CONFlict OF INTEREST: 

Diabetes diagnosis- n (%) 7,442 (13.2) 1,294 (9.5) 2,806 (12.3) 3,342 (16.4)

Age (yrs) 92.2 (2.6) 92.4 (2.5) 92.4 (2.6) 91.9 (2.5)

hospitalization rates for AIS in NGs from 2009 - 2012 may indicate a true increase in stroke incidence or may re-

marginally increased between 2009 - 2012 in the NG cohort.

The PR (or PQ) interval is the delay between the excitation of the atria and ven-

tricles and is determined by the sum of atrial and atrioventricular nodal conduction. Both long

FIBRILLATION IN THE UNITED STATES: A 15 YEAR EXPERIENCE

RESULTS: There were 2214 (62.5%) users of VKA and 1328 (37.5%) users of NOAC. CHA2DS2-VASc

in VKA group was 3.4 ± 1.8, in NOAC group it was 2.5 ± 1.3. Significantly higher incidence of side effects was detected among VKA compared to NOAC users. Bleeding: 31% in VKA vs 3.5% in NOAC users (p < 0.001); CRMB in VKA群体 had 52% (2.1%) vs 3.0% (2.2%) were observed in

NOAC (762 dabigatran and 426 rivaroxaban). CRMB in VKA group had 194 pts (8.76%) vs 21 (1.6%) in NOAC (p < 0.01). No significant difference between dabigatran 150 mg and Rivaroxaban 20 mg, 1 CRMB in dabigatran 110 mg. More than 50% of the VKA users had difficulties to adjust OAC dose and to keep the INR between 2.0 and 3.0 and 31.8% had problems with INR control. NOAC’s were preferred in pts in electrical cardioversion group 67.4% vs 35.3% with significantly lower rates of adverse events (p < 0.001) as bleeding and high safety.

Patients 13%) cardiologists, 28.5% internal specialists, 23.9% general practitioners, 8.9% sur-

genists and others, 32.7% resident physicians. – 48.5% did use NOAC in their practice, but 81.3% of physicians were willing to do it more often. High costs and not sufficient clinical experience were men-

ctioned as main problems for NOAC. According to the physicians, the main problems for VKA are lack of compliance, poor DR control and difficulties in dose adjustment. 82% of doctors did explain inter-

action of active substances with OAC and NOAC in practice.

Conclusions: Clinical usage of OAC for AF patients is more complicated in VKA group due to side effects, complexity of use and lack of information. NOAC are more safe and have significantly less complications and bleeding rate. In electrical cardioversion group NOAC are preferable for use before and after procedure. Physicians find the usage of NOAC less problematic and they would be ready to use NOAC in practice more often. Thrombosis and bleeding risk factors are not considered properly enough before starting OAC therapy

CONFLICT OF INTEREST: none