



## New Guidelines For Peri- and Postoperative AFib



Evidence-based guidelines for the prevention and treatment of perioperative and postoperative atrial fibrillation (POAF) and flutter for thoracic surgical procedures have been released by The American Association for Thoracic Surgery (AATS). The new guidelines have been published in *The Journal of Thoracic and Cardiovascular Surgery*.

According to David J. Sugarbaker, MD, Director of The Lung Institute and Professor of Surgery, Baylor College of Medicine in Houston, TX and past president of the AATS, "These guidelines have the potential to prevent the occurrence of atrial fibrillation in thousands of patients who undergo lung surgery in the United States each year. The AATS is committed to its goal of improving the care of patients around the globe who undergo cardiothoracic surgery each year. These guidelines will have a very positive impact on the outcomes of these patients."

Atrial fibrillation is the most common sustained cardiac arrhythmia and occurs in approximately one to two percent of the general population. The evidence-based guidelines were developed by a task force of sixteen experts which included cardiologists, electrophysiology specialists, anaesthesiologists, intensive care specialists, thoracic and cardiac surgeons, and a clinical pharmacist.

Studies have shown that patients with POAF have a higher mortality rate; however, there is no specific evidence of the extent that arrhythmia itself contributes to mortality. In addition, patients with POAF have longer intensive care unit and hospital stays (around two to four days longer in the hospital) and increased morbidities. Incidence of strokes and central neurologic events are higher in such patients and the use of resources is also greater. It is thus safe to conclude that patients with pre-existing AF have a higher risk of stroke, heart failure and other POAF-related complications.

This particular task force adapted a standard definition of POAF and developed recommendations with respect to diagnosing POAF, using physiological monitoring of patients, managing and treating POAF, using rate control and antiarrhythmic drugs, managing patients with pre-existing AF, managing anticoagulation for new-onset POAF and managing long-term patients with persistent new-onset POAF. The key recommendations include:

- Electrophysiologically-documented AF and clinically diagnosed AF should be included in clinical documentation and should be reported in trials and studies.
- Patients at risk of POAF should be monitored with continuous ECG telemetry postoperatively for 48 to 72 hours.
- In patients with a history of AF or those with clinical signs of possible AF, ECG recordings and ongoing telemetry should be immediately implemented.
- Patients taking beta-blockers before thoracic surgery should continue taking them during the postoperative period.
- Intravenous magnesium supplementation may be considered to prevent postoperative AF if serum magnesium level is low or total body magnesium is depleted.
- Digoxin should not be used for prophylaxis against AF.
- Catheter or surgical pulmonary vein isolation should not be used for prevention of POAF in patients with no history of AF.
- Complete or partial pulmonary vein isolation at the time of lung surgery should not be considered for the prevention of POAF.
- Using diltiazem or amiodarone in patients with increased risk for the development of POAF is reasonable but not useful for all thoracic surgical patients.

Source: Newswise

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Published on : Mon, 29 Sep 2014