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## How Do We Best Incorporate Latest Guidance in Optimizing Care for the Patient with AF?

### Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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### Dr. Pokorney:

I'm Sean Pokorney, an electrophysiologist and Assistant Professor of Medicine at Duke University. Thanks so much for joining me to discuss how we can best incorporate the latest guidance in optimizing care for patients with atrial fibrillation.

And I'd really like to take this opportunity to focus specifically on the recent release of the American Heart Association, American College of Cardiology, and Heart Rhythm Society guidelines around atrial fibrillation. And I think one of the most practice-changing components of the guidelines, in my opinion, was around the management of patients with early atrial fibrillation. And that's because there's been a big shift within the management of these patients with atrial fibrillation early in their disease state relative to historical data. And really, historically, we'd thought mostly about rate control in patients unless they had some symptoms related to atrial fibrillation. And that was really related to the AFFIRM trial from years ago. But there were a lot of complexities in the AFFIRM trial, many patients stopped anticoagulation. And so, it wasn't necessarily an equal comparison.

We now have more recent data. And I would say that probably this data first started building around EAST-AFNET 4, which was a trial that looked at patients with atrial fibrillation who were diagnosed within the past year. And it randomized those patients to a rate control versus a rhythm control strategy. And most of the rhythm control was actually antiarrhythmic medication, but a portion of those patients received ablation as well. And when they looked at the composite endpoint of cardiovascular death, stroke, and cardiovascular hospitalization, they found that there was actually a reduction in that composite with a rhythm control strategy. And interestingly, when you look at each of the components, there was no difference in the rates of cardiovascular hospitalization. And so really, that difference in the composite endpoint was driven by cardiovascular death and stroke.

And there have been some other studies that have, you know, looked at this issue as well. EARLY-AF and STOP-AF were both studies that looked at ablation with a cryoablation strategy relative to an antiarrhythmic medication. Both showed a decrease in the recurrence of atrial fibrillation with an ablation strategy relative to an antiarrhythmic medication strategy as well as less progression of atrial fibrillation to more severe atrial fibrillation such as progressing from paroxysmal to persistent atrial fibrillation.

And so, you know, really this combined data in combination with the CABANA trial, which looked at a first rhythm control strategy with ablation versus medical therapy and found that there was higher quality of life with ablation, there was less occurrence of atrial fibrillation with ablation, and there was less cardiovascular hospitalization with ablation.

And so, I think this combination of data has really led us to focus more on rhythm control in these patients with early atrial fibrillation, patients that were really identified within the first year. And I think that certainly the field is shifting more in the direction of ablation over time, although, based on the guidelines, again, antiarrhythmic medication is a very reasonable strategy. And at least for me, you know, it's important that patients are engaged in the decision-making. I think that's emphasized in the guidelines and emphasized in many of

our clinical practices where we really want to get patients' opinions of what they want. Some patients want to avoid procedures and are happy to take medications, and other patients really want to avoid medications and are happy to pursue procedures. I think that again, the data really suggests that the key is preventing atrial fibrillation and controlling that early on in their disease state. And that's really for a few reasons. One reason is as you all likely know, AFib is really a disease continuum. So, on one end, there's paroxysmal atrial fibrillation, on the other end, there's permanent atrial fibrillation. And unless you do something to prevent that trajectory, all patients will head in that direction towards permanent atrial fibrillation. And so, part of that is that atrial fibrillation begets atrial fibrillation, and atrial fibrillation itself causes scarring and fibrosis in the atrium, it causes this atrial myopathy, and that makes it more difficult to control atrial fibrillation over time. And again, what we've realized when we've done meta-analyses of ablation trials, when we've looked at the data from EAST-AFNET 4, and now ultimately with the guideline recommendation, everything points towards managing patients with atrial fibrillation with a rhythm control strategy earlier in their disease course before they progress down that continuum to the point where they have significant fibrosis in the atrium.

So, thanks so much for joining me on this discussion about optimizing care for our patients with atrial fibrillation. I hope that you all found it helpful.

**Announcer:**

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