

**ANTITHROMBOTIC THERAPY PROFILE AND ITS ASSOCIATION WITH
CLINICAL AND SOCIODEMOGRAPHIC FACTORS INPATIENTS WITH
ATRIAL FIBRILLATION**

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Non-valvular atrial fibrillation (AF) is a major risk factor for ischemic stroke and systemic thromboembolism. According to international guidelines, oral anticoagulant (OAC) therapy is the cornerstone of stroke prevention in patients at high thromboembolic risk. In the multicenter EORP-AF and APHRS-AF observational studies, more than 80% of such patients received OAC therapy. Antiplatelet therapy is not considered an alternative to OAC for this purpose. Nevertheless, inadequate OAC coverage and clinical and demographic disparities persist in certain regions.

To assess the antithrombotic therapy profile and its concordance with international clinical guidelines in patients with non-valvular AF, and to analyze the clinical and sociodemographic factors associated with OAC use.

A single-center cross-sectional study included 110 patients with non-valvular AF admitted to RSSPMCC between July 2025 and July 2026. Antithrombotic therapy at admission was recorded, with OAC use as the primary outcome; patients receiving antiplatelet or no therapy were classified as non-OAC. Thromboembolic and bleeding risks were assessed using CHA₂DS₂-VASc and HAS-BLED scores, respectively. Statistical analyses included chi-squared/Fisher's exact, Mann-Whitney U, Kruskal-Wallis, and Fisher-Freeman-Halton tests, with unadjusted ORs and 95% CIs calculated for sex–OAC associations. A two-sided $p < 0.05$ indicated statistical significance.

The median age was 68 [63–75.8] years, with women comprising 55.5% of patients. The median CHA₂DS₂-VASc and HAS-BLED scores were 4 [3–5] and 2 [2–2], respectively. OACs were used in 39 patients (35.5%), antiplatelet agents in 50 (45.5%), and no antithrombotic therapy in 21 (19.1%). Rivaroxaban was the predominant OAC (34/39; 87.2%), while acetylsalicylic acid was the main antiplatelet agent (42/50; 84.0%). OAC use was significantly higher in men than women (51.0% vs. 23.0%; $\chi^2 = 9.36$; $p = 0.002$), with 3.50-fold higher odds in men (95% CI 1.54–7.93). Therapy category was also associated with sex ($\chi^2 = 10.56$; $df = 2$; $p = 0.005$). Among women, 50.8% received antiplatelets and 26.2% received no therapy, compared with 38.8% and 10.2% of men. No significant associations were observed between OAC use and age, residence, education, AF characteristics, CHA₂DS₂-VASc/HAS-BLED scores, or left ventricular ejection fraction (all $p > 0.05$). Vascular disease ($p = 0.034$) and renal/liver dysfunction ($p = 0.023$) showed nominal associations with OAC use; however, these findings were considered exploratory due to the small subgroup ($n = 8$) and lack of adjustment for confounders or multiple comparisons.

At hospital presentation, OAC coverage was less than half that reported in international observational data and was significantly higher in men than in women. No significant associations were observed with the other factors examined. These findings highlight the need to optimize OAC therapy based on thromboembolic risk. To improve OAC use in eligible patients and reduce inappropriate substitution with antiplatelet agents, primary care physicians should be encouraged to use standardized risk assessment and algorithms based on international guidelines.