impairs early evolution.10–13 In addition, fluctuations in AC control, which are commonly observed after the initiation of VKA therapy, may explain, at least in part, the early excess of

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**Table 3** Breakdown of primary outcomes by type of event at 2-year follow-up

<table>
<thead>
<tr>
<th>Event</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause death</td>
<td>1181</td>
<td>40.5</td>
</tr>
<tr>
<td>Cardiovascular causes</td>
<td>478</td>
<td>15.4</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>128</td>
<td>7.5</td>
</tr>
<tr>
<td>Sudden or unwitnessed death</td>
<td>89</td>
<td>5.9</td>
</tr>
<tr>
<td>Acute coronary syndromes</td>
<td>70</td>
<td>2.2</td>
</tr>
<tr>
<td>Ischaemic stroke</td>
<td>60</td>
<td>1.7</td>
</tr>
<tr>
<td>Otherb</td>
<td>131</td>
<td>11.1</td>
</tr>
<tr>
<td>Non-cardiovascular causes</td>
<td>423</td>
<td>35.8</td>
</tr>
<tr>
<td>Malignancy</td>
<td>121</td>
<td>10.3</td>
</tr>
<tr>
<td>Respiratory failure</td>
<td>95</td>
<td>8.0</td>
</tr>
<tr>
<td>Infection/sepsis</td>
<td>79</td>
<td>6.7</td>
</tr>
<tr>
<td>Otherc</td>
<td>128</td>
<td>10.8</td>
</tr>
<tr>
<td>Undetermined causes</td>
<td>280</td>
<td>23.7</td>
</tr>
<tr>
<td>Stroke (not including systemic embolism)</td>
<td>365</td>
<td></td>
</tr>
<tr>
<td>Primary ischaemic</td>
<td>260</td>
<td>71.2</td>
</tr>
<tr>
<td>Secondary haemorrhagic ischaemic</td>
<td>15</td>
<td>4.1</td>
</tr>
<tr>
<td>Primary intracerebral haemorrhage</td>
<td>37</td>
<td>10.1</td>
</tr>
<tr>
<td>Intracerebral</td>
<td>20</td>
<td>5.5</td>
</tr>
<tr>
<td>Intraventricular</td>
<td>5</td>
<td>1.4</td>
</tr>
<tr>
<td>Subarachnoid</td>
<td>3</td>
<td>0.8</td>
</tr>
<tr>
<td>Undeterminedd</td>
<td>9</td>
<td>2.5</td>
</tr>
<tr>
<td>Undeterminede</td>
<td>68</td>
<td>18.6</td>
</tr>
<tr>
<td>Bleeding events (not including minor bleeds)</td>
<td>504</td>
<td></td>
</tr>
<tr>
<td>Severity of bleed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-major, clinically relevant</td>
<td>288</td>
<td>57.1</td>
</tr>
<tr>
<td>Major</td>
<td>216</td>
<td>42.9</td>
</tr>
<tr>
<td>Fatalf</td>
<td>24</td>
<td>4.8</td>
</tr>
</tbody>
</table>

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*a* Only the first occurrence of each event was taken into account.

*b* Includes deaths due to intracranial haemorrhage, atherosclerotic vascular disease, dysrhythmia, pulmonary embolism, and haemorrhagic stroke.

*c* Includes deaths due to accidents/trauma, renal disease, and liver disease.

*d* Includes patients with unknown type of primary intracerebral haemorrhage and patients with combinations of types of stroke.

*e* Includes patients with unknown types of stroke and those with both primary ischaemic and primary intracerebral haemorrhagic strokes.

*f* All fatal bleeds are included in major bleeds and are also included in the mortality analysis.
events, as suboptimal VKA control was shown to result in higher rates of stroke/SE, bleeding, and death.\textsuperscript{14} Furthermore, higher rates of ischaemic events have been observed at the initiation of warfarin in VKA-naïve patients, possibly linked to a transient hypercoagulable state due to differential depletion of certain vitamin K-dependent clotting factors.\textsuperscript{15} Marked hypercoagulability when NVAF first becomes clinically apparent may also play a role. The decline in the rates of events after 4 months (Figure 2 and see Supplementary material online, Table S1) may be related to better AC control and/or to a change in the risk profile of patients over time, and also to the fact that the sickest patients suffered their first event early on after diagnosis of NVAF.

A further important finding relates to the causes of death. As in most\textsuperscript{12,16,17} but not all reports,\textsuperscript{18,19} cardiovascular and non-cardiovascular deaths occurred at quite similar rates, but ischaemic and haemorrhagic strokes were clearly not the main drivers of mortality risk, since they accounted for fewer than 10% of all known causes of death.\textsuperscript{19,20} Such a low rate of stroke-related death may be because >60% of the population was anticoagulated. In contrast, the most frequent causes of death, namely CHF, sudden or unobserved death, ACS, malignancy, respiratory failure, and infection/sepsis, which accounted for 65% of all known causes of death (Table 3), are not, or only modestly, affected by AC therapy. Nevertheless, AC therapy was associated with a 35% lower risk of death. Evidently, AC therapy has a favourable impact on the risk of stroke-related death, but part of the reduction in mortality risk is most probably the consequence of prevention of thromboembolism other than stroke/SE, associated with venous thromboembolism in CHF and malignancy. In addition, occurrence and/or complications of ACS can potentially be prevented by AC treatment, as supported by trial data of anticoagulation after myocardial infarction or ACS.\textsuperscript{21} Conversely, patients without AC treatment (almost 40% of the total population) had a worse outcome compared with anticoagulated patients, despite the fact that they were younger and had a lower risk of stroke.

Newly diagnosed NVAF, in this context, could represent a marker of early death, as a consequence of worsening baseline disease, since survival from several comorbidities, such as CHF, ACS, and respiratory failure, is affected by the occurrence of AF.\textsuperscript{22–26} Conversely, co-morbidities/risk factors may affect the course of NVAF over time, through gradual remodelling of heart chambers triggered by uncontrolled hypertension, progression of CAD, worsening of heart failure, and also ageing that may precipitate the evolution of persistent or paroxysmal NVAF towards permanent NVAF.\textsuperscript{22,24,26–28} Concomitant with these observations is the strikingly high rate of worsening of heart failure (and to a lesser extent, the rate of new ACS) recorded in these patients (Table 2). Both conditions are risk factors and causes of death, but they are also precipitating factors for the occurrence and progression of AF, and furthermore, they are worsened by the occurrence of AF.\textsuperscript{22–26,29}

The CHA\textsubscript{DS}-VASc score was shown to be an equally good predictor of the risks of all three outcome measures (Figure 4). Most of the variables strongly associated with the risk of death, namely older age, CHF, history of bleeding, CKD, diabetes mellitus, smoking, and pattern of AF, were also associated with the risk of stroke/SE (data not shown). This seems to indicate that the overall prognosis of NVAF in terms of death, stroke/SE and, to some extent, bleeding is tightly linked to the same risk factors/comorbidities.

**Study limitations**

Most study patients were Caucasians and, to a lesser extent, Asians. Hispanic/Latino and Afro-Caribbean ethnicities were less represented in this analysis of the first two cohorts because recruitment did not start at the same time in all countries involved in GARFIELD-AF.

**Study strengths**

Several surveys, registries, and regional or national healthcare databases have reported outcomes for patients with NVAF but most studies had a limited duration of follow-up.\textsuperscript{30–37} Prior studies vary in terms of inclusion criteria, duration of follow-up, and care settings, and in the characterization of outcome events. In contrast, the design of the GARFIELD-AF registry is unique; it has a global reach and extended follow-up and incorporates patients with newly diagnosed NVAF from all care settings, making it representative of
real-life management of NVAF worldwide. In addition, GARFIELD-AF audit and quality assurances exceed the standards of most large-scale registries and even some randomized trials.5

**Conclusions**

Death was the most frequent adverse outcome in NVAF. The highest event rates for death, stroke/SE, and major bleeding occurred during the first 4 months of follow-up, gradually diminishing over time. Stroke-related mortality was not the most frequent cause of death, suggesting that a more comprehensive approach to the management of patients with NVAF may be needed to improve outcome. This could include interventions targeting other modifiable, cause-specific risk factors for death (such as CHF, CAD, ACS, diabetes, and hypertension) in addition to anticoagulation.20,23

CHA2DS2-VASc and HAS-BLED scores were both predictive of all three major outcome measures, suggesting that a single integrated risk score derived from a large cohort of patients like the GARFIELD-AF registry, encompassing all three major outcome measures, may have an added value compared with existing risk scores.

**Authors’ contributions**

J.-P.B. drafted the report. All authors critically reviewed the report and approved the final manuscript. A.K.K. and G.K. handled funding and supervised the registry.

**Supplementary material**

Supplementary material is available at European Heart Journal online.

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