

Zit er iets nieuws voor de huisarts in de nieuwe ESC praktijkrichtlijnen voorkamerfibrillatie?

Andrea Sarkozy

Kennis / Ervaring / Zorg

Universiteit Antwerpen

UZA

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AF management domains

- **Diagnosis**
- **Structured characterization**
- **ABC treatment strategy**

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2020 ESC Guidelines for the diagnosis and management of atrial fibrillation
(European Heart Journal 2020-doi/10.1093/eurheartj/ehaa612)

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Diagnosis - screening

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 ≥ 30 s showing heart rhythm with no discernible repeating P waves and irregular RR intervals (when atrioventricular conduction is not impaired) is diagnostic of clinical AF.

I	B
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Recommendations for screening of AF

Opportunistic screening for AF by pulse taking or ECG rhythm strip is recommended in patients ≥ 65 years of age.

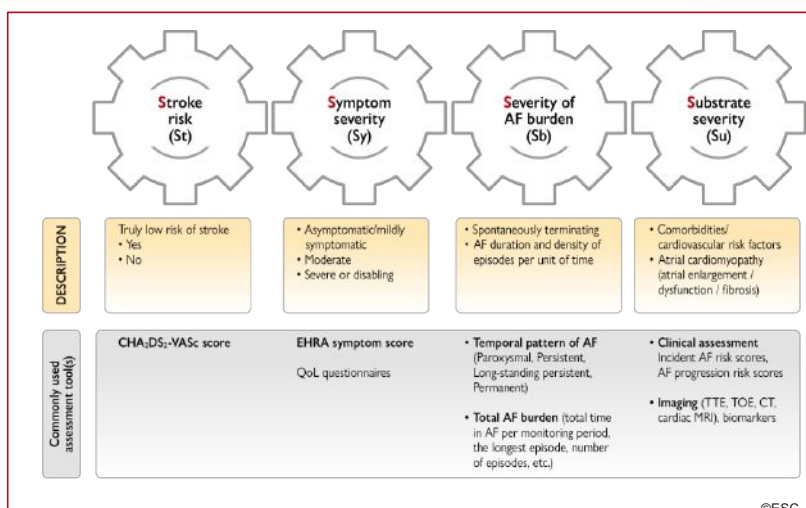
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Structured characterization of AF patients - 4S scheme



Recommendations for structured characterization of AF

Structured characterization of AF, which includes clinical assessment of stroke risk, symptom status, burden of AF, and evaluation of substrate, should be considered in all AF patients, to streamline the assessment of AF patients at different healthcare levels, inform treatment decision making, and facilitate optimal management of AF patients.

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Structured characterization of AF 4S scheme – CHA₂-VASc, HAS-BLED and EHRA scores

CHA ₂ -VASc score	Risk factors and definitions	Points awarded
C	Congestive heart failure Clinical HF, or objective evidence of moderate to severe LV dysfunction, or HCM	1
H	Hypertension or on antihypertensive therapy	1
A	Age 75 years or older	2
D	Diabetes mellitus Treatment with oral hypoglycaemic drugs and/or insulin or fasting blood glucose >125 mg/dL (7 mmol/L)	1
S	Stroke Previous stroke, TIA, or thromboembolism	2
V	Vascular disease Angiographically significant CAD, previous myocardial infarction, PAD, or aortic plaque	1
A	Age 65 – 74 years	1
Sc	Sex category (female)	1
Maximum score		9

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 ≥ 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

Table 10 Clinical risk factors in the HAS-BLED score³⁹⁵

Risk factors and definitions	Points awarded
H Uncontrolled hypertension SBP >160 mmHg	1
A Abnormal renal and/or hepatic function Dialysis, transplant, serum creatinine >200 µmol/L, cirrhosis, bilirubin > × 2 upper limit of normal, AST/ALT/ALP >3 × upper limit of normal	1 point for each
S Stroke Previous ischaemic or haemorrhagic stroke	1
B Bleeding history or predisposition Previous major haemorrhage or anaemia or severe thrombocytopenia	1
L Labile INR^a TTR <60% in patient receiving VKA	1
E Elderly Aged >65 years or extreme frailty	1
D Drugs or excessive alcohol drinking Concomitant use of antiplatelet or NSAID; and/or excessive alcohol per week	1 point for each

Table 6 EHRA symptom scale

Score	Symptoms	Description
1	None	AF does not cause any symptoms
2a	Mild	Normal daily activity not affected by symptoms related to AF
2b	Moderate	Normal daily activity not affected by symptoms related to AF, but patient troubled by symptoms
3	Severe	Normal daily activity affected by symptoms related to AF
4	Disabling	Normal daily activity discontinued

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ABC – Patient-centered integrated AF management

INTEGRATED AF MANAGEMENT

Structured follow-up and clear communication between primary and secondary care

Recommendations about integrated AF management

2020	Class ^a	2016	Class ^a
To optimize shared decision making about specific AF treatment option(s) in consideration, it is recommended that:	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

• Physicians inform the patient about advantages/limitations and benefits/risks associated with considered treatment option(s); and
• Discuss the potential burden of the treatment with the patient and include the patient's perception of treatment burden in the treatment decision.

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A- Anticoagulation- Avoid stroke

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
IIa	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

In patients on VKAs with low time in INR therapeutic range (e.g. TTR < 70%), recommended options are:

- Switching to a NOAC but ensuring good adherence and persistence with therapy or
- Efforts to improve TTR (e.g. education/counseling and more frequent INR checks).

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B- Better symptom control

Recommendations for rhythm control/catheter ablation of AF		
<i>General recommendations</i>		
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	
<i>AF catheter ablation after antiarrhythmic drug therapy failure</i>		
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	
<i>First-line therapy</i>		
AF catheter ablation for PVI should/may be considered as first-line rhythm control therapy to improve symptoms in selected patients with symptomatic:	IIa	
<ul style="list-style-type: none"> 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	

Recommendations for rhythm control/catheter ablation of AF

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	Catheter or surgical ablation should be considered in patients with symptomatic persistent or long-standing persistent AF refractory to AAD therapy to improve symptoms, considering patient choice, benefit and risk, supported by an AF Heart Team.	IIa
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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 HF/EF to improve survival and reduce HF hospitalization.

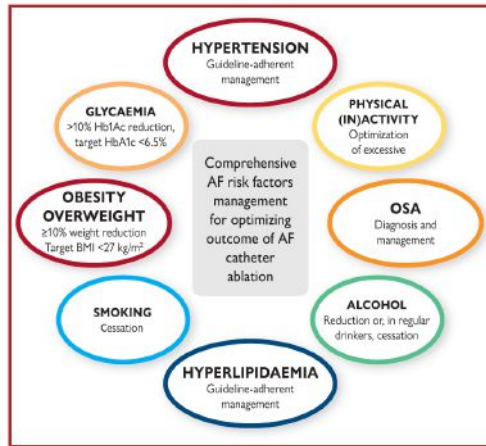
I	AF ablation should be considered in symptomatic patients with AF and HF/EF to improve symptoms and cardiac function when tachycardia-induced cardiomyopathy is suspected.	IIa
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C – Cardiovascular risk factor and concomitant disease management



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.
 Modification of unhealthy lifestyle and targeted therapy of intercurrent conditions is recommended to reduce AF burden and symptom severity.
 Opportunistic screening for AF is recommended in hypertensive patients.
 Opportunistic screening for AF should be considered in patients with OSA.

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Recommendations for lifestyle interventions and management of risk factors and concomitant diseases in patients with AF

Attention to good BP control is recommended in AF patients with hypertension to reduce AF recurrences and risk of stroke and bleeding.
 Physical activity should be considered to help prevent AF incidence or recurrence, with the exception of excessive endurance exercise, which may promote AF.
 Optimal management of OSA may be considered, to reduce AF incidence, AF progression, AF recurrences, and symptoms.

BP control in anticoagulated patients with hypertension should be considered to reduce the risk of bleeding

Moderate regular physical activity is recommended to prevent AF, while athletes should be counselled that long-lasting intense sports participation can promote AF

OSA treatment should be optimized to reduce AF recurrences and improve AF treatment results.

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Key messages – CC

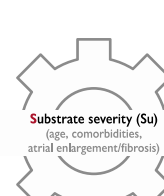
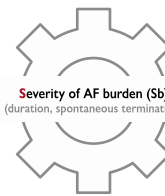
CC To ABC

Confirm AF



A 12-lead ECG or a rhythm strip showing AF pattern for ≥30 s

Characterize AF (the 4S-AF scheme)



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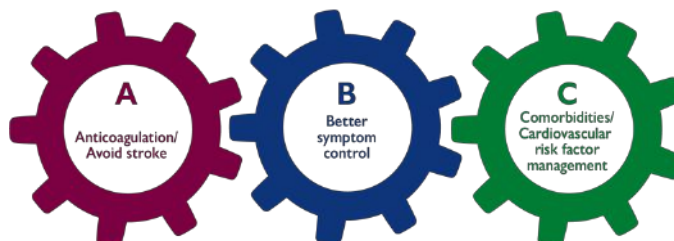
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Key messages: ABC Treatment

European Society of Cardiology

Treat AF: The ABC pathway



1. Identify low-risk patients
CHA₂DS₂-VASc 0(m), 1(f)
2. Offer stroke prevention if
CHA₂DS₂-VASc ≥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.)

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