Four F's of AFib: Forgetfulness
Project Length: 00:19:30

File Name: May25 Edited Audio - No Music_01.mp3

FULL TRANSCRIPT

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Dr. Allred: Hello and welcome to today's episode of the Four F's of AFib, where we address gaps and barriers to care for the diagnosed and undertreated AFib patient around the four key areas of concern: frailty falls, fear of bleeding and forgetfulness. In this episode, we will focus on answering questions around forgetfulness. My name is Dr. James Allred. I'm an electrophysiologist at Cone Health in Greensboro, North Carolina, and your host for this podcast series. Today we are joined by Dr. Miguel Leal, an Associate Professor in the Division of Cardiovascular Medicine with the University of Wisconsin Department of Medicine. Welcome to the podcast today

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Dr. Leal: Well, Dr. Allred, it's a pleasure and a privilege to be here and participate in this podcast, which highlights such an important topic when it comes to the management of our patients with atrial fibrillation, and I really thank the American Heart Association for this important initiative and for having me here with you today

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Dr. Allred: Dr. Leal, I understand that you have some changes in your pathway going forward. Tell us a little bit about that. Tell us a little bit more about yourself.

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Dr. Leal: You're right. It's interesting to say that after 15 years, well-spent in Madison at University of Wisconsin, I am now moving towards Emory University in Atlanta. So it's certainly a bittersweet move with a lot of friends that probably remain our friends. But we're going to move a little bit south and continue this academic journey in the world of clinical cardiac electrophysiology including education and research as well. So, once again, thank you for having me here.

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programs. And so I know that you're fortunate to have been at the University of Wisconsin, and I know that you're ecited about Emory and probably some changes in weather.

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Dr. Leal: Absolutely yes. As a native Brazilian, it was definitely a very interestinj f(03)10.8 (-)4.6 s13(1(TJ1rr6 (-)2 (a)11.3 /AMCID 24 BD-4.m

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Dr. Allred: That's eactlyright. We're in North Carolina. So, as you think about forgetfulness, what are the perceived versus actual barriers to appropriate anticoagulation? And we'll talk about that as a provider as we think about our patients and also as their familyand caregivers get involved. Again, what are the perceived versus actual barriers to appropriate anticoagulation for these patients?

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Dr. Leal: That is a great question to get our conversation started because atrial fibrillation, as we know, is the most common form of cardiac arrhythmia that affects men and women all over the world. And the prevalence in the United States alone is remarkablyescal ating. And this is not necessarilysomething that is surprising us because atrial fibrillation comes together with a series of comorbidities such as hypertension or high blood pressure, diabetes mellitus, peripheral vascular disease, coronaryartery disease, obesitysleep apnea, and manyother comorbidities that make atrial fibrillation more likelyto be present.

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Dr. Leal: And as patients have a higher percentage of these conditions, the likelihood that he or she will develop atrial fibrillation at some point in their lifetime grows over time. The problem is that this arrhythmia has the unique abilityto make the patient prone to clotting, to the formation of thrombi or coagulum inside their hearts. Because the top chamber of their hearts is not pumping blood anymore. They're just essentiallyquivering or fibrillating, as the name suggests, and that stagnation of blood in the upper chambers of the heart, especiallyin certain areas like the left atrial appendage, which is this little recess in the left atrium, that has a perfect shape and contour for harboring a clot or two that mayform.

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Dr. Leal: And the problem that comes from that is if this clot decides to embolize or to travel through the circulation to anypa rt of the bodyit can have devastating effects. For instance, if it travels towards the central circulation in the brain, it maylead to a stroke. Even if it does not cause a disabling stroke at first, multiple showering of emboli towards the central circulation maycause progressive loss of cognitive function. Basicallyit is equating to a patient who has several mini -strokes throughout, sometimes, the course of weeks or months or years, and then he or she has a progressive decline in their cognitive function, which is something that can, at times, be relativelysubtle and noticeable bypeople who maynot be with that person everyday,who visit them after a few weeks or months and suddenlyrealize that something is wrong. That the waythe person is proce ssing, his or her reasoning, or trying to remember things maynot be as accurate as theyused to be just a few weeks or months ago.

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Dr. Leal: As you know, Dr. Allred, unfortunatelythere is this stigma that this is all part of aging when we know it's not necessarilythe case. There are manyways to age in a healthymanner. And when somebodyhas this progressive decline of cognitive function, which we're going to call under our mnemonic to this, forgetfulness, this could be a sign that a cardiac arrhythmia, like atrial fibrillation, coulh.8 (acc)16 (a)11(6.9 (-)4.10.9 (ul)2 (8.213 (Twnu)10.92 e thit , rhise

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Dr. Leal: And fortunately, we have a plethora of scientific evidence and good data to suggest and support which patient populations benefit from it the most, and also predictors of potential risk from that therapy so that an educated decision can be made between patients, families and clinicians alike. The problem is oftentimes there is a perception from either of these stakeholders - the patients, the family members or the physicians treating the patients - that one might be eposed to a higher risk of either falls or trauma or

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Dr. Leal: And todaywe

therapy, but rather to create that educated, or shared, decision making process so that both the physician and the patient, obviously the ir families as well, know exactly where they're getting into here . What kind of stroke risk they're trying to avoid, and what kind of bleeding risk that may add to that. The good news is that with the modern anticoagulation therapies available, and they ha ve been launched in addition to warfarin, which is all we had for over five decades, now we have these direct oral anticoagulant agents, or DOACs, and they came with very interesting safety and efficacy profile, which has rendered them now more commonly pr escribed for stroke prevention in atrial fibrillation than warfarin which, again, preceded them by over five decades. But the fact that they have a more convenient user profile with less interactions with other medications, and nearly no interactions with food, for instance, these have opened the door for a more compliant patient population to anticoagulation therapy

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Dr. Allred: You know, I'm glad that you mentioned the shared decision- making process because I think so much of what we should do is to empower our patients to make an educated, informed decision, right? Because the end of the day there are risks to anticoagulation and there are huge benefits of anticoagulation. And for any individual patient, they often have lots of thoughts and they should have input and impact into how we approach their care.

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Dr. Allred: So, I love that. As we think about University of Wisconsin, we know that your team is amazing. They've worked diligently to help take care of patients and to figure these things out in lots of ways. And I talk to lots of different hospitals, and so I would love to hear maybe just some of your best practices. If a patient's in the hospital, as you mentioned earlier, and you're talking about anticoagulation with that patient, or it could be someone in your office . But are there some best practices that you would

apnea, for instance, is one of them. We look for untreated hypertension, one of the most common conditions and sometimes relatively simple to assess, if one takes the time to measure that blood pressure once or twice, sometimes through frequent assessments throughout the day or the week, sometimes utilizing ambulatory blood pressure monitors if necessary. So, the moment one undertakes this approach,

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