New guidelines for the management of atrial fibrillation: what's new?

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At the ESC Congress 2010 in Stockholm, four new practice guidelines were introduced concerning 1) grown-up congenital heart disease, 2) myocardial revascularisation, 3) use of cardiac resynchronisation therapy (CRT) and devices in patients with heart failure, and 4) atrial fibrillation (AF). In this Editor's page a short summary is given of the new guidelines on AF. The Task Force on AF was chaired by Professor John Camm (London, UK) and included 24 European experts in arrhythmias. There are a number of important modifications compared with the previous 2006 AF guidelines.

First, based on the presentation and duration of the arrhythmia, five types of AF can clinically be distinguished: 1) first diagnosed, 2) paroxysmal, 3) persistent, 4) long-standing, and 5) permanent AF.

Second, the new 2010 AF guidelines clearly state that initial clinical evaluation should include 1) a determination of the European Heart Rhythm Association (EHRA) score of AF-related symptoms, 2) an estimation of stroke-bleeding risk, and 3) a check for conditions that predispose to AF and for further complications.

Third, regarding antithrombotic treatment, in patients with a CHADS₂ score of 0-1, it has been recommended to use the CHA₂DS₂-VASc score. CHADS₂ stands for Cardiac Failure, Hypertension, Age, Diabetes, and Stroke (doubled). VASc stands for Vascular disease, Age 65-74 years, and Sex category. The CHADS₂ stroke risk stratification scheme allows the assessment of risk, particularly suited to assist primary care physicians. Unless contraindicated, chronic oral anticoagulation therapy (OAC) is recommended in patients with a CHADS₂ score of ≥ 2 . The international normalised ratio (INR) should be in the range of 2.0 to 3.0, unless contraindicated. For a more detailed stroke risk assessment, the CHA₂DS₂-VASc score is recommended.

Fourth, the new AF guidelines emphasise the importance of bleeding risk assessment before starting anticoagulation. In this case the HAS-BLED bleeding risk score is recommended (Hypertension, Abnormal renal and liver function, Stroke, Bleeding, Labile INRs, Elderly >5 years, Drugs or alcohol). A score of ≥ 3 is considered indicative of 'high-risk' patients who require caution and regular review after starting antithrombotic therapy.

Fifth, the guidelines extensively address the choice of antiarrhythmic therapy for recurrent AF. Recommendations are made on the basis of selecting safer medication instead of more effective, but less safe therapy. The results of current clinical trials with dronedarone now allow, for the first time, recommendation of dronedarone in patients with AF. In patients with adrenergic AF and no or minimal structural heart disease, dronedarone is recommended if β -blocking agents (including sotalol) are not effective. In patients with left ventricular hypertrophy, coronary artery disease, and stable New York Heart Association (NYHA) class I/II, dronedarone is the antiarrhythmic drug of choice. However, dronedarone should not be used in AF patients with NYHA class III/IV or in unstable patients with NYHA class II. In these patients, β -blocking agents are recommended as first-line therapy.

Lastly, the new Guidelines recommend that catheter ablation for paroxysmal AF should be considered in symptomatic patients who have previously failed a trial of antiarrhythmic medication (Class IIa, level of evidence A). At present, there is insufficient evidence that successful AF ablation will result in reduced mortality. Surgical ablation of AF should be considered in patients with symptomatic AF undergoing cardiac surgery.

To conclude, the new 2010 AF practice guidelines are a true step forward and their clinical implementation will have major impact in appropriately treating patients with AF (see also the article of I.C. van Gelder et al. on page 522-3). ■

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