

for bleeding. However, only the difference in mortality persisted after adjustment (Fig). Adjusted HRs also showed higher mortality for non-paroxysmal vs paroxysmal AF and for permanent vs paroxysmal/persistent AF (Fig). We found no interaction between type of AF and AC therapy.

**Conclusion:** Persistent and permanent AF were associated with higher mortality risk vs paroxysmal AF but had similar adjusted risks of stroke/SE and major bleeding in 2 yrs of follow-up.

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#### P4602 | BEDSIDE

##### Similar clinical outcomes of asymptomatic and symptomatic patients with newly diagnosed atrial fibrillation: results from GARFIELD-AF

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**Purpose:** To compare the characteristics, treatment and outcomes of asymptomatic vs symptomatic patients with newly diagnosed nonvalvular atrial fibrillation (NVAF).

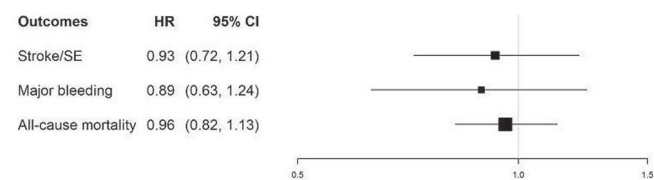
**Methods:** 39,898 adults (≥18 yrs) with NVAF diagnosed in the past 6 wks and ≥1 investigator-defined stroke risk factor were enrolled in the prospective GARFIELD-AF registry from 35 countries from Mar 2010–Sep 2015. At enrolment 28,843/78.0% patients presented with symptoms (palpitations, shortness of breath, chest pain/discomfort, dizziness, tiredness, sweating, fainting, other), 8125/22.0% did not (data missing in 2930). We analysed baseline characteristics, antithrombotic therapy and 1-yr incidence of outcomes.

**Results:** The asymptomatic group included more men (65.3% vs 52.7%), and had a higher mean age (71.8 vs 69.0 yrs) and lower prevalence of congestive heart failure (CHF, 11.7% vs 23.2%), including NYHA Class III–IV CHF (17.1% vs 34.9%) vs the symptomatic group. The two groups had similar mean CHA<sub>2</sub>DS<sub>2</sub>-VASc (both 3.2 [SD 1.6]) and HAS-BLED (1.5 [0.9], 1.4 [0.9]). Fewer asymptomatic patients were diagnosed in a hospital (52.6% vs 60.7%) or emergency room (4.3% vs 13.6%) and more in an office (42.2% vs 25.0%). Use of antithrombotic therapies was similar in both groups (Tab). Unadjusted and adjusted HRs showed no difference in the rate of stroke/systemic embolism (SE) or of major bleeding in the two groups. Unadjusted HRs showed slightly lower all-cause mortality (0.87 [95% CI 0.77; 0.99]) in asymptomatic patients, although this difference was not present after adjustment for baseline characteristics. The annual incidence rates of stroke/SE and all-cause mortality were 1.40 and 3.81 per 100 person-yrs in asymptomatic patients, despite anticoagulation in 68.3%.

#### Antithrombotic therapy at diagnosis

%	Asymptomatic patients (n=8061)	Symptomatic patients (n=28,420)
VKA +/- AP	43.2	42.6
FXa +/- AP	18.5	15.1
DTI +/- AP	6.6	6.9
AP only	18.9	23.3
None	12.8	12.2

AP, antiplatelet; DTI, direct thrombin inhibitor; FXaI, factor Xa inhibitor; VKA, vitamin K antagonist.



Hazard ratios were adjusted for age group, gender, race, smoking, diabetes, hypertension, previous stroke/transient ischaemic attack/systemic embolism, history of bleeding, cardiac failure, vascular disease, moderate-to-severe renal disease, anticoagulant treatment, type of atrial fibrillation and alcohol consumption. Reference group: Patients with symptomatic NVAF.

Adjusted hazard ratios of 1-yr outcomes

#### Abstract P4603 – Table 1. Country-specific TADC

Country	UK (N=2,347)		Spain (N=1,949)		France (N=1,221)		Italy (N=1,518)		Germany (N=2,823)	
	Mean (SEM) (£)	%	Mean (SEM) (£)	%	Mean (SEM) (£)	%	Mean (SEM) (£)	%	Mean (SEM) (£)	%
Drug	113 (4.9)	4.0	136.7 (5.5)	11.0	369.2 (13.6)	21.7	106.2 (5.3)	6.9	277.9 (6.6)	11.1
Inpatient	2,118.3 (186.0)	74.1	793.5 (127.6)	63.9	1,109.9 (180.1)	65.2	1,294.7 (362.4)	83.7	1,968.5 (166.1)	78.6
Outpatient	625.5 (16.6)	21.9	311.0 (26.1)	25.1	222.9 (18.8)	13.1	145.9 (25.7)	9.4	257.6 (76.0)	10.3
Total	2,857.3 (187.8)	100	1,241.2 (131.7)	100	1,702.0 (181.2)	100	1,546.8 (363.4)	100	2,504.1 (183.4)	100

**Conclusion:** One-fifth of patients newly diagnosed with NVAF had no symptoms. Prescription of antithrombotic therapies was similar in asymptomatic and symptomatic patients. Adjusted 1-yr mortality, stroke/SE and major bleeding were the same in each group, indicating that asymptomatic newly diagnosed AF is not benign. This supports systematic approaches to detect and treat asymptomatic NVAF.

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#### P4603 | BEDSIDE

##### The burden of atrial fibrillation in the more populated European countries: perspectives from the GARFIELD-AF registry

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**Purpose:** We evaluated the economic burden attributable to atrial fibrillation (AF) and related anticoagulant (AC) therapy in patients with incident AF during the first yr from diagnosis in the 5 more populated European countries.

**Methods:** GARFIELD-AF is an ongoing, prospective, non-interventional study of adults (≥18 yrs) with newly diagnosed nonvalvular AF and ≥1 stroke risk factor. We analysed GARFIELD-AF patients enrolled in France, Germany, Italy, Spain, UK during 2010–5. Total annualised direct cost (TADC) attributable to AF was calculated as the sum of the annual cost of medical visits (incl. monitoring), drug therapy, hospital admissions, diagnostic procedures and other medical events attributable to AF, quantified in the perspective of the third-party payer. We focused on the incremental cost specifically attributable to events related to AF and to AC therapy.

For indirect costs, we identified patients who died during follow-up whose death happened during working age (ie before local age of retirement). We calculated yrs of working life lost as the difference between the age of retirement and the age at death. We used the human capital approach and county-specific average salary/worker to calculate the cost of production losses attributable to premature mortality.

Based on AF prevalence estimates, we projected the direct and indirect costs attributable to AF in the 5 countries.

**Results:** Enrolled patients generated a total of 8,574 person-yrs of observation. TADCs are shown in Table 1. Twenty-seven deaths occurred during working age. Mean loss of working yrs/patient was 6.4 (SD 6.8) and 7.6 (7.2) yrs for females and males, with a total of 198.4 working yrs lost, corresponding to €263,696/patient who died during working age. Estimates indicate that AF generates in the 5 countries an overall additional annual cost of 18 billion Euro, 12 billion Euro attributable to healthcare and 6 billion Euro to premature mortality.

**Conclusions:** AF imposes a high financial, economic and human burden to societies. Based on population dynamics, the burden is likely to grow in the future. Premature mortality substantially adds to the already considerable direct cost of the disease.

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#### P4604 | BEDSIDE

##### Residual stroke risk of anticoagulated patients with atrial fibrillation: PREFER in AF European registry

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**Background:** Stroke prevention is a major goal in the treatment of AF. The resid-