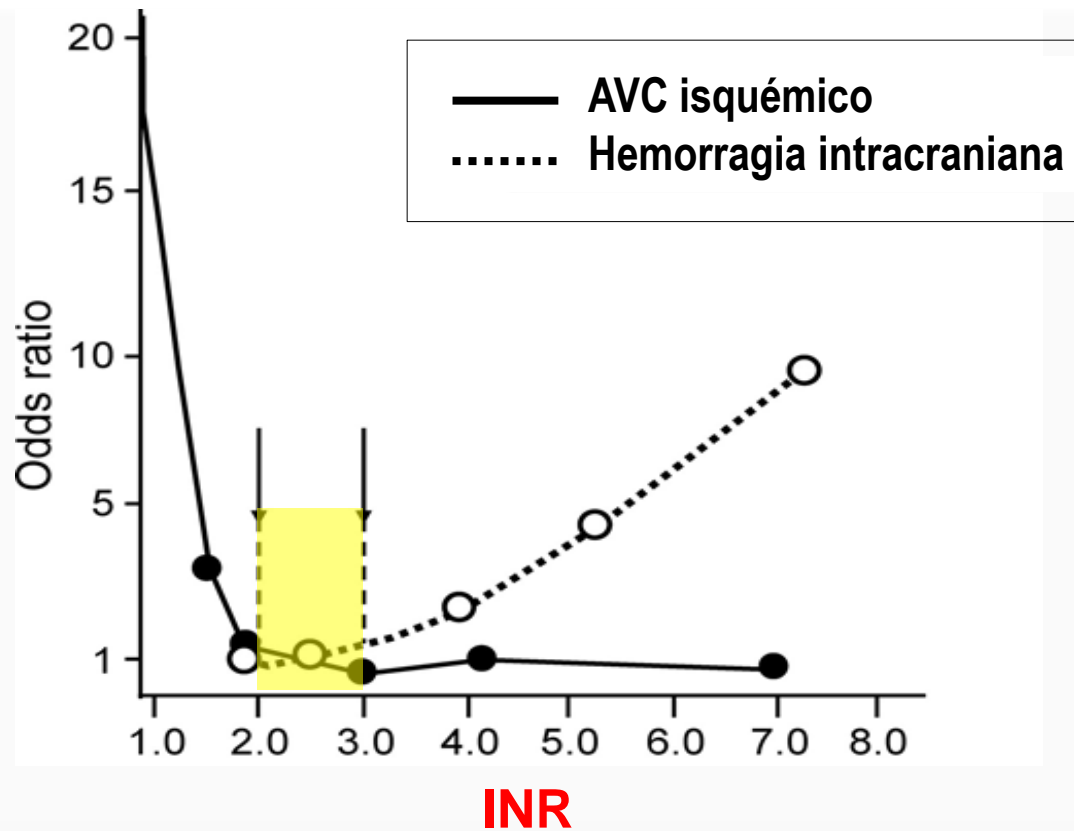


15 DE ABRIL — 6ª FEIRA

AS NOVAS GUIDELINES PARA A TERAPÊUTICA ANTITROMBÓTICA NA FIBRILHAÇÃO AURICULAR

**ANTÓNIO PEDRO MACHADO
CARLOS RABAÇAL**

Intervalo terapêutico estreito



ACC/AHA/ESC 2006 Guidelines for the Management of Patients With Atrial Fibrillation

A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the European Society of Cardiology Committee for Practice Guidelines (Writing Committee to Revise the 2001 Guidelines for the Management of Patients With Atrial Fibrillation)

Developed in Collaboration With the European Heart Rhythm Association and the Heart Rhythm Society

WRITING COMMITTEE MEMBERS

Valentin Fuster, MD, PhD, FACC, FAHA, FESC, Co-Chair;
Lars E. Rydén, MD, PhD, FACC, FESC, FAHA, Co-Chair; David S. Cannom, MD, FACC;
Harry J. Crijns, MD, FACC, FESC*; Anne B. Curtis, MD, FACC, FAHA;
Kenneth A. Ellenbogen, MD, FACC†; Jonathan L. Halperin, MD, FACC, FAHA; Jean-Yves Le Heuzey, MD, FESC;
G. Neal Kay, MD, FACC; James E. Lowe, MD, FACC; S. Bertil Olsson, MD, PhD, FESC;
Eric N. Prystowsky, MD, FACC; Juan Luis Tamargo, MD, FESC; Samuel Wann, MD, FACC, FESC

ACC/AHA TASK FORCE MEMBERS

Sidney C. Smith, Jr, MD, FACC, FAHA, FESC, Chair; Alice K. Jacobs, MD, FACC, FAHA, Vice-Chair;
Cynthia D. Adams, MSN, APRN-BC, FAHA; Jeffery L. Anderson, MD, FACC, FAHA;
Elliott M. Antman, MD, FACC, FAHA‡; Jonathan L. Halperin, MD, FACC, FAHA;
Sharon Ann Hunt, MD, FACC, FAHA; Rick Nishimura, MD, FACC, FAHA; Joseph P. Ornato, MD, FACC, FAHA;
Richard L. Page, MD, FACC, FAHA; Barbara Riegel, DNSc, RN, FAHA

ESC COMMITTEE FOR PRACTICE GUIDELINES

Silvia G. Priori, MD, PhD, FESC, Chair; Jean-Jacques Blanc, MD, FESC, France; Andrzej Budaj, MD, FESC, Poland;
A. John Camm, MD, FESC, FACC, FAHA, United Kingdom; Veronica Dean, France;
Jaap W. Deckers, MD, FESC, The Netherlands; Catherine Despres, France;
Kenneth Dickstein, MD, PhD, FESC, Norway; John Lekakis, MD, FESC, Greece; Keith McGregor, PhD, France;
Marco Metra, MD, Italy; Joao Morais, MD, FESC, Portugal; Ady Osterspey, MD, Germany;
Juan Luis Tamargo, MD, FESC, Spain; José Luis Zamorano, MD, FESC, Spain

*European Heart Rhythm Association Official Representative.

†Heart Rhythm Society Official Representative.

‡Immediate Past Chair.

This document was approved by the American College of Cardiology Foundation Board of Trustees in June 2006; by the American Heart Association Science Advisory and Coordinating Committee in June 2006; and by the European Society of Cardiology Committee for Practice Guidelines in June 2006.

When this document is cited, the American College of Cardiology Foundation, the American Heart Association, and the European Society of Cardiology request that the following citation format be used: Fuster V, Rydén LE, Cannom DS, Crijns HJ, Curtis AB, Ellenbogen KA, Halperin JL, Le Heuzey J-Y, Kay GN, Lowe JE, Olsson SB, Prystowsky EN, Tamargo JL, Wann S, Smith SC Jr, Jacobs AK, Adams CD, Anderson JL, Antman EM, Hunt SA, Nishimura R, Ornato JP, Page RL, Riegel B, Priori SG, Blanc JJ, Budaj A, Camm AJ, Dean V, Deckers JW, Despres C, Dickstein K, Lekakis J, McGregor K, Metra M, Morais J, Osterspey A, Zamorano JL. ACC/AHA/ESC 2006 guidelines for the management of patients with atrial fibrillation: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the European Society of Cardiology Committee for Practice Guidelines (Writing Committee to Revise the 2001 Guidelines for the Management of Patients With Atrial Fibrillation). *Circulation*. 2006;114:e257-e354.

This article has been copublished in the August 15, 2006, issues of *Circulation* and the *Journal of the American College of Cardiology* and the September 2006 issue of *Europace*.

Copies: This document is available on the World Wide Web sites of the American College of Cardiology (www.acc.org), the American Heart Association (www.americanheart.org), and the European Society of Cardiology (www.escardio.org). Single and bulk reprints of both the online full-text guidelines and the published executive summary (published in the August 15, 2006, issues of the *Journal of the American College of Cardiology* and *Circulation* and the August 16, 2006, issue of the *European Heart Journal*) are available from Oxford University Press by contacting Special Sales (special.sales@oxfordjournals.org), Journals Division, Oxford University Press, Great Clarendon Street, Oxford, OX2 6DP, UK. Phone +44 (0) 1865 353827, Fax +44 (0) 1865 353774, Work Mobile +44 07841322925. Single copies of the executive summary and the full-text guidelines are also available by calling 800-253-4636 or writing the American College of Cardiology Foundation, Resource Center, at 9111 Old Georgetown Road, Bethesda, MD 20814-1699. To purchase bulk reprints, fax 212-633-3820 or e-mail reprints@elsevier.com.

Permissions: Multiple copies, modification, alteration, enhancement, and/or distribution of this document are not permitted without the express permission of the American Heart Association or the European Society of Cardiology. Please direct requests to copyright.permissions@heart.org or journals.permissions@oxfordjournals.org.

(*Circulation*. 2006;114:e257-e354.)

© 2006 by the American College of Cardiology Foundation, the American Heart Association, Inc., and the European Society of Cardiology.

Circulation is available at <http://www.circulationaha.org>

DOI: 10.1161/CIRCULATIONAHA.106.177292

C

H

A

D

S₂

↓
AVC / AIT

Tromboembolismo

↓
Diabetes

↓
Idade ≥ 75 anos

↓
Hipertensão

↓
Insuf. Cardíaca

Score ≥ 2 → Indicação para anticoagulação

C



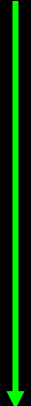
Insuf. Cardíaca

H



Hipertensão

A



Idade ≥ 75 anos

D



Diabetes

S₂



AVC / AIT

Tromboembolismo

Score =1

Fibrilhação auricular

Indicações para terapêutica antitrombótica (Guidelines 2006)

CHADS₂

Categoria de Risco	Terapêutica recomendada
Sem factores de risco	Aspirina: 100 mg/dia ou nada
1 factor de risco moderado	Aspirina: 100 mg/dia ou Varfarina INR alvo 2.5 (2.0 – 3.0)
> 1 factor de risco moderado ou Qualquer factor de risco elevado	Varfarina INR alvo 2.5 (2.0 – 3.0)

Meta-análises de estudos que avaliaram a eficácia da terapêutica antitrombótica na prevenção do AVC isquêmico

Tratamento	RRR %
Anticoagulação versus não tratamento	68 (50-79)
Aspirina versus não tratamento	21 (0-38)
Anticoagulação versus Aspirina	52 (37-63)



Guidelines for the management of atrial fibrillation

The Task Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC)

Developed with the special contribution of the European Heart Rhythm Association (EHRA)[†]

Endorsed by the European Association for Cardio-Thoracic Surgery (EACTS)

Authors/Task Force Members: A. John Camm (Chairperson) (UK)*, Paulus Kirchhof (Germany), Gregory Y. H. Lip (UK), Ulrich Schotten (The Netherlands), Irene Savelieva (UK), Sabine Ernst (UK), Isabelle C. Van Gelder (The Netherlands), Nawwar Al-Attar (France), Gerhard Hindricks (Germany), Bernard Prendergast (UK), Hein Heidbuchel (Belgium), Ottavio Alfieri (Italy), Annalisa Angelini (Italy), Dan Atar (Norway), Paolo Colonna (Italy), Raffaele De Caterina (Italy), Johan De Sutter (Belgium), Andreas Goette (Germany), Bulent Gorenek (Turkey), Magnus Heldal (Norway), Stefan H. Hohnloser (Germany), Philippe Kolh (Belgium), Jean-Yves Le Heuzey (France), Piotr Ponikowski (Poland), Frans H. Rutten (The Netherlands).

ESC Committee for Practice Guidelines (CPG): Alec Vahanian (Chairperson) (France), Angelo Auricchio (Switzerland), Jeroen Bax (The Netherlands), Claudio Ceconi (Italy), Veronica Dean (France), Gerasimos Filippatos (Greece), Christian Funck-Brentano (France), Richard Hobbs (UK), Peter Kearney (Ireland), Theresa McDonagh (UK), Bogdan A. Popescu (Romania), Zeljko Reiner (Croatia), Udo Sechtem (Germany), Per Anton Sirnes (Norway), Michal Tendera (Poland), Panos E. Vardas (Greece), Petr Widimsky (Czech Republic).

Document Reviewers: Panos E. Vardas (CPG Review Coordinator) (Greece), Vazha Agladze (Georgia), Etienne Aliot (France), Toshio Balabanski (Bulgaria), Carina Blomstrom-Lundqvist (Sweden), Alessandro Capucci (Italy), Harry Crijns (The Netherlands), Björn Dahlöf (Sweden), Thierry Folliguet (France), Michael Glikson (Israel), Marnix Goethals (Belgium), Dietrich C. Gulba (Germany), Siew Yen Ho (UK), Robert J. M. Klautz (The Netherlands), Sedat Kose (Turkey), John McMurray (UK), Pasquale Perrone Filardi (Italy), Pekka Raatikainen (Finland), Maria Jesus Salvador (Spain), Martin J. Schalij (The Netherlands), Alexander Shpektov (Russian Federation), João Sousa (Portugal), Janina Stepinska (Poland), Hasso Uuetoa (Estonia), Jose Luis Zamorano (Spain), Igor Zupan (Slovenia).

The disclosure forms of the authors and reviewers are available on the ESC website www.escardio.org/guidelines

* Corresponding author: A. John Camm, St George's University of London, Cranmer Terrace, London SW17 0RE, UK; Tel: +44 20 8725 3414; Fax: +44 20 8725 3416; Email: jcam@sgul.ac.uk

The content of these European Society of Cardiology (ESC) Guidelines has been published for personal and educational use only. No commercial use is authorized. No part of the ESC Guidelines may be translated or reproduced in any form without written permission from the ESC. Permission can be obtained upon submission of a written request to Oxford University Press, the publisher of the *European Heart Journal* and the party authorized to handle such permissions on behalf of the ESC.

[†] Other ESC entities having participated in the development of this document:

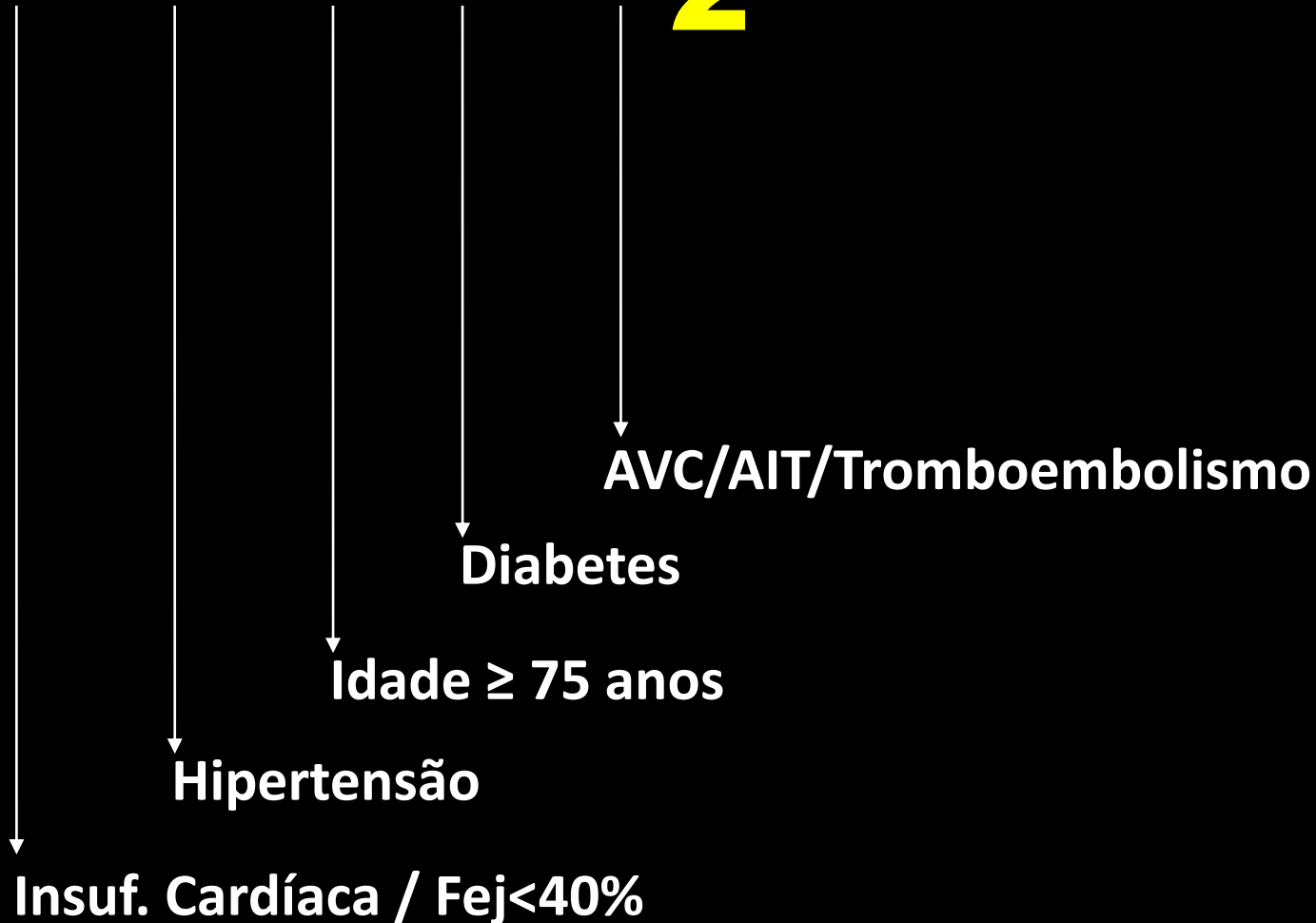
Associations: European Association of Echocardiography (EAE), European Association for Cardiovascular Prevention & Rehabilitation (EACPR), Heart Failure Association (HFA), Working Groups: Cardiovascular Surgery, Developmental Anatomy and Pathology, Cardiovascular Pharmacology and Drug Therapy, Thrombosis, Acute Cardiac Care, Valvular Heart Disease.

Councils: Cardiovascular Imaging, Cardiology Practice, Cardiovascular Primary Care.

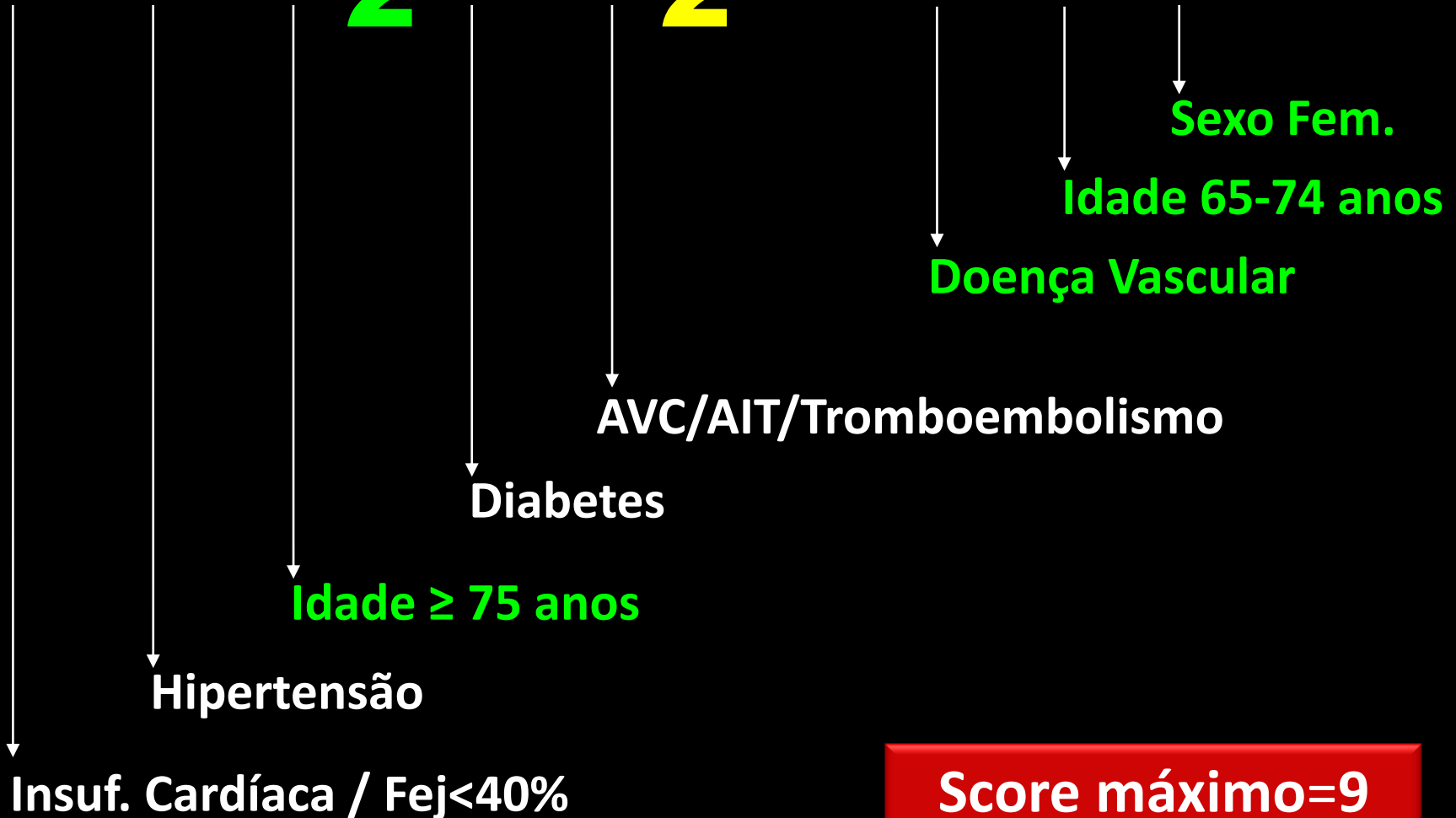
Disclaimer. The ESC Guidelines represent the views of the ESC and were arrived at after careful consideration of the available evidence at the time they were written. Health professionals are encouraged to take them fully into account when exercising their clinical judgement. The guidelines do not, however, override the individual responsibility of health professionals to make appropriate decisions in the circumstances of the individual patients, in consultation with that patient, and where appropriate and necessary the patient's guardian or carer. It is also the health professional's responsibility to verify the rules and regulations applicable to drugs and devices at the time of prescription.

© The European Society of Cardiology 2010. All rights reserved. For Permissions please email: journals.permissions@oxfordjournals.org

CHADS₂



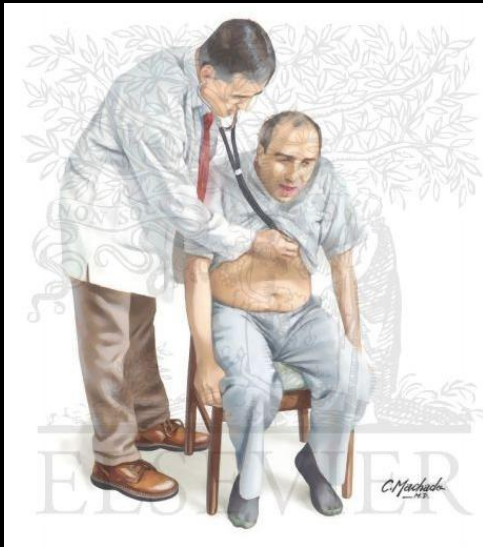
CHA₂DS₂ - VASc



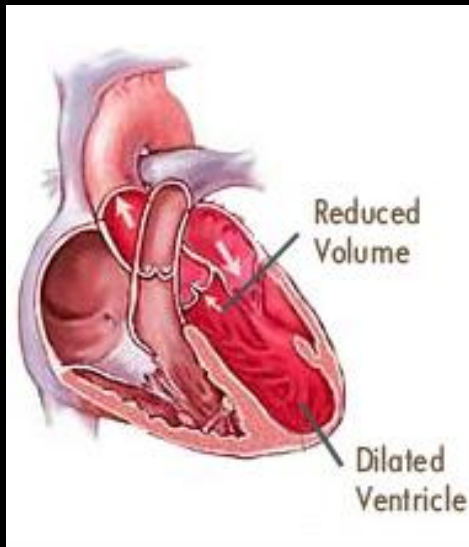
CHA₂DS₂ - VASc

Insuficiência Cardíaca

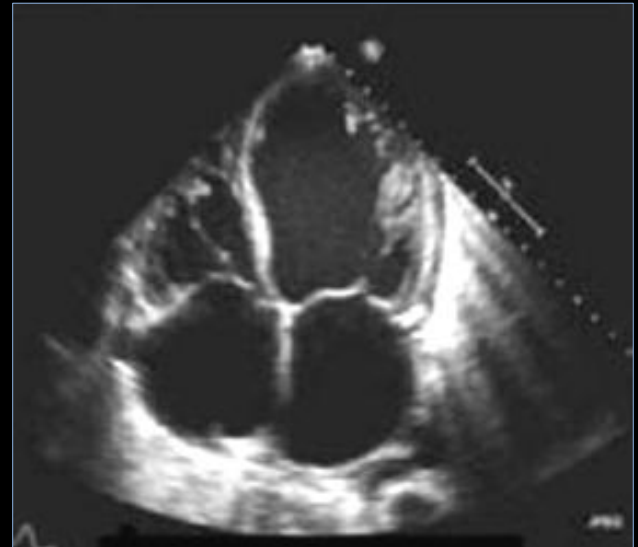
**Insuficiência Cardíaca
Diastólica**



**Insuficiência cardíaca
Sistólica**

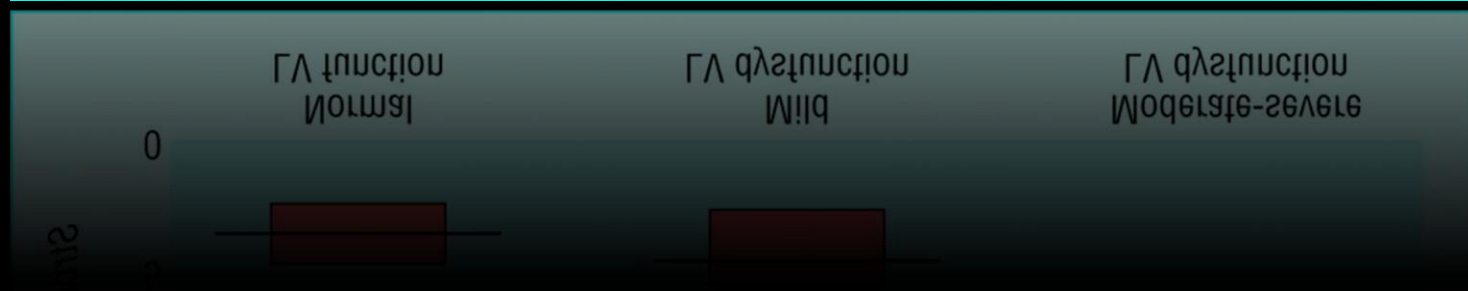
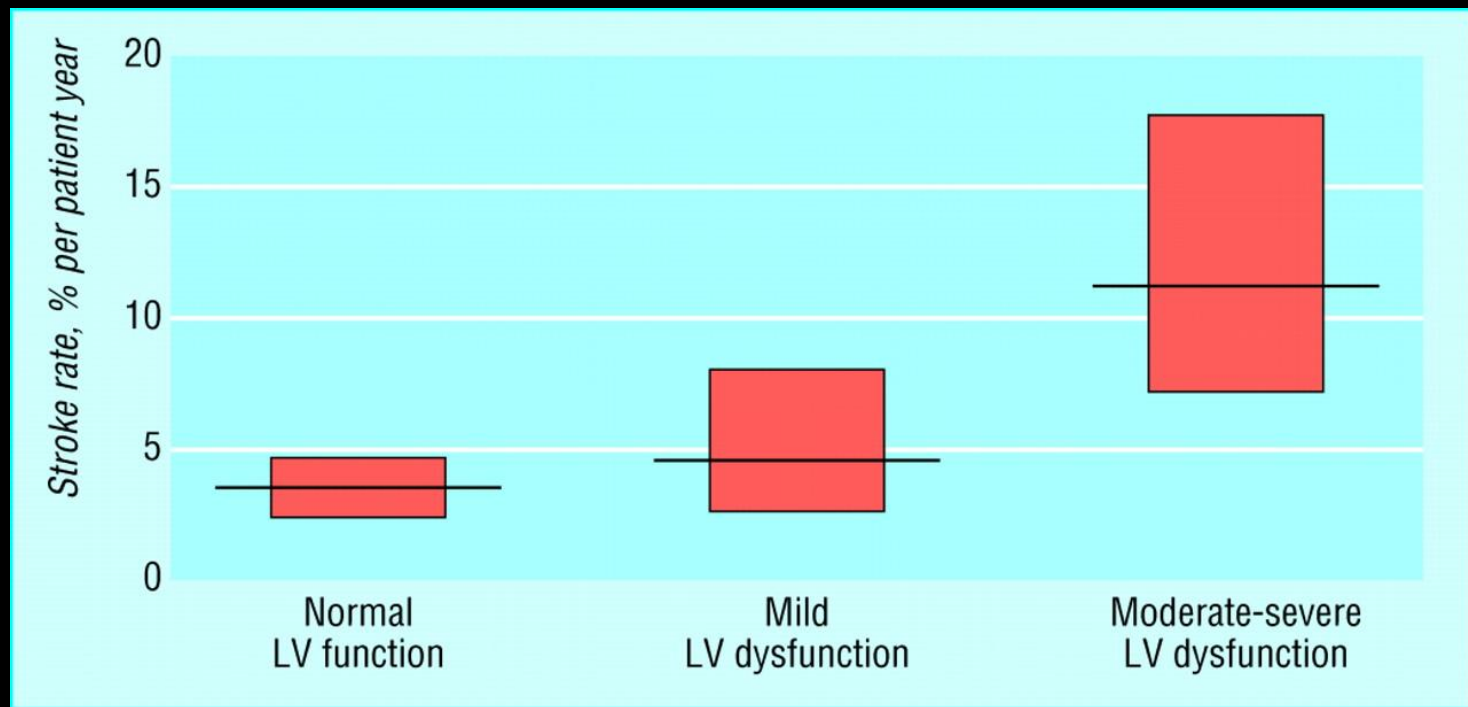


**Disfunção Ventricular esquerda
moderada a grave (F. Ej<40%)**



CHA₂DS₂ - VASc

Influência da disfunção ventricular esquerda
no risco de AVC



CHA₂DS₂ - VASc

Hipertensão

HTA não tratada ou uso de
anti-hipertensores



HTA bem controlada



PA>160/95 mmHg

CHA₂DS₂ - VASc

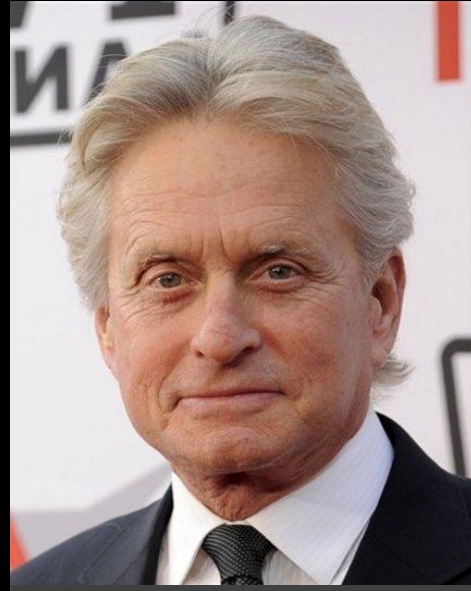
Idade (**A**ge)

≥ 75 anos



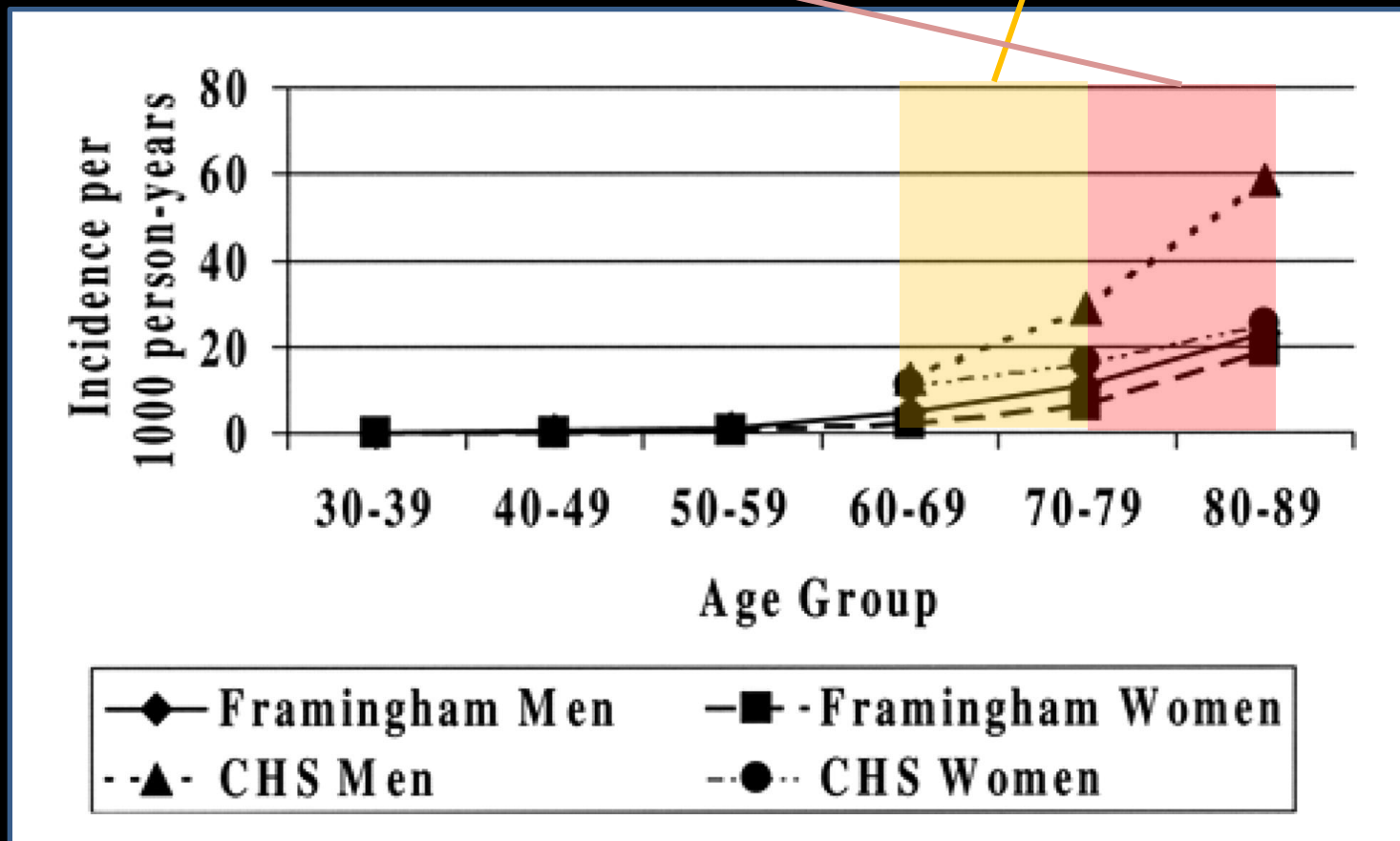
Score 2

65-74 anos



Score 1

CHA₂DS₂ - VASc



Influência da idade na ocorrência de AVC em indivíduos de controle não tratados, com FA

CHA₂DS₂ - VASc

Diabetes

DM tipo 2



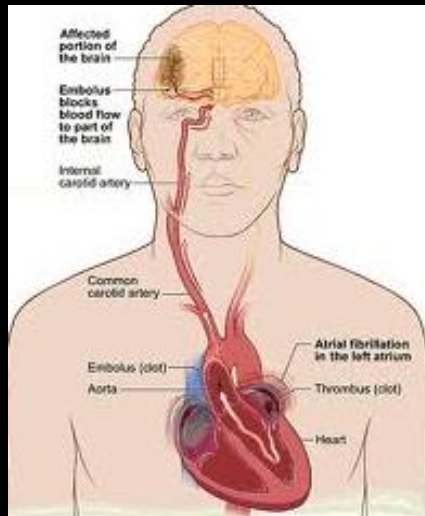
DM tipo 1



CHA₂DS₂ - VASc

AVC (**S**troke), AIT ou tromboembolismo

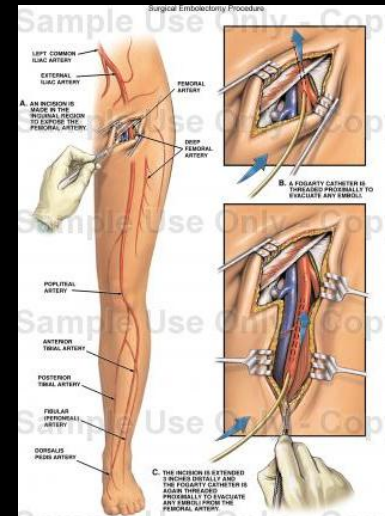
AVC



AIT



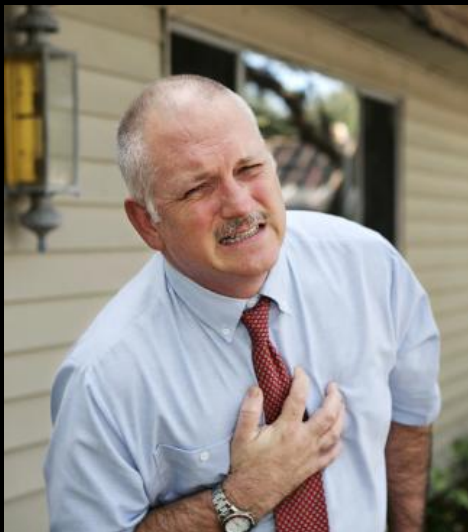
Tromboembolismo



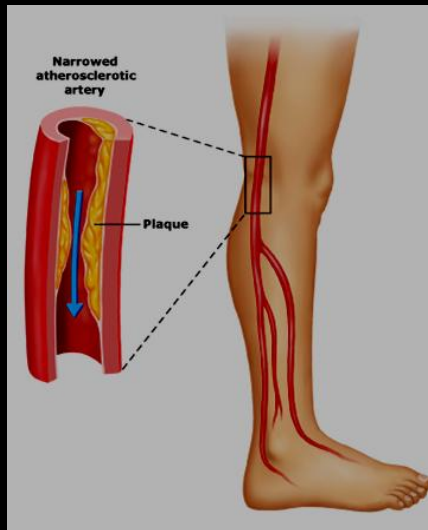
CHA₂DS₂ - VASc

Doença Vascular

Enfarte do miocárdio



D. Arterial Periférica



Placas complexas na aorta



CHA₂DS₂ - VASc

Idade (**A**ge)

≥ 75 anos



Score 2

65-74 anos



Score 1

CHA₂DS₂ - VASc

Sex category

Sexo feminino



≥ 75 anos

CHADS₂

```
graph TD; CHADS2[CHADS2] --> ScoreGe2[Score ≥ 2]; CHADS2 --> Score01[Score 0-1]; ScoreGe2 --> ACO[ACO]; Score01 --> CHA2DS2VASc[CHA2DS2 - VASc]
```

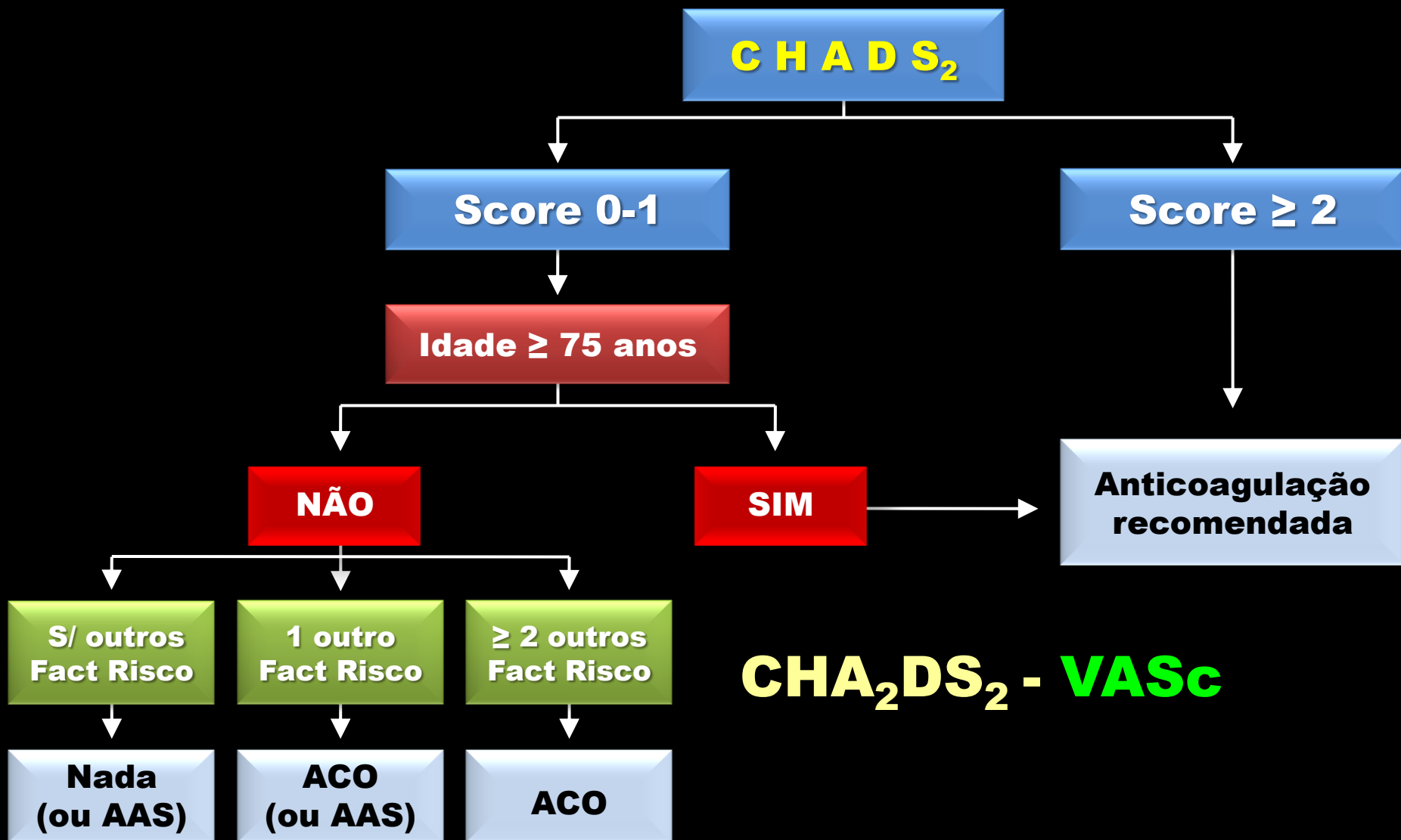
The diagram is a flowchart starting with a blue box labeled 'CHADS₂'. Two arrows point down from this box to two separate blue boxes: 'Score ≥ 2' on the left and 'Score 0-1' on the right. From 'Score ≥ 2', an arrow points down to a red box labeled 'ACO'. From 'Score 0-1', an arrow points down to a light blue box labeled 'CHA₂DS₂ - VASc'.

Score ≥ 2

ACO

Score 0-1

CHA₂DS₂ - VASc



CHA₂DS₂ - VASc

Ponderar o risco hemorrágico nos doentes com indicação para anticoagulação

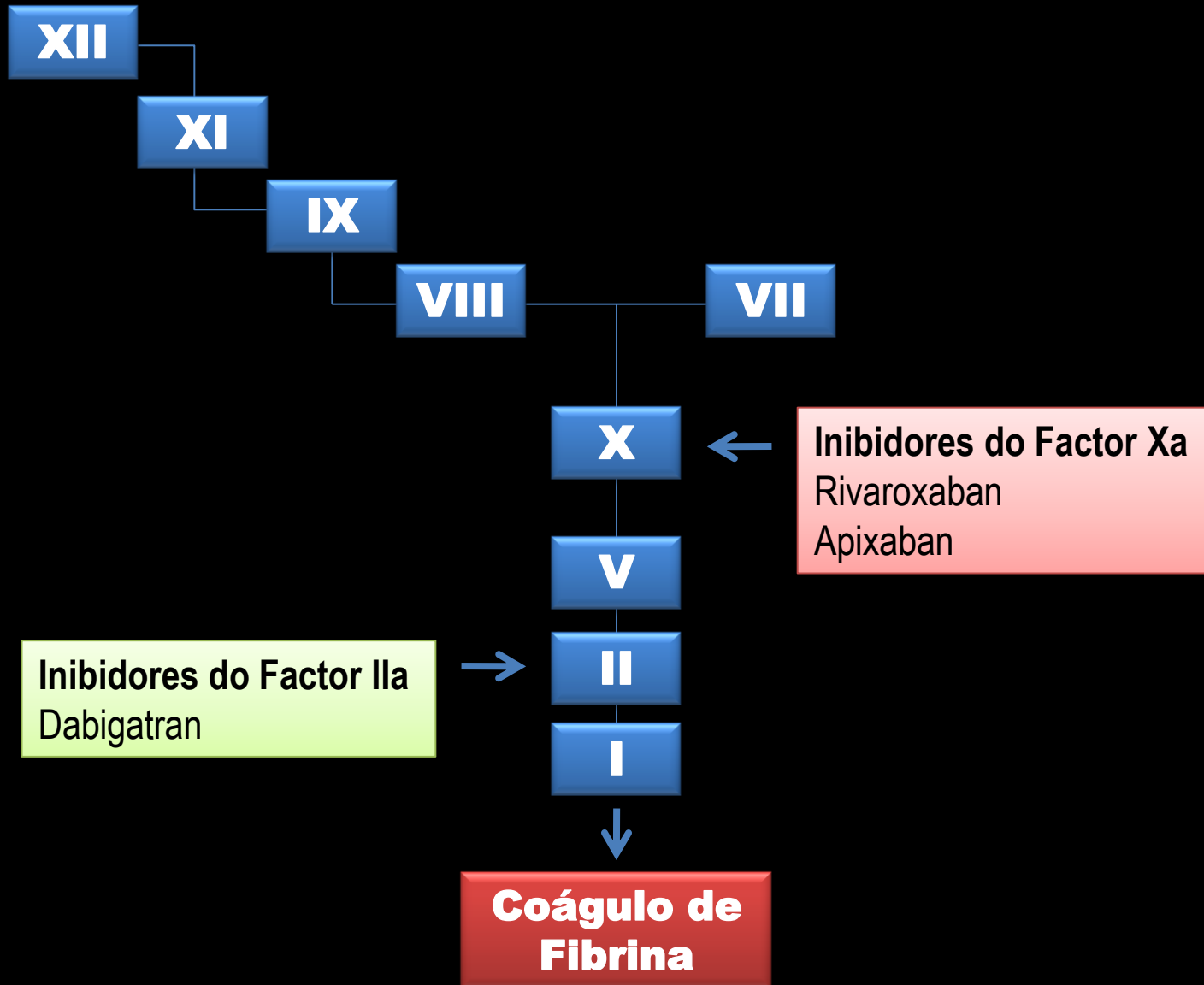


Score de risco hemorrágico

HAS-BLED

Letter	Clinical characteristic ^a	Points awarded
H	Hypertension	1
A	Abnormal renal and liver function (1 point each)	1 or 2
S	Stroke	1
B	Bleeding	1
L	Labile INRs	1
E	Elderly (e.g. age >65 years)	1
D	Drugs or alcohol (1 point each)	1 or 2
		Maximum 9 points

Os novos anticoagulantes orais



The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812

SEPTEMBER 17, 2009

VOL. 361 NO. 12

Dabigatran versus Warfarin in Patients with Atrial Fibrillation

Stuart J. Connolly, M.D., Michael D. Ezekowitz, M.B., Ch.B., D.Phil., Salim Yusuf, F.R.C.P.C., D.Phil., John Eikelboom, M.D., Jonas Oldgren, M.D., Ph.D., Amit Parekh, M.D., Janice Pogue, M.Sc., Paul A. Reilly, Ph.D., Ellison Themeles, B.A., Jeanne Varrone, M.D., Susan Wang, Ph.D., Marco Alings, M.D., Ph.D., Denis Xavier, M.D., Jun Zhu, M.D., Rafael Diaz, M.D., Basil S. Lewis, M.D., Harald Darius, M.D., Hans-Christoph Diener, M.D., Ph.D., Campbell D. Joyner, M.D., Lars Wallentin, M.D., Ph.D., and the RE-LY Steering Committee and Investigators*

ABSTRACT

BACKGROUND

Warfarin reduces the risk of stroke in patients with atrial fibrillation but increases the risk of hemorrhage and is difficult to use. Dabigatran is a new oral direct thrombin inhibitor.

METHODS

In this noninferiority trial, we randomly assigned 18,113 patients who had atrial fibrillation and a risk of stroke to receive, in a blinded fashion, fixed doses of dabigatran — 110 mg or 150 mg twice daily — or, in an unblinded fashion, adjusted-dose warfarin. The median duration of the follow-up period was 2.0 years. The primary outcome was stroke or systemic embolism.

RESULTS

Rates of the primary outcome were 1.69% per year in the warfarin group, as compared with 1.53% per year in the group that received 110 mg of dabigatran (relative risk with dabigatran, 0.91; 95% confidence interval [CI], 0.74 to 1.11; $P < 0.001$ for noninferiority) and 1.11% per year in the group that received 150 mg of dabigatran (relative risk, 0.66; 95% CI, 0.53 to 0.82; $P < 0.001$ for superiority). The rate of major bleeding was 3.36% per year in the warfarin group, as compared with 2.71% per year in the group receiving 110 mg of dabigatran ($P = 0.003$) and 3.11% per year in the group receiving 150 mg of dabigatran ($P = 0.31$). The rate of hemorrhagic stroke was 0.38% per year in the warfarin group, as compared with 0.12% per year with 110 mg of dabigatran ($P < 0.001$) and 0.10% per year with 150 mg of dabigatran ($P < 0.001$). The mortality rate was 4.13% per year in the warfarin group, as compared with 3.75% per year with 110 mg of dabigatran ($P = 0.13$) and 3.64% per year with 150 mg of dabigatran ($P = 0.051$).

CONCLUSIONS

In patients with atrial fibrillation, dabigatran given at a dose of 110 mg was associated with rates of stroke and systemic embolism that were similar to those associated with warfarin, as well as lower rates of major hemorrhage. Dabigatran administered at a dose of 150 mg, as compared with warfarin, was associated with lower rates of stroke and systemic embolism but similar rates of major hemorrhage. (ClinicalTrials.gov number, NCT00262600.)

From the Population Health Research Institute, McMaster University and Hamilton Health Sciences, Hamilton, ON, Canada (S.J.C., S.Y., J.E., J.P., E.T.); Lankenau Institute for Medical Research and the Heart Center, Wynnewood, PA (M.D.E., A.P.); Uppsala Clinical Research Center, Uppsala, Sweden (J.O., L.W.); Boehringer Ingelheim Pharmaceuticals, Ridgefield, CT (P.A.R., J.V., S.W.); Working Group on Cardiovascular Research the Netherlands, Utrecht, the Netherlands (M.A.); St. John's National Academy of Health Sciences, Bangalore, India (D.X.); FuWai Hospital, Beijing (J.Z.); Estudios Clínicos Latinoamérica, Rosario, Argentina (R.D.); Lady Davis Carmel Medical Center, Haifa, Israel (B.S.L.); Vivantes Klinikum Neukölln, Berlin (H.D.); University Duisburg-Essen, Essen, Germany (H.-C.D.); and Sunnybrook Health Sciences Centre, Toronto (C.D.J.). Address reprint requests to Dr. Connolly at the Population Health Research Institute, 237 Barton St. E., Hamilton, ON L8L 2X2, Canada, or at connostu@phr.ca.

*Members of the Randomized Evaluation of Long-Term Anticoagulation Therapy (RE-LY) Study Group are listed in the Appendix and the Supplementary Appendix, available with the full text of this article at NEJM.org.

Drs. Connolly, Ezekowitz, Yusuf, and Wallentin contributed equally to this article.

This article (10.1056/NEJMoa0905561) was published on August 30, 2009, and updated on September 16, 2009, at NEJM.org.

N Engl J Med 2009;361:1139-51.
Copyright © 2009 Massachusetts Medical Society.

N ENGL J MED 361:12 NEJM.ORG SEPTEMBER 17, 2009

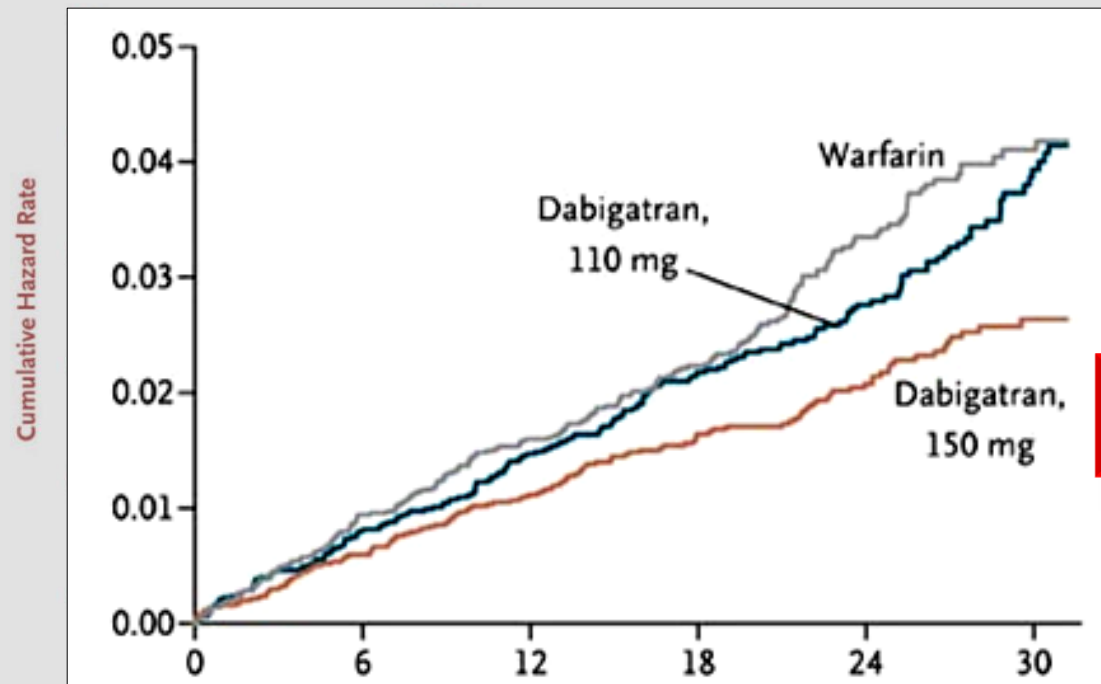
1139

The New England Journal of Medicine

Downloaded from nejm.org by ANTONIO MACHADO on March 14, 2011. For personal use only. No other uses without permission.

Copyright © 2009 Massachusetts Medical Society. All rights reserved.

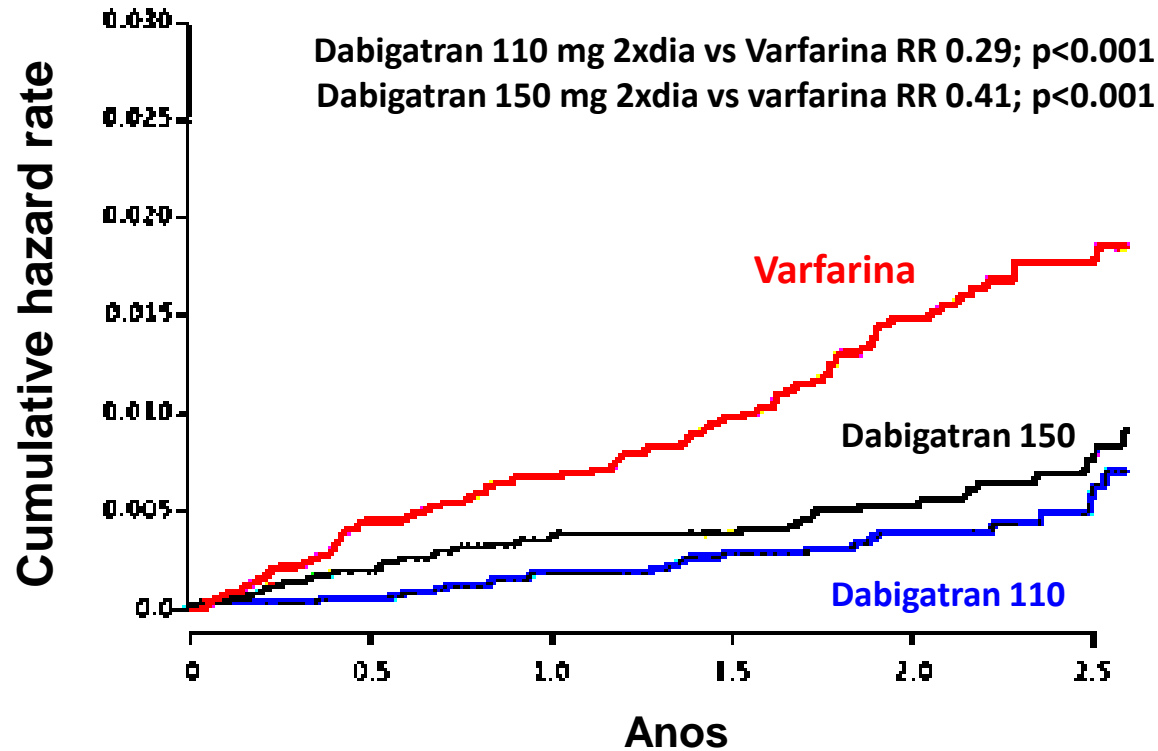
RE-LY - AVC e embolismo sistémico



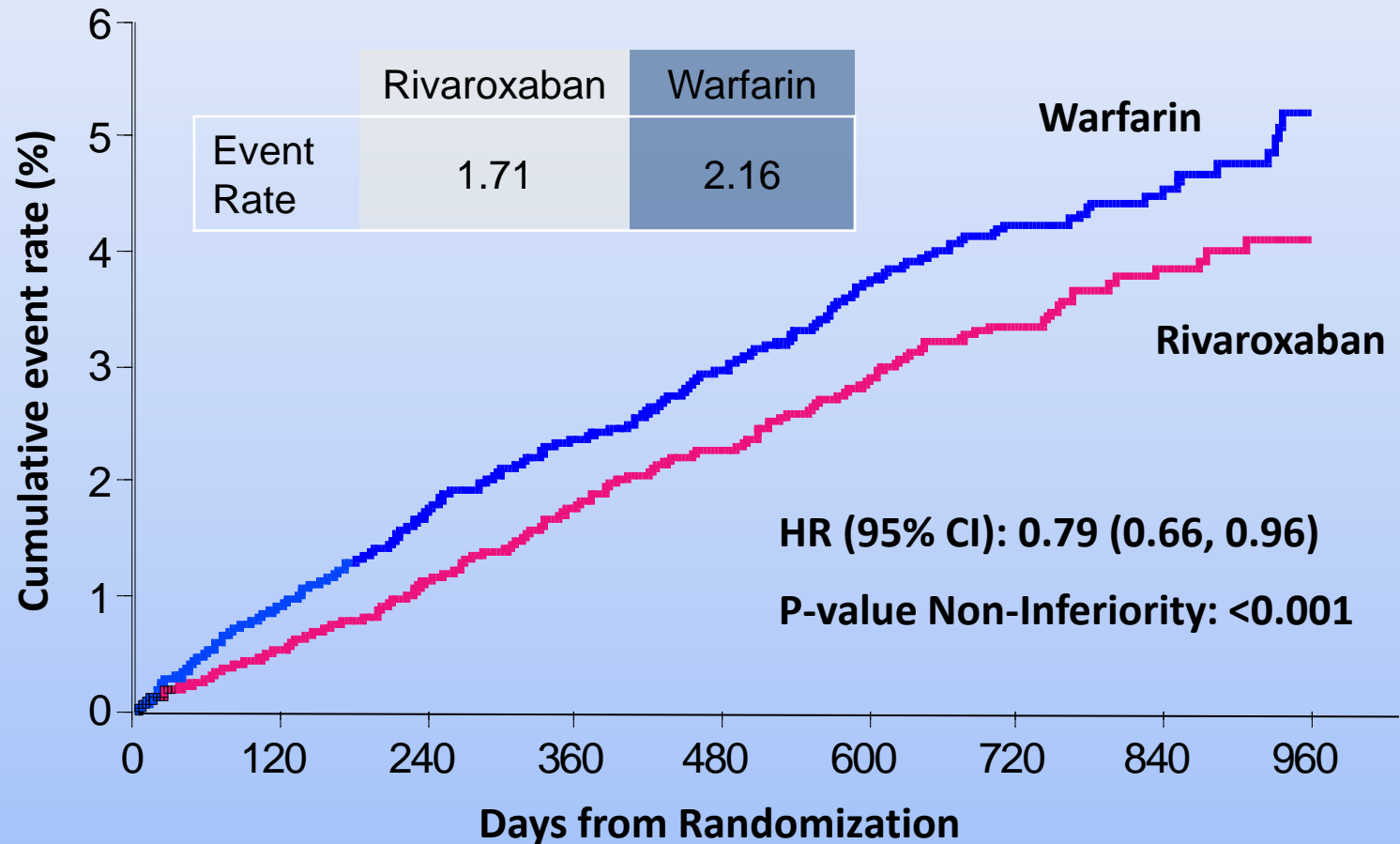
No. at Risk

Warfarin	6022	5862	5718	4593	2890	1322
Dabigatran, 110 mg	6015	5862	5710	4593	2945	1385
Dabigatran, 150 mg	6076	5939	5779	4682	3044	1429

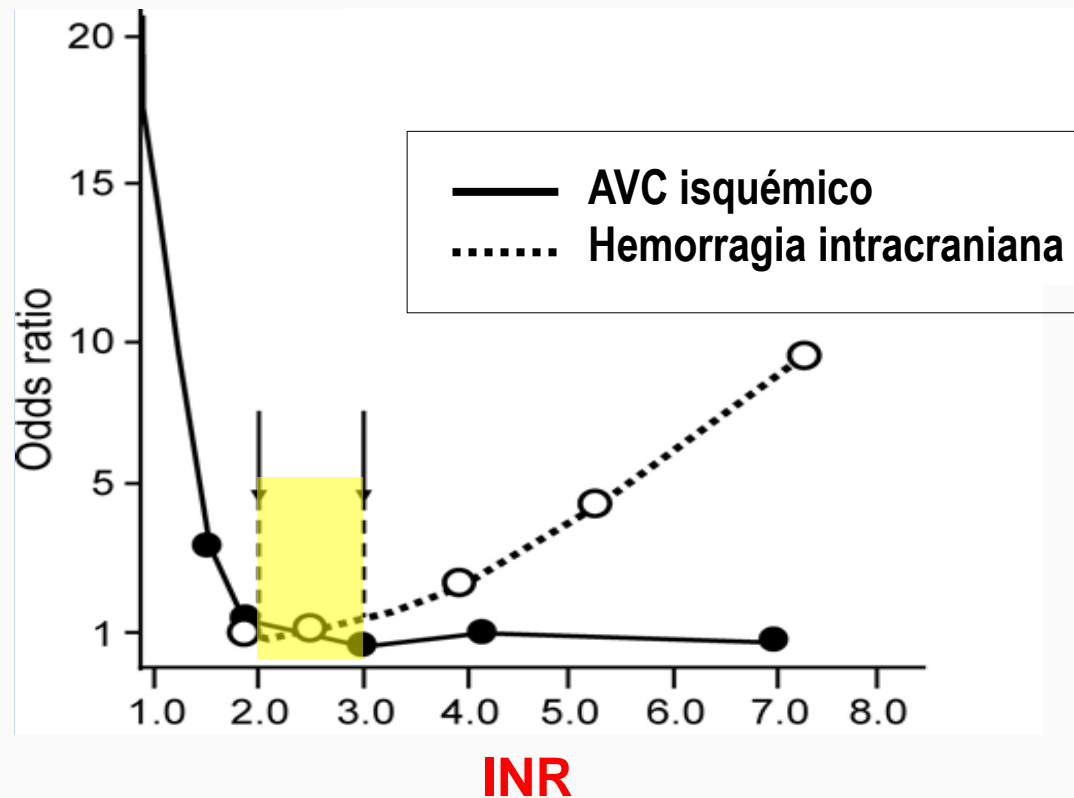
RE-LY - Hemorragia intracraniana



Rocket-AF – AVC e embolismo sistémico



Varfarina - Intervalo terapêutico estreito



ORIGINAL ARTICLE

Apixaban in Patients with Atrial Fibrillation

Stuart J. Connolly, M.D., John Eikelboom, M.B., B.S., Campbell Joyner, M.D., Hans-Christoph Diener, M.D., Ph.D., Robert Hart, M.D., Sergey Golitsyn, M.D., Ph.D., Greg Flaker, M.D., Alvaro Avezum, M.D., Ph.D., Stefan H. Hohnloser, M.D., Rafael Diaz, M.D., Mario Talajic, M.D., Jun Zhu, M.D., Prem Pais, M.B., B.S., M.D., Andrzej Budaj, M.D., Ph.D., Alexander Parkhomenko, M.D., Ph.D., Petr Jansky, M.D., Patrick Commerford, M.B., Ch.B., Ru San Tan, M.B., B.S., Kui-Hian Sim, M.B., B.S., Basil S. Lewis, M.D., Walter Van Mieghem, M.D., Gregory Y.H. Lip, M.D., Jae Hyung Kim, M.D., Ph.D., Fernando Lanas-Zanetti, M.D., Antonio Gonzalez-Hermosillo, M.D., Antonio L. Dans, M.D., Muhammad Munawar, M.D., Ph.D., Martin O'Donnell, M.B., Ph.D., John Lawrence, M.D., Gayle Lewis, Rizwan Afzal, M.Sc., and Salim Yusuf, M.B., B.S., D.Phil., for the AVERROES Steering Committee and Investigators*

ABSTRACT

BACKGROUND

Vitamin K antagonists have been shown to prevent stroke in patients with atrial fibrillation. However, many patients are not suitable candidates for or are unwilling to receive vitamin K antagonist therapy, and these patients have a high risk of stroke. Apixaban, a novel factor Xa inhibitor, may be an alternative treatment for such patients.

METHODS

In a double-blind study, we randomly assigned 5599 patients with atrial fibrillation who were at increased risk for stroke and for whom vitamin K antagonist therapy was unsuitable to receive apixaban (at a dose of 5 mg twice daily) or aspirin (81 to 324 mg per day), to determine whether apixaban was superior. The mean follow up period was 1.1 years. The primary outcome was the occurrence of stroke or systemic embolism.

RESULTS

Before enrollment, 40% of the patients had used a vitamin K antagonist. The data and safety monitoring board recommended early termination of the study because of a clear benefit in favor of apixaban. There were 51 primary outcome events (1.6% per year) among patients assigned to apixaban and 113 (3.7% per year) among those assigned to aspirin (hazard ratio with apixaban, 0.45; 95% confidence interval [CI], 0.32 to 0.62; $P < 0.001$). The rates of death were 3.5% per year in the apixaban group and 4.4% per year in the aspirin group (hazard ratio, 0.79; 95% CI, 0.62 to 1.02; $P = 0.07$). There were 44 cases of major bleeding (1.4% per year) in the apixaban group and 39 (1.2% per year) in the aspirin group (hazard ratio with apixaban, 1.13; 95% CI, 0.74 to 1.75; $P = 0.57$); there were 11 cases of intracranial bleeding with apixaban and 13 with aspirin. The risk of a first hospitalization for cardiovascular causes was reduced with apixaban as compared with aspirin (12.6% per year vs. 15.9% per year, $P < 0.001$). The treatment effects were consistent among important subgroups.

CONCLUSIONS

In patients with atrial fibrillation for whom vitamin K antagonist therapy was unsuitable, apixaban reduced the risk of stroke or systemic embolism without significantly increasing the risk of major bleeding or intracranial hemorrhage. (Funded by Bristol-Myers Squibb and Pfizer; ClinicalTrials.gov number, NCT00496769.)

The affiliations of the authors are listed in the Appendix. Address reprint requests to Dr. Connolly at Population Health Research Institute, 237 Barton St. E., Hamilton, ON L8L 2X2, Canada, or at stuart.connolly@phri.ca.

*A complete list of the AVERROES (Apixaban Versus Acetylsalicylic Acid [ASA] to Prevent Stroke in Atrial Fibrillation Patients Who Have Failed or Are Unsuitable for Vitamin K Antagonist Treatment) Steering Committee members and site investigators is available in the Supplementary Appendix, available at NEJM.org.

This article (10.1056/NEJMoa1007432) was published on February 10, 2011, at NEJM.org.

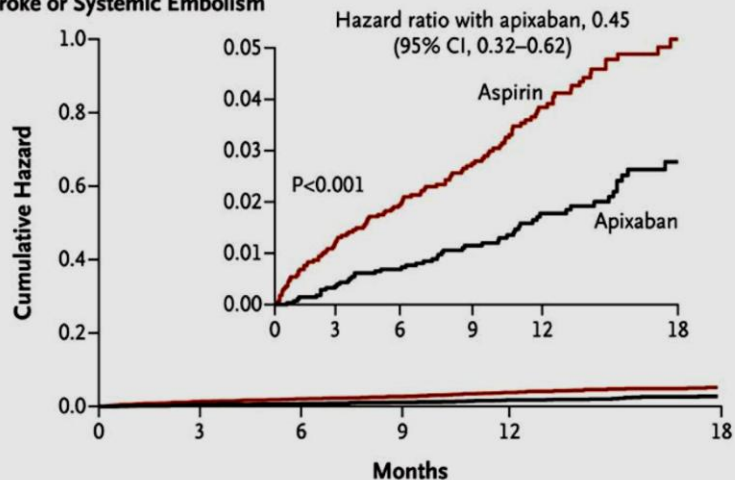
N Engl J Med 2011;364:806-17.

Copyright © 2011 Massachusetts Medical Society.

Averroes – Apixaban versus AAS

AVC e Embolismo Sistémico

A Stroke or Systemic Embolism

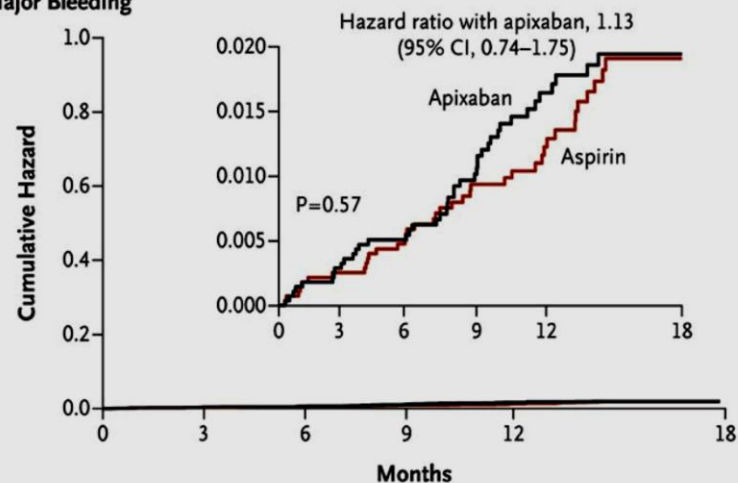


No. at Risk

Aspirin	2791	2716	2530	2112	1543	628
Apixaban	2808	2758	2566	2125	1522	615

Hemorragias Major

B Major Bleeding



No. at Risk

Aspirin	2791	2738	2557	2140	1571	642
Apixaban	2808	2759	2566	2120	1521	622



Guidelines for the management of atrial fibrillation

The Task Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC)

CHA₂DS₂ – VASc

HAS – BLED

Novos anticoagulante orais