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Current AF Guidelines - Important Differences

Guidelines regarding the management of atrial fibrillation have been published by major cardiovascular societies. Although the majority of recommendations within the current guidelines are similar, important differences are observed particularly when the quality of evidence is moderate or low, according to a review article to appear in the Canadian Journal of Cardiology.

Atrial fibrillation (AF), the most common sustained cardiac arrhythmia, is associated with reduced quality of life, functional status, cardiac performance, and overall survival. The contemporary management of AF is centred on symptomatic improvement, reduction in AF-related emergency room visits or hospitalisations, and reduction in morbidity and mortality. To aid clinicians in the management of these complex patients a multitude of evidence-based guidelines has been created. These guidelines are continually published and updated, reflecting the rapid progress in AF understanding and therapeutic options.

The journal article compares and contrasts the current recommendations in the American College of Cardiology (ACC)/American Heart Association (AHA)/Heart Rhythm Society (HRS), European Society of Cardiology (ESC), and Canadian Cardiovascular Society (CCS) atrial fibrillation guidelines. The article says important differences can be observed in several areas, including:

- The definition of non-valvular AF, which subsequently impacts anticoagulation choices and candidacy for non-vitamin K antagonist oral anticoagulants (NOACs)
- The symptom-score used to guide management decisions and longitudinal patient profiling
- The stroke-risk stratification algorithm used to determine indications for OAC therapy
- The role of “first-line” catheter ablation, open surgical ablation, and left atrial appendage exclusion

According to the article, the CCS and ESC guideline documents place substantial importance on AF-related symptoms and recommend the use of a symptom-score to guide management decisions and longitudinal patient-profiling. The AHA/ACC/HRS makes no recommendation regarding symptom evaluation.

Each of the three guidelines takes a slightly different approach to stroke-risk stratification. The AHA/ACC/HRS guidelines use the CHA2DS2-VASc score. Although the ESC was first to adopt CHA2DS2-VASc, the most recent guidelines have modified the consideration of female sex as an independent risk factor, recognising that “female sex does not appear to increase stroke risk in the absence of other stroke risk factors.” The CCS guidelines do not consider female sex or vascular disease as indications for OAC. "Because of these variations in risk assessment, the treatment-threshold for use of OAC differs among the three guidelines," the article notes.

For many highly-symptomatic patients catheter ablation offers an efficacious option for maintaining sinus rhythm when anti-arrhythmic drugs (AADs) have been ineffective, are contra-indicated or cannot be tolerated. "The CCS guidelines provide a conditional recommendation for AF-ablation as first-line therapy, reserving it for highly-selected patients with symptomatic paroxysmal AF," the article says. "The ESC and AHA/ACC/HRS provide a Class IIa recommendation with similar wording."

The contemporary management of AF continues to evolve as the evidence base matures and new trials are published, the article notes.

Source: Canadian Journal of Cardiology
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