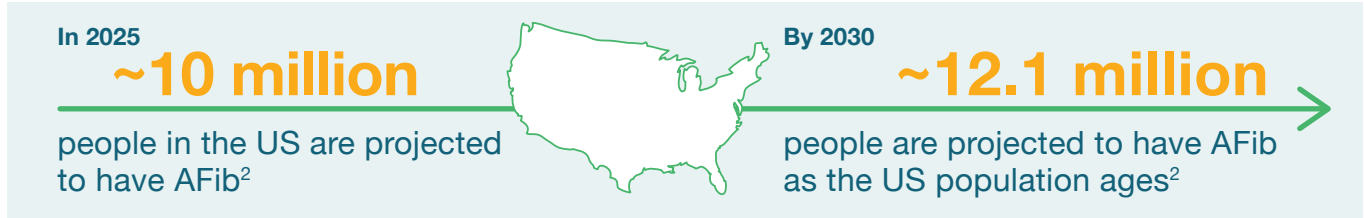


AFib is a powerful risk factor for stroke¹

Don't let AFib go undetected



Based on a retrospective study with a natural history progression model²:



Analyses of the Framingham Heart Study show*:

<p>Patients with AFib are</p> <p>~5x</p> <p>more likely to have a stroke¹</p>	<p>Those who had an AFib-related stroke were</p> <p>~2x</p> <p>more likely to die within 30 days post-stroke based on age-adjusted model³</p>	<p>Approximately</p> <p>23%</p> <p>of people were newly diagnosed with AFib during hospitalization for a stroke⁴</p>
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*The Framingham Heart Study cohort consisted of 5,070 men and women aged 30 to 62 years, free of cardiovascular disease including stroke at study entry in 1948–1950, and who were followed prospectively with biennial examinations.^{1,3-6}

¹The Framingham Heart Study analysis evaluated the influence of AFib on stroke mortality by means of systematic and serial assessments in stroke subjects using the long-term prospective follow-up of the original Framingham Study cohort over a 40-year period. Among 501 initial ischemic strokes, 103 (20%) had documented AFib. **Study limitations:** Social and psychological factors were not evaluated and not all stroke survivors attended each set-time follow-up examination, which may have introduced bias into the analyses.³

⁴The Framingham Heart Study analysis evaluated the relationship between acute stroke and admission-detected AFib in patients suffering stroke without previous diagnosis of AFib. During 38 years of follow-up, 656 initial strokes occurred, and 115 of these strokes occurred in association with AFib; 21 of these patients had AFib discovered upon hospital admission for a stroke and an additional 5 developed AFib while hospitalized for stroke. The percentage of patients with newly diagnosed AFib (23%) represents those with AFib discovered upon hospital admission (n=21) and those that developed AFib while hospitalized (n=5) expressed as a percent of total number of patients with AFib-related strokes (n=115). **Key study limitation:** the number of study cases was small.⁴

Certain patients are at increased risk for AFib

In addition to advancing age,⁷ the risk of AFib increases by[§]:

<p>~2x with obstructive sleep apnea^{11B}</p>		<p>~50% with diabetes^{*15}</p>
<p>~50% with obesity^{#6}</p>		<p>~45% with hypertension^{*15}</p>

[§]This is not an inclusive list of risk factors.

A pulse check for at-risk patients can be a critical first step toward diagnosing AFib^{9,10}

⁹Based on a 2018 meta-analysis of 9 studies (2006–2017; N=19,837) that demonstrated an OR of 2.120 (CI: 1.845–2.436) of AFib among patients with OSA vs the control group (defined as no recent or prior diagnosis of OSA by history or diagnostic testing). Note that associations between OSA and AFib may be driven in part by shared risk factors. **Select study limitations:** limited ability to draw conclusions about temporality and incident risk due to cross-sectional data; no knowledge of diagnostic tests used to determine OSA; inherent limitations of apnea-hypopnea index for OSA assessment; increased diagnostic of AFib in patients from the prospective cohort studies vs symptomatic AFib patients in the general population.⁸

¹⁰The Framingham Heart Study analysis (n=562), with up to 38 years of follow-up, identified that diabetes is associated with an increased risk for AFib: OR of 1.4 for men and OR of 1.6 for women (after adjustment for confounders) and that hypertension is associated with risk for AFib: OR of 1.5 (95% CI: 1.2–2.0) for men and OR of 1.4 (95% CI: 1.1–1.8) for women (after multivariable adjustment). **Select study limitations:** misclassification of AFib due to undetected AFib episodes (if brief or not severe); analyses restricted to patients with non-acute AFib; study findings may not be generalizable to non-white individuals or ages other than 55 to 94.⁵

¹¹The Framingham Heart Study analysis (n=526) with mean follow-up of 13.7 years found that multivariable adjusted HRs for AFib were 1.52 (95% CI: 1.09–2.13) for obese men and 1.46 (95% CI: 1.03–2.07) for obese women. **Select study limitations:** potential for missed AFib due to asymptomatic, minimally symptomatic, and transient episodes; inclusion of atrial flutter and AFib into the endpoint; potential misclassification of individuals with high muscle mass due to use of BMI; study findings may not be generalizable to non-white individuals or those with very advanced age or severe hypertension.⁸

DETECTAFib

Primary care clinicians can be the first line of AFib detection¹¹



Keep in mind symptoms of AFib in at-risk patients

- Symptoms of AFib may include⁷:

Irregular heartbeat

Lightheadedness

Heart palpitations

Shortness of breath

Chest pain

Fatigue



AFib can be difficult to detect

- Patients can be asymptomatic¹²
 - ↳ A pulse check as part of routine care can help detect AFib⁹
- Patients can have paroxysmal (intermittent) AFib¹²
 - ↳ Remote monitoring with FDA-cleared devices may help detect irregularities such as AFib beyond the office^{9,13}

Evaluating at-risk patients can lead to earlier AFib detection.
Which of your patients are at increased risk?

Go to www.detect-afib.com for more information

AFib=atrial fibrillation; BMI=body mass index; CI=confidence interval; HR=hazard ratio; OR=odds ratio; OSA=obstructive sleep apnea.

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DETECT AFib