FIBRILLATION ATRIALE : NOUVEAUTÉS 2016-2017

- Dr Philippe Houplon - Thionville

EPIDÉMIOLOGIQUE ET MORBIMORTALITÉ

- 20 millions en 2010 dans les pays développés
- En 2030 : 15 millions en Europe
- ¼ des adultes d'âge moyen en Europe et aux USA → FA
- Insuffisance cardiaque, Mort subite, AVC (20-30% des AVC), baisse QoL, déclin cognitif, démence…
- Hospitalisation (10-40% pts en FA / an)

NOUVEAUTÉS 2016-2017

- Détection FA silencieuse ou infra clinique
- Détection et prise en charge des co-morbidités
- Score Cha2ds2-Vasc
- Critères de FA valvulaire simplifiés
- (Occlusion auricule G)
- AOD 1ère intention (risque TE et après 1er accident)
- Complications hémorragiques
- (Ablation 2^{e} intention)
- SCA : « porte ouverte AOD »

Patterns of atrial fibrillation

AF pattern	Definition
First diagnosed AF	AF that has not been diagnosed before, irrespective of the duration of the arrhythmia or the presence and severity of AF-related symptoms.
Paroxysmal AF	Self-terminating, in most cases within 48 hours. Some AF paroxysms may continue for up to 7 days. AF episodes that are cardioverted within 7 days should be considered paroxysmal.
Persistent AF	AF that lasts longer than 7 days, including episodes that are terminated by cardioversion, either with drugs or by direct current cardioversion, after 7 days or more.
Long-standing persistent AF	Continuous AF lasting for ≥1 year when it is decided to adopt a rhythm control strategy.
Permanent AF	AF that is accepted by the patient (and physician). Hence, rhythm control interventions are, by definition, not pursued in patients with permanent AF. Should a rhythm control strategy be adopted, the arrhythmia would be re-classified as 'long-standing persistent AF'.

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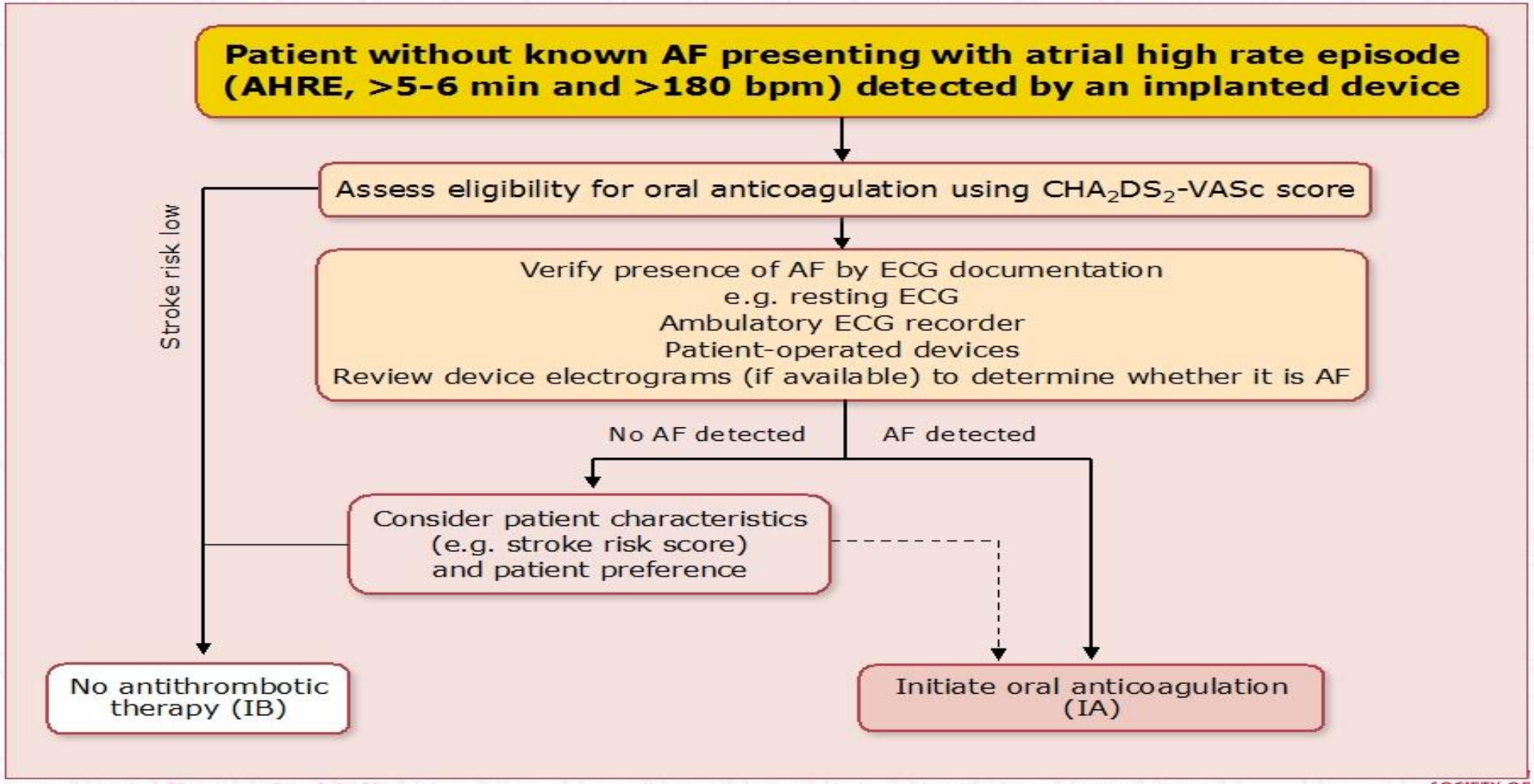
Management of atrial high rate episodes detected by an implanted device



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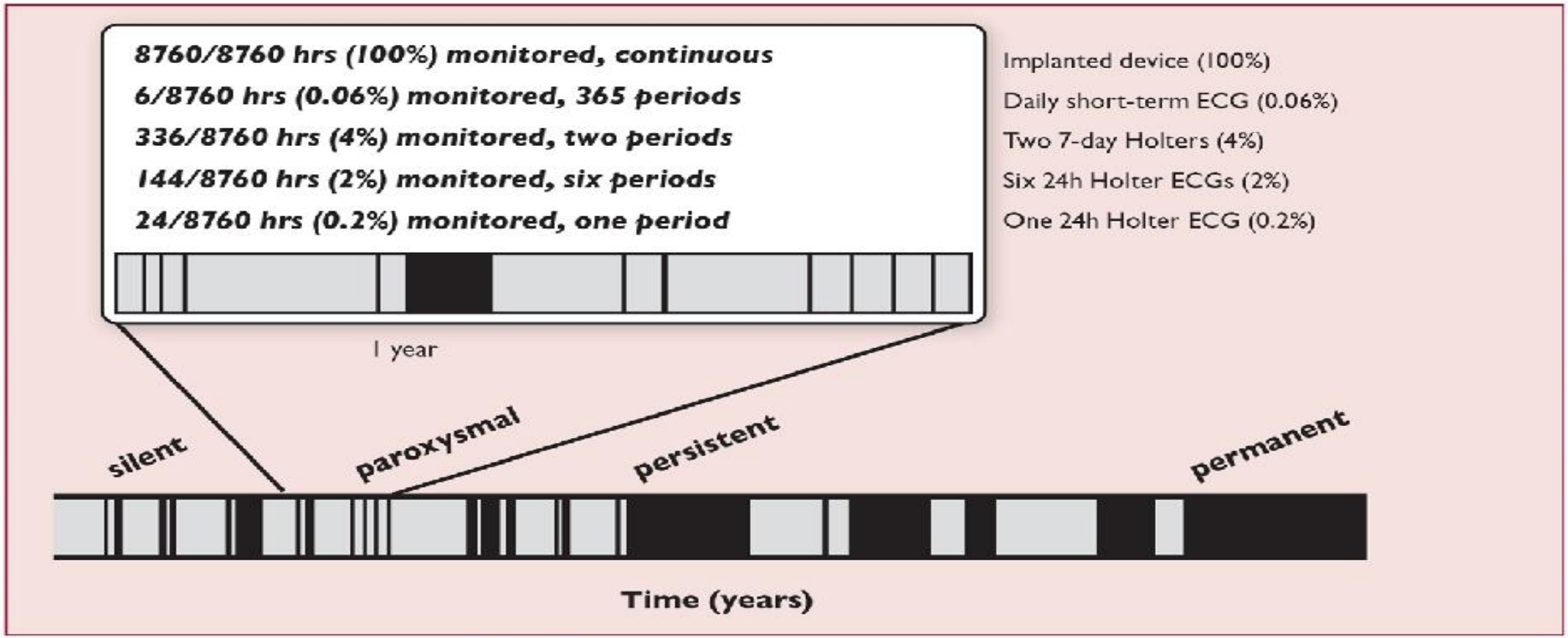
Diagnostic yield of different ECG screening techniques for paroxysmal or silent atrial fibrillation



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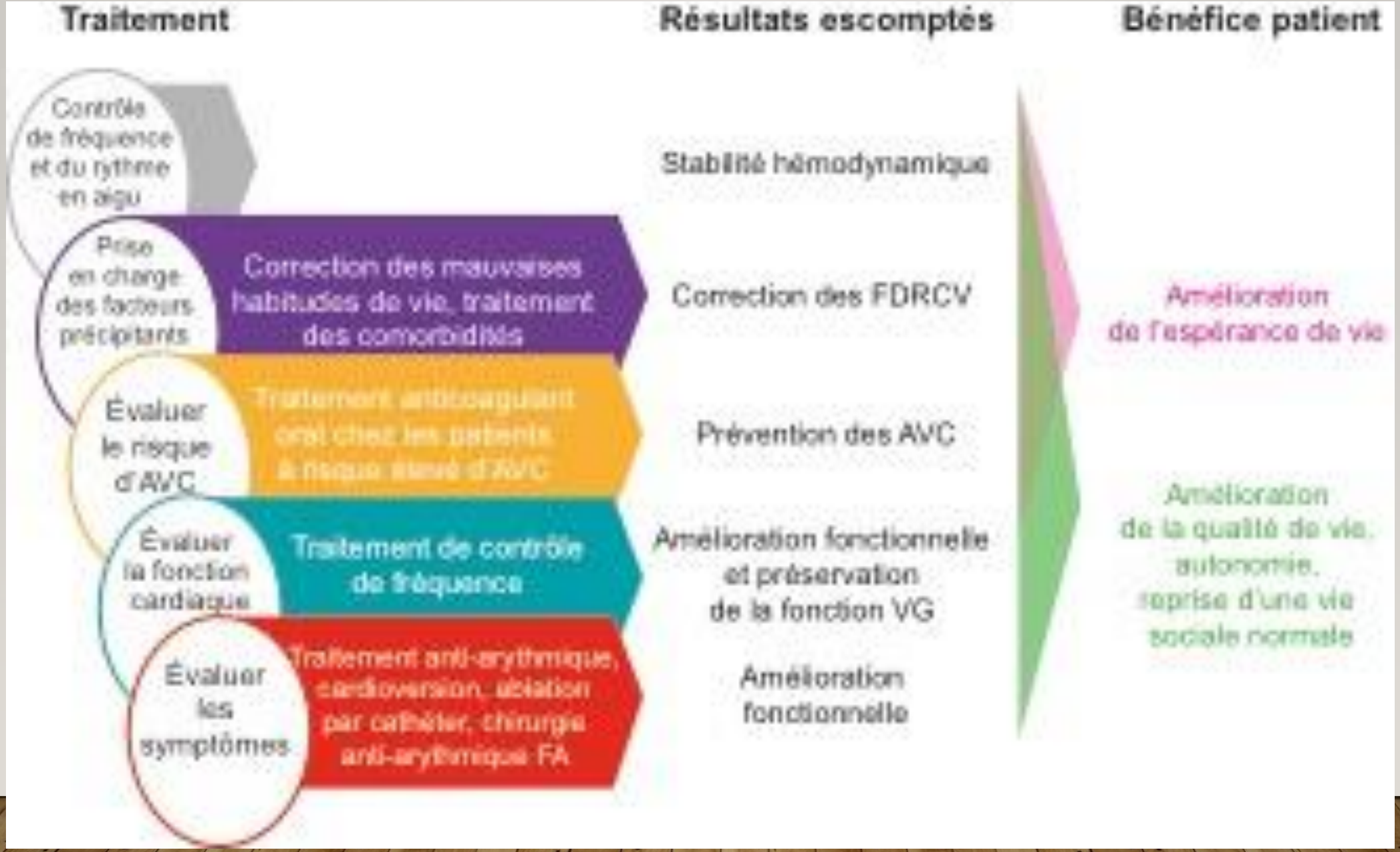
PRISE EN CHARGE GLOBALE

- Détection et prise en charge des Co-morbidités
- Obésité, BPCO, SAS, Act. phys intense, Diabète, Ins rénale, tabac, alcoolisme…
- Ces facteurs augmentent le risque de survenue, de rechute et de complications de la FA


Traitement
Résultats escomptés
Bénéfice patient
Contrôle de fréquence et du rythme en aigu
Prise en charge des facteurs précipitants
Correction des mauvaises habitudes de vie, traitement des comorbidités
Évaluer le risque d'AVC
Traitement anticoagulant oral chez les patients à risque élevé d'AVC
Évaluer la fonction cardiaque
Traitement de contrôle de fréquence
Évaluer les symptômes
Traitement anti-arythmique, cardioversion, ablation par cathéter, chirurgie anti-arythmique FA
Stabilité hémodynamique
Correction des FDRCV
Prévention des AVC
Amélioration fonctionnelle et préservation de la fonction VG
Amélioration fonctionnelle
Amélioration de l'espérance de vie
Amélioration de la qualité de vie, autonomie, reprise d'une vie sociale normale

Prediction of stroke and bleeding risk

Recommendations	Class	Level
The CHA_2DS_2-VASc score is recommended for stroke risk prediction in patients with AF.	I	A
Bleeding risk scores should be considered in AF patients on oral anticoagulation to identify modifiable risk factors for major bleeding.	IIa	B
Biomarkers such as high-sensitivity troponin and natriuretic peptide may be considered to further refine stroke and bleeding risk in AF patients.	IIb	B

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Classes of recommendations	Definition	Suggested wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended/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

Level of evidence A	Data derived from multiple randomized clinical trials or meta-analyses.
Level of evidence B	Data derived from a single randomized clinical trial or large non-randomized studies.
Level of evidence C	Consensus of opinion of the experts and/ or small studies, retrospective studies, registries.

www.escardio.org/guidelines

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Clinical risk factors for stroke, transient ischaemic attack, and systemic embolism

CHA_2DS_2-VASc risk factor	Points
Congestive heart failure Signs/symptoms of heart failure or objective evidence of reduced left-ventricular ejection fraction	1
Hypertension Resting blood pressure >140/90 mmHg on at least two occasions or current antihypertensive treatment	1
Age 75 years or older	2
Diabetes mellitus Fasting glucose >125 mg/dL (7 mmol/L) or treatment with oral hypoglycaemic agent and/or insulin	1
Previous stroke, transient ischaemic attack, or thromboembolism	2
Vascular disease Previous myocardial infarction, peripheral artery disease, or aortic plaque	1
Age 65–74 years	1
Sex category (female)	1

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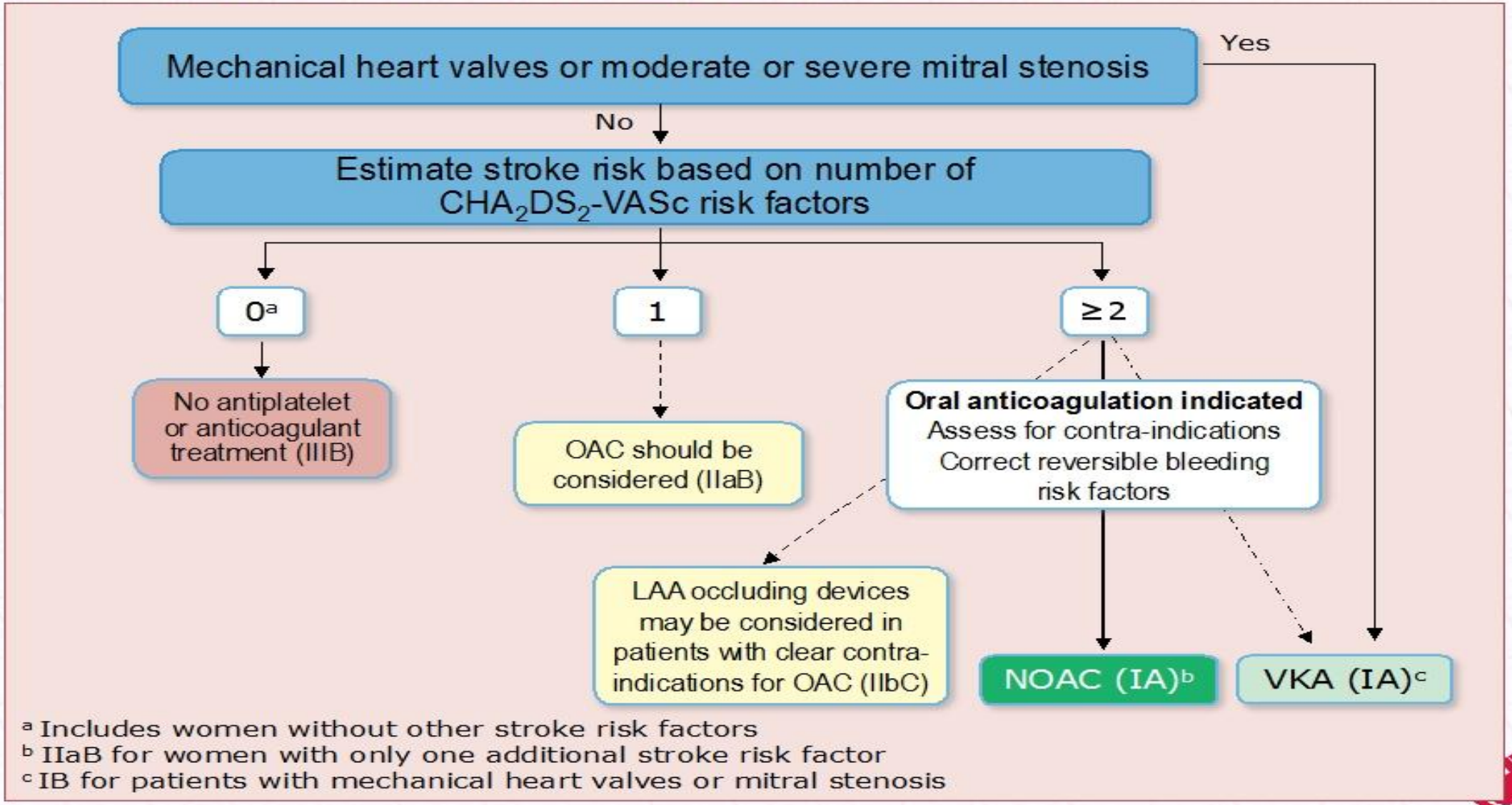
Stroke prevention in atrial fibrillation



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Stroke prevention in patients with atrial fibrillation (1)

Recommendations	Class	Level
Oral anticoagulation therapy to prevent thromboembolism is recommended for all male AF patients with a CHA_2DS_2-VASc score of 2 or more.	I	A
Oral anticoagulation therapy to prevent thromboembolism is recommended in all female AF patients with a CHA_2DS_2-VASc score of 3 or more.	I	A
Oral anticoagulation therapy to prevent thromboembolism should be considered in male AF patients with a CHA_2DS_2-VASc score of 1, considering individual characteristics and patient preferences.	IIa	B
Oral anticoagulation therapy to prevent thromboembolism should be considered in female AF patients with a CHA_2DS_2-VASc score of 2, considering individual characteristics and patient preferences.	IIa	B
Vitamin K antagonist therapy (INR 2.0–3.0 or higher) is recommended for stroke prevention in AF patients with moderate-to-severe mitral stenosis or mechanical heart valves.	I	B
When oral anticoagulation is initiated in a patient with AF who is eligible for a NOAC (apixaban, dabigatran, edoxaban, or rivaroxaban), a NOAC is recommended in preference to a Vitamin K antagonist.	I	A

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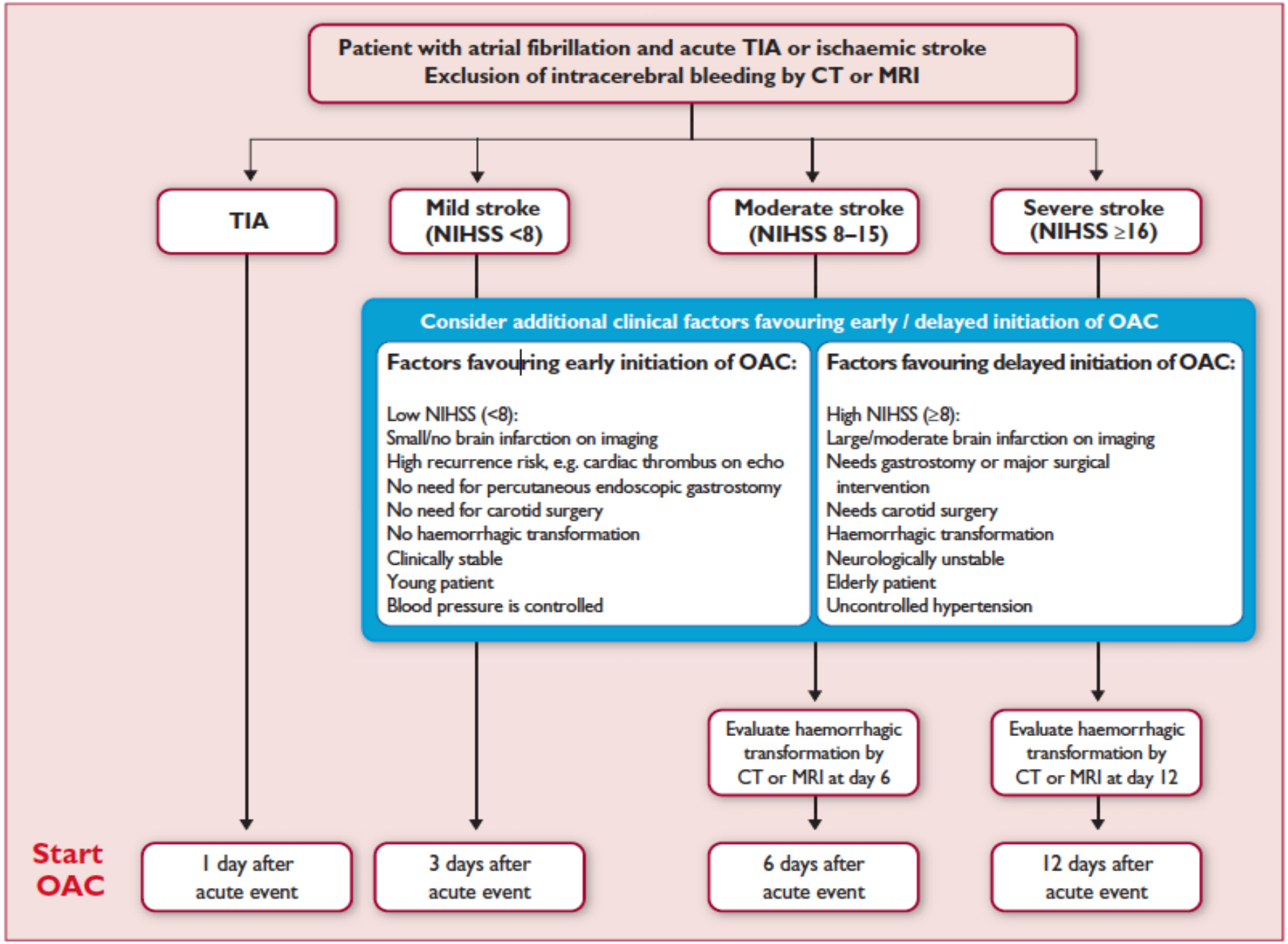

AF = atrial fibrillation; CT = computed tomography; NIHSS = National Institutes of Health stroke severity scale (available at http://www.strokecenter.org/wp-content/uploads/2011/08/NIH_Stroke_Scale.pdf); OAC = oral anticoagulation; TIA = transient ischaemic attack

Modifiable and non-modifiable risk factors for bleeding in anticoagulated patients with AF

Modifiable bleeding risk factors:
Hypertension (especially when systolic blood pressure is >160 mmHg)
Labile INR or time in therapeutic range <60% in patients on vitamin K antagonists
Medication predisposing to bleeding, such as antiplatelet drugs and non-steroidal anti-inflammatory drugs
Excess alcohol (≥8 drinks/week)
Potentially modifiable bleeding risk factors:
Anaemia
Impaired renal function
Impaired liver function
Reduced platelet count or function

Non-modifiable bleeding risk factors:
Age (>65 years) (≥75 years)
History of major bleeding
Previous stroke
Dialysis-dependent kidney disease or renal transplant
Cirrhotic liver disease
Malignancy
Genetic factors
Biomarker-based bleeding risk factors:
High-sensitivity troponin
Growth differentiation factor-15
Serum creatinine/estimated CrCl

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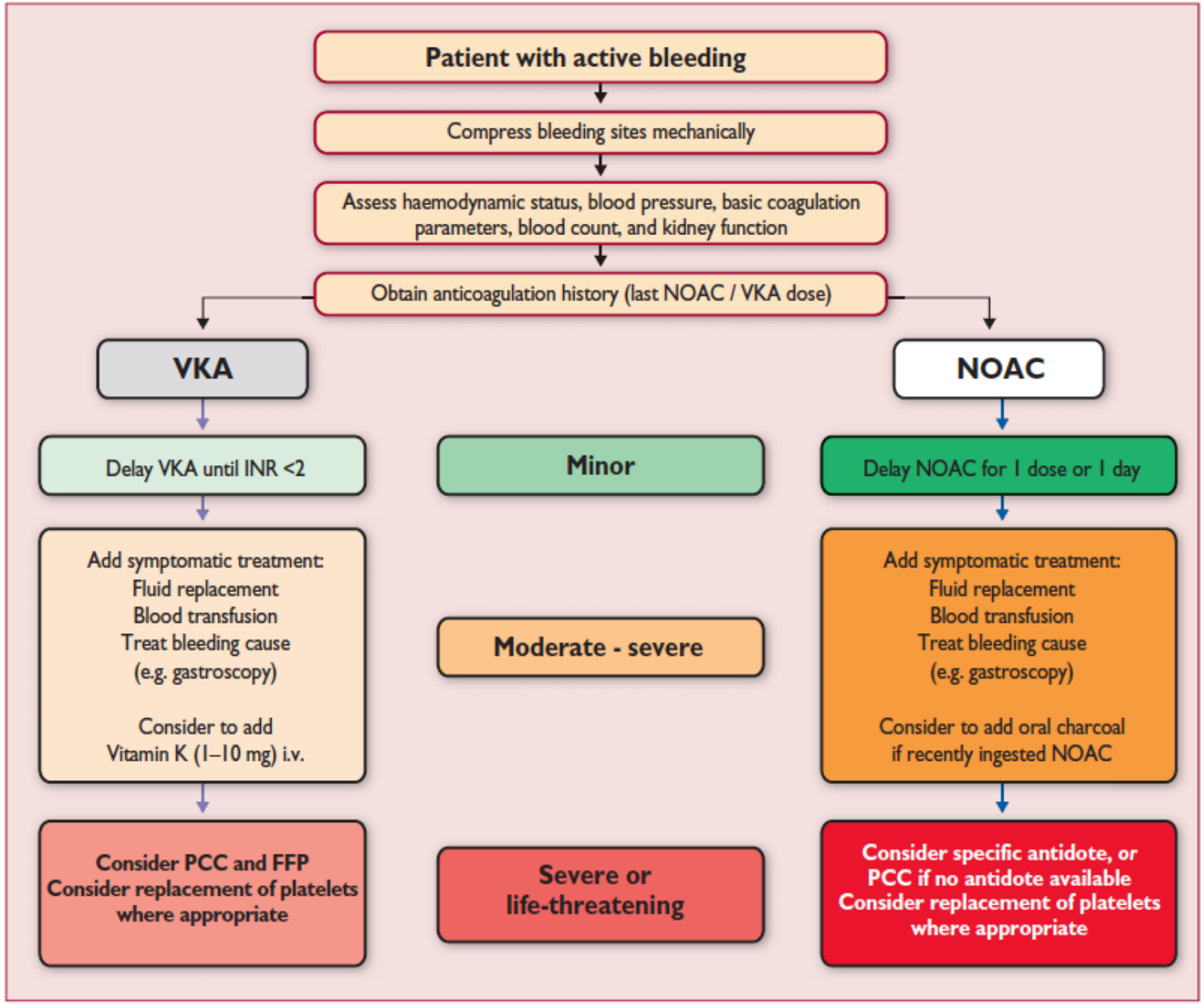

FFP = fresh frozen plasma; INR = international normalized ratio; i.v. = intravenous; NOAC = non-vitamin K antagonist oral anticoagulant; OAC = oral anticoagulation; PCC = prothrombin complex concentrates; VKA = vitamin K antagonist.

Figure 11 Management of active bleeding in patients receiving anticoagulation. Institutions should have an agreed procedure in place.

Combination therapy with oral anticoagulants and antiplatelets

Recommendations	Class	Level
After elective coronary stenting for stable coronary artery disease in AF patients at risk of stroke, combination triple therapy with aspirin, clopidogrel and an oral anticoagulant should be considered for 1 month to prevent recurrent coronary and cerebral ischaemic events.	IIa	B
After an ACS with stent implantation in AF patients at risk of stroke, combination triple therapy with aspirin, clopidogrel and an oral anticoagulant should be considered for 1–6 months to prevent recurrent coronary and cerebral ischaemic events.	IIa	C
After an ACS without stent implantation in AF patients at risk of stroke, dual treatment with an oral anticoagulant and aspirin or clopidogrel should be considered for up to 12 months to prevent recurrent coronary and cerebral ischaemic events.	IIa	C
The duration of combination antithrombotic therapy, especially triple therapy, should be kept to a limited period, balancing the estimated risk of recurrent coronary events and bleeding.	IIa	B
Dual therapy with any oral anticoagulant plus clopidogrel 75 mg/day may be considered as an alternative to initial triple therapy in selected patients.	IIb	C

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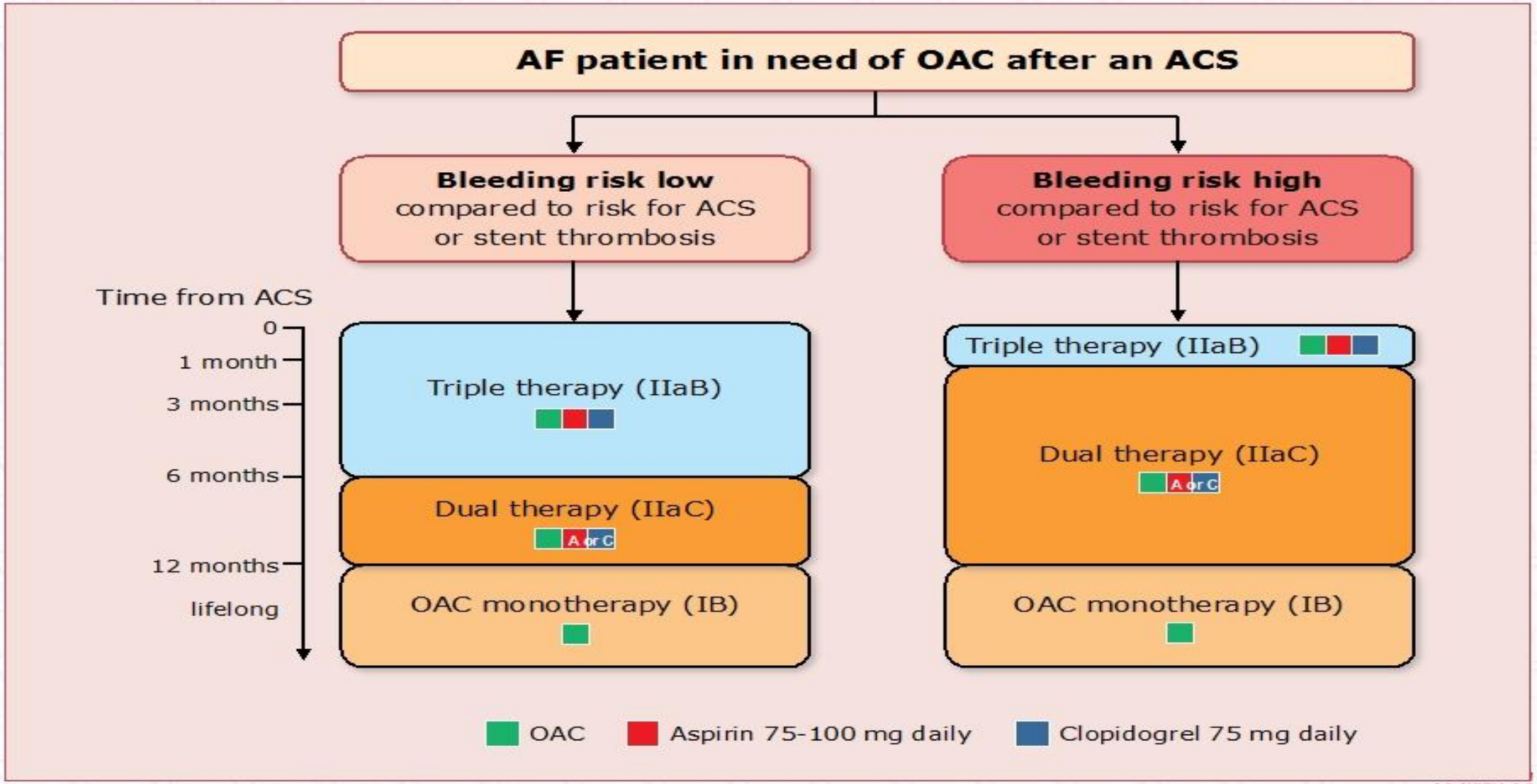
Antithrombotic therapy after an acute coronary syndrome in atrial fibrillation patients requiring anticoagulation



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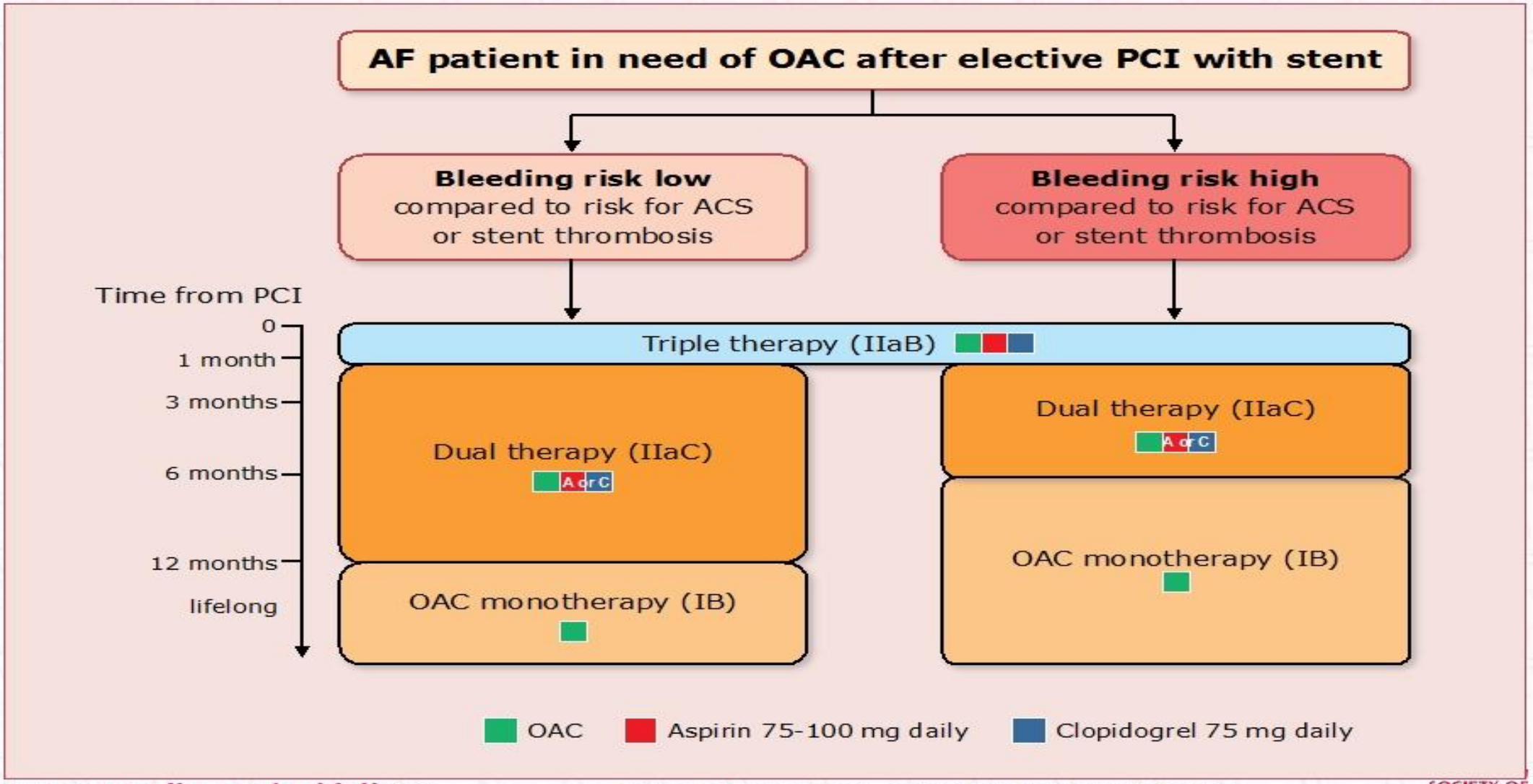
Antithrombotic therapy after elective percutaneous intervention in atrial fibrillation patients requiring anticoagulation



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