

# Liderando el conocimiento del mañana

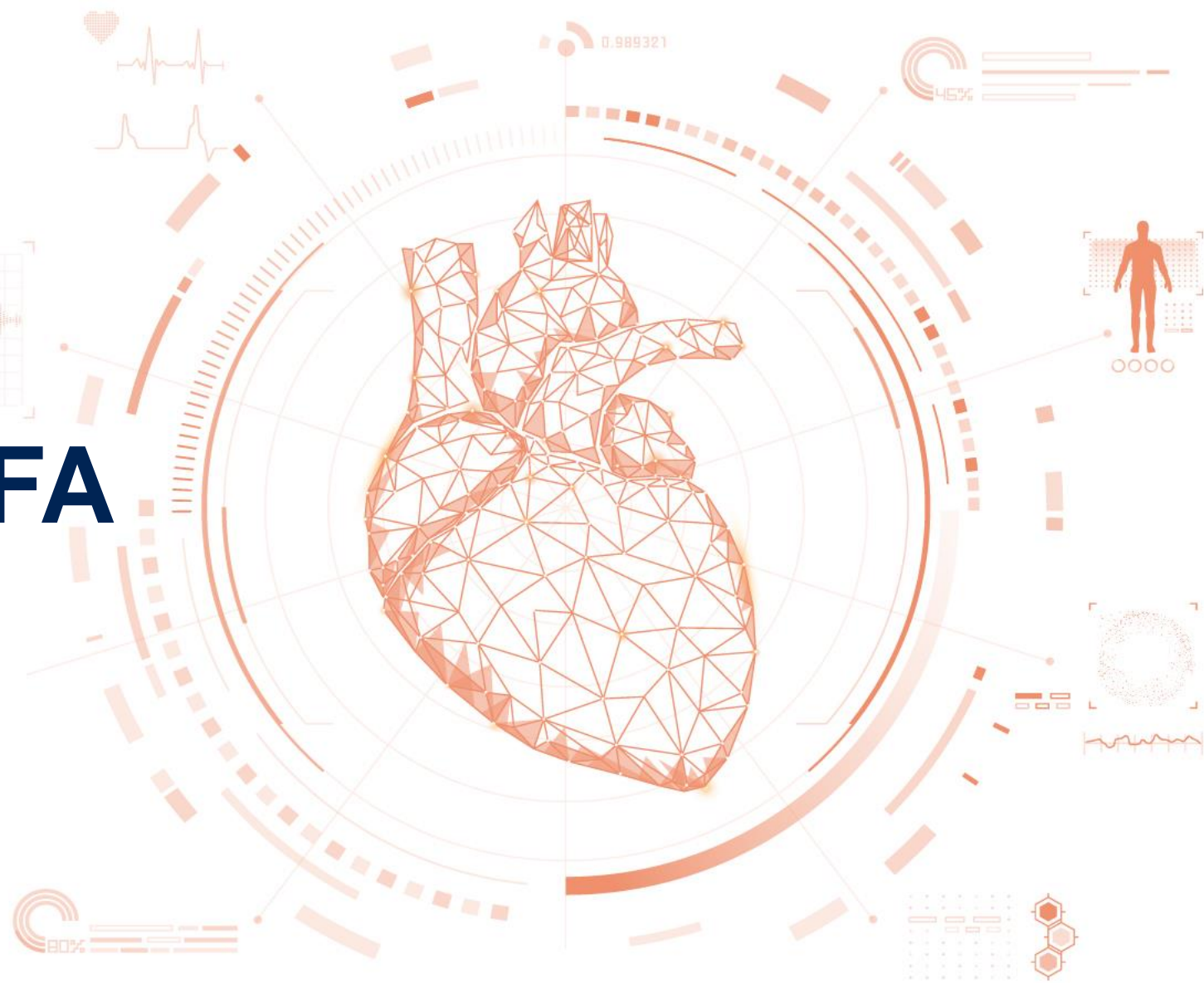
Cardio**Advanced**Forum'20



# Resumen de las nuevas guías de FA

Elena Fortuny Frau MD, PhD

Cardiología Hospital Universitario Son Espases,  
Palma de Mallorca





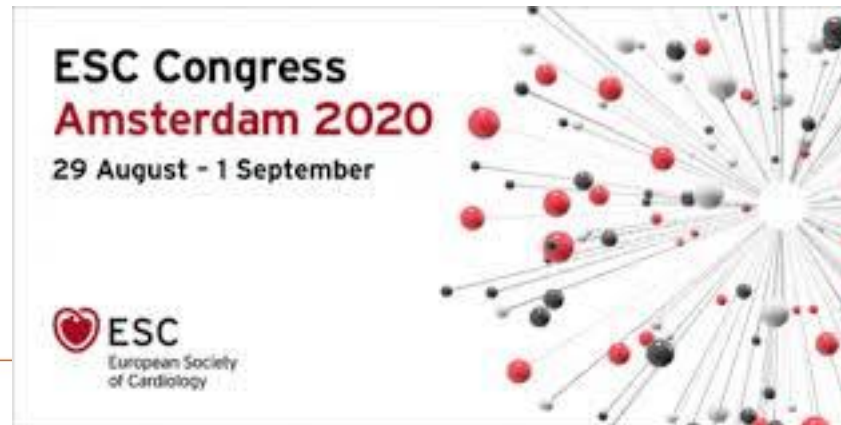
**ESC**

European Society  
of Cardiology

European Heart Journal (2020) **00**, 1–126  
doi:10.1093/eurheartj/ehaa612

**ESC GUIDELINES**

# 2020 ESC Guidelines for the diagnosis and management of atrial fibrillation developed in collaboration with the European Association of Cardio-Thoracic Surgery (EACTS)



**Liderando el conocimiento del mañana**  
Cardio**Advanced**Forum'20

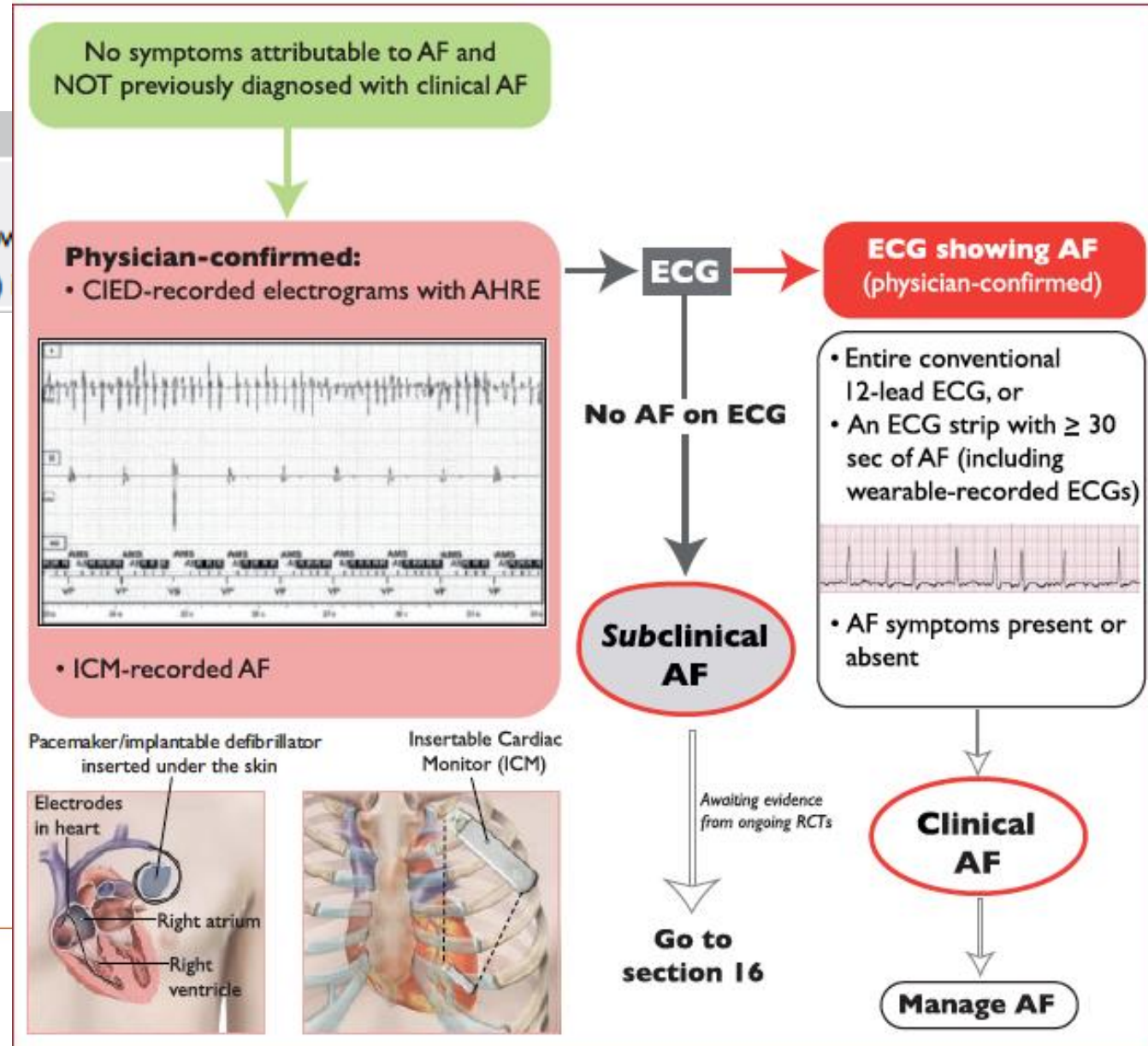
# Introducción

- 84 páginas de contenido
- 1492 referencias bibliográficas
- 22 tablas
- 25 imágenes y 1 ilustración central. MUY VISUAL
- Clase de recomendación y nivel de evidencia según la clasificación habitual

# Novedades guías FA ESC 2020

## Recommendations for diagnosis of AF

ECG documentation is required to establish the diagnosis of AF.  
A standard 12-lead ECG recording or a single-lead ECG tracing of  $\geq 30$  s showing irregular RR intervals (when atrioventricular conduction is not impaired)



# Novedades guías FA ESC 2020

## Recommendations for the prevention of thrombo-embolic events in AF

For a formal risk-score-based assessment of bleeding risk, the HAS-BLED score should be considered to help address modifiable bleeding risk factors, and to identify patients at high risk of bleeding (HAS-BLED score  $\geq 3$ ) for early and more frequent clinical review and follow-up.

**IIa**

Stroke and bleeding risk reassessment at periodic intervals is recommended to inform treatment decisions (e.g. initiation of OAC in patients no longer at low risk of stroke) and address potentially modifiable bleeding risk factors

**I**

In patients with AF initially at low risk of stroke, first reassessment of stroke risk should be made 4 - 6 months after the index evaluation.

**IIa**

Estimated bleeding risk, in the absence of absolute contraindications to OAC, should not in itself guide treatment decisions to use OAC for stroke prevention.

**III**

Clinical pattern of AF (i.e. first detected, paroxysmal, persistent, long-standing persistent, permanent) should not condition the indication to thromboprophylaxis.

**III**

# Novedades guías FA ESC 2020

## Recommendations for cardioversion

Pharmacological cardioversion of AF is indicated only in a haemodynamically stable patient, after consideration of the thrombo-embolic risk.

I

For patients with sick-sinus syndrome, atrioventricular conduction disturbances or prolonged QTc (>500 ms), pharmacological cardioversion should not be attempted unless risks for proarrhythmia and bradycardia have been considered.

III

# Novedades guías FA ESC 2020

## Recommendations for rhythm control/catheter ablation of AF

### General recommendations

For the decision on AF catheter ablation, it is recommended to take into consideration the procedural risks and the major risk factors for AF recurrence following the procedure and discuss them with the patient.

I

Repeated PVI procedures should be considered in patients with AF recurrence provided the patient's symptoms were improved after the initial PVI.

IIa

### AF catheter ablation after antiarrhythmic drug therapy failure

AF catheter ablation for PVI should be considered for rhythm control after one failed or intolerant to beta-blocker treatment to improve symptoms of AF recurrences in patients with paroxysmal and persistent AF.

IIa

### First-line therapy

AF catheter ablation for PVI should/may be considered as first-line rhythm control therapy to improve symptoms in selected patients with symptomatic:

IIa

- Paroxysmal AF episodes, or
- Persistent AF without major risk factors for AF recurrence as an alternative to AAD class I or III, considering patient choice, benefit, and risk.

IIb



# Novedades guías FA ESC 2020

## AF catheter ablation after drug therapy failure

AF catheter ablation for PVI is recommended for rhythm control after one failed or intolerant class I or III AAD, to improve symptoms of AF recurrences in patients with:

- Paroxysmal AF, or
- Persistent AF without major risk factors for AF recurrence, or
- Persistent AF with major risk factors for AF recurrence.

I

## First-line therapy

AF catheter ablation:

- Is recommended to reverse LV dysfunction in AF patients when tachycardia-induced cardiomyopathy is highly probable, independent of their symptom status.
- Should be considered in selected AF patients with HFrEF to improve survival and reduce HF hospitalization.

I

IIa

## Techniques and technologies

Complete electrical isolation of the pulmonary veins is recommended during all AF catheter-ablation procedures.

I

After AF catheter ablation, it is recommended that:

- Systemic anticoagulation with warfarin or a NOAC is continued for at least 2 months post ablation, and
- Long-term continuation of systemic anticoagulation beyond 2 months post ablation is based on the patient's stroke risk profile and not on the apparent success or failure of the ablation procedure.

I

# Novedades guías FA ESC 2020

## *Lifestyle modification and other strategies to improve outcomes of ablation*

Strict control of risk factors and avoidance of triggers are recommended as part of rhythm control strategy.

I

## **Recommendations for lifestyle interventions and management of risk factors and concomitant diseases in AF**

Identification and management of risk factors and concomitant diseases is recommended as an integral part of treatment in AF patients.

I

Modification of unhealthy lifestyle and targeted therapy of intercurrent conditions is recommended to reduce AF burden and symptom severity.

I

Opportunistic screening for AF is recommended in hypertensive patients.

I

Opportunistic screening for AF should be considered in patients with OSA.

IIa

# Novedades guías FA ESC 2020

## Recommendations for stroke risk management peri-cardioversion

It is recommended that the importance of adherence and persistence to NOAC treatment both before and after cardioversion is strongly emphasized to patients.

I

In patients with AF duration of >24 h undergoing cardioversion, therapeutic anticoagulation should be continued for at least 4 weeks even after successful cardioversion to sinus rhythm (beyond 4 weeks, the decision about long-term OAC treatment is determined by the presence of stroke risk factors).

IIa

In patients with a definite duration of AF  $\leq$ 24 h and a very low stroke risk (CHA<sub>2</sub>DS<sub>2</sub>-VASc of 0 in men or 1 in women) post-cardioversion anticoagulation for 4 weeks may be omitted.

IIb

# Novedades guías FA ESC 2020

## Recommendations for patients with AF and an ACS, PCI, or CCS

### Recommendations for AF patients with ACS

In AF patients with ACS undergoing an uncomplicated PCI, early cessation ( $\leq 1$  week) of aspirin and continuation of dual therapy with an OAC and a P2Y<sub>12</sub> inhibitor (preferably clopidogrel) for up to 12 months is recommended if the risk of stent thrombosis is low or if concerns about bleeding risk prevail over concerns about risk of stent thrombosis, irrespective of the type of stent used.

I

### Recommendations in AF patients with a CCS undergoing PCI

After uncomplicated PCI, early cessation ( $\leq 1$  week) of aspirin and continuation of dual therapy with OAC for up to 6 months and clopidogrel is recommended if the risk of stent thrombosis is low or if concerns about bleeding risk prevail over concerns about risk of stent thrombosis, irrespective of the type of stent used.

I

# Novedades guías FA ESC 2020

## Recommendations for the management of active bleeding on OAC

Four-factor prothrombin complex concentrates should be considered in AF patients on VKA who develop a severe bleeding complication.

**IIa**

## Recommendations for postoperative AF

Long-term OAC therapy to prevent thrombo-embolic events should be considered in patients at risk for stroke with postoperative AF after non-cardiac surgery, considering the anticipated net clinical benefit of OAC and informed patient preferences.

**IIa**

Beta-blockers should not be used routinely for the prevention of postoperative AF in patients undergoing non-cardiac surgery.

**III**

# Cambios más relevantes respecto guías 2016

Recommendations about integrated AF management			
2020	Class <sup>a</sup>	2016	Class <sup>a</sup>
<p>To optimize shared decision making about specific AF treatment option(s) in consideration, it is recommended that:</p> <ul style="list-style-type: none"> <li>● Physicians inform the patient about advantages/limitations and benefit/risks associated with considered treatment option(s); and</li> <li>● Discuss the potential burden of the treatment with the patient and include the patient's perception of treatment burden in the treatment decision.</li> </ul>	I	Placing patients in a central role in decision making should be considered in order to tailor management to patient preferences and improve adherence to long-term therapy	IIa
Recommendations for long-term antiarrhythmic drugs			
Amiodarone is recommended for long-term rhythm control in all AF patients, including those with HFrEF. However, owing to its extracardiac toxicity, other AADs should be considered first whenever possible.	I	Amiodarone is more effective in preventing AF recurrences than other AAD, but extracardiac toxic effects are common and increase with time. For this reason, other AAD should be considered first.	IIa

# Cambios más relevantes respecto guías 2016

Recommendations for the prevention of thrombo-embolic events in AF			
For bleeding risk assessment, a formal structured risk-score-based bleeding risk assessment is recommended to help identify non-modifiable and address modifiable bleeding risk factors in all AF patients, and to identify patients potentially at high risk of bleeding who should be scheduled for early and more frequent clinical review and follow-up.	I	Bleeding risk scores should be considered in AF patients on oral anticoagulation to identify modifiable risk factors for major bleeding.	IIa
In patients on VKAs with low time in INR therapeutic range (e.g. TTR<70%), recommended options are: <ul style="list-style-type: none"> <li>● Switching to a NOAC but ensuring good adherence and persistence with therapy; or</li> <li>● Efforts to improve TTR (e.g. education/counselling and more frequent INR checks).</li> </ul>	I	AF patients already on treatment with a VKAs may be considered for NOAC treatment if TTR is not well controlled despite good adherence, or if patient preference without contraindications to NOAC (e.g. prosthetic valve).	IIb
	IIa		
Recommendations for stroke risk management peri-cardioversion			
In patients with AF undergoing cardioversion, NOACs are recommended with at least similar efficacy and safety as warfarin.	I	Anticoagulation with heparin or a NOAC should be initiated as soon as possible before every cardioversion of AF or atrial flutter.	IIa

# Ilustración central

## CC To ABC

### Confirm AF



A 12-lead ECG or a rhythm strip showing AF pattern for  $\geq 30$  s

### Characterise AF (the 4S-AF scheme)



### Treat AF: The ABC pathway



1. Identify low-risk patients  
CHA<sub>2</sub>DS<sub>2</sub>-VASc 0(m), 1(f)
2. Offer stroke prevention if  
CHA<sub>2</sub>DS<sub>2</sub>-VASc  $\geq 1$ (m), 2(f)  
Assess bleeding risk, address  
modifiable bleeding risk factors
3. Choose OAC (NOAC or VKA  
with well-managed TTR)

Assess symptoms,  
QoL and patient's  
preferences

Optimize rate  
control

Consider a rhythm  
control strategy  
(CV, AADs, ablation)

Comorbidities and  
cardiovascular risk  
factors

Lifestyle changes  
(obesity reduction,  
regular exercise,  
reduction of alcohol use,  
etc.)



**Muchas gracias**

