NOVEDADES GUÍAS ESC/EACTS FIBRILACIÓN AURICULAR 2020

Alejandro Broch Petit y Òscar Lorente Furió

Residentes Medicina Interna

Hospital General Universitario de València

Niveles evidencia

Classes of recommendations	Definition	Wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended or is indicated
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/ efficacy of the given treatment or procedure.	
Class IIa	Weight of evidence/opinion is in favour of usefulness/efficacy.	Should be considered
Class IIb	Usefulness/efficacy is less well established by evidence/opinion.	May be considered
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended

Cambio

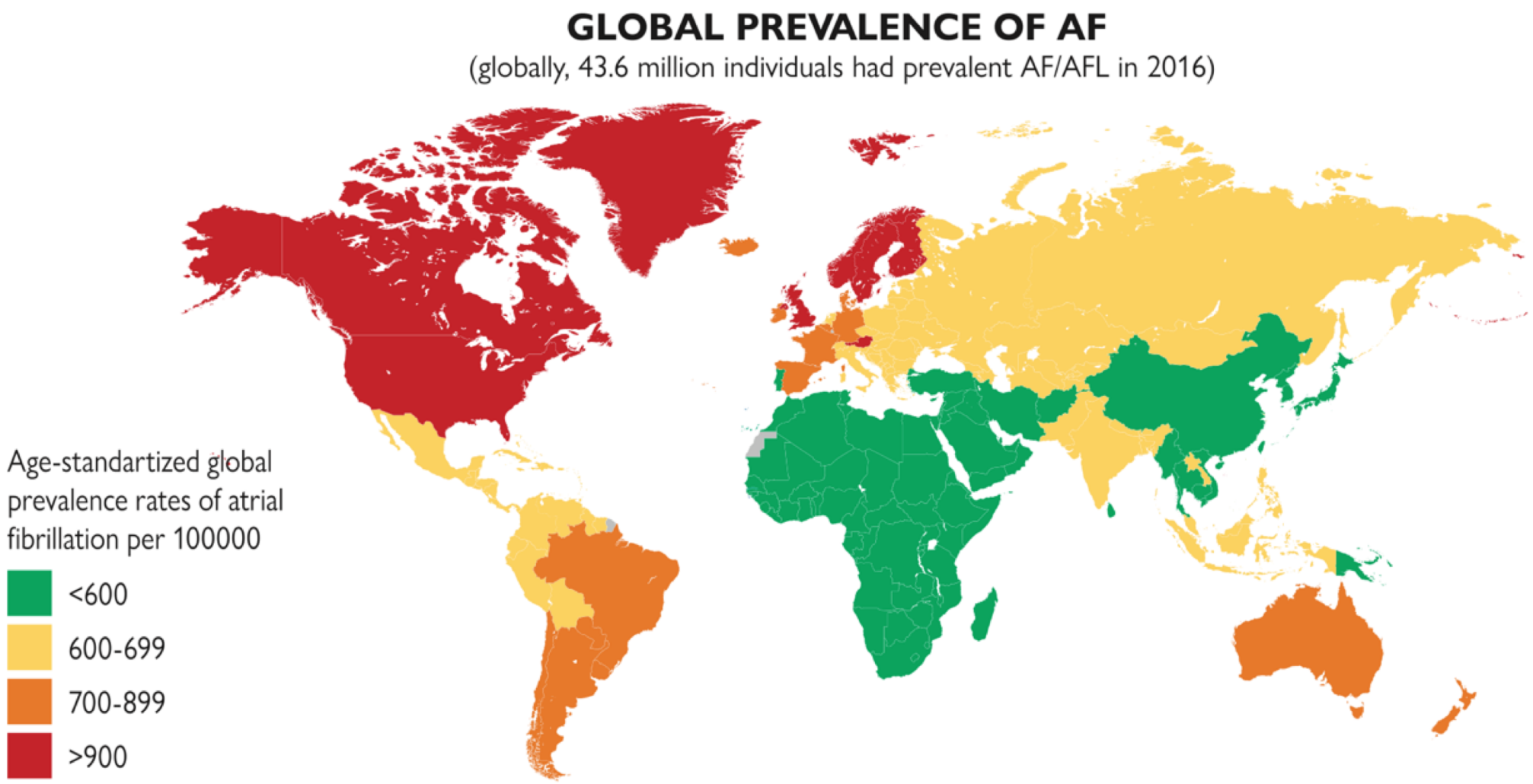
Novedad

Definición

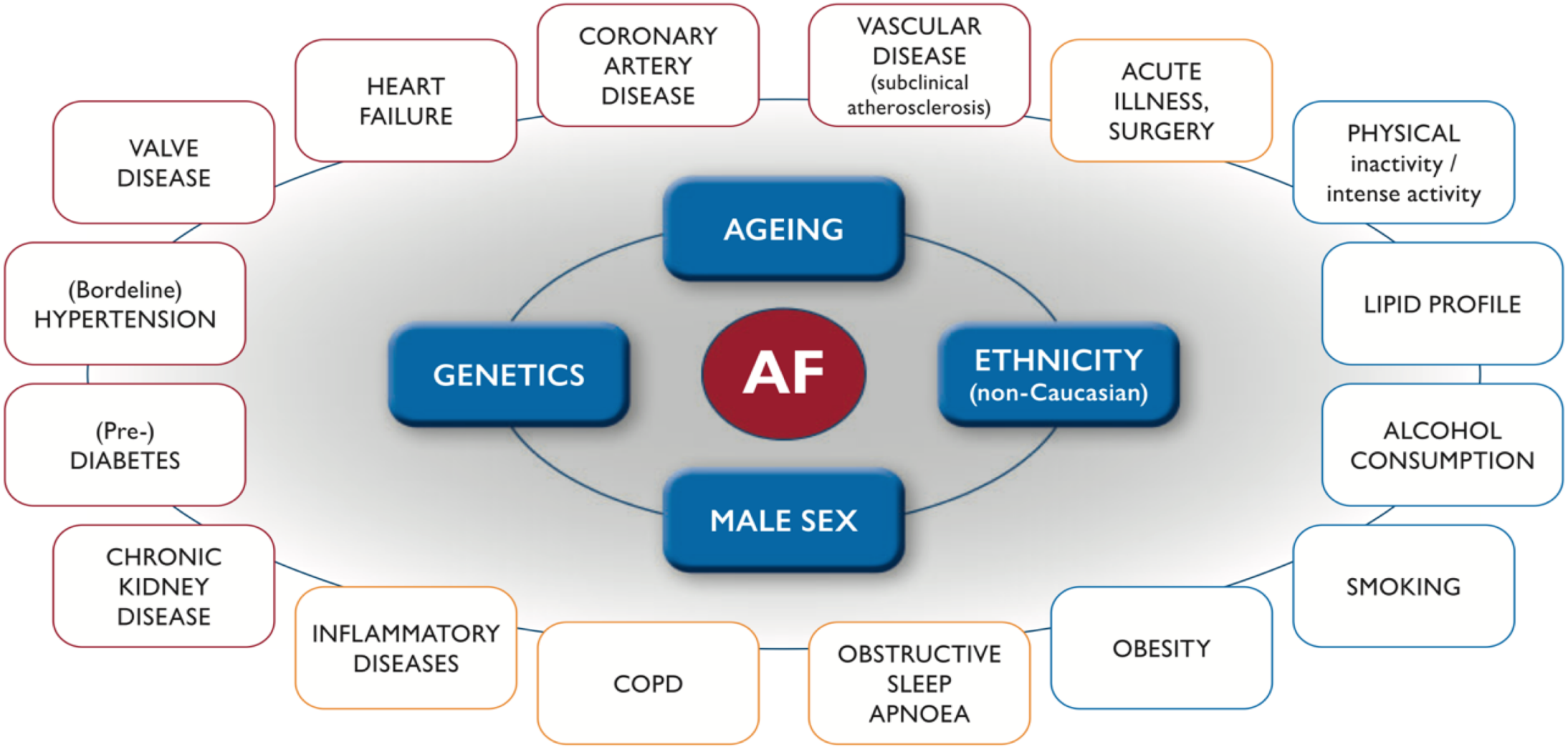
Arritmia **supraventricular** con **activación auricular eléctrica descoordinada**

DURACIÓN MÍNIMA DE 30 SEGUNDOS

Epidemiología



Epidemiología



Clasificación

- **Paroxística** (7 días)
- **Persistente** (7 días -12 meses)
- **Persistente de larga data** (>12 meses)
- **Permanente** (aceptada) → No control de ritmo

~~
- FA valvular o no valvular
- FA crónica
- FA solitaria
~~

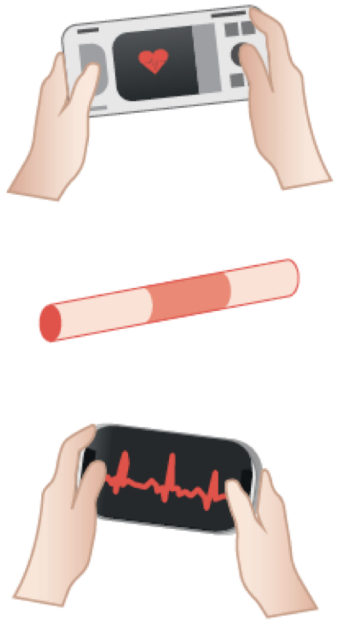
Screening

RIESGOS	BENEFICIOS
• **Ansiedad** • Mala interpretación (FP) → **sobretratameinto**	• **Prevención :** ○ **Ictus** ○ **Taquimiocardiopatía** ○ **Remodelado auricular** • Control de **síntomas** • **Reducción de hospitalización, mortalidad y morbilidad**.

Screening

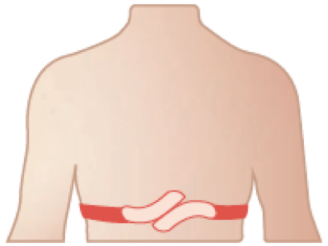
Patient initiated (or medical professional) oscillometric blood pressure cuff

Pulse palpitation, auscultation



Patient initiated (or medical professional) intermittent ECG rhythm strip using smartphone or dedicated connectable device

Intermittent smartwatch ECG initiated by semi-continuous photoplethysmogram with prompt notification of irregular rhythm or symptoms

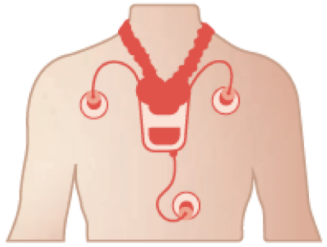


Wearable belts for continuous recordings

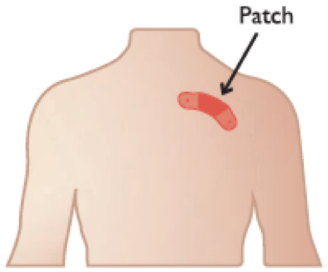
Stroke unit/in hospital telemetry monitoring

Patient initiated photoplethysmogram on smartphone

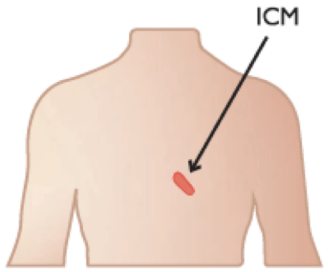
Semi-continuous photoplethysmogram on a smartwatch or wearable



Long-term Holter



1-2 week continuous ECG patches

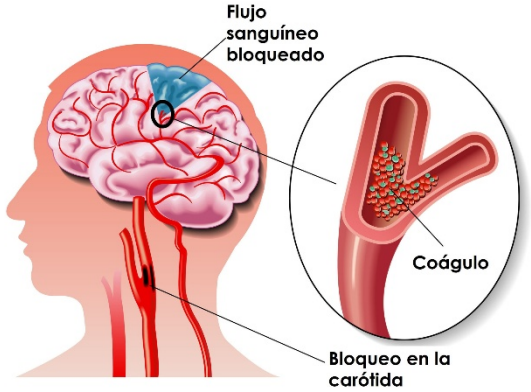


Implantable cardiac monitors

Screening

Recomendación:

- **Mayores de 65 años**
- Otras características que sean sugestivas de **alto riesgo de ictus (HTA y SAOS)**



Evaluación diagnóstica

All AF patients → **Selected** AF patients → **Structured follow-up**

Medical history:
- AF-related symptoms
- AF pattern
- Concomitant conditions
- CHA_2DS_2-VASc score

12-lead ECG

Thyroid and kidney function, electrolytes and full blood count

Transthoracic echocardiography

Ambulatory ECG monitoring:
- Adequacy of rate control
- Relate symptoms to AF recurrences

Transoesophageal echocardiography:
- Valvular heart disease
- LAA thrombus

cTnT-hs, CRP, BNP/NT-ProBNP
Cognitive function assessment

Coronary CTA or ischaemia imaging:
- Patients with suspected CAD

Brain CT and MRI:
- Patients with suspected stroke

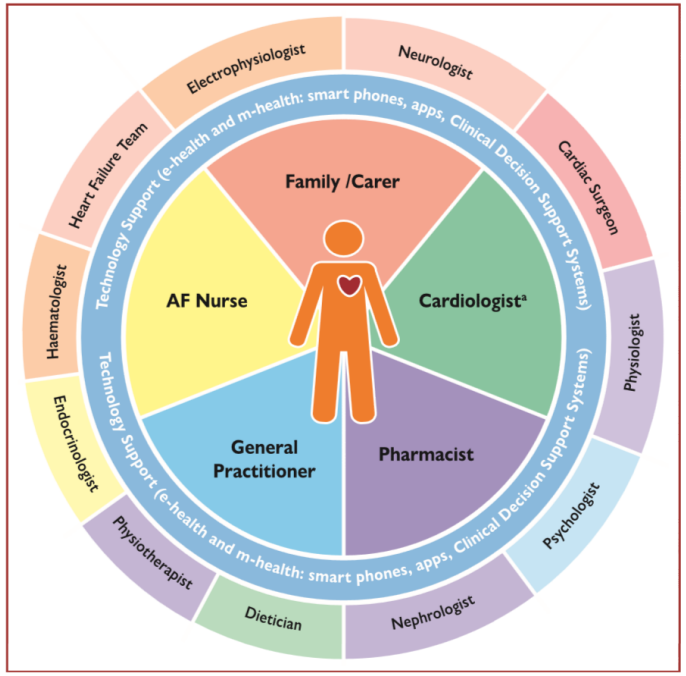
LGE-CMR of the LA:
- To help decision-making in AF treatment

- **To ensure continued optimal management**
- **A cardiologist / AF specialist coordinates the follow-up in collaboration with specially trained nurses and primary care physicians**

Tratamiento

"Manejo integral de los pacientes por un equipo multidisciplinar" → IIA

Fundamental: deseos del paciente --> Decisión conjunta (I)



¿Medicina Interna?

Tratamiento - ABC

"**Atrial fibrillation Better Care** (ABC)"

'A' Anticoagulation/Avoid stroke

'**B' Better** symptom management

'C' Cardiovascular and **Comorbidity** optimization

↓mortalidad, eventos cardiovasculares y costes

Tratamiento - 'A' Anticoagulation/Avoid stroke

EVALUACIÓN RIESGO DE ICTUS (x5)

Bajo riesgo: CHA2DS2-VASc 0 (H) o 1 (F) → **No necesaria prevención**

↓

Revalorar a los 4-6 meses → IIA

Los **cambios** en el CHADSVASC **aumentan riesgo**

El patrón de la FA no es criterio para guiar la tromboprofilaxis → III

Table 8 CHA_2DS_2-VASc score[334]

CHA_2DS_2-VASc score Risk factors and definitions		Points awarded	Comment
C	**Congestive heart failure** Clinical HF, or objective evidence of moderate to severe LV dysfunction, or HCM	1	Recent decompensated HF irrespective of LVEF (thus incorporating HFrEF or HFpEF), or the presence (even if asymptomatic) of moderate-severe LV systolic impairment on cardiac imaging[335]; HCM confers a high stroke risk[336] and OAC is beneficial for stroke reduction.[337]
H	**Hypertension** or on antihypertensive therapy	1	History of hypertension may result in vascular changes that predispose to stroke, and a well-controlled BP today may not be well-controlled over time.[324] Uncontrolled BP - the optimal BP target associated with the lowest risk of ischaemic stroke, death, and other cardiovascular outcomes is 120 - 129/<80 mmHg.[338]
A	**Age 75 years or older**	2	Age is a powerful driver of stroke risk, and most population cohorts show that the risk rises from age 65 years upwards.[339] Age-related risk is a continuum, but for reasons of simplicity and practicality, 1 point is given for age 65 - 74 years and 2 points for age ≥75 years.
D	**Diabetes mellitus** Treatment with oral hypoglycaemic drugs and/or insulin or fasting blood glucose >125 mg/dL (7 mmol/L)	1	Diabetes mellitus is a well-established risk factor for stroke, and more recently stroke risk has been related to duration of diabetes mellitus (the longer the duration of diabetes mellitus, the higher the risk of thromboembolism[340]) and presence of diabetic target organ damage, e.g. retinopathy.[341] Both type 1 and type 2 diabetes mellitus confer broadly similar thromboembolic risk in AF, although the risk may be slightly higher in patients aged <65 years with type 2 diabetes mellitus compared to patients with type 1 diabetes mellitus.[342]
S	**Stroke**Previous stroke, TIA, or thromboembolism	2	Previous stroke, systemic embolism, or TIA confers a particularly high risk of ischaemic stroke, hence weighted 2 points. Although excluded from RCTs, AF patients with ICH (including haemorrhagic stroke) are at very high risk of subsequent ischaemic stroke, and recent observational studies suggest that such patients would benefit from oral anticoagulation.[343–345]
V	**Vascular disease** Angiographically significant CAD, previous myocardial infarction, PAD, or aortic plaque	1	Vascular disease (PAD or myocardial infarction) confers a 17 - 22% excess risk, particularly in Asian patients.[346–348] Angiographically significant CAD is also an independent risk factor for ischaemic stroke among AF patients (adjusted incidence rate ratio 1.29, 95% CI 1.08 - 1.53).[349] Complex aortic plaque on the descending aorta, as an indicator of significant vascular disease, is also a strong predictor of ischaemic stroke.[350]
A	**Age 65 – 74 years**	1	See above. Recent data from Asia suggest that the risk of stroke may rise from age 50 - 55 years upwards and that a modified CHA_2DS_2-VASc score may be used in Asian patients.[351,352]
Sc	**Sex category (female)**	1	A stroke risk modifier rather than a risk factor.[353]
Maximum score		**9**	

Tratamiento - ’A’ Anticoagulation/Avoid stroke

EVALUACIÓN RIESGO DE SANGRADO

HAS-BLED:

- **Riesgo: aumento reciente**
- **Bajo riesgo: 0-2**

- **Utilidad: ≥3 → Control factores R sangrado**

↓

NO debe evitar el uso de los AC → Sólo si la contraindicación es absoluta* (III)

↓

Revalorar periódicamente el riesgo → I

*Hemorragia de alto R (intracraneal) y sangrado activo + comorbilidad

Table 10 Clinical risk factors in the HAS-BLED score[395]

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[a] stroke	1
B	**Bleeding history or predisposition** Previous major haemorrhage or anaemia or severe thrombocytopenia	1
L	**Labile INR**[b] 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[c] alcohol per week	1 point for each
Maximum score		**9**

ALP = alkaline phosphatase; ALT = alanine aminotransferase; AST = aspartate aminotransferase; SBP = systolic blood pressure; INR = international normalized ratio; NSAID = Non-steroidal anti-inflammatory drug; TTR = time in therapeutic range; VKA = vitamin K antagonist.
[a]Haemorrhagic stroke would also score 1 point under the ‘B’ criterion.
[b]Only relevant if patient receiving a VKA.
[c]Alcohol excess or abuse refers to a high intake (e.g. >14 units per week), where the clinician assesses there would be an impact on health or bleeding risk.

Tratamiento - 'A' Anticoagulation/Avoid stroke

FÁRMACOS

Anti-vitK

- Objetivo **TTR >70%.** Ante TTR bajo: cambiar a ACOD (I) o intentar mejorar el INR con educación/controles (IIa)

ACOD

- **Son de primera elección** (I)
- **No dar dosis reducidas excepto cuando necesarias** (FG<30 en edoxaban, rivaroxaban y apixaban) → **Aumenta R de ictus sin reducir el de sangrado**

Antiagregantes

- **NO usar en general**

Tratamiento - 'A' Anticoagulation/Avoid stroke

CIERRE OREJUELA (evidencia baja)

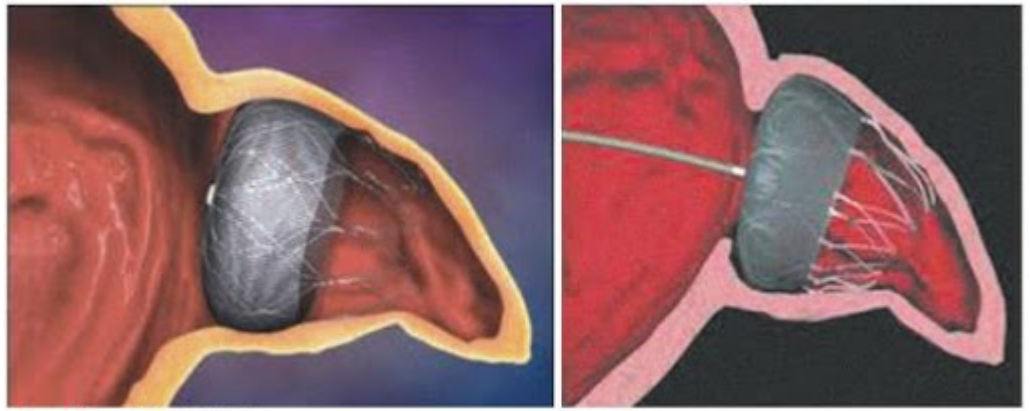
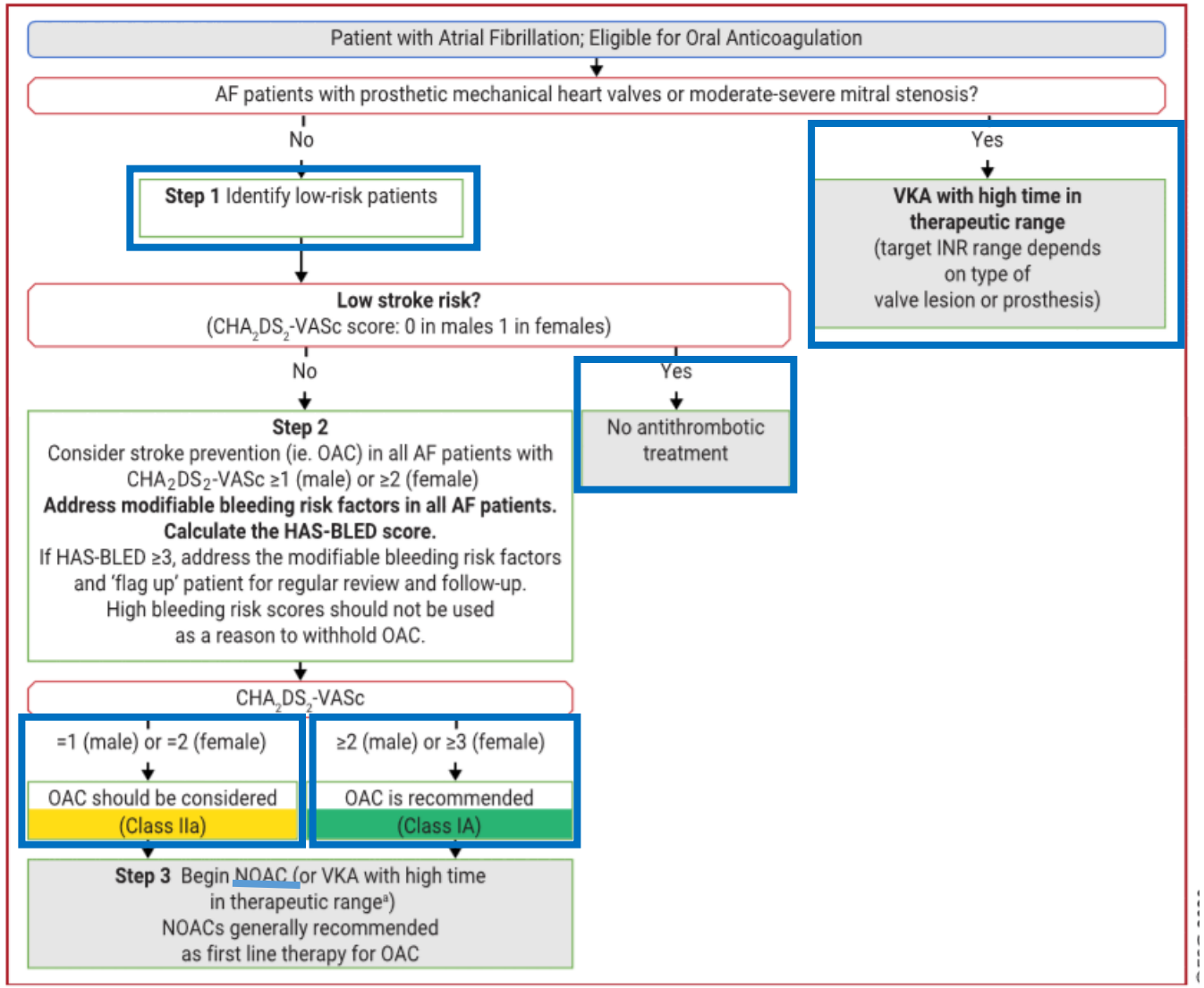


Figura 1. Dispositivo de Watchman.

- ¿A quién?: pacientes con CI a ACO

- **¿Cómo?**
  - **Dispositivo Watchman**
  - **Cierre QX**. Especialmente útil si el paciente se **va a operar por otro motivo**

Tratamiento - 'A' Anticoagulation/Avoid stroke



Tratamiento - ‘B’ Better symptom control

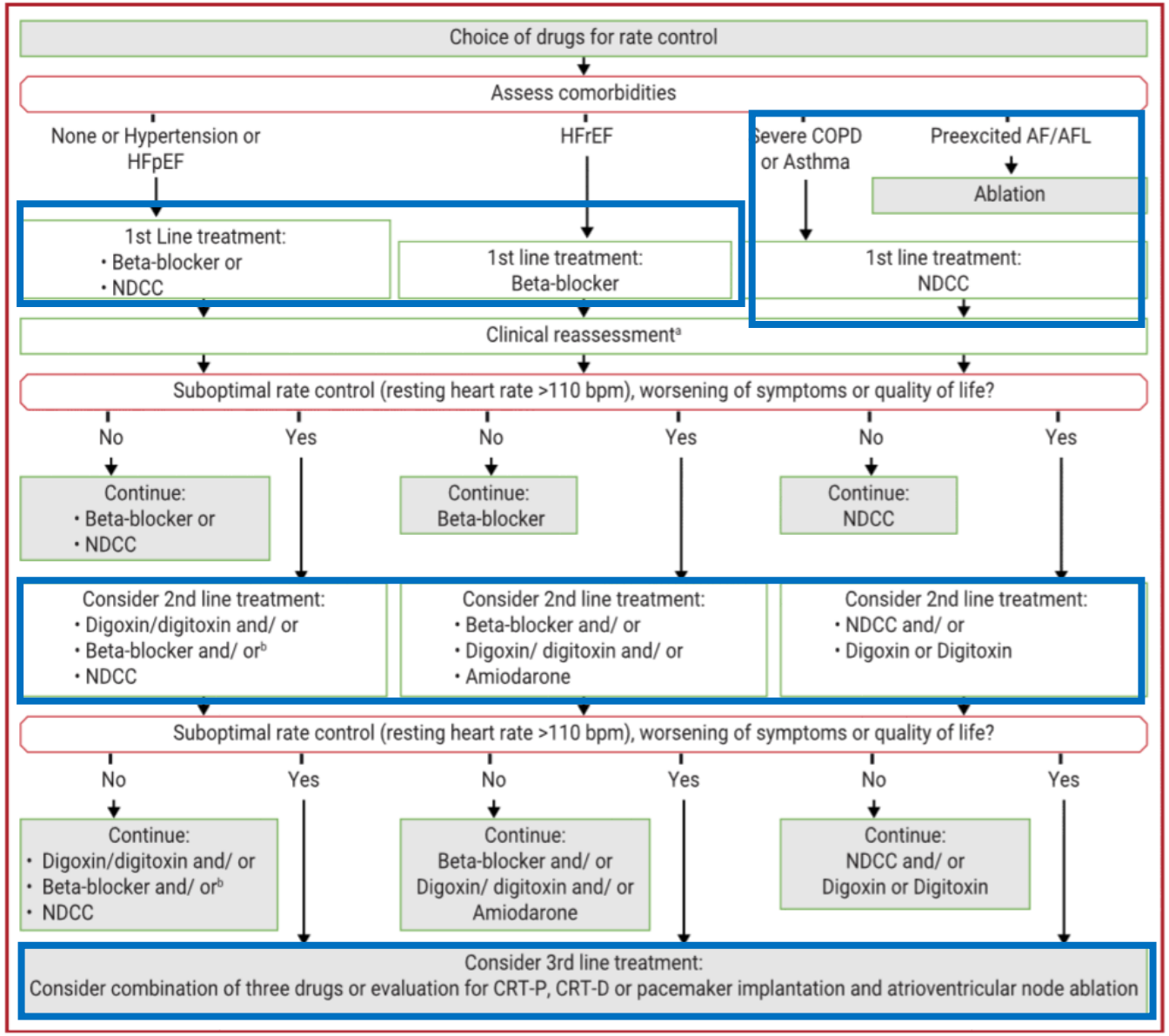
CONTROL DE FRECUENCIA

Objetivo: < 80 lpm reposo y <110 lpm ejercicio moderado

- **B-bloq**: elección
- **CAT**: podrían controlar mejor los síntomas
- **Digoxina**: útil a dosis bajas, a dosis altas aumenta mortalidad
- **Amiodarona**: cuando no posible control con varios fármacos
- **Ablación y MCP:** cuando no posible control

- **Tto agudo**: beta bloqueantes y CAT → Más rápidos
- **Inestabilidad**: amiodarona / CVE

Tratamiento - ‘B’ Better symptom control



Tratamiento - ‘B’ Better symptom control

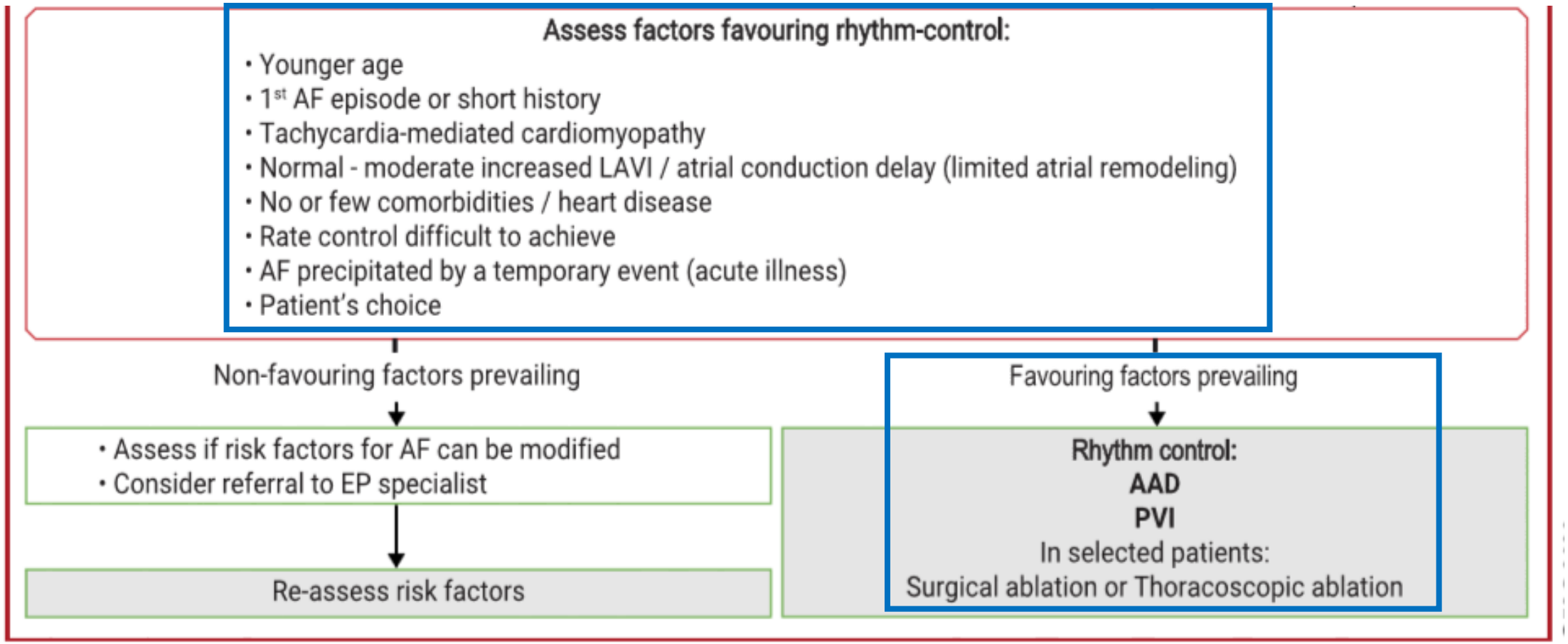
CONTROL DE RITMO

Objetivo: disminuir síntomas y mejorar calidad de vida

Incluye **fármacos**, **cardioversión** y **ablación**

Control temprano: podría evitar progresión de las alteraciones estructurales

Tratamiento - 'B' Better symptom control



Tratamiento - ‘B’ Better symptom control

CONTROL DE RITMO: CARDIOVERSIÓN

- Si **inestabilidad hemodinámica** → **Eléctrica** (más efectiva)

- Si estable: farmacológica (I)

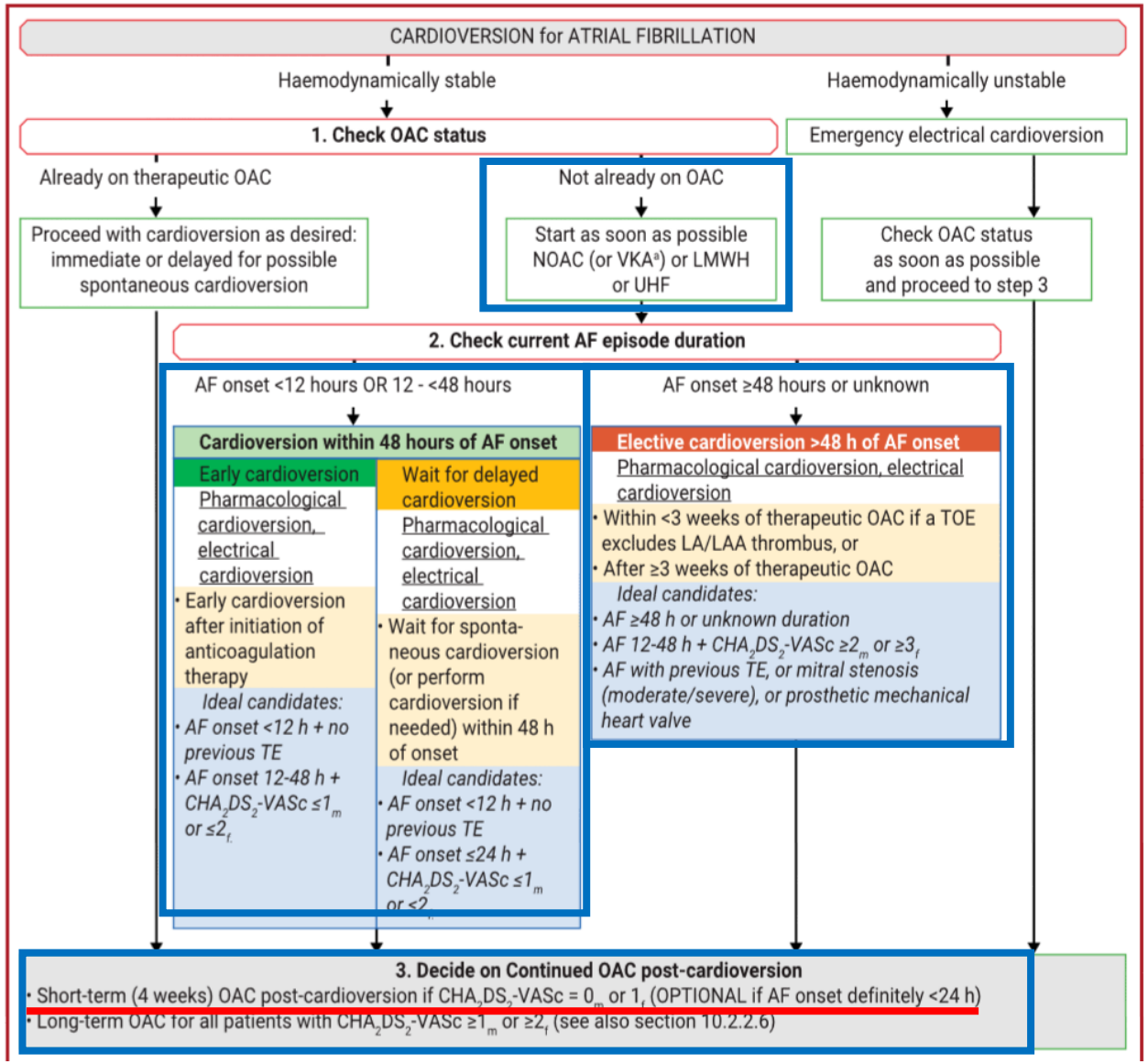
- **No alteración estructural**: **flecainida***, **propafenona*** y **vernakalant** (no SCA ni IC grave). Más efectivas y rápidas
- **Alteración estructural/IC**: **amiodarona**.
- No en enfermedad del seno, QT largo y alt. conducción AV (III)

**”pill in the pocket”*

Tratamiento - ‘B’ Better symptom control

CONTROL DE RITMO: CARDIOVERSIÓN

Se pueden usar ACOD, iguales en eficacia y seguridad (I)



Tratamiento - ‘B’ Better symptom control

CONTROL DE RITMO: FÁRMACOS PARA MANTENIMIENTO

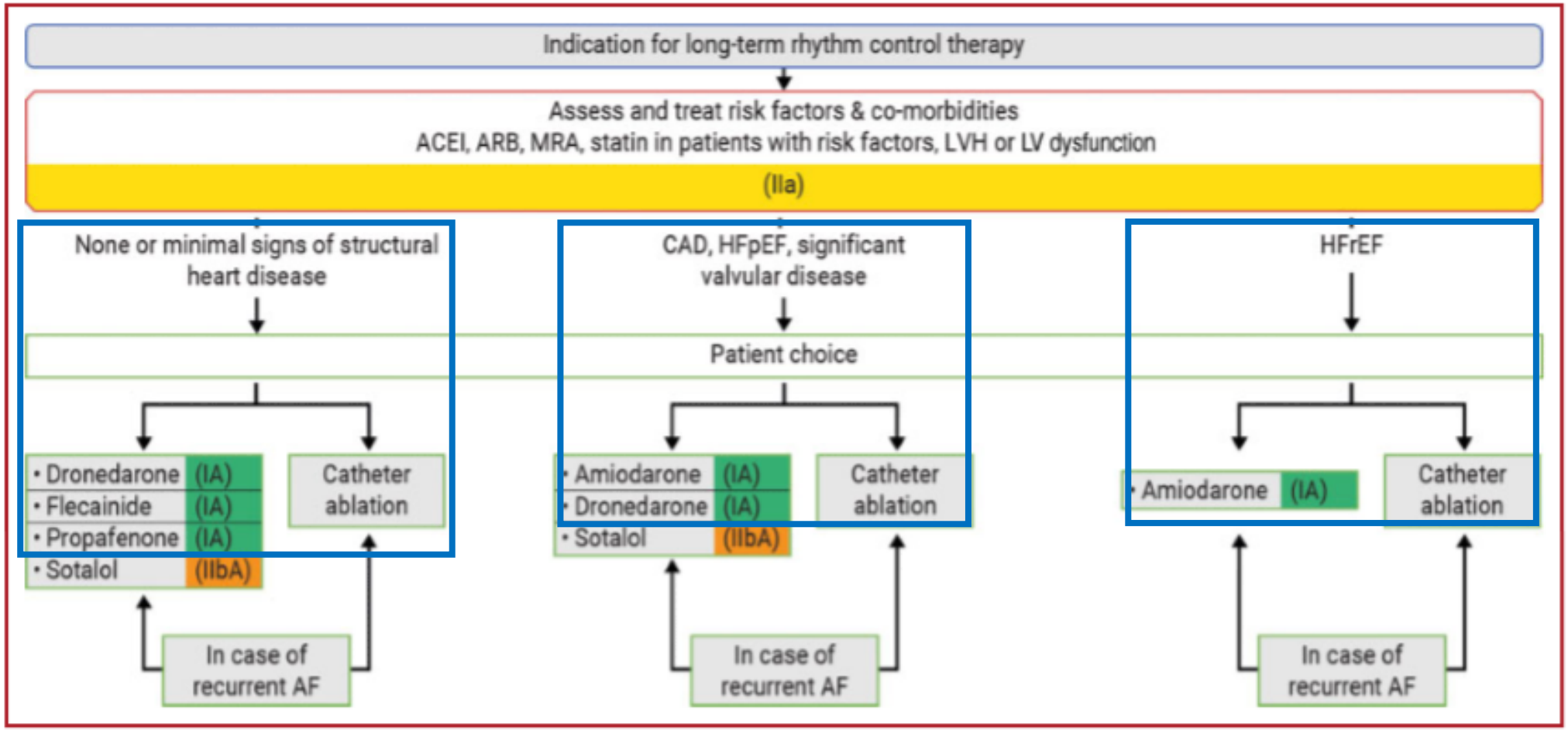
- **Menos efectividad** que la ablación

→**Si falla: cambiar fármaco**

→**Si funcionaba pero intolerancia: mantener clase**

- **Frecuentes: arritmias y efectos extracardíacos**

Tratamiento - 'B' Better symptom control

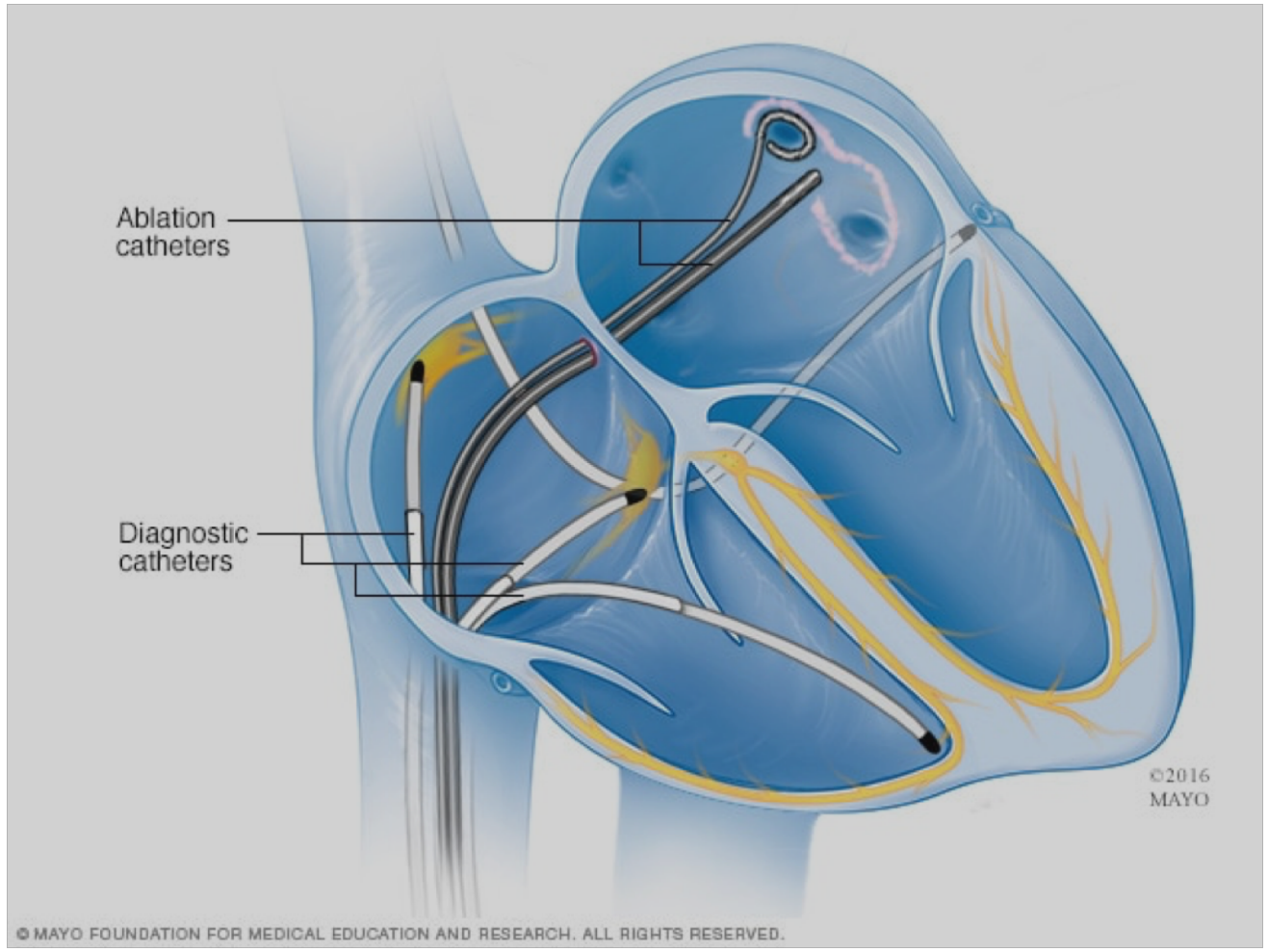


Amiodarona: el más efectivo → Dronedarona menos efectos adversos

Flecainida y propafenona → Cuidado conducción 1:1 → Uso concomitante fármaco frenador, IIA

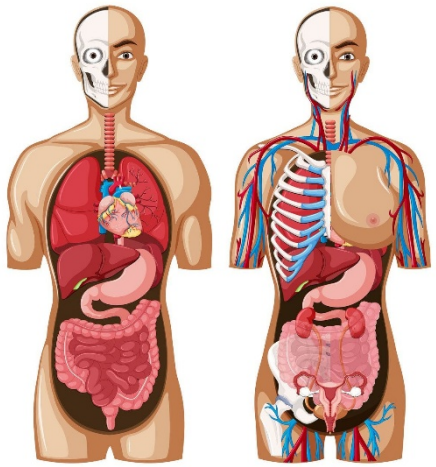
Tratamiento - ‘B’ Better symptom control

CONTROL DE RITMO: ABLACIÓN POR CATÉTER (evidencia baja)



Tratamiento - ‘C’ Cardiovascular risk and Concomitant diseases

- Tratar los FR y las enfermedades concomitantes → Actuar sobre el estilo de vida (I)



Factores de riesgo

- **Pérdida de peso**
- **OH**
- **Ejercicio moderado**. No el deporte de alto nivel (IIa)
- **HTA** → <130/80
- **Diabetes** → Reducen FA **pioglitazona y metformina**
- **SAHS**

Tratamiento en situaciones especiales

SÍNDROME CORONARIO AGUDO

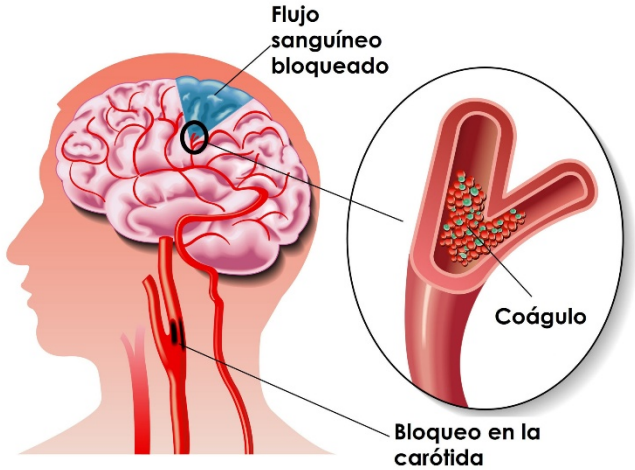
- **Mejor ACOD** . Si anti-VITK INR 2-2,5 y TTR >70%

- Si HASBLED>3 dosis de dabigatrán y rivaroxabán reducidas

- **Fármacos**:

- AAS: 1 semana (↓ R trombosis), si no 1 mes (I)
- Clopidogrel: SCA 12 meses, enfermedad coronaria crónica 6 meses
- Monoterapia ACO: después de 1 año independientemente de tipo de stent

Tratamiento en situaciones especiales



ICTUS

- **Estudio etiológico**: **24-72h ECG** +/- **Reveal®** si criptogenético

- Ictus isquémico + FA: **mejor ACOD** (hemorrágico o no) que anti-vitK (IIa) → **Introducción según NIHSS**, no en las primeras 48h

- **Hemorrágico + FA: 4 semanas** y si ↑ R sangrado oclusión de orejuela

- Si **ictus a pesar de ACO: cambiar** a/de ACOD o TTR>70%

Tratamiento en situaciones especiales

ANCIANOS

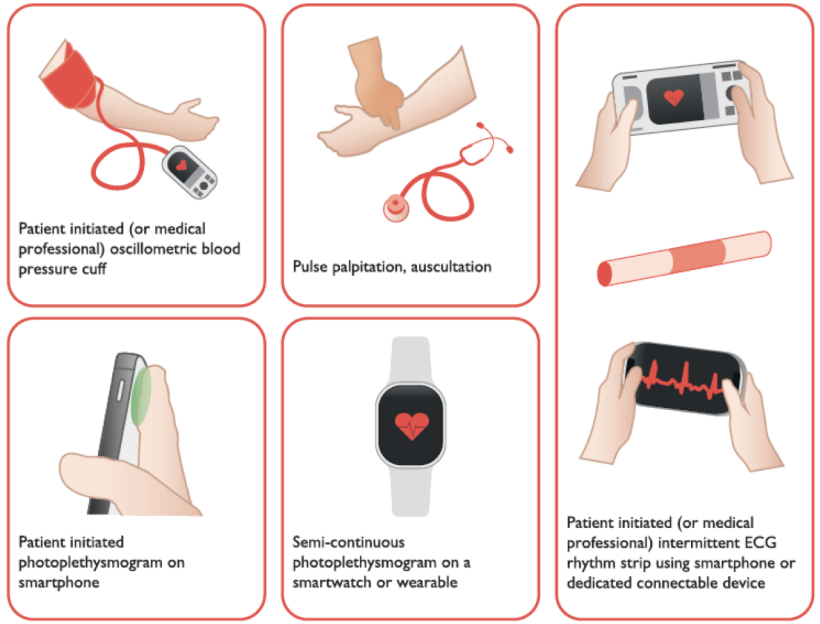
- **Mejor: control de ritmo**
- En **demencia ACOD** más seguros

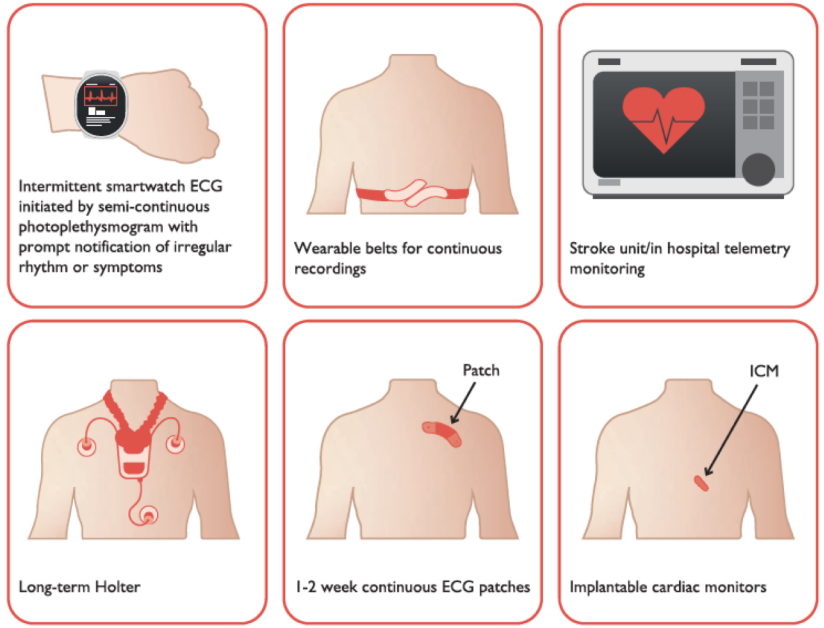
EMBARAZO

- **HBPM 1T y preparto**. **Anti-vitK en 2-3T**
- Preferible **parto vaginal**
- Control de FC con **beta-bloq. Digoxina y verapamilo** si no respuesta previa (IIa)
- Control de ritmo agudo: flecainida (IIb), si inestable CVE (IIa)
- Control de ritmo crónico: flecainida, propafenona (IIa)

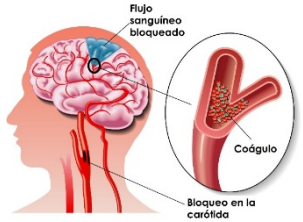
Conclusiones

- **Nueva definición** (30 segundos) **+ métodos detección:**





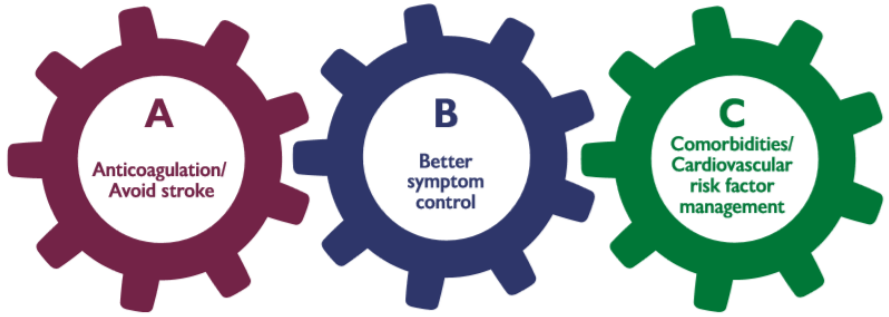
- **Screening**: >65 años y R de ictus



Conclusiones

- Tratamiento:

- **A:**
  - **Cambios en CHADSVASC y HASBLED IMP** → HASBLED no CI ACO
  - **ACOD de primera elección** → Reducir dosis sólo si necesario
  - **CI a ACO: cierre orejuela**
- **B:**
  - **Control FC**: b-bloq, CAT y digoxina → MCP/ablación
  - **Control ritmo:**
    - ❑ **CV (ACO previa y posterior):**
      - **Eléctrica**
      - **Fármacos:** propafenona, flecainida +/- amiodarona
    - ❑ **Fármacos crónico:** propafenona, flecainida, dronedarona +/- amiodarona
    - ❑ **Ablación:** si fallo anteriores o FEVIr



- **C:** Identificar y tratar los FR y las enfermedades concomitantes → Estilo de vida

Conclusiones

- Por saber: biomarcadores, ACOD en ERC avanzada, pesos extremos, en enfermedad reumática o bioprótesis…

“Manejo integral de los pacientes por un equipo multidisciplinar”

↓

Medicina Interna

GRACIAS