CORRESPONDENCE

Bleeding Complications and Liver Injuries During Phenprocoumon Treatment: a Multicentre Prospective Observational Study in Internal Medicine Departments

by Dr. med. Sven Schmiedl, Dipl.-Stat. Marietta Rottenkolber, Jacek Szymanski, Prof. Dr. med. Werner Siegmund, PD Dr. rer. nat. Marion Hippius, PD Dr. med. Katrin Farker, Prof. Dr. med. Bernd Drewelow, Prof. Dr. med. Joerg Hasford, Prof. Dr. med. Petra Thürmann in volume 14/2013

Excessive Treatment With Anticoagulants

Over recent years I have observed an extreme increase in anticoagulation therapy among my patients. Consistent with guidelines, almost all patients with a diagnosis of atrial fibrillation are started on therapy with phenprocoumon, warfarin, and also the new oral anticoagulants (NOACs) by cardiologists in private practice as well as in hospitals. A patient’s life expectancy, their mental status, and practicability are not taken into consideration when determining the indication for treatment.

In addition to the enormous logistical complexities, too many patients in my practice have experienced serious complications—such as subdural, gastrointestinal, and retroperitoneal hemorrhage—as a result of this treatment, which is given as a merely prophylactic measure. In the same context, the less serious complications—such as hemorrhaxis, epistaxis, and hematuria—should also be mentioned.

I thank the authors for their valuable and overdue multicenter observational study (1). I hope that the study will rapidly prompt a rethink and modification of current guidelines. In my long years of experience in clinical practice, the potential risk of an embolic cerebrovascular accident is not weighed up by the serious, occasionally fatal complications of prophylactic anticoagulation therapy. DOI: 10.3238/arztebl.2013.0541a

REFERENCES


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Conflict of interest statement
The author declares that no conflict of interest exists.

In Reply:

We thank our correspondents and other colleagues for their feedback on their analysis of phenprocoumon related bleeding complications and liver injuries (1). Dr Sroka reports on patients with atrial fibrillation who developed bleeding complications while taking guideline-conform prophylactic phenprocoumon or new oral anticoagulants (NOACs). At the same time he expresses hope that current guidelines will be rethought and assessed in the near future. As a matter of fact, in

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Dr Fischer is the provider of an education and treatment program for patients receiving long-term oral anticoagulation treatment. He has received honoraria for speaking from Roche.

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the scenario of guideline-conform therapy, it is primarily older patients who are given a multitude of medications for existing comorbidities, which may trigger interactions and adverse effects (2). The fundamental problem is that guidelines are based on randomized controlled studies that are more likely to include younger, less multimorbid patients who take far fewer additional medications (3). This does not do justice to the age-related higher risks associated with anticoagulant therapy (for example, after a fall), nor the potential interactions, for example, with phenprocoumon. Our analysis of the risk of bleeding complications associated with phenprocoumon treatment and practice conditions also showed a notable increase with older age. Especially the combination with analgesics, which is common in older age, represents a substantial risk factor for gastrointestinal bleeding complications. We have to concede, however, that, although we were able to quantify the risks of bleeding complications in detail, we were not able to calculate the benefit of anticoagulation—that is, the number of prevented thromboembolic complications in the studied population.

Dr Fischer in his reader’s letter emphasizes the importance of educational training programs for patients taking anticoagulants. In the context of our study, participation in and, where applicable, the intensity of, training programs were regrettably not documented. However, our results also show that the international normalized ratio (INR) was too high in about two-thirds of patients with bleeding complications. Routine clinical practice will show the extent to which exactly these patients benefit from NOACs (4). The product information for the three currently available NOACs includes dosage reductions and contraindications taking into consideration renal function—but the question remains about whether such dosage adjustments or stopping/switching medications are even feasible in routine clinical practice in older patients and in case of fluctuating renal function (5).

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