Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/clinical-practice/cardiology/dare-af-trial-dapagliflozin-to-reduce-af-burden-after-catheter-ablation-in-patients-without-diabetes-or-heart-failure/48682/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

DARE AF Trial: Dapagliflozin to Reduce AF Burden After Catheter Ablation in Patients Without Diabetes or Heart Failure

Announcer:
Welcome to DataPulse from AHA 2025 Scientific Sessions on ReachMD. This activity, titled “DARE AF Trial: Dapagliflozin to Reduce AF Burden After Catheter Ablation in Patients Without Diabetes or Heart Failure” is provided by Medcon International.

Dr. Yancy:
Colleagues, friends. Hi, this is Clyde Yancy, a long-standing volunteer for the American Heart Association, former president, professor and chief of cardiology at Northwestern University Feinberg School of Medicine, Northwestern Medicine in Chicago. I'm here at the American Heart Association, Scientific Sessions 2025. What a fabulous meeting. What makes it so fabulous is that we're able to talk once again about this new emphasis of cardio-kidney-metabolic scenarios that have a direct bearing on cardiovascular disease. Specifically, this morning, we had a very intriguing session, a session which discussed the intersectionality between atrial fibrillation, lifestyle change, risk factors, and managing the cardiometabolic milieu.

DARE-AF was a very important clinical trial presented this morning. Let me give you a capsule of what was done. In patients with persistent atrial fibrillation, not paroxysmal, many of which were on background antiarrhythmic therapy, those patients were randomized to either an SGLT2 inhibitor or a placebo. Now, why an SGLT2 inhibitor in a setting of atrial fibrillation? It turns out that this incredible array of benefits attributable to the SGLT2 inhibitors seems to encompass not only managing ventricular substrates, but perhaps atrial substrates. So the biological hypothesis is reasonable, and certain large clinical trials, in secondary analysis, suggest that at least in the diabetic population, the use of the SGLT2 inhibitors reduce the frequency of atrial fibrillation. So a reasonable hypothesis.

So what we were trying to solve with DARE-AF was whether or not we could reduce recurrent AF. In working with the presenters, reviewing their data, and reviewing the ancillary information, what came together was a very important conversation. No, adding SGLT2 inhibitors to patients with persistent AF who were not diabetic failed to reduce recurrent AF. But that's not a disappointment because it accommodated a conversation about what we know that does work. I'll make reference to another clinical trial mentioned 3 times in this session, ARREST-AF.

In a structured, randomized manner, there was clear demonstration that adherence to lifestyle change, weight loss, improving sleep apnea, improving glycemic control, and assiduous control of blood pressure associated with a dramatic reduction in recurrent AF. So even though the SGLT2 inhibitors in that specific population didn't work, we know that they do work in diabetic patients, patients with heart failure, and it's worth further study.

But at least we had an opportunity to think about proven-to-be beneficial strategies, which once again tracked to a message so central to the American Heart Association, and that is of lifestyle change and risk factor mitigation.

I hope that this messaging, I hope that these findings are helpful in your clinical practice, helpful in your understanding of what we can do in the setting of atrial fibrillation.

From AHA 2025, I'm Claude Yancey. Thank you for watching. Delighted to share this information with you.

Announcer:

Thank you for listening to this DataPulse from AHA 2025 Scientific Sessions on ReachMD. This activity is provided by Medcon International. Thank you for listening.