ESC session

Un cas de Fibrillation auriculaire

Sana Ouali, MD
Hôpital La Rabta

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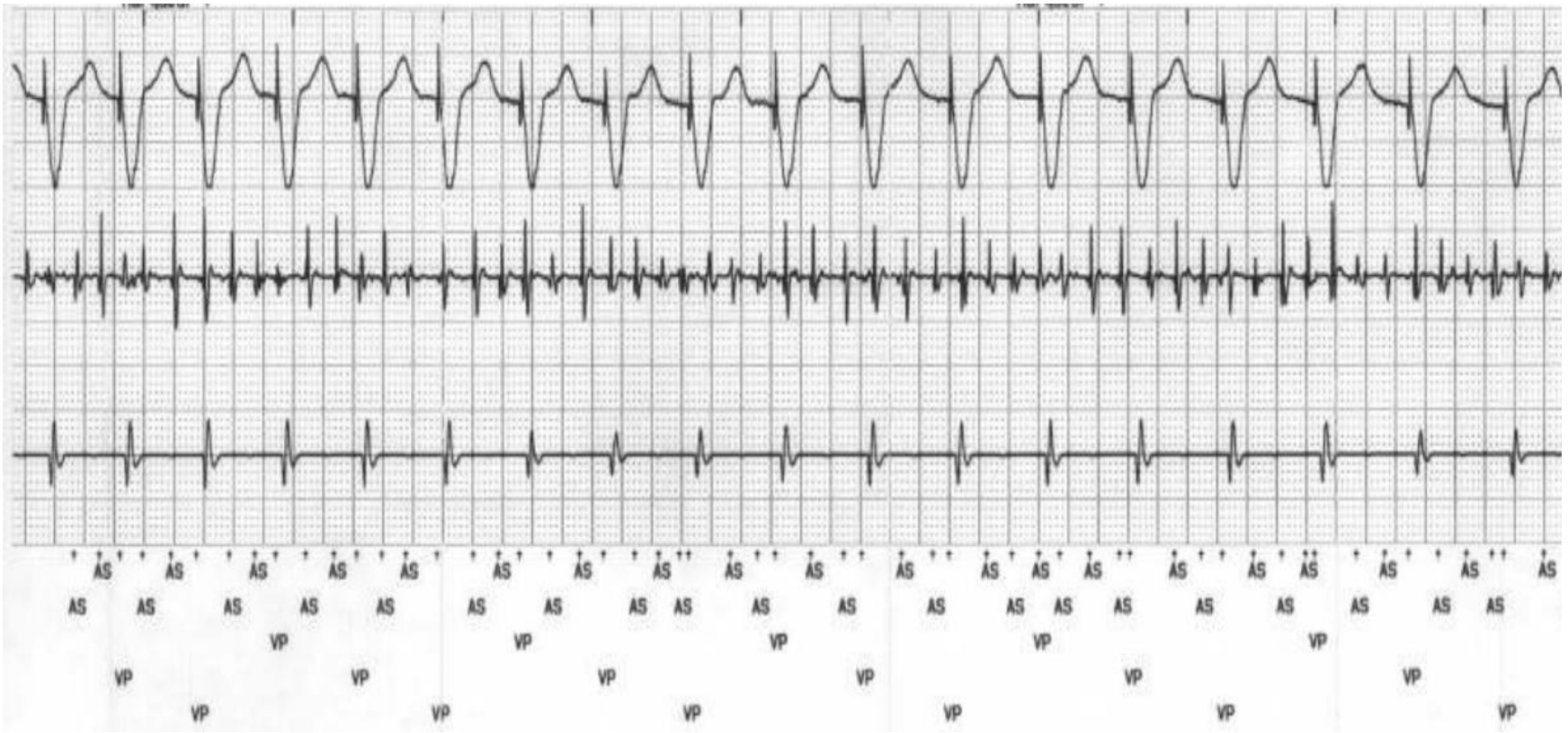
EUROPEAN SOCIETY OF CARDIOLOGY®

Observation

- **Mme S F porteuse d'un PM double chambre pour un BAV permanent**
  - 62 ans
  - HTA modérée non traitée
  - SAS sévère
  - Hypothyroïdie sous L thyroxine
  - surpoids (IMC:30kg/m²)
  - Sédentaire
  - Insuffisance rénale (clairance: 48)
  - AINS pour une arthrose cervicale
  - Asymptomatique à part une DE stade II NYHA.
- **Suivie périodiquement à la consultation des stimulateurs cardiaque**

VP: 99%

EGM endocavitaire



La fibrillation atriale chez cette patiente constitue

A. Un marqueur de risque d'accidents thromboemboliques

B. Un facteur de risque d'accidents thromboembolique

Réponse A

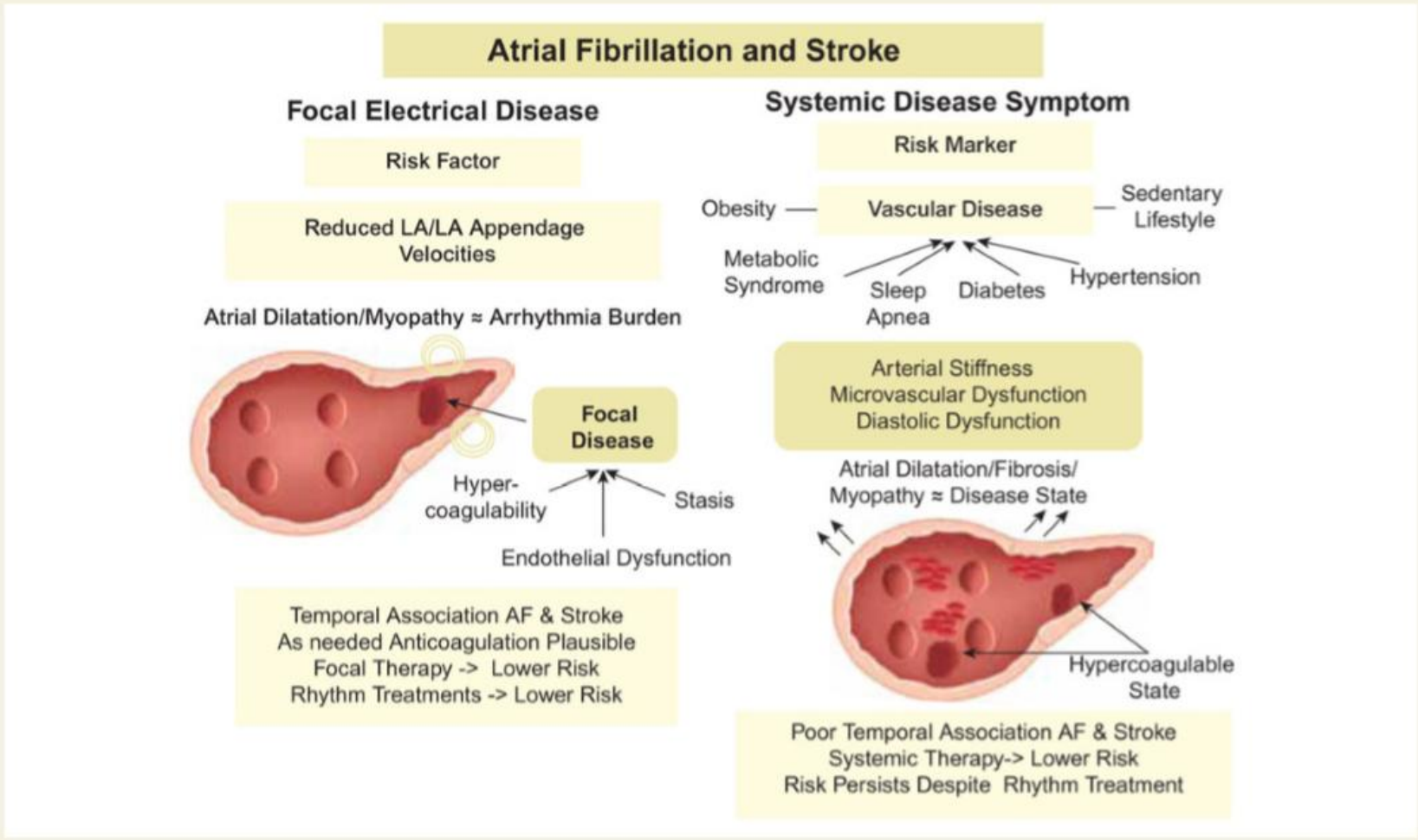


Figure 1 Shown are mechanistic considerations of atrial fibrillation as a focal disease state and risk factor (left) and as part of a systemic disease state and risk marker (right).

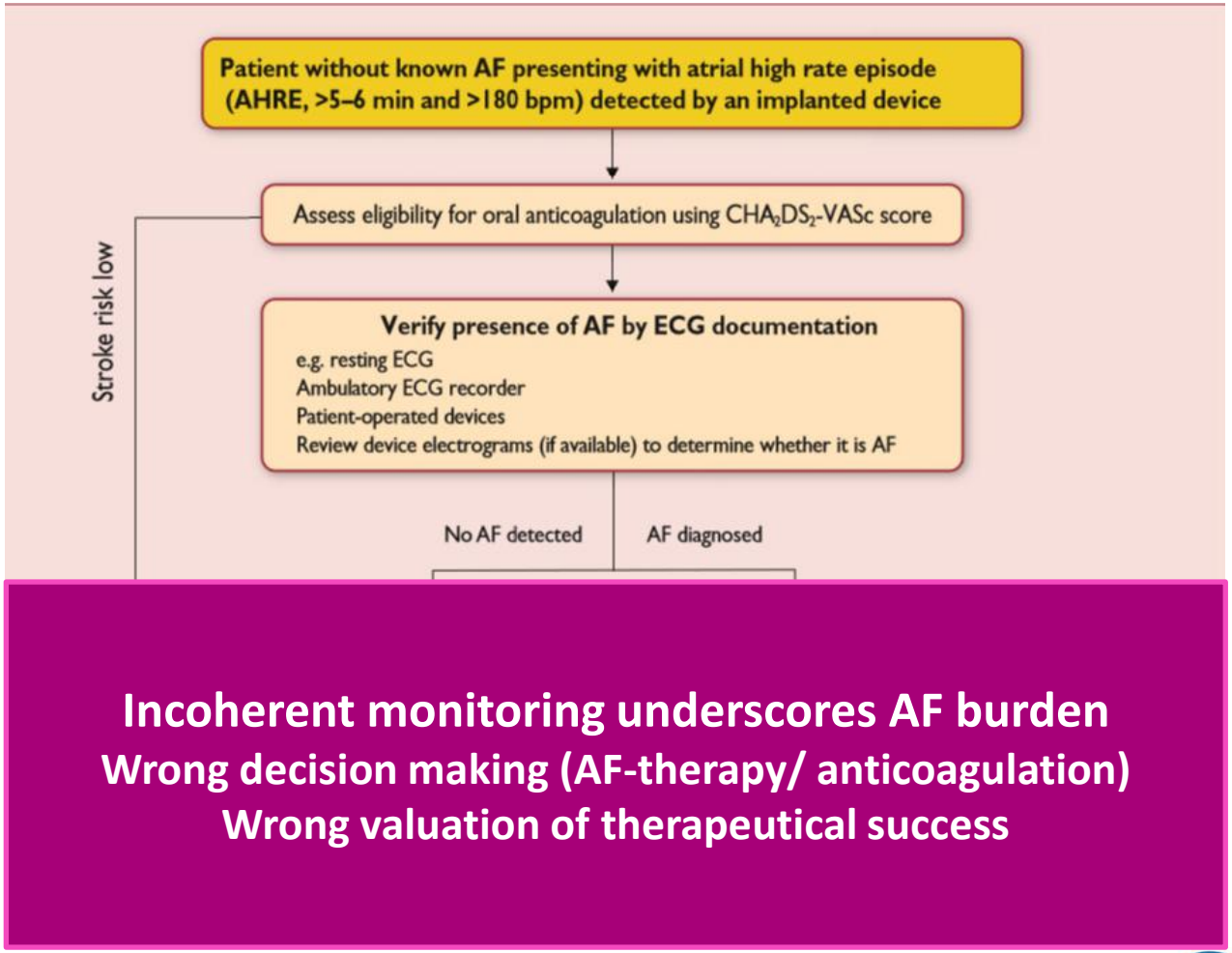
Bunch T J .Eu Heart. J 2016

Quelle est la durée de FA qui implique un traitement anticoagulant?

A. Une minute de FA
B. 06 minutes de FA
C. 15 minutes de FA
D. 30 minutes de FA
E. 90 minutes de FA
F. 24 heures de fibrillation auriculaire
G. 48 heures de fibrillation auriculaire

Réponse: B

Importance de la télémédecine pour le dépistage précoce de la FA



Incoherent monitoring underscores AF burden
Wrong decision making (AF-therapy/ anticoagulation)
Wrong valuation of therapeutical success

Recommendations for screening for atrial fibrillation

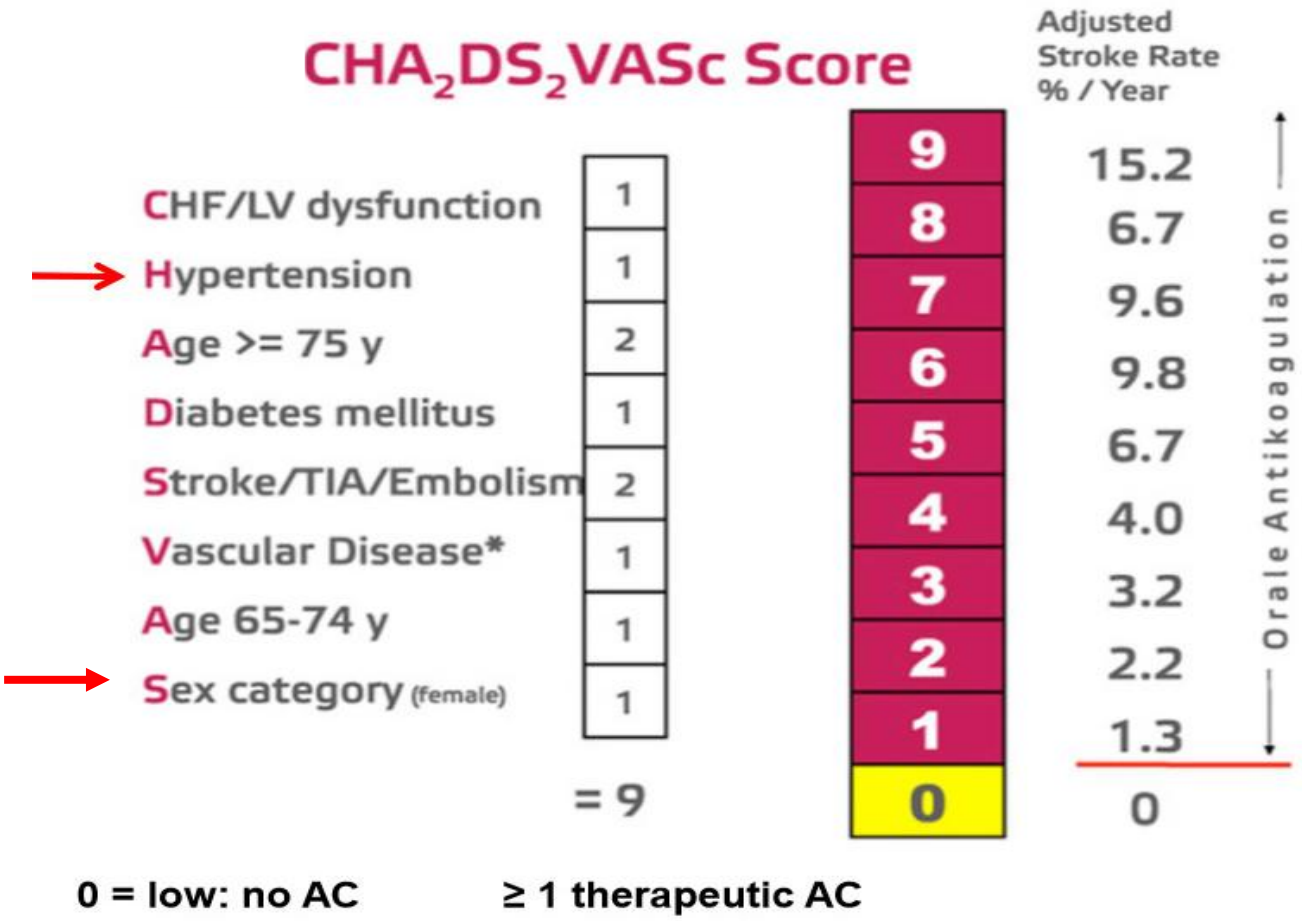
Recommendations	Class[a]	Level[b]	Ref[c]
Opportunistic screening for AF is recommended by pulse taking or ECG rhythm strip in patients >65 years of age.	I	B	130, 134, 155
In patients with TIA or ischaemic stroke, screening for AF is recommended by short-term ECG recording followed by continuous ECG monitoring for at least 72 hours.	I	B	27, 127
It is recommended to interrogate pacemakers and ICDs on a regular basis for atrial high rate episodes (AHRE). Patients with AHRE should undergo further ECG monitoring to document AF before initiating AF therapy.	I	B	141, 156
In stroke patients, additional ECG monitoring by long-term non-invasive ECG monitors or implanted loop recorders should be considered to document silent atrial fibrillation.	IIa	B	18, 128
Systematic ECG screening may be considered to detect AF in patients aged >75 years, or those at high stroke risk.	IIb	B	130, 135, 157

Quel est son score CHA_2DS_2 VASc ?

A. 0
B. 1
C. 2
D. 3
E. 4

Réponse C

Le risque thromboembolique



Son score HASBLED est à

HAS-BLED Score

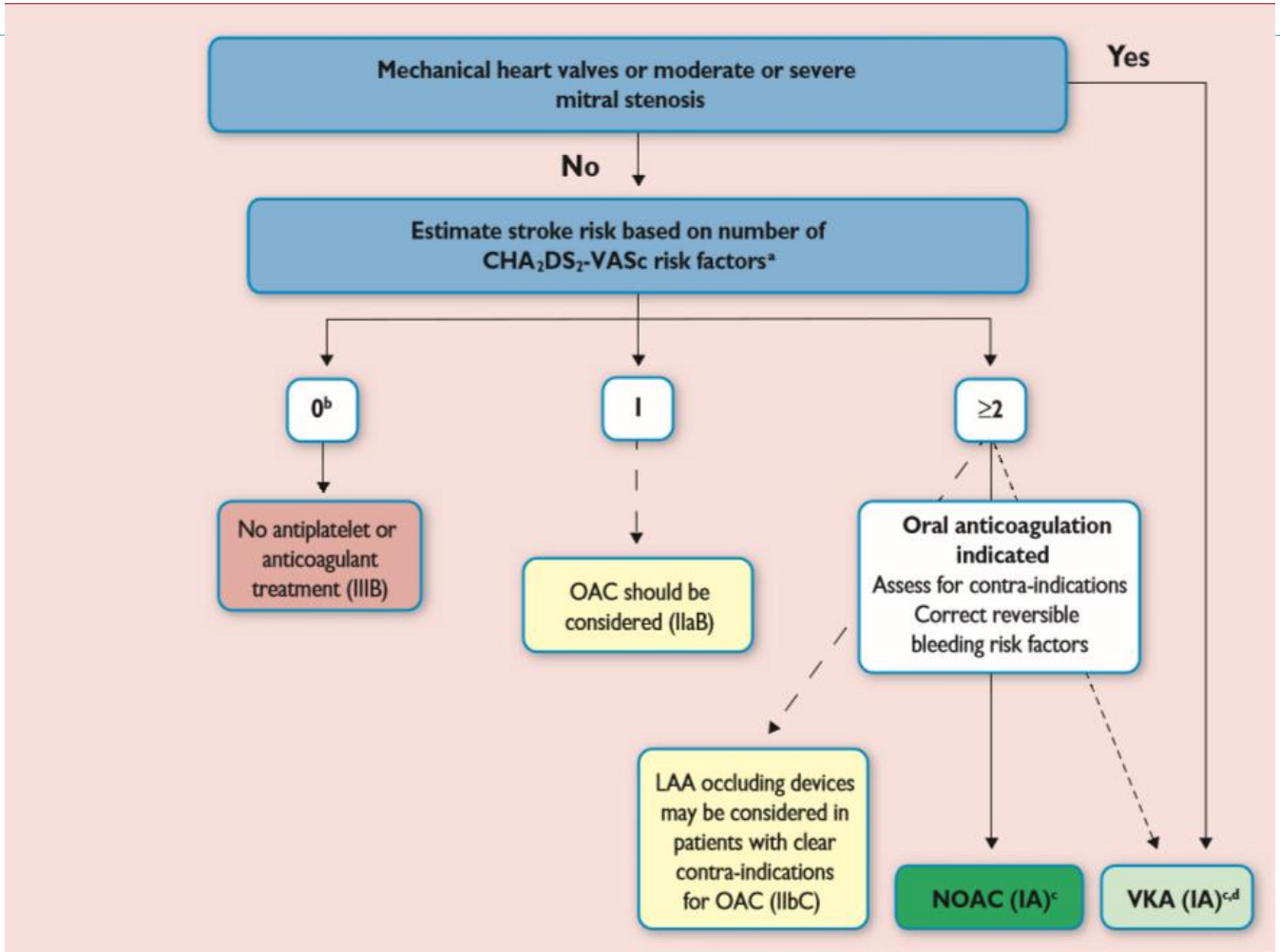
			Score
→	H	Hypertension	1
→	A	abnormal renal or liver function	1 or 2
	S	Stroke	1
	B	Bleeding	1
	L	labile INRs	1
	E	Elderly (age > 65 y)	1
→	D	Drugs or alcohol	1 or 2
			= 9

Score >= 3 = High Risk

La PEC de cette patiente comporte

A. Un traitement anticoagulant à long cours
B. Un traitement antiagrégant au long cours
C. Un traitement au long cours d'amiodarone
D. Une ablation par radiofréquence de sa fibrillation auriculaire permettant l'arrêt de son traitement anticoagulant
E. Un appareillage de son SAS
F. Une activité physique régulière
G. Réduction de sa surchage pondérale

Réponse: A, E, F, G


Mechanical heart valves or moderate or severe mitral stenosis
Yes
No
Estimate stroke risk based on number of CHA2DS2-VASc risk factors[a]
0[b]
1
≥2
No antiplatelet or anticoagulant treatment (IIIB)
OAC should be considered (IIaB)
Oral anticoagulation indicated
Assess for contra-indications
Correct reversible bleeding risk factors
LAA occluding devices may be considered in patients with clear contra-indications for OAC (IIbC)
NOAC (IA)[c]
VKA (IA)[c,d]

Recommendations	Class[a]	Level[b]	Ref[c]
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	38, 318–321, 354, 404
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	38, 318–321, 354, 404
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	371, 375–377
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	371, 376, 377
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	274, 435–440
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	39, 318–321, 404
When patients are treated with a vitamin K antagonist, time in therapeutic range (TTR) should be kept as high as possible and closely monitored.	I	A	395, 432, 441-444
AF patients already on treatment with a vitamin K antagonist may be considered for NOAC treatment if TTR is not well controlled despite good adherence, or if patient preference without contra-indications to NOAC (e.g. prosthetic valve).	IIb	A	39, 318, 319, 404, 408
Combinations of oral anticoagulants and platelet inhibitors increase bleeding risk and should be avoided in AF patients without another indication for platelet inhibition.	III (harm)	B	429, 445
In male or female AF patients without additional stroke risk factors, anticoagulant or antiplatelet therapy is not recommended for stroke prevention.	III (harm)	B	368, 371, 376, 377
Antiplatelet monotherapy is not recommended for stroke prevention in AF patients, regardless of stroke risk.	III (harm)	A	38, 429, 430
NOACs (apixaban, dabigatran, edoxaban, and rivaroxaban) are not recommended in patients with mechanical heart valves (Level of evidence B) or moderate-to-severe mitral stenosis (Level of evidence C).	III (harm)	B C	318–321, 400, 404

Recommendation for obese patients with atrial fibrillation

Recommendation	Class[a]	Level[b]	Ref[c]
In obese patients with AF, weight loss together with management of other risk factors should be considered to reduce AF burden and symptoms.	IIa	B	204, 288, 296

Recommendations for patients with atrial fibrillation and respiratory diseases

Recommendations	Class[a]	Level[b]	Ref[c]
Correction of hypoxaemia and acidosis should be considered as initial management for patients who develop AF during an acute pulmonary illness or exacerbation of chronic pulmonary disease.	IIa	C	
Interrogation for clinical signs of obstructive sleep apnoea should be considered in all AF patients.	IIa	B	304, 305, 314, 315
Obstructive sleep apnoea treatment should be optimized to reduce AF recurrences and improve AF treatment results.	IIa	B	307–311

Recommendations for patients with kidney disease and atrial fibrillation

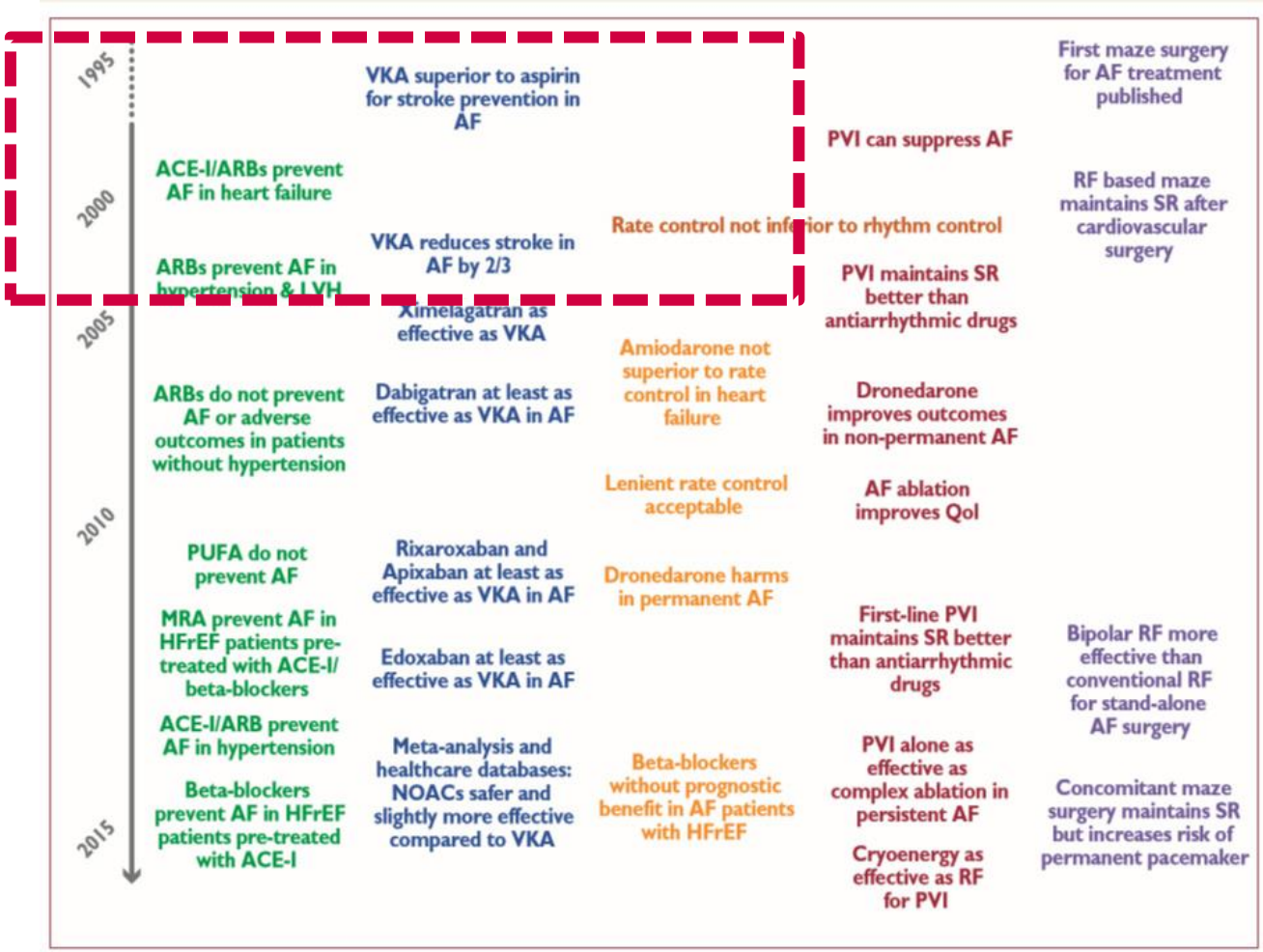
Recommendations	Class[a]	Level[b]	Ref[c]
The assessment of kidney function by serum creatinine or creatinine clearance is recommended in all AF patients to detect kidney disease and to support correct dosing of AF therapy.	I	A	316, 318–321
All AF patients treated with oral anticoagulation should be considered for at least yearly renal function evaluation to detect chronic kidney disease.	IIa	B	

Vous décidez d'anticoaguler
Quel(s) anticoagulant(s) vous utilisez ?

A. La warfarine
B. Le rivaroxaban
C. L'apixaban
D. Le Dabigatran
E. L'edoxaban
F. Aucune réponse n'est juste

Réponse F !

En Tunisie: pas de warfarine, pas d'AOD pas de couverture sociale pour l'ablation



ACE-I = angiotensin-converting enzyme inhibitor; AF = atrial fibrillation; ARB = angiotensin receptor blocker; HF = heart failure; HFrEF = heart failure with reduced ejection fraction; LVH = left ventricular hypertrophy; NOAC = non-vitamin K antagonist oral anticoagulant; PUFA = polyunsaturated fatty acid; PVI = pulmonary vein isolation; QoL = quality of life; RF = radiofrequency; SR = sinus rhythm; VKA = vitamin K antagonist.

La patiente présente un syndrome coronarien aigu (dl th 3h, ECG: électroentrainée)

- **Patiente sous Sintrom Son INR a 2,8**

- **Vous réalisez en urgence une coronarographie, vous mettez en évidence une occlusion de l'IVA vous décidez de réaliser:**

A. Une thrombolyse intracoronaire
B. Une ATC primaire avec mise en place d'un stent nu car il s'agit d'une patiente sous AVK
C. Une ATC primaire avec mise en place d'un stent actif car il s'agit de l'IVA proximale
D. La voie d'abord fémorale est préférée
E. Ne rien faire

Réponse B

Le traitement antithrombotique consiste en:

A. Une association d'un traitement anticoagulant à une double antiagrégation plaquettaire pendant 1 mois en cas d'ATC avec stent nu

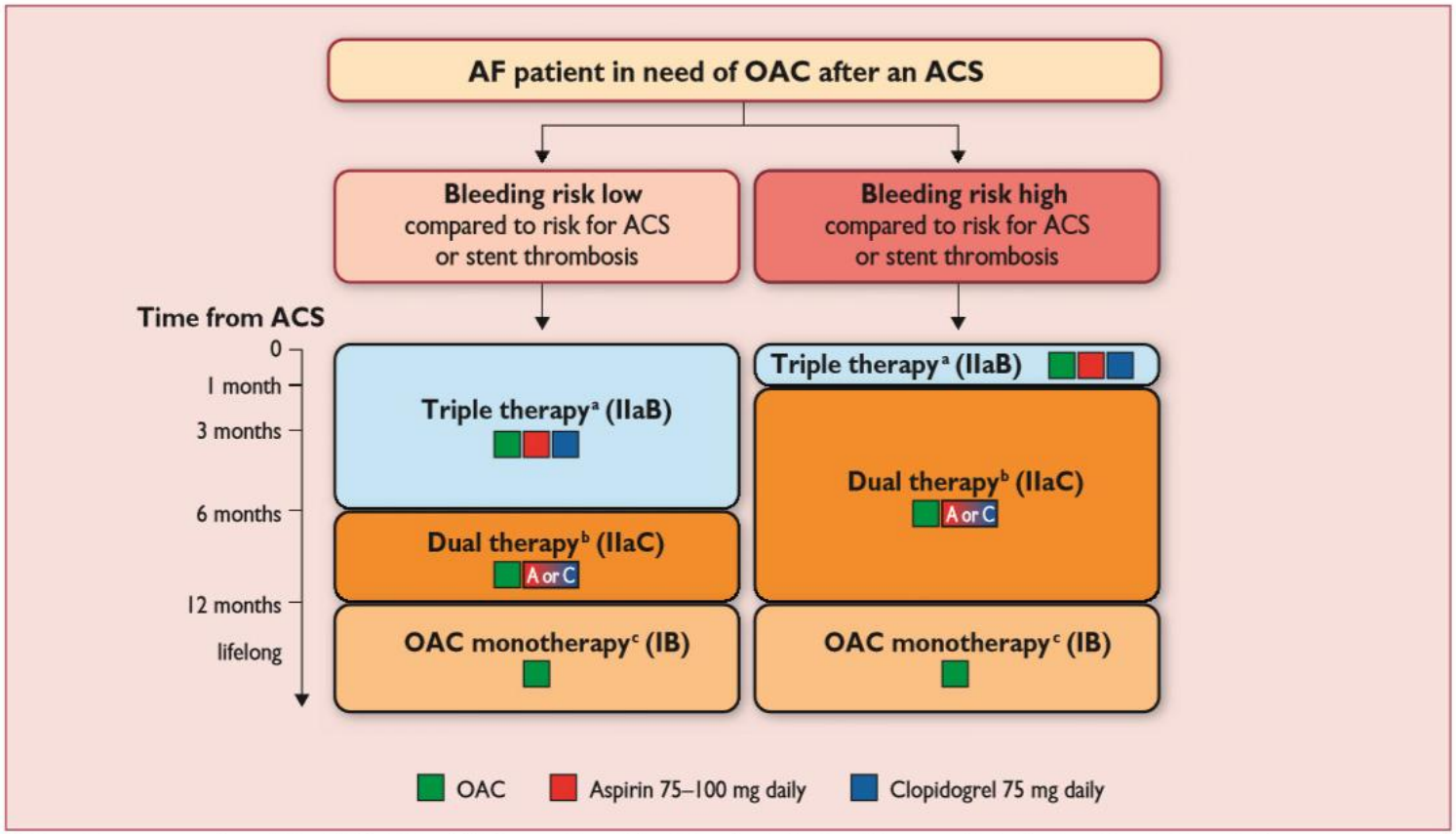
B. Une association d'un ttt anticoagulant à une double antiagrégation plaquettaire pendant 6 mois en cas d'ATC avec stent actif

C. La triple thérapie est à éviter car le risque hémorragique élevé

D. Au delà de 6 mois, seul un traitement anticoagulant à long cours est indiqué

E. Au-delà de 12 mois, seul un antiagrégangt à long cours est indiqué

Réponse A



ACS = acute coronary syndrome; AF = atrial fibrillation; OAC = oral anticoagulation (using vitamin K antagonists or non-vitamin K antagonist oral anticoagulants); PCI = percutaneous coronary intervention.

[a]Dual therapy with OAC and aspirin or clopidogrel may be considered in selected patients, especially those not receiving a stent or patients at a longer time from the index event.

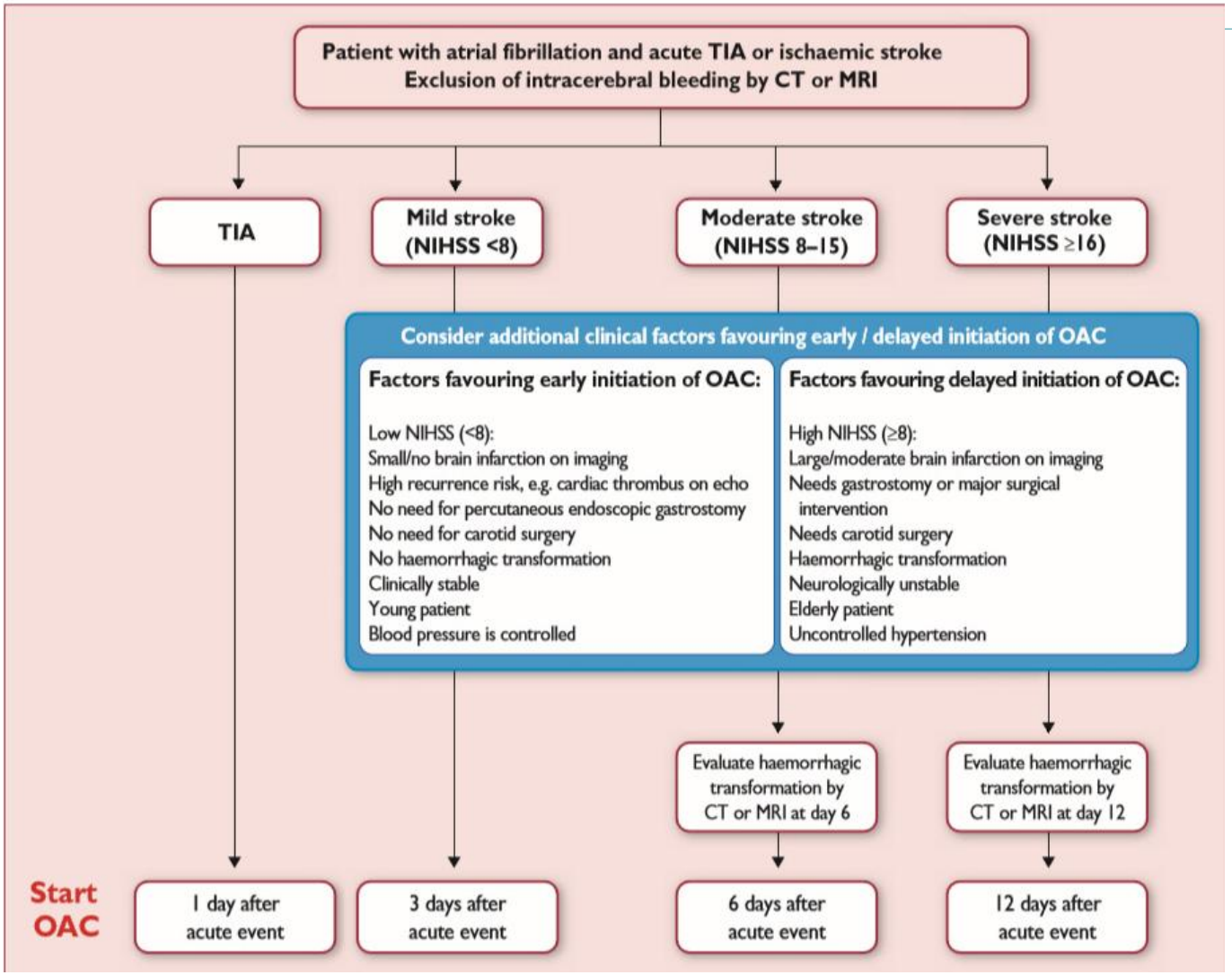
[b]OAC plus single antiplatelet.

[c]Dual therapy with OAC and an antiplatelet agent (aspirin or clopidogrel) may be considered in patients at high risk of coronary events.

Après un suivi de 48 mois, stable sur le plan coronarien, INR est labile, AVC ischémique

A. Indication légitime à une exclusion de l'auricule
B. Le traitement AVK doit être arrêté en urgence et remplacé par une héparine
C. Tout traitement anticoagulant doit être arrêté en urgence et remplacé par un antiagrégant
D. Seul un traitement antiagrégant sera proposé à long cours
E. Le traitement anticoagulant sera impérativement repris 6 à 12 jours après l'AVC

Réponse E


Patient with atrial fibrillation and acute TIA or ischaemic stroke
Exclusion of intracerebral bleeding by CT or MRI
TIA
Mild stroke (NIHSS <8)
Moderate stroke (NIHSS 8–15)
Severe stroke (NIHSS ≥16)
Consider additional clinical factors favouring early / delayed initiation of OAC
Factors favouring early initiation of OAC:
Low NIHSS (<8):
Small/no brain infarction on imaging
High recurrence risk, e.g. cardiac thrombus on echo
No need for percutaneous endoscopic gastrostomy
No need for carotid surgery
No haemorrhagic transformation
Clinically stable
Young patient
Blood pressure is controlled
Factors favouring delayed initiation of OAC:
High NIHSS (≥8):
Large/moderate brain infarction on imaging
Needs gastrostomy or major surgical intervention
Needs carotid surgery
Haemorrhagic transformation
Neurologically unstable
Elderly patient
Uncontrolled hypertension
Evaluate haemorrhagic transformation by CT or MRI at day 6
Evaluate haemorrhagic transformation by CT or MRI at day 12
Start OAC
1 day after acute event
3 days after acute event
6 days after acute event
12 days after acute event

Recommendations for secondary stroke prevention

Recommendations	Class[a]	Level[b]	Ref[c]
Anticoagulation with heparin or LMWH immediately after an ischaemic stroke is not recommended in AF patients.	III (harm)	A	477
In patients who suffer a TIA or stroke while on anticoagulation, adherence to therapy should be assessed and optimized.	IIa	C	
In patients who suffer a moderate-to-severe ischaemic stroke while on anticoagulation, anticoagulation should be interrupted for 3–12 days based on a multidisciplinary assessment of acute stroke and bleeding risk.	IIa	C	
In AF patients who suffer a stroke, aspirin should be considered for prevention of secondary stroke until the initiation or resumption of oral anticoagulation.	IIa	B	485
Systemic thrombolysis with rtPA is not recommended if the INR is above 1.7 (or, for patients on dabigatran, if aPTT is outside normal range).	III (harm)	C	472, 474
NOACs are recommended in preference to VKAs or aspirin in AF patients with a previous stroke.	I	B	363,482
After TIA or stroke, combination therapy of OAC and an antiplatelet is not recommended.	III (harm)	B	486
After intracranial haemorrhage, oral anticoagulation in patients with AF may be reinitiated after 4–8 weeks provided the cause of bleeding or the relevant risk factor has been treated or controlled.	IIb	B	483, 484, 487

Recommendations for occlusion or exclusion of the left atrial appendage

Recommendations	Class[a]	Level[b]	Ref[c]
After surgical occlusion or exclusion of the LAA, it is recommended to continue anticoagulation in at-risk patients with AF for stroke prevention.	I	B	461, 462
LAA occlusion may be considered for stroke prevention in patients with AF and contra-indications for long-term anticoagulant treatment (e.g. those with a previous life-threatening bleed without a reversible cause).	IIb	B	449, 453, 454
Surgical occlusion or exclusion of the LAA may be considered for stroke prevention in patients with AF undergoing cardiac surgery.	IIb	B	463
Surgical occlusion or exclusion of the LAA may be considered for stroke prevention in patients undergoing thoracoscopic AF surgery.	IIb	B	468

The ideal patient

- 30-55 years
- Highly symptomatic, frequent episodes
- Paroxysmal or short persistend AF

- No structural heart disease
- No comorbidity
- Motivated

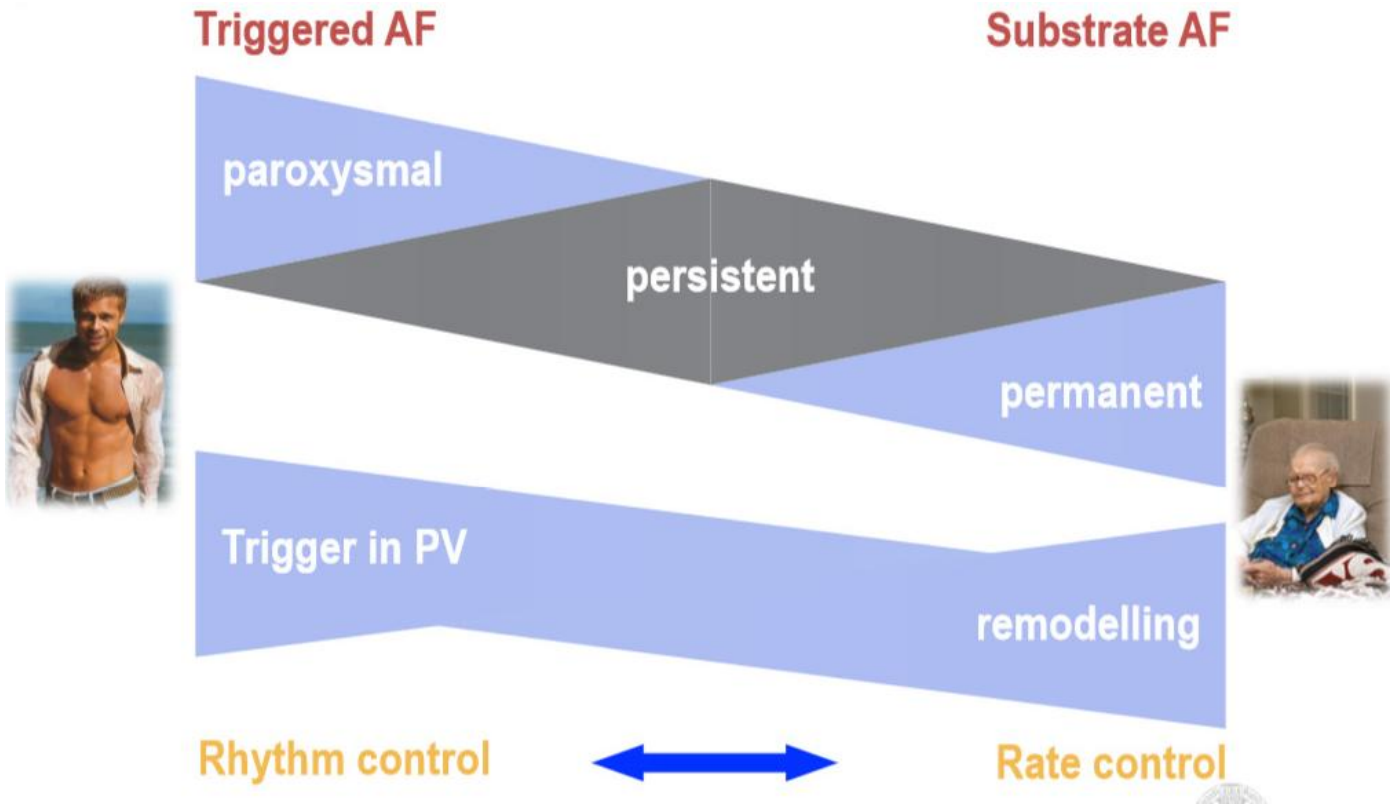
The real challenging patient

The less-than-ideal patient

- >70 years
- Permanent AF
- Significant structural heart disease
- CAD, Valve disease, heart failure

- Significant comorbidity
  - COPD
  - Renal insufficiency

Selection des patients



Electrical disease

Systemic disease

Conclusion, Nos maillons faibles …….

- **Pas de Registre National pour avoir nos données épidémiologiques et évaluer notre façon de prendre en charge la fibrillation auriculaire !!!!**
- **Seul Sintrom comme AVK !!!**
- **Pas d'Anticoagulants Oraux Directs !!**
- **Les difficultés à diffuser l'ablation par RF de la FA !**