

Anticoagulation for atrial fibrillation

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TO THE EDITOR: As a geriatric medicine fellow, I eagerly read Hagerty and Rich's review "Fall risk and anticoagulation for atrial fibrillation in the elderly: A delicate balance"¹ and Suh's editorial, "Whether to anticoagulate: Toward a more reasoned approach"² in the January 2017 issue. Both pieces were helpful and informative.

I appreciate that Dr. Suh encourages shared decision-making between physicians and patients that balances patient preferences and risk stratification to inform whether to anticoagulate. He states, "Unfortunately, there is no similar screening tool to predict bleeding risk from anticoagulation with greater precision in the middle to lower part of the risk spectrum...The patient's life expectancy and personal preferences are important independent factors that affect the decision of whether to anticoagulate or not."

Dr. Mark Eckman's Atrial Fibrillation Decision Support Tool (AFDST) incorporates patients' CHA₂DS₂-VASc and HAS-BLED scores to determine their quality-adjusted life expectancy on or off anticoagulation. The tool helps guide physicians and patients to make shared decisions about anticoagulation.³⁻⁵ The AFDST informs clinicians if a patient is undertreated or being treated unnecessarily. Eckman and his colleagues have demonstrated the AFDST's effective application in clinical practice, including for older adults. I invite readers to learn more about Eckman's work!

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IN REPLY: I appreciate Dr. Henning's letter in response to my editorial.¹ Indeed, Dr. Eckman's Atrial Fibrillation Decision Support Tool (AFDST) is useful for determining quality-adjusted life expectancy on or off anticoagulation, and could possibly help with shared decision-making in regard to anticoagulation.²⁻⁴

However, the AFDST does not incorporate personal preferences regarding anticoagulant or medication use in general. Many older adults are on too many medications (ie, polypharmacy) and wish to reduce their overall pill count.

A number of potential barriers to shared decision-making regarding medication use have been identified, including poor physician communication skills, the growing number of available medications, multiple prescribers for the same patient, lack of trust in the prescribing physician, and patients feeling that their preferences are not valued or important.⁵ Until communication and acceptance between prescribers and patients regarding possible medication choices improves, shared decision-making for medication use in general and anticoagulant use in particular will be an unfulfilled ideal.

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Cardiac mass: Tumor or thrombus?

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TO THE EDITOR: We read with great interest the article by Patnaik et al¹ about a patient who had a cardiac metastasis of ovarian cancer, and we would like to raise a few points.

It is important to clarify that metastatic cardiac tumors are not necessarily malignant. Intravenous leiomyomatosis is a benign small-muscle tumor that can spread to the heart, causing various cardiac symptoms.² Even with extensive disease, patients with intravenous leiomyomatosis may remain asymptomatic until cardiac involvement occurs. The most common cardiac symptoms are dyspnea, syncope, and lower-extremity edema.

Cardiac involvement in intravenous leiomyomatosis may occur via direct invasion or hematogenous or lymphatic spread of the tumor. In leiomyoma and leiomyosarcoma, cardiac invasion usually occurs via direct spread through the inferior vena cava into the right atrium and ventricle. Thus, cardiac involvement with these tumors (except for nephroma) was reported to exclusively involve the right side of the heart.

In 2014, we reported a unique case of intravenous leiomyomatosis that extended from the right side into the left side of the heart and the aorta via an atrial septal defect.² Intracardiac extension of intravenous leiomyomatosis may result in pulmonary embolism, systemic embolization if involving the left

side, and, rarely, sudden death.²

In patients with malignancy, differentiating between thrombosis and tumor is critical. These patients have a hypercoagulable state and a fourfold increase in thrombosis risk, and chemotherapy increases this risk even more.³ Although tissue pathology examination is important for differentiating thrombosis from tumor, visualization of the direct extension of the mass from the primary source into the heart through the inferior vena cava by ultrasonography, computed tomography, or magnetic resonance imaging may help in making this distinction.²

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