

The treatment of paroxysmal atrial fibrillation in UK primary care

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Title

The treatment of paroxysmal atrial fibrillation in UK primary care.

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ABSTRACT

Objective

To determine whether patients with paroxysmal atrial fibrillation (AF) are less likely to be treated with anticoagulants than patients with persistent/permanent AF, and to investigate trends in treatment between 2000 and 2015. UK and European guidelines recommend that anticoagulants are offered to all AF patients at increased risk of stroke, irrespective of AF type.

Methods

16 sequential cross-sectional analyses from 2000 to 2015 were carried out with index dates on 1st May each year. The data source was primary care data from 648 practices across the UK contributing to The Health Improvement Network (THIN) database. All patients with a diagnosis of AF aged ≥ 35 years and registered for at least one year were included. The main outcome measure was prescription of anticoagulant medication.

Results

The proportion of AF patients with a diagnosis of paroxysmal AF increased from 7.4% (95% CI 7.0, 7.8) in 2000 to 14.0% (95% CI 13.7, 14.3) in 2015. Among patients with a CHADS₂ score ≥ 1 , between 2000 and 2015 the proportion prescribed anticoagulants increased from 18.8% (95% CI 16.4, 21.4) to 56.2% (95% CI 55.0, 57.3) and from 34.2% (95% CI 33.3, 35.0) to 69.4% (95% CI 68.9, 69.8) in paroxysmal and other (persistent/permanent) AF patients respectively; RR for treatment of paroxysmal AF patients compared to other AF patients increased from 0.48 (95% CI 0.42, 0.55) to 0.76 (95% CI 0.74, 0.77). Adjusting for age, sex, Townsend score and presence or absence of contraindications had little effect on the results.

Conclusions

In 2000, eligible paroxysmal AF patients were half as likely to be treated with anticoagulants as other AF patients; this has improved over time, but in 2015, eligible paroxysmal AF patients were still around 20% less likely to be prescribed anticoagulant medication.

KEY MESSAGES

What is already known about this subject?

Patients with paroxysmal atrial fibrillation (AF) are at an elevated risk of stroke. Guidelines recommend anticoagulants for patients with paroxysmal AF.

What does this study add?

In 2000 patients with paroxysmal AF were half as likely to be prescribed anticoagulants as those with permanent AF. In 2015 patients with paroxysmal AF were 20% less likely to be prescribed anticoagulants as those with permanent AF.

How might this impact on clinical practice?

Clinicians should be aware that eligible patients with paroxysmal AF should be prescribed anticoagulants.

THE TREATMENT OF PAROXYSMAL ATRIAL FIBRILLATION IN UK PRIMARY CARE

INTRODUCTION

Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia and a major global public health problem. It is associated with a five-fold increase in risk of stroke, increased incidence of congestive heart failure, and higher mortality.¹

Recurrent AF is either labelled ‘paroxysmal’ when it is self-terminating or ‘persistent’ when it lasts more than 7 days or is terminated earlier using either pharmacological means or direct current cardioversion; AF is defined as permanent when cardioversion fails to restore normal heart rhythm.² Evidence varies regarding the similarity in stroke risk between paroxysmal, persistent and permanent AF patients: some studies have shown comparable stroke risk, while others suggest that risk may be lower in paroxysmal AF patients.^{3,4,5,6,7,8} Nevertheless, paroxysmal AF patients remain at an elevated risk of stroke relative to patients without AF. Within 1.5 years over a fifth of patients with paroxysmal AF progress to permanent AF.^{9,10}

Prophylactic treatment of AF with anticoagulants reduces risk of stroke by approximately two thirds.^{11,12,13,14,15} Current UK and European guidelines recommend that anticoagulants are offered to all AF patients with a CHA₂DS₂-VASc score ≥ 2 , and are considered for men with a CHA₂DS₂-VASc score of 1, regardless of whether the pattern of AF is paroxysmal, persistent or permanent, or the duration of AF.^{1,16,17,18}

Recent data from two international studies, the GARFIELD Registry and the GLORIA-AF Registry, indicate that anticoagulant therapy is not consistently prescribed across AF categories, with lower rates of use in paroxysmal AF patients than in those with persistent or permanent AF.^{19,20,21}

The aim of this analysis was to determine whether patients with paroxysmal AF are less likely to be treated with anticoagulants than patients with persistent or permanent AF in the UK, and to investigate trends in treatment between 2000 and 2015. To date, this question has not been addressed in a UK primary care setting.

METHODS

Data source

Analysis was performed using data from The Health Improvement Network (THIN), an anonymised database of electronic medical records from UK general practices using Vision software. The version of the THIN database used in this study (THIN1505) included primary care data for approximately 14.0 million patients at 648 practices across the UK. General practices were eligible for inclusion in the study from the latest of: the practice acceptable mortality recording (AMR) date,²² the Vision installation date, and the study start date (one year prior to the first index date).

Study design

Sixteen sequential cross-sectional analyses were carried out with index dates on 1st May each year from 2000 to 2015. All analyses were conducted using StataIC 13. Data was not used prior to 2000 as there were fewer practices and patients contributing data, and data accuracy is better in more recent years.

The study population included all patients with a diagnosis of atrial fibrillation aged 35 years and over on the index date who were registered at least one year prior to the index date. The exposure was a diagnosis of paroxysmal AF, with all other types of AF (persistent or permanent AF, hereafter referred to as 'other AF') as the comparator group. Outcome was treatment with anticoagulants.

Analysis

The proportions of patients with paroxysmal AF and other AF prescribed anticoagulants on each index date were calculated, with 95% confidence intervals (CI); p-values for trends in treatment between 2000 and 2015 were calculated using chi-squared tests. Patients were stratified according to eligibility for anticoagulant treatment: in primary analysis, this was defined according to CHADS₂ score (≥ 1), since CHADS₂ score has been in use for a longer period of time than CHA₂DS₂-VASc score;^{23,24} in sensitivity analysis, eligibility was defined according to CHA₂DS₂-VASc score (≥ 1). Crude and adjusted risk ratios (RR) were calculated on each index date. RRs were calculated using Cox regression, setting follow-up time to 1 for all patients, using the Breslow method to break ties, and using the robust variance estimator;²⁵ RRs were adjusted for age and sex only, and for age, sex, Townsend score, CHADS₂ score, and presence of any contraindication.

Definitions of variables

AF was defined as a clinical code for atrial fibrillation or atrial flutter recorded ever prior to the index date, excluding patients with a clinical code indicating AF resolved recorded on or after the last recorded AF clinical code and prior to the index date. Patients were categorised as having paroxysmal AF if the last AF clinical code prior to the index date indicated paroxysmal atrial fibrillation or paroxysmal atrial flutter; otherwise patients were categorised as having other (persistent or permanent) AF. Current anticoagulant treatment was defined as a record of a prescription for any anticoagulant drug (including warfarin, parenteral anticoagulants, other vitamin K antagonists and new oral anticoagulants) within 90 days prior to the index date or a clinical code indicating provision of anticoagulant therapy within 365 days prior to the index date.

CHADS₂ scores were calculated by adding one point for a history of congestive heart failure, hypertension, age ≥ 75 and diabetes, and two points for a history of stroke or transient ischaemic attack (TIA). CHA₂DS₂-VASc scores were calculated by adding one point for a history of congestive heart failure, hypertension, diabetes, vascular disease, age 65-74 years and female sex (if another risk factor was present, otherwise 0), and two points for age ≥ 75 and history of stroke, TIA or thromboembolism. History of congestive heart failure, stroke, TIA, thromboembolism, vascular disease and diabetes were defined by a relevant clinical code recorded ever prior to the index date, excluding patients with a clinical code indicating diabetes resolved recorded after the last recorded diabetes code and prior to the index date; hypertension was defined as a current (previous 90 days) prescription of antihypertensive drugs or the mean of the three most recent systolic blood pressures in the last 3 years ≥ 160 mm Hg.

Contraindications to anticoagulants were defined as a clinical code within the 2 years prior to the index date of peptic ulcer, intracranial, intraocular or retroperitoneal bleeding, bleeding disorders, haemorrhagic stroke, oesophageal varices, aneurysm, or proliferative retinopathy; a clinical code recording allergy or adverse reactions to anticoagulants ever prior to the index date; a clinical code indicating pregnancy in the 9 months prior to the index date; or severe hypertension with a mean (of the 3 most recent measures in the last 3 years prior to the index date) systolic blood pressure >200 mm Hg or diastolic blood pressure >120 mm Hg.

RESULTS

A total of 179,343 of the 4,419,659 patients eligible for inclusion in the study between 2000 and 2015 had AF. As an individual could contribute to the analysis in more than one year, the analyses consisted of a total of 848,852 AF patient records. The proportion of AF patients with a diagnosis of paroxysmal AF increased from 7.4% (95% CI 7.0, 7.8) in 2000 to 14.0%

(95% CI 13.7, 14.3) in 2015, an increase in prevalence from 0.14% (95% CI 0.13, 0.15) to 0.43% (95% CI 0.42, 0.44). Baseline characteristics of paroxysmal and other (persistent/permanent) AF patients are shown in Table 1. Across all years, in paroxysmal compared to other AF patients the mean age was 4.5 years (95% CI 4.4, 4.6) lower; 6.4% (95% CI 6.1, 6.7) fewer were males; mean CHADS₂ score was 0.43 (95% CI 0.42, 0.44) points lower; 1.6% (95% CI 1.4, 1.8) fewer were in the most deprived Townsend quintile; and 0.5% (95% CI 0.4, 0.7) fewer had one or more contraindications to anticoagulants.

Over the 15 year period studied, the proportion of paroxysmal AF patients prescribed anticoagulants increased from 16.0% (95% CI 14.0, 18.2) to 50.7% (95% CI 49.6, 51.8), while the proportion of other AF patients prescribed anticoagulants increased from 33.5% (95% CI 32.7, 34.3) to 67.1% (95% CI 66.6, 67.5). Among eligible patients only, defined as those with a CHADS₂ score of 1 or more, the proportion of paroxysmal AF patients prescribed anticoagulants increased from 18.8% (95% CI 16.4, 21.4) to 56.2% (95% CI 55.0, 57.3), and the proportion of other AF patients increased from 34.2% (95% CI 33.3, 35.0) to 69.4% (95% CI 68.9, 69.8) (Figure 1).

In 2000, paroxysmal AF patients were half as likely to receive anticoagulant treatment as other AF patients, risk ratio (RR) 0.48 (95% CI 0.42, 0.55); this disparity has declined, particularly since 2011/12, but in 2015, paroxysmal AF patients are still less likely to be prescribed anticoagulants, RR 0.76 (95% CI 0.74, 0.77) (Table 2). Adjusting for age, sex, Townsend score, CHADS₂ score and presence or absence of contraindications made only a small difference to the results: fully adjusted RR increased from 0.41 (95% CI 0.36, 0.48) in 2000 to 0.77 (95% CI 0.75, 0.79) in 2015.

Among only those AF patients eligible for anticoagulant treatment, RR increased from 0.55 (95% CI 0.48, 0.63) to 0.81 (95% CI 0.79, 0.83) between 2000 and 2015. Adjusting for age,

sex, Townsend score and presence or absence of contraindications had little effect on the results in recent years, but caused an increase in effect size in earlier years: adjusted RR increased from 0.46 (95% CI 0.40, 0.53) in 2000 to 0.80 (95% CI 0.79, 0.82) in 2015 (Table 2); the slightly increased effect of adjustment in earlier years is likely to be due the greater difference in mean age between paroxysmal and other AF patients, particularly between 2000 and 2006. In sensitivity analysis, eligibility for anticoagulant treatment was defined according to CHA₂DS₂-VASc score (1 or more); this made only a marginal difference to the observed RRs (Supplementary Table 1).

Table 1: Baseline characteristic of AF patients with paroxysmal or other AF, 2000-2015

Year AF type	n (%)	Age Mean (SD)	Sex (male) n (%)	CHADS ₂ score			Most deprived quintile n (%)	One or more contra- indication n (%)
				0 n (%)	1 n (%)	2+ n (%)		
2000 Paroxysmal	1169 (7.4)	69.4 (12.5)	589 (50.4)	248 (21.2)	448 (38.3)	473 (40.5)	145 (13.1)	62 (5.3)
2000 Other	14627 (92.6)	75.5 (10.7)	7567 (51.7)	1613 (11.0)	3982 (27.2)	9032 (61.8)	1906 (14.0)	771 (5.3)
2001 Paroxysmal	2111 (8.6)	70.5 (12.4)	1027 (48.7)	422 (20.0)	759 (36.0)	930 (44.1)	226 (11.2)	117 (5.5)
2001 Other	22426 (91.4)	75.6 (10.8)	11740 (52.4)	2296 (10.2)	6018 (26.8)	14112 (62.9)	2731 (12.9)	1298 (5.8)
2002 Paroxysmal	2980 (9.4)	70.4 (12.3)	1467 (49.2)	574 (19.3)	1051 (35.3)	1355 (45.5)	316 (11.1)	183 (6.1)
2002 Other	28713 (90.6)	75.8 (10.7)	15101 (52.6)	2707 (9.4)	7439 (25.9)	18567 (64.7)	3492 (12.8)	1843 (6.4)
2003 Paroxysmal	4126 (10.1)	70.7 (12.2)	2023 (49.0)	762 (18.5)	1409 (34.2)	1955 (47.4)	441 (11.2)	270 (6.5)
2003 Other	36762 (89.9)	75.8 (10.8)	19510 (53.1)	3235 (8.8)	9469 (25.8)	24058 (65.4)	4355 (12.5)	2326 (6.3)
2004 Paroxysmal	4827 (10.6)	70.9 (12.2)	2333 (48.3)	789 (16.4)	1645 (34.1)	2393 (49.6)	519 (11.1)	313 (6.5)
2004 Other	40502 (89.4)	76.0 (10.8)	21533 (53.2)	3298 (8.1)	10162 (25.1)	27042 (66.8)	4716 (12.1)	2658 (6.6)
2005 Paroxysmal	5588 (10.9)	71.1 (12.3)	2705 (48.4)	905 (16.2)	1873 (33.5)	2810 (50.3)	568 (10.4)	336 (6.0)
2005 Other	45584 (89.1)	76.1 (10.8)	24411 (53.6)	3460 (7.6)	11478 (25.2)	30646 (67.2)	5209 (11.8)	2944 (6.5)
2006 Paroxysmal	6476 (11.6)	71.4 (12.2)	3127 (48.3)	1022 (15.8)	2162 (33.4)	3292 (50.8)	661 (10.5)	350 (5.4)
2006 Other	49463 (88.4)	76.2 (10.9)	26666 (53.9)	3586 (7.3)	12301 (24.9)	33576 (67.9)	5645 (11.8)	3152 (6.4)
2007 Paroxysmal	6781 (11.6)	72.0 (12.1)	3269 (48.2)	923 (13.6)	2242 (33.1)	3616 (53.3)	658 (10.0)	371 (5.5)
2007 Other	51714 (88.4)	76.6 (10.7)	28036 (54.2)	3224 (6.2)	12689 (24.5)	35801 (69.2)	5739 (11.4)	3116 (6.0)
2008 Paroxysmal	7460 (12.1)	72.3 (12.0)	3556 (47.7)	960 (12.9)	2453 (32.9)	4047 (54.3)	715 (9.8)	372 (5.0)
2008 Other	54066 (87.9)	76.8 (10.7)	29567 (54.7)	3099 (5.7)	12938 (23.9)	38029 (70.3)	6048 (11.5)	3238 (6.0)
2009 Paroxysmal	8299 (12.7)	72.4 (11.9)	3981 (48.0)	1029 (12.4)	2733 (32.9)	4537 (54.7)	794 (9.8)	437 (5.3)
2009 Other	57253 (87.3)	76.8 (10.6)	31659 (55.3)	3019 (5.3)	13554 (23.7)	40680 (71.1)	6288 (11.2)	3532 (6.2)
2010 Paroxysmal	8620 (13.0)	72.4 (12.1)	4175 (48.4)	1065 (12.4)	2818 (32.7)	4737 (55.0)	830 (9.9)	463 (5.4)
2010 Other	57825 (87.0)	76.9 (10.7)	32263 (55.8)	2899 (5.0)	13567 (23.5)	41359 (71.5)	6316 (11.2)	3561 (6.2)
2011 Paroxysmal	9182 (13.5)	72.6 (12.0)	4413 (48.1)	1090 (11.9)	2982 (32.5)	5110 (55.7)	863 (9.6)	516 (5.6)
2011 Other	59011 (86.5)	77.0 (10.7)	33171 (56.2)	2891 (4.9)	13689 (23.2)	42431 (71.9)	6356 (11.0)	3587 (6.1)
2012 Paroxysmal	9641 (13.8)	72.7 (12.0)	4650 (48.2)	1138 (11.8)	3065 (31.8)	5438 (56.4)	875 (9.3)	514 (5.3)
2012 Other	60012 (86.2)	77.0 (10.7)	33900 (56.5)	2899 (4.8)	13834 (23.1)	43279 (72.1)	6508 (11.1)	3734 (6.2)
2013 Paroxysmal	9638 (13.9)	72.7 (12.0)	4754 (49.3)	1156 (12.0)	3015 (31.3)	5467 (56.7)	890 (9.5)	551 (5.7)
2013 Other	59595 (86.1)	76.9 (10.8)	33956 (57.0)	2984 (5.0)	13677 (23.0)	42934 (72.0)	6618 (11.4)	3697 (6.2)
2014 Paroxysmal	9368 (14.0)	72.7 (12.1)	4674 (49.9)	1136 (12.1)	2919 (31.2)	5313 (56.7)	860 (9.4)	568 (6.1)
2014 Other	57580 (86.0)	76.9 (10.8)	32939 (57.2)	2913 (5.1)	13028 (22.6)	41639 (72.3)	6206 (11.0)	3525 (6.1)
2015 Paroxysmal	8036 (14.0)	72.7 (12.2)	4082 (50.8)	1006 (12.5)	2458 (30.6)	4572 (56.9)	753 (9.6)	467 (5.8)
2015 Other	49417 (86.0)	76.9 (10.9)	28534 (57.7)	2544 (5.2)	11172 (22.6)	35701 (72.2)	5428 (11.3)	2886 (5.8)

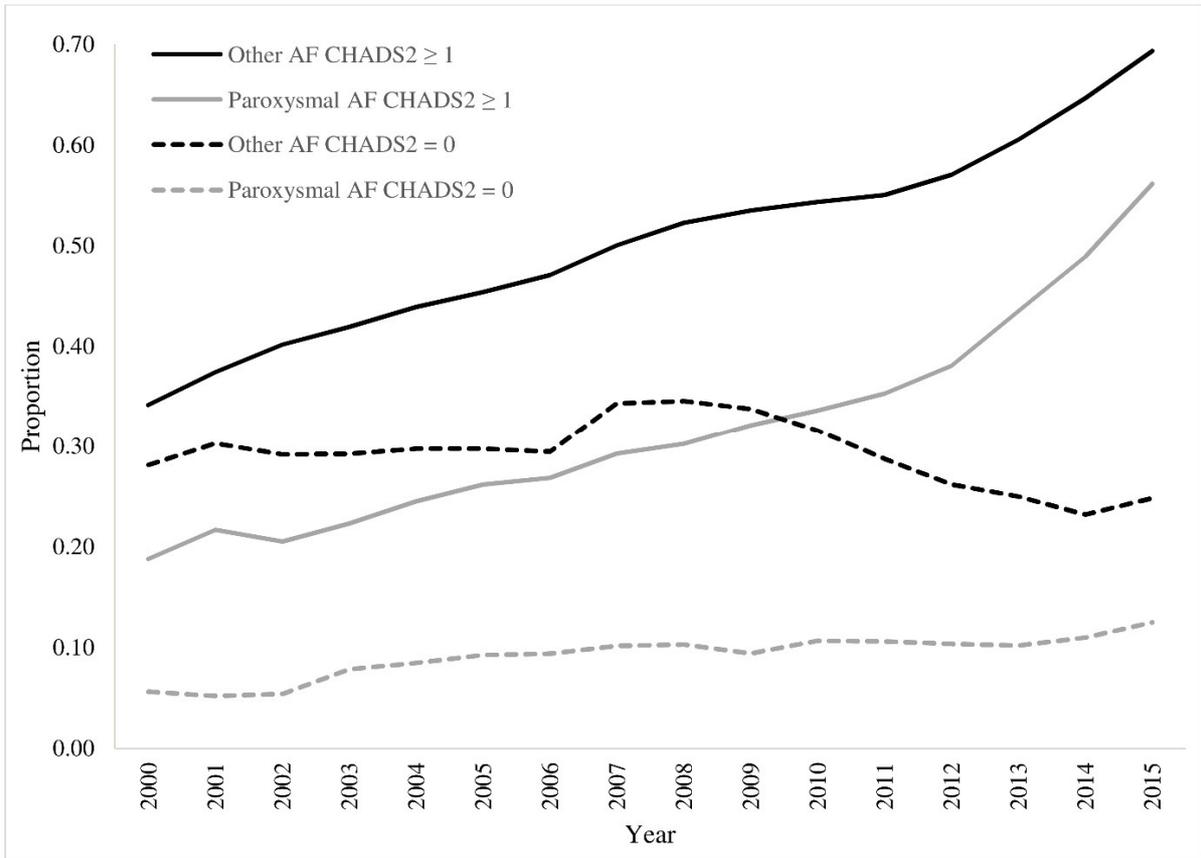


Figure 1. Proportion of paroxysmal and other AF patients prescribed anticoagulant treatment by CHADS₂ score, 2000-2015

Table 2: Risk ratios for anticoagulant treatment of paroxysmal AF patients relative to other AF patients, 2000-2015

Year	All			Eligible CHADS ₂ ≥ 1		Ineligible CHADS ₂ = 0
	Unadjusted	Adjusted for age and sex	Fully adjusted [†]	Unadjusted	Fully adjusted ^{††}	Unadjusted
	RR (95% CI)	RR (95% CI)	RR (95% CI)	RR (95% CI)	RR (95% CI)	RR (95% CI)
2000	0.48 (0.42, 0.55)	0.43 (0.37, 0.49)	0.41 (0.36, 0.48)	0.55 (0.48, 0.63)	0.46 (0.40, 0.53)	0.20 (0.12, 0.34)
2001	0.50 (0.46, 0.55)	0.46 (0.42, 0.51)	0.46 (0.42, 0.51)	0.58 (0.53, 0.64)	0.52 (0.48, 0.58)	0.17 (0.11, 0.26)
2002	0.45 (0.42, 0.49)	0.42 (0.39, 0.46)	0.42 (0.38, 0.45)	0.51 (0.47, 0.55)	0.47 (0.43, 0.51)	0.19 (0.13, 0.26)
2003	0.48 (0.45, 0.51)	0.46 (0.43, 0.49)	0.46 (0.43, 0.49)	0.53 (0.50, 0.57)	0.50 (0.47, 0.53)	0.27 (0.21, 0.35)
2004	0.51 (0.49, 0.54)	0.49 (0.46, 0.52)	0.49 (0.46, 0.52)	0.56 (0.53, 0.59)	0.52 (0.49, 0.55)	0.29 (0.23, 0.36)
2005	0.53 (0.51, 0.56)	0.51 (0.49, 0.54)	0.51 (0.48, 0.53)	0.58 (0.55, 0.61)	0.54 (0.51, 0.57)	0.31 (0.25, 0.39)
2006	0.53 (0.50, 0.55)	0.51 (0.49, 0.53)	0.51 (0.48, 0.53)	0.57 (0.55, 0.60)	0.54 (0.51, 0.56)	0.32 (0.26, 0.39)
2007	0.54 (0.52, 0.57)	0.52 (0.50, 0.55)	0.52 (0.50, 0.54)	0.58 (0.56, 0.61)	0.55 (0.53, 0.58)	0.30 (0.24, 0.36)
2008	0.54 (0.52, 0.56)	0.52 (0.50, 0.54)	0.52 (0.50, 0.54)	0.58 (0.56, 0.60)	0.55 (0.53, 0.57)	0.30 (0.25, 0.36)
2009	0.56 (0.54, 0.58)	0.55 (0.53, 0.57)	0.55 (0.53, 0.56)	0.60 (0.58, 0.62)	0.58 (0.56, 0.60)	0.28 (0.23, 0.34)
2010	0.58 (0.56, 0.60)	0.57 (0.55, 0.59)	0.57 (0.55, 0.59)	0.62 (0.60, 0.64)	0.60 (0.58, 0.62)	0.34 (0.28, 0.41)
2011	0.60 (0.58, 0.62)	0.60 (0.58, 0.62)	0.60 (0.58, 0.62)	0.64 (0.62, 0.66)	0.63 (0.61, 0.65)	0.37 (0.31, 0.44)
2012	0.63 (0.61, 0.64)	0.63 (0.61, 0.65)	0.63 (0.61, 0.64)	0.67 (0.65, 0.69)	0.65 (0.64, 0.67)	0.40 (0.33, 0.47)
2013	0.67 (0.66, 0.69)	0.68 (0.66, 0.70)	0.68 (0.66, 0.70)	0.72 (0.70, 0.74)	0.71 (0.69, 0.73)	0.41 (0.34, 0.49)
2014	0.71 (0.69, 0.73)	0.72 (0.71, 0.74)	0.72 (0.70, 0.74)	0.76 (0.74, 0.77)	0.75 (0.73, 0.77)	0.47 (0.40, 0.57)
2015	0.76 (0.74, 0.77)	0.77 (0.76, 0.79)	0.77 (0.75, 0.79)	0.81 (0.79, 0.83)	0.80 (0.79, 0.82)	0.50 (0.42, 0.60)

All p values < 0.001. [†]Adjusted for age, sex, Townsend score, CHADS₂ score and presence or absence of contraindications (binary). ^{††}Adjusted for age, sex, Townsend score and presence or absence of contraindications.

DISCUSSION

Paroxysmal AF is becoming more commonly recorded as a diagnosis in UK primary care. Patients with paroxysmal AF are less likely to be treated with anticoagulants than patients with other types of AF: in 2000, paroxysmal AF patients who were eligible for treatment were almost half as likely to receive anticoagulants as other AF patients, and while this has been steadily improving over the last 15 years, paroxysmal AF patients continue to be around 20% less likely to receive anticoagulants than other AF patients. This holds true after adjusting the data for age, sex and other potential confounders. The absolute anticoagulant treatment gap for paroxysmal AF remained relatively constant between 2002 and 2012, at around 20%; in recent years, this gap has narrowed, but remains around 13%.

These results are consistent with findings from studies carried out in the USA among hospital outpatients with AF, in which paroxysmal AF patients were found to be around 20% less likely to receive oral anticoagulants than patients with persistent/permanent AF after adjusting for potential confounders.^{26,27} Similar results were also found in a study of AF patients admitted to hospital in Greece,²⁸ and in the Euro Heart Survey on Atrial Fibrillation, an observational study of AF patients attending hospital in the ESC member countries (including the UK).²⁹ No comparable studies using primary care data in the UK are known to the authors.

ESC guideline-adherent antithrombotic management is associated with significantly better outcomes, including those related to mortality, thromboembolism, stroke and transient ischaemic attack.³⁰ Current treatment practice does not appear to closely follow published treatment guidelines,³¹ which most likely results in elevated levels of preventable ischaemic stroke among patients with paroxysmal AF, even more so than in the wider atrial fibrillation population, leading to greater morbidity, mortality and overall cost to health care systems.^{32,33}

Further research is needed to establish whether the difference in treatment between paroxysmal and other AF patients is the result of lower levels of treatment initiation by clinicians or whether paroxysmal AF patients are more likely to stop their treatment, and to explore reasons why this is the case.²⁰ This will facilitate the development of methods to improve guideline adherence and/or uptake of anticoagulant prophylaxis, leading to improved outcomes for patients with paroxysmal AF.⁷

Strengths and limitations

This study utilises a large dataset which is representative of the AF population in UK primary care, and includes recent data up to 2015. The dataset comprises routinely collected data used by GPs to make clinical decisions.

It is possible that AF type could be misclassified, as some cases of paroxysmal AF may be recorded under a non-specific AF clinical code; however, this is more likely to dilute rather than inflate observed effect sizes. Treatment may be underreported if patients are prescribed anticoagulants by their hospital; however, most anticoagulants are prescribed in primary care, and most secondary care prescriptions should be captured by anticoagulant/INR monitoring clinical codes, so underreporting is likely to be minimal.

CONCLUSION

Patients with paroxysmal AF are less likely to be treated with anticoagulants than patients with persistent or permanent AF. This difference is not explained by differences in patient demographics, stroke risk, or contraindications. The question remains as to whether the difference in treatment between paroxysmal and other AF patients is the result of lower levels of treatment initiation by clinicians or whether paroxysmal AF patients are more likely to stop their treatment, and to explore the reasons why.

CONTRIBUTION

AI had the original research idea. RR undertook data extraction. NA designed and performed the analysis. NA and AI wrote the first draft of the paper, which was revised in collaboration with TM, DF and RR.

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COMPETING INTERESTS

The authors have no competing interests to declare.

ETHICS

The THIN data collection scheme and research carried out using THIN data were approved by the NHS South-East Multicentre Research Ethics Committee (MREC) in 2003; under the terms of this ethics approval, studies must undergo scientific review. Approval for this analysis was obtained from the Scientific Review Committee (for the use of THIN data) on 2nd April 2015 (SRC reference number 15THIN021).

LICENCE

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TRANSPARENCY DECLARATION

The lead author, Andrea Isaew, affirms that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

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Supplementary Table 1: Risk ratios for treatment of paroxysmal AF patients relative to other AF patients using CHA₂DS₂-VASc score to define eligibility, 2000-2015

Year	Eligible CHA ₂ DS ₂ -VASc ≥ 1		Ineligible CHA ₂ DS ₂ - VASc = 0
	Unadjusted RR (95% CI)	Fully adjusted [†] RR (95% CI)	Unadjusted RR (95% CI)
2000	0.52 (0.46, 0.60)	0.44 (0.38, 0.51)	0.17 (0.08, 0.38)
2001	0.55 (0.50, 0.60)	0.50 (0.45, 0.55)	0.16 (0.09, 0.30)
2002	0.50 (0.46, 0.54)	0.45 (0.42, 0.49)	0.12 (0.06, 0.22)
2003	0.52 (0.49, 0.55)	0.49 (0.45, 0.52)	0.27 (0.19, 0.40)
2004	0.55 (0.52, 0.58)	0.52 (0.49, 0.54)	0.19 (0.12, 0.29)
2005	0.57 (0.54, 0.59)	0.53 (0.51, 0.56)	0.25 (0.18, 0.37)
2006	0.56 (0.53, 0.58)	0.53 (0.51, 0.55)	0.30 (0.22, 0.41)
2007	0.58 (0.55, 0.60)	0.55 (0.52, 0.57)	0.22 (0.15, 0.31)
2008	0.57 (0.55, 0.59)	0.54 (0.52, 0.56)	0.26 (0.19, 0.37)
2009	0.59 (0.57, 0.61)	0.57 (0.55, 0.59)	0.23 (0.16, 0.33)
2010	0.61 (0.59, 0.63)	0.59 (0.57, 0.61)	0.35 (0.26, 0.48)
2011	0.63 (0.61, 0.65)	0.62 (0.60, 0.64)	0.34 (0.25, 0.47)
2012	0.66 (0.64, 0.67)	0.64 (0.63, 0.66)	0.38 (0.27, 0.52)
2013	0.71 (0.69, 0.72)	0.70 (0.68, 0.71)	0.41 (0.30, 0.57)
2014	0.74 (0.73, 0.76)	0.74 (0.72, 0.76)	0.41 (0.29, 0.59)
2015	0.80 (0.78, 0.81)	0.79 (0.78, 0.81)	0.37 (0.24, 0.56)

All p values < 0.001. [†]Adjusted for age, sex, Townsend score and presence or absence of contraindications (binary).