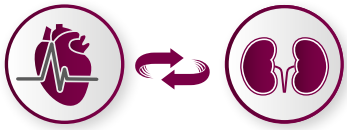
DILEMMAS IN MANAGING AF & CKD

Atrial fibrillation (AF) and chronic kidney disease (CKD) are interconnected conditions[1]

1 in 3 **patients with AF have CKD[2]**

16–21% **of CKD patients also have AF[3]**

AF increases the risk of CKD progression and development of ESRD by *67%*[4]



CKD increases the risk of AF occurrence by *1.3–3.2 times*[5]

OAC strategies in CKD: Current evidence and key considerations[6,7]

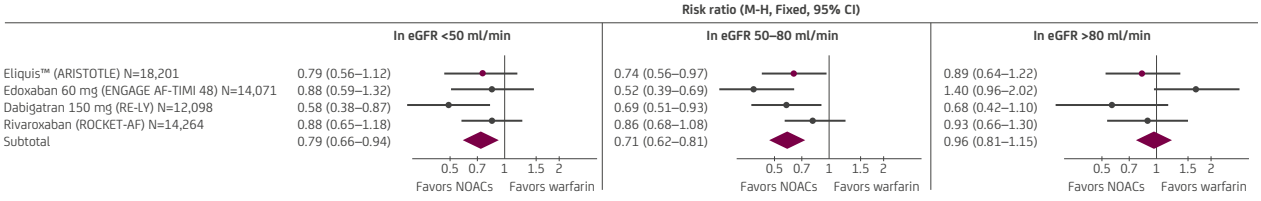
All NOACs show **consistent efficacy and safety in CKD vs non-CKD patients** in subgroup analyses of pivotal NOAC trials[6,7*]

All NOACs are **not recommended** for patients with CrCl <15 mL/min or on dialysis[6]

Since **observational study results for VKA are conflicting**, treatment decisions require a high degree of individualization[6†]

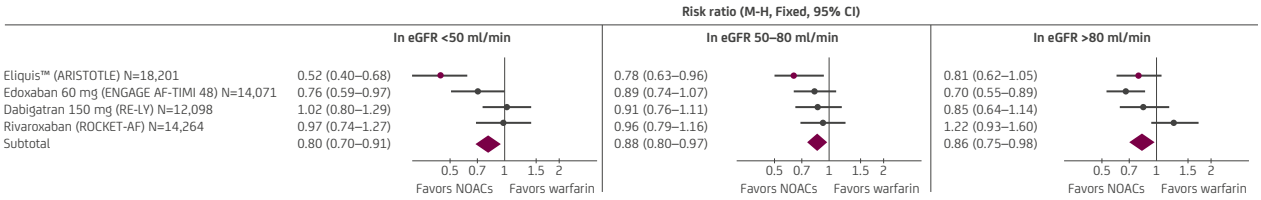
*In patients with mild or moderate CKD (CrCl ≥30 mL/min)
†In patients with ESRD (CrCl <15 mL/min) or on dialysis

NOACs reduce the risk of stroke/SE in patients with mild or moderate CKD[7*†]



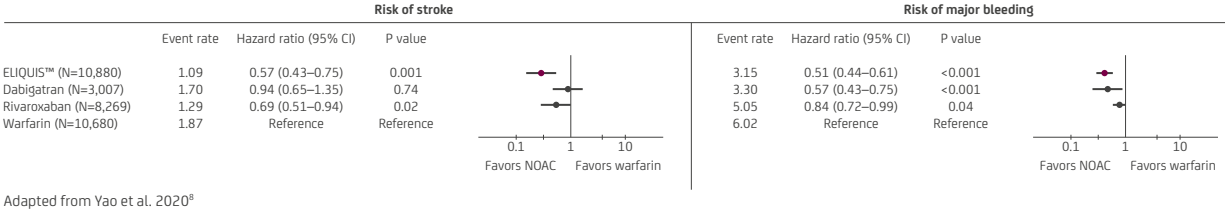
Adapted from Munoz et al. 2016[7]
Head-to-head studies do not exist, and direct comparisons between the NOACs may not be made
*Versus warfarin
†Mild renal impairment is defined as eGFR 50–80 mL/min, and moderate renal impairment is defined as eGFR <50 mL/min

The risk of bleeding is lower with the use of NOACs, independently of renal function[7*]



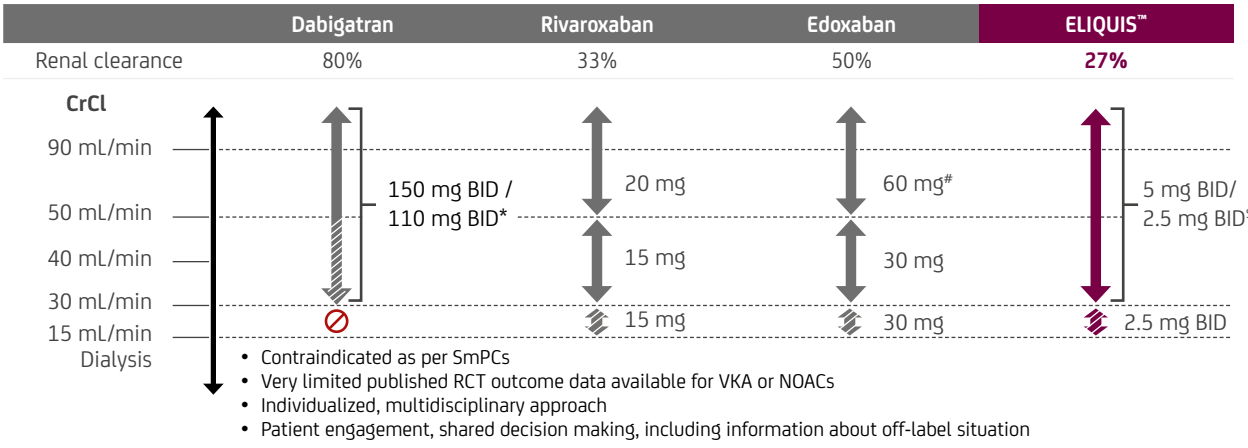
Adapted from Munoz et al. 2016[7]
Head-to-head studies do not exist, and direct comparisons between the NOACs may not be made
*Versus warfarin

Real-world data showed consistent results with clinical trials in patients with eGFR ≥15 mL/min[8*]



Adapted from Yao et al. 2020[8]
*Except for the risk of major bleeding when comparing dabigatran to warfarin and rivaroxaban to warfarin: Both showed a similar risk with warfarin in clinical trials, while they were associated with a lower risk than warfarin in the current study. This may be due to better INR control in trials than routine practice

Clear dose-reduction criteria with ELIQUIS™ in AF patients across different levels of renal function[6,9]



* 110 mg BID in patients at high risk of bleeding. # Other dose reduction criteria may apply (weight ≤60 kg, concomitant potent P-glycoprotein inhibitor therapy). $ 2×2.5 mg only if at least 2 out of 3 fulfilled: age ≥80 years, body weight ≤60 kg, creatinine ≥1.5 mg/dL (133 µmol/L). Striped arrows indicate cautionary use.

Adapted from Steffel et al. 2021[6]

Recommended ELIQUIS™ dose for treatment of AF[10,11]	Level of renal impairment, CrCl (mL/min)			
	None (>80)	Mild (51–80)	Moderate (30–50)	Severe (15–29)
5 mg BID	No dose adjustment			2.5 mg BID*

* For the prevention of stroke/SE in patients with AF, patients with severe renal impairment, and patients with serum creatinine ≥1.5 mg/dL (133 mmol/L) associated with age ≥80 years or body weight ≤60 kg should receive the adjusted ELIQUIS™ dose of 2.5 mg BID.

Adapted from ELIQUIS™ Prescribing Information 2021[10,11]

ELIQUIS™: The safer choice vs warfarin for AF patients with CKD (up to CrCl 30 mL/min)[12†]

Significant risk reduction in both stroke/SE and major bleeding in patients with moderate renal impairment[7]

Consistent benefits in reducing the rate of stroke/SE and mortality in AF patients **with mild-moderate renal impairment**[12]

Significantly greater benefit in reducing bleeding risk as renal function declines[12‡]

Significant stroke/SE risk reduction by 68% with **comparable safety profile vs aspirin**[13]

† ELIQUIS™ significantly lowers the risk of major bleeding in AF compared to warfarin, up to CrCl 30 mL/min
‡ eGFR <50 mL/min

AF, atrial fibrillation; BID, twice daily; CI, confidence interval; CKD, chronic kidney disease; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; ESRD, end-stage renal disease; INR, international normalized ratio; NOAC, non-VKA oral anticoagulant; OAC, oral anticoagulant; RCT, randomized controlled trial; SE, systemic embolism; VKA, vitamin K antagonist

References 1. McManus D, et al. *J Atr Fibrillation* 2012;5:442. **2.** Kooiman J, et al. *J Thromb Haemost* 2011;9:1652-1653. **3.** Turakhia MP, et al. *Eur Heart J* 2018;39:2314-2325. **4.** Bansal N, et al. *Circulation* 2013;127:569-574. **5.** Alonso A, et al. *Circulation* 2011;123:2946-2953. **6.** Steffel J, et al. *Europace* 2021;23:1612-1676. **7.** Munoz FDA, et al. *Am J Cardiol* 2016;117:69-75. **8.** Yao X, et al. *Cir Cardiovasc Qual Outcomes* 2020;13:e006515. **9.** Heine GH, et al. *Dtsch Arztebl Int* 2018;115:287-294. **10.** ELIQUIS™ (apixaban) 2.5 mg Prescribing Information. Pfizer Corporation Hong Kong Limited. Version: Jun 2021. **11.** ELIQUIS™ (apixaban) 5 mg Prescribing Information. Pfizer Corporation Hong Kong Limited. Version: Sep 2021. **12.** Hohnloser SH, et al. *Eur Heart J* 2012;33:2821-2830. **13.** Eikelboom JW, et al. *J Stroke Cerebrovasc Dis* 2012;21:429-435.

Scan the QR codes or type the URLs in your browser to find the full Prescribing Information of apixaban:

Apixaban (2.5 mg)
https://www.pfi.sr/Jzi

Apixaban (5 mg)
https://www.pfi.sr/JzT

The QR codes/URL links to the latest Prescribing Information approved by the Department of Health in Hong Kong and may not be effective and the same as presented in the actual product package.

Pfizer Corporation Hong Kong Limited
21/F, Kerry Centre, 683 King's Road, Quarry Bay, Hong Kong.
Tel: (852) 2811 9711 Fax: (852) 2579 0599
Website: www.Pfizer.com.hk | HCP Portal: www.PfizerPro.com.hk

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