Patients with AFib ≥80 years randomized to edoxaban 30 mg experienced similar rates of stroke or systemic embolism and significantly lower rates of major bleeding, net outcomes, and all-cause death compared with warfarin, regardless of presence or absence of dose-reduction criteria.

**BACKGROUND**
Since bleeding risk increases with age, clinicians often use lower dose anticoagulants in the elderly. However, the efficacy and safety of lower dose anticoagulants in the very elderly is not well-described.

**METHODS**
ENGAGE AF-TIMI 48 randomized 21,105 patients with atrial fibrillation (AF) to edoxaban (60 mg or 30 mg) vs warfarin (W). Edoxaban dose was reduced by 50% (i.e., to 30 mg and 15 mg, respectively) in patients with CrCl ≤50 ml/min, weight ≤60 kg, or on strong P-glycoprotein inhibitors.

In a post-hoc analysis, we compared outcomes in 2,406 patients age ≥80 years treated with edoxaban 30 mg (E30) vs W (Figure 1). Analyses were stratified by whether the patient met dose-reduction criteria (1,266; 53%) or not (1,140; 47%). Patients on E60 or E15 were excluded.

**RESULTS**
- Baseline characteristics were well-matched: median age 82 years, 45% female, and 53% exhibited dose-reduction criteria (Table 1).
- Stroke/systemic embolism (SSE) rates were similar with E30 vs W (Figure 2).
- Major bleeding and the net clinical outcome (death, SSE, major bleeding) were both significantly reduced with E30 vs W.
- All-cause mortality was significantly reduced with E30 vs W.
- No significant treatment interactions by dose-reduction criteria were present (all Pinteraction >0.05) (Figure 3).

**CONCLUSION**
In 2,406 patients with AF age ≥80 years, patients randomized to edoxaban 30 mg experienced similar rates of SSE and significantly lower rates of major bleeding, net outcomes, and all-cause death compared with warfarin, regardless of presence or absence of dose-reduction criteria.

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**TABLE 1**

<table>
<thead>
<tr>
<th></th>
<th>Edoxaban 30 mg (N=1,201)</th>
<th>Warfarin (N=1,205)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>82 (81-85)</td>
<td>82 (81-84)</td>
</tr>
<tr>
<td>Female sex</td>
<td>46 (45)</td>
<td>46</td>
</tr>
<tr>
<td>Prior stroke or transient ischemic attack</td>
<td>25 (28)</td>
<td>25 (28)</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>47 (45)</td>
<td>45</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>26 (28)</td>
<td>26</td>
</tr>
<tr>
<td>CHA2DS2-VASc score 4-9</td>
<td>89 (89)</td>
<td>89</td>
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<tr>
<td>HAS-BLED score 23</td>
<td>58 (59)</td>
<td>59</td>
</tr>
<tr>
<td>Dose reduction at randomization</td>
<td>52 (53)</td>
<td>53</td>
</tr>
<tr>
<td>Creatinine clearance ≤55 mL/min</td>
<td>50 (51)</td>
<td>50</td>
</tr>
<tr>
<td>Weight ≤60 kg</td>
<td>17 (17)</td>
<td>17</td>
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<tr>
<td>Use of verapamil or quinidine</td>
<td>2.6 (3.1)</td>
<td>2.6</td>
</tr>
<tr>
<td>Time in therapeutic range</td>
<td>N/A</td>
<td>69.5 (57-78.5)</td>
</tr>
</tbody>
</table>

Notes: Continuous variables are reported as median (interquartile range) and categorical variables are reported as %. There was no statistically significant difference between the groups (all p-values were >0.10).

**DISCLOSURES**
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