CORRESPONDENCE

Atrial Fibrillation: Established and Innovative Methods of Evaluation and Treatment

by Prof. Dr. med. Hans-Joachim Trappe in volume 1–2/2012

Combination Treatment Entails Risks

Trappe mentions the ACTIVE-A study in his review article on atrial fibrillation (2). Even though he does not take any particular position, the description suggests that ASA plus clopidogrel is superior to monotherapy with ASA in patients with atrial fibrillation (with an indication for coumarin treatment in coexisting contraindications or refusal of treatment). When considering the risk-benefit ratio, this cannot be deduced from the data of the cited study. As explained in the *Arzneimitteltelegramm* newsletter (1), the risk of hemorrhage is notably higher in patients with dual platelet inhibition, so that altogether no advantage has been shown for combination treatment in the patient group under study. It is incomprehensible to me that the current article did not even mention the increased risk of combination therapy.

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Conflict of interest statement

The author declares that no conflict of interest exists.

What's New?

I wish to point out that the interesting and detailed article does not actually offer anything new.

Atrial fibrillation is common in patients with sleep apnea (1). In any form of atrial fibrillation, whether paroxysmal or permanent, and in the absence of structural cardiac disease, the patient should not only be investigated with regard to hyperthyroidism but also in regard to possible sleep apnea. If sleep apnea is present, it should be treated by using continued positive airway pressure (CPAP). It will then become obvious that atrial fibrillation will disappear in a considerable number of patients, or that more patients will respond better to the antiarrhythmic drugs mentioned in the article.

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Effective Alternatives

Primary care physicians are confronted with this problem on an almost daily basis and have to make decisions in the acute setting as well as for patients' long term care. Professor Trappe's article is thus enormously important and worth reading.

However, I think a few additional comments are warranted:

- It seems worth discussing, and readers did not receive a sufficiently clear answer, whether the available and reported study results even justify medical treatment of cardiac arrhythmia.
- The author's explanations regarding dronedarone are euphemistic when he says that the current state of the evidence, after a relatively short period of observation of the effects of dronedarone, does not justify the prominent position accorded to this drug in the published guidelines. After the PALLAS trial was stopped (clinicaltrials.org), it seems obvious that this drug, which was initially provocatively advertised, does not provide a further, potential treatment option for permanent atrial fibrillation.
- I would have wished for a specialist cardiological assessment of the use of pulmonary vein isolation.
- I wonder which ethics committee gave approval for a substance such as vernakalant to be tested in at least three studies versus placebo (!) when effective alternative therapeutics are available, for which conversion rates of 40–60% in the acute setting have been described and confirmed. This expensive new drug cannot achieve any more than that, and it remains unclear whether it offers any additional advantages compared with flecainide or propafenone.
- In my opinion, it would have been important to mention for dabigatran the significantly increased risk of provoking myocardial infarction (Uchino K, Hernandez AV: Circulation 2011; 124: Abstract 15500), which should be an additional factor in the decision-making process.

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The author declares that no conflict of interest exists.

In Reply:

Review articles in *Deutsches Ärzteblatt* are published in as comprehensive a format as possible, but at the same time they are compressed. For this reason, not all aspects of a given topic can be included.

Atrial fibrillation is the subject of extensive discussion in the current guidelines (60 pages), especially questions surrounding anticoagulation (1). The ESC recommendations are based on large data sets from the BAFTA and ACTIVE-W studies, as well as a Japanese study. All studies showed that oral anticoagulation is superior to platelet inhibition, including dual platelet inhibition, but that on the other hand, acetylsalicylic acid is no better than placebo in terms of the prognosis. It goes without saying that the risk of hemorrhage increases the more aggressive the anticoagulation measures (2).

Obstructive sleep apnea has a raised prevalence in patients with atrial fibrillation (3). Bitter and colleagues showed in 150 patients with atrial fibrillation that 74% had obstructive sleep apnea. The influence of obstructive sleep apnea on the recurrence of atrial fibrillation was also documented after cardioversion: 82% of patients with atrial fibrillation and untreated obstructive sleep apnea had recurrences of atrial fibrillation, compared with 42% who received treatment with CPAP devices. In patients with atrial fibrillation, sleep screening (if required, with treatment) is indicated.

The high expectations for new drug treatments have not been met. Vernakalant is not only very expensive but has conversion rates of only 50%, which limits its use compared with electric cardioversion. The initial euphoria associated with dronedarone has also turned into disappointment, especially after the results of the PALLAS study, which showed increased rates of death, stroke, and heart failure in patients with permanent atrial fibrillation receiving dronedarone, and which therefore had to be stopped. Pulmonary vein isolation is an established intervention with success rates of 70% and is an option for patients with symptomatic atrial fibrillation.

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Professor Trappe has received travel and hotel expenses from St Jude Medical, Boston Scientific for ASC and DKG Mannheim. He has also received honoraria for continuing medical educational events from St Jude Medical and Boston Scientific.