used multivariable adjusted logistic regression with GEE to model the odds of our primary outcome and Cox proportional hazards regression with robust variance estimation to model secondary outcomes. Individuals with missing race/ethnicity (3.6%) were excluded from the analysis.

Results: Among 69,553 patients hospitalized with AF from 159 sites between 2014-2020, 85.6% were White, 7.3% Black, 5.8% Hispanic and 1.2% Asian patients. Overall, 48.8% were women; mean age was 68.6 years; mean CHADS$_2$VASc score was 3.8. Overall, 56,385 (78.5%) were discharged on any OAC. Black patients, adjusted odds ratio (aOR) 0.75; 95% CI 0.67-0.84, were less likely than White patients to be discharged on any OAC (Table 1). Black patients discharged on OAC were less likely to receive direct oral anticoagulants (DOACs) vs. warfarin (aOR 0.82; 95% CI 0.65-0.96). At 1 year, bleeding (aOR 2.08; 95% CI 1.5-2.8) and stroke (aOR 2.07; 95% CI 1.34-3.20) rates were higher in Black than White patients (Table 2). Hispanic patients also had higher stroke rates (aOR 2.02; 95% CI 1.38-2.95). Mortality rates were higher in Black than White patients (aOR 1.22; 95% CI 1.02-1.47).

Conclusion: In a national registry of patients hospitalized with AF, Black compared to White patients were less likely to be discharged on OAC. Black patients also had higher rates of AF-related outcomes including stroke (also in Hispanic patients), bleeding, and mortality. Understanding the drivers of racial/ethnic differences in OAC prescribing, such as the higher cost of DOACs vs. warfarin, will help guide interventions to reduce OAC inequities and improve AF outcomes.

Background: Oral anticoagulation (OAC) is recommended for stroke prophylaxis after diagnosis of atrial fibrillation (AF). However, the optimal strategy or timing for continuing OAC use after bleeding events in these patients has not been well established.

Objective: This analysis seeks to characterize real-world patterns of OAC utilization after bleeding events in patients with prior ischemic stroke and diagnosed AF.

Methods: Patients with a diagnosis code for a bleeding event between 1/01/2007-3/31/2021 were identified in the U.S. de-identified Optum® Clinformatics® claims database. Bleed events were identified based on the presence of an ICD-9/10 diagnosis code for bleeding in any site of service, and included: hemorrhagic stroke (HS), other intracranial hemorrhage (ICH), or extracranial hemorrhage (ECH). Patients were required to have any prior evidence of AF diagnosis, and must have OAC prescription coverage within the 3 months prior to the index bleed event. Kaplan-Meier curves were created to estimate the rate at which OACs were restarted after index for each bleed type, including all available follow-up time in the database for each patient.

Results: A total of 44,207 patients were identified: 7,755 patients with HS, 781 with ICH, and 35,671 with ECH. After HS, an estimated 26% of patients resumed OAC early, within 30 days of the bleed event; 45% restarted later (36% between 30 days-1 year, 9% after 1 year), and the remaining 29% permanently discontinued. Overall, the median time to refill was 3.1 months. After an Other ICH event: 36% resumed early, 42% restarted later (36% within 1 year and 6% after 1 year), and 22% discontinued; median time to refill was 1.9 months. After ECH: 42% resumed early, 48% restarted later (40% within 1 year and 8% beyond 1 year), with 10% discontinuing; median time to refill was 1.4 months.

Conclusion: Although the risk-benefit profile of OAC resumption after bleeding events in AF patients has not been definitively characterized to-date, our analysis of a large claims database indicates that resumption of OAC after bleeding is common in clinical practice, with 71%-90% of patients either continuing or restarting after a brief pause. Upcoming randomized trials aim to provide more information in this space and may enable development of a clearer clinical consensus.

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LARGE OBSERVATIONAL STUDY EVALUATING SAFETY AND EFFICACY OF DIRECT ORAL ANTICOAGULANTS IN EXTREME OBESITY

Sherry J. Saxonhouse MD, MS, FHRS; KAMALA SWAYAMPAKALA PhD; Stephen Perle Sc B and Sophia E. Saxonhouse

Background: Obesity is an independent risk factor for atrial fibrillation (AF) influencing the pharmacokinetics and pharmacodynamics of drug therapy and direct oral anticoagulants (DOACs). There is limited data in the randomized clinical trials for patients with extreme obesity (BMI ≥ 40.0 kg/m$^2$ or weight > 120 Kg).

Objective: To evaluate the effectiveness and safety of DOACs versus vitamin K antagonists (VKA) for the treatment of nonvalvular AF (NVAF) in extreme obese patients.

Methods: Using retrospective cohort study design, adult extreme obese patients with NVAF using DOACs or VKA during 2014 - 2020 with BMI ≥ 40.0 or weight > 120 Kg were selected from a large south-east hospital system. Patients were categorized into four groups based on BMI and weight (weight > 120 Kg and BMI ≥ 40; BMI 41-44; BMI 45-49; BMI ≥ 50). Primary