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What Are the 10 Key Takeaways for the 2023 ACC/AHA/ACCP/HRS Guideline for AF?

Announcer:
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Dr. Patel:
Hi, my name is Manesh Patel. I'm the chief of cardiology at Duke, and thanks for joining us for another episode of Duke Heart on The Go, A-fib Guideline Updates. And you know, recently, the American Heart Association, the American College of Cardiology, and our Heart Rhythm Society colleagues updated the guidelines for management and detection and care of patients with atrial fibrillation. Talk about something almost all of us see in some part of our clinical practice, whether you're a cardiologist, primary care physician, or you take care of patients in the hospital. Atrial fibrillation is certainly a disease that is quite frequent; up to 8% to 10% of people over 60, at some point in their lifetime, may have atrial fibrillation. So what an important guideline. It's also a marker and an important disease in which we can change patients' outcomes, both for how they feel but also stroke prevention.

On this episode, I'm going to be talking to you about what are the 10 key takeaways from the 2023 ACC/AHA/HRS guidelines for atrial fibrillation. And I guess the first thing they recognize is – they're fairly comprehensive guidelines, and these 10 takeaways, I think, start with at least thinking about the diagnosis and management. And the first takeaway is that instead of just calling it atrial fibrillation – and the previous classifications of atrial fibrillation were based really only on the arrhythmia duration – there are now stages of atrial fibrillation, which are intended to emphasize therapeutic interventions. One can imagine that the new proposed classification uses stages to recognize A-fib as a disease continuum and that means that we want to identify even brief, early episodes of A-fib as opportunities to intervene. But even before people get atrial fibrillation, thinking about lifestyle prevention and risk factor modification to reduce the risk of atrial fibrillation, and then moving to when you can be screening when people are at higher risk to therapy.

The second key takeaway is A-fib risk factor modification and prevention. Sort of highlights from the stages, which is to, again, highlight the opportunity where we've thought long and hard about making sure, obviously, heart rate and anticoagulation and rhythm control might occur. But to reduce the risk of long-term atrial fibrillation and understand recurrent and A-fib reduction is to think about progression and adverse events. And so treating obesity, weight loss, physical activity, smoking cessation, alcohol, hypertension, other comorbidities really plays a role. So stages of A-fib and then risk factor modification prevention.

The third takeaway is making sure we think about clinical risk and expanding beyond CHA_2DS_2-VASc 2, which is important because the CHA_2DS_2-VASc score for prediction of stroke and systemic embolism is what's used, for patients with the intermediate annual risk score may remain uncertain and there's different sort of risk variables identified to help you with that decision on how to follow those individuals, including risk scores that help us think about the electronic medical record or other features these patients may have where we identify more episodes of atrial fibrillation.

The next important takeaway is risk factor modifiers. So patients with those low A-fib risk, less than 2% annual risk, can benefit from factors that might modify their risk to think about how to care for them. So the burden of A-fib, how much A-fib does that patient have,

non-modifiable risk factors such as sex, women seem to have it happen a little later and less risk early on, and other dynamic modifiable factors, such as blood pressure and obviously blood glucose. They also highlight the importance of shared decision-making in this aspect of our risk modifiers.

The next sort of pathway that we've learned from the ACCHA guidelines is the earlier rhythm control, moving towards new and consistent evidence that earlier rhythm control and management of patients for atrial fibrillation might be important and is important for maintaining sinus rhythm, minimizing the A-fib burden, but also for patients with heart failure leading to improved clinical outcomes. So I think that's an important feature for us to think about.

All right. So that was the first 5. What about the next 5? If you think about rhythm control, then you can imagine that one of the main ways we can think about rhythm control was catheter ablation. And for the first time in a long time, A-fib ablation with catheters is – as a first line therapy is given a Class 1 recommendation. And this is an important change in the guidelines based on recent randomized studies that have demonstrated catheter ablation over drug therapy for rhythm control is superior in appropriately selected patients. And so in most of our recent reviews, we would say that these recommendations now move towards patients that you should be thinking through. I would be pushing towards our patients with heart failure and those that you can think might have longer or higher risk.

The next sort of takeaway is around catheter ablation A-fib in patients that are appropriate with heart failure, as I just highlighted. So it's sort of moved faster towards rhythm control. And then Class 1 indication for those with heart failure where evidence is starting to show us that they may even have better long-term outcomes.

Now a really important part that the guidelines then goes to the next takeaway is, I'll call it, recommendations have been updated on what I'll call device-detected A-fib. So many, many patients may have a device implanted. One can imagine that there're not just pacemakers now, but these implantable devices that can identify patients at risk. And in view of these studies, there's some more prescriptive recommendations that say that patients with device-detected A-fib, you can consider the idea of their risk of thromboembolism, including considering treating some of these patients. So using device-detected A-fib is important because it may be a way to find those patients at risk to treat those patients, and emerging data to say that they may benefit.

Two other takeaways that I want to make sure you understand. Left atrial appendage occlusion, which was an important therapy and identified as an opportunity with occlusion devices, actually was moved up from Class 2b to 2a based on, I'll say, some longer-term information and contraindications to atrial fibrillation, anticoagulation, or also, I'll say, some observational data. In my own opinion here, I'll say that wasn't a tremendous amount of data, so I think the 2b to 2a is sort of because practice has changed that way. I still think you should be taking a lot of conversations with your patients as you think about that because the DOACs [direct oral anticoagulants] or other anticoagulants are so well tolerated.

And finally, recommendations are made for patients identified during medical illness and surgery, and I think this is important to think about on those patients that have noncardiac illness and recognize that their risk when they get surgery with that A-fib is important because they may have recurrent A-fib.

And lastly, I'll just say the guidelines really emphasized shared decision-making. I just want to highlight for you that means sharing information about the patient, understanding their preferences and beliefs, and then coming to a common decision, hopefully with that conveying of information back and forth.

All right. That was a whirlwind exposure to the guidelines. Thanks for listening. That was the 10 key takeaways from the ACC/AHA/HRS guidelines on atrial fibrillation.

Announcer:
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