

Study finds no benefit in adding third drug to therapy for older patients

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Triple therapy is no better than dual antiplatelet therapy in preventing major adverse cardiac events in older patients with atrial fibrillation who had a heart attack treated with angioplasty, and triple therapy resulted in more complications, according to a study published today in the *Journal of the American College of Cardiology*.

Patients on a [triple therapy](#) regimen are treated with warfarin, a common blood thinner, and two antiplatelet medications. When compared with patients receiving only dual antiplatelet treatment, patients on a triple therapy regimen had the same rates of adverse cardiac events but had a higher incidence of bleeding requiring hospitalization in the two years following discharge.

Using data from the National Cardiovascular Data Registry ACTION Registry-GWTG linked with Centers for Medicare and Medicaid Services data, researchers examined records between January 2007 and December 2010 from nearly 5,000 patients 65 years or older with a history of atrial fibrillation presenting with a heart attack and being treated with angioplasty and placement of a stent.

During the study period, researchers examined major adverse cardiac events, including death and readmission due to a heart attack or stroke, as well as readmission due to bleeding.

Researchers found that almost 28 percent of patients were discharged on triple therapy compared to 72 percent discharged on dual [antiplatelet](#)

[therapy](#). Those receiving triple therapy were more likely to be male, have a history of either angioplasty or coronary artery bypass surgery, and have a history of stroke. These patients also were frequently already on warfarin before admission to the hospital. In contrast, patients released on dual antiplatelet therapy were more likely to have had an in-hospital major bleeding event.

Results showed that after adjusting for patient, treatment, and hospital characteristics, triple therapy was not associated with a lower two-year risk of major adverse cardiac events compared to dual antiplatelet therapy. The risk of bleeding requiring hospitalization within two years after discharge was more than 6 percent higher for patients on triple therapy compared with those on a dual-therapy regimen.

To verify findings from the primary study, researchers analyzed records from 1,591 Medicare Part D patients and found 93 percent continued to take warfarin 90 days after being discharged from the hospital. The findings from this secondary study were consistent with the results from the primary study: the risk of major adverse cardiac events had not been reduced, and the bleeding risk was higher.

Connie N. Hess, M.D., M.H.S., the study's lead author and assistant professor, Department of Medicine, Division of Cardiology at Duke University School of Medicine, and a member of the Duke Clinical Research Institute, said, "The increased risk of bleeding without apparent benefit of triple therapy observed in this study suggests that clinicians should carefully consider the risk-to-benefit ratio of triple therapy use in older [atrial fibrillation](#) patients who have had a [heart attack](#) treated with angioplasty. Further prospective studies of different combinations of anti-clotting agents are needed to define the optimal treatment regimen for this population."

In an accompanying editorial, Javier A. Valle, M.D., and John C.

Messenger, M.D., both from the Division of Cardiology at the University of Colorado School of Medicine, wrote that while the benefits of triple therapy for preventing major adverse cardiac events remain "troublingly uncertain," the data are convincing for bleeding. They add that recent investigations have focused on redefining the agents used in triple therapy. Valentin Fuster, M.D., Ph.D., editor-in-chief of the *Journal of the American College of Cardiology*, acknowledged that the critical question to be answered at present is whether oral anticoagulants plus a single platelet inhibitor - such as Clopidogrel - is of a higher benefit-to-risk than triple therapy or dual antiplatelet therapy.

At this point, however, Valle and Messenger note that "more" does not appear to be "better." They conclude by asking, "Can we replace 'more' with a better alternative?" The answer to date, they say, is "not yet."

Provided by American College of Cardiology

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