However, none of these trials included a control group with no oral anticoagulation, which is needed to access whether anticoagulation therapy is of benefit in these patients. It is important to wait for the results of the Oral Anticoagulation in Haemodialysis Patients (AVKDIAL) study, which will compare the hemorrhagic and thrombotic risks of vitamin K antagonists with no anticoagulation in hemodialysis patients with AF.

In conclusion, considering the strong uncertainty and conflicting results about anticoagulation in AF patients with ESRD, we advocate the following: *a)* the development of specific scoring systems for the prediction of stroke and bleeding; and *b)* the need for randomized control trials evaluating the risk-to-benefit ratio of anticoagulation compared with placebo instead of comparing various oral anticoagulants in this population.

CONFLICTS OF INTEREST

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Jun Li, Xinyue Liu, Sulin Zheng, and Yuli Huang*

Department of Cardiology, Shunde Hospital (First People's Hospital of Shunde), Southern Medical University, Shunde District, Foshan, China

* Corresponding author:
E-mail address: hyuli821@163.com (Y. Huang).

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Use of Oral Anticoagulation in Patients With Atrial Fibrillation and End-stage Renal Disease: What Is Needed Nowadays? Response

Anticoagulación oral en pacientes con fibrilación auricular e insuficiencia renal terminal: ¿qué es lo más apropiado? Respuesta

To the Editor,

We thank Huang et al. for their interest in our review.[1] Dialysis patients in all CHA_2DS_2-VASc risk strata have a higher risk of stroke,[2] but this validated score still appears to be the most accurate in predicting ischemic stroke and warfarin may be considered especially in high risk patients.[3] This must be balanced with bleeding risk factors, but the net benefit is generally positive, especially with well managed warfarin.

Atrial fibrillation patients with end-stage renal disease (ESRD) have been excluded from trials of nonvitamin K antagonist oral anticoagulants and thus any recommendations from regulatory authorities are not supported by trial evidence. Warfarin may reduce the risk of ischemic stroke, although this is controversial,[4] since major bleeding is frequent in ESRD. A major caveat is that previous studies variably consider the quality of anticoagulation control, as reflected by time in therapeutic range, and a high therapeutic range is associated with good outcomes in ESRD.

Hence, an individualized patient approach is required, although the benefits of stroke and mortality reduction usually outweigh the risks of serious bleeds.[5] For instance, if a stable ESRD patient can maintain a therapeutic range $\geq$ 70%–which is hard to achieve but not impossible–and has significant risk factors for stroke (CHA_2DS_2-VASc $\geq$ 2) and a low bleeding risk (HAS-BLED score $<$ 3), warfarin may be considered after an in-depth risk/benefit discussion.[6] Patients on peritoneal dialysis and hemodialysis should be analyzed separately because of the potential differences in drug removal in these renal replacement modalities.

CONFLICTS OF INTEREST

G.Y.H. Lip is a consultant for Bayer/Janssen, BMS/Pfizer, Medtronic, Boehringer Ingelheim, Novartis, Verseon and Daiichi-Sankyo and a speaker for Bayer, BMS/Pfizer, Medtronic, Boehringer Ingelheim, and Daiichi-Sankyo; he declares not directly receiving any personal fees derived from these activities.

Maria Mahmood[a] and Gregory Y.H. Lip[a,b,*]

[a]*Institute of Cardiovascular Sciences, University of Birmingham, Birmingham, United Kingdom*
[b]*Aalborg Thrombosis Research Unit, Department of Clinical Medicine, Aalborg University, Aalborg, Denmark*

* Corresponding author:
E-mail address: g.y.h.lip@bham.ac.uk (G.Y.H. Lip).
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Use of High-potency Statins After Percutaneous Revascularization

Uso de estatinas de alta potencia tras revascularización percutánea

To the Editor,

We have read with interest the editorial by Parikh and Kirtane[1] on the indication for higher-intensity lipid-lowering therapy after drug-eluting stent implantation. Statins reduce the risk of atherosclerotic cardiovascular disease and improve prognosis after acute coronary syndrome. The effectiveness of the therapy has been linked to the magnitude of the drug-induced reduction in low-density lipoproteins. Thus, high-potency statins provide an even greater benefit than lower-potency statins.[2]

Our group recently compared the percutaneous revascularization strategy for severe lesions in secondary coronary branches (diameter $\geq$ 2 mm) of major epicardial arteries vs conservative treatment in 589 patients.[3] After a mean follow-up of 24 months, there were no significant differences in the occurrence of cardiovascular events between percutaneous treatment (376 patients, 63.8%) and conservative treatment (213 patients, 36.2%).

We also analyzed whether the use of high-potency statins (atorvastatin, rosuvastatin, pitavastatin, and simvastatin 80 mg) vs low-potency statins differed according to the revascularization strategy adopted. None of the patients–neither overall nor when stratified according to the treatment received–showed differences in cardiovascular events during follow-up according to whether they received percutaneous revascularization or optimal medical therapy.

We believe that 2 important aspects should be considered by researchers evaluating the benefit of the use of high-potency statins after percutaneous revascularization. The first is the possible prescription bias that leads physicians to prescribe more intensive treatments after stenting vs optimal medical treatment.[4] The second aspect is the greater adherence to lipid-lowering therapy in patients receiving percutaneous treatment vs those who do not.[5]

Mercedes Millán Gómez,[a,*] Macarena Cano García,[b] Carlos Sánchez González,[b] and Manuel Jiménez Navarro[a]

[a]*Unidad de Gestión Clínica, Área del Corazón, Instituto de Investigación Biomédica de Málaga (IBIMA), Hospital Universitario Virgen de la Victoria, Universidad de Málaga (UMA), Centro de Investigación Biomédica en Red de Enfermedades Cardiovasculares (CIBERCV), Málaga, Spain*
[b]*Unidad de Gestión Clínica del Corazón y Patología Vascular, Instituto de Investigación Biomédica de Málaga (IBIMA), Hospital Regional Universitario de Málaga, Málaga, Spain*

*Corresponding author:
E-mail address: mercedesmillang@gmail.com (M. Millán Gómez).

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