Revisión de Guía para el manejo de la FA 2024 de la ESC.

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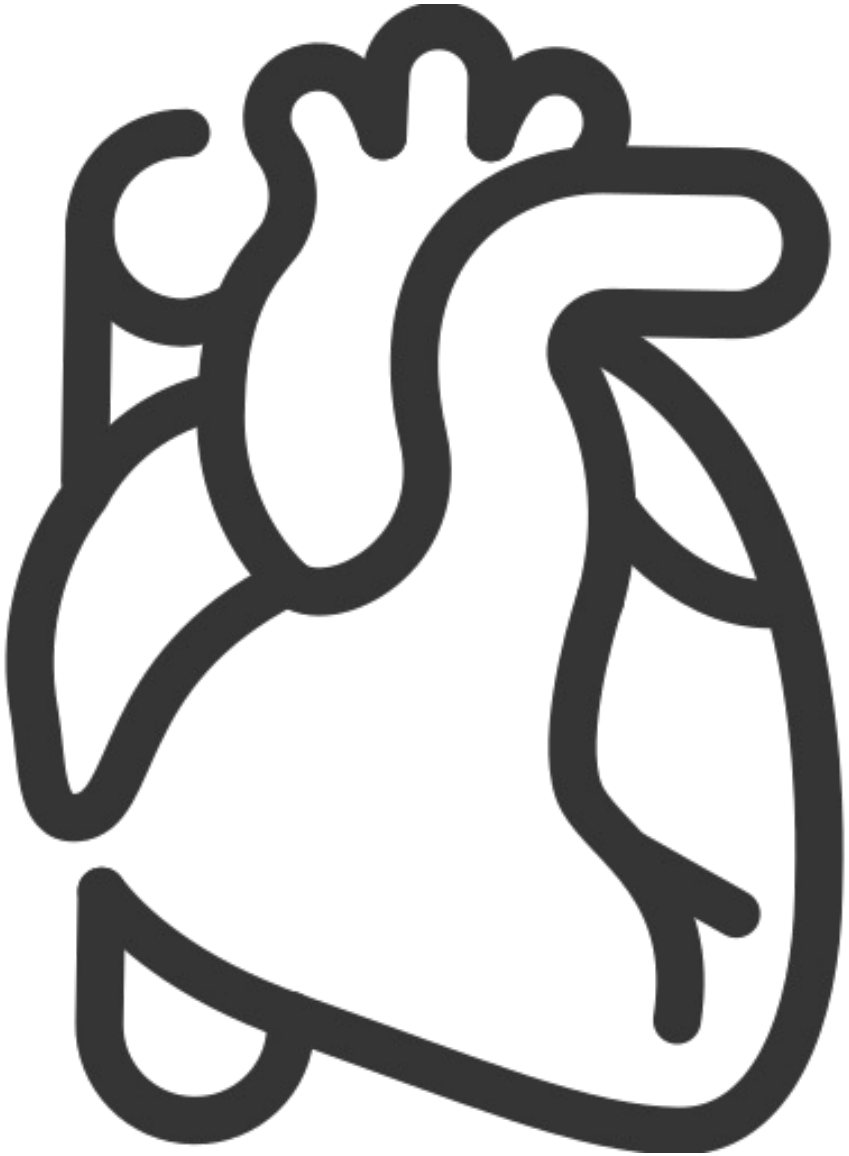
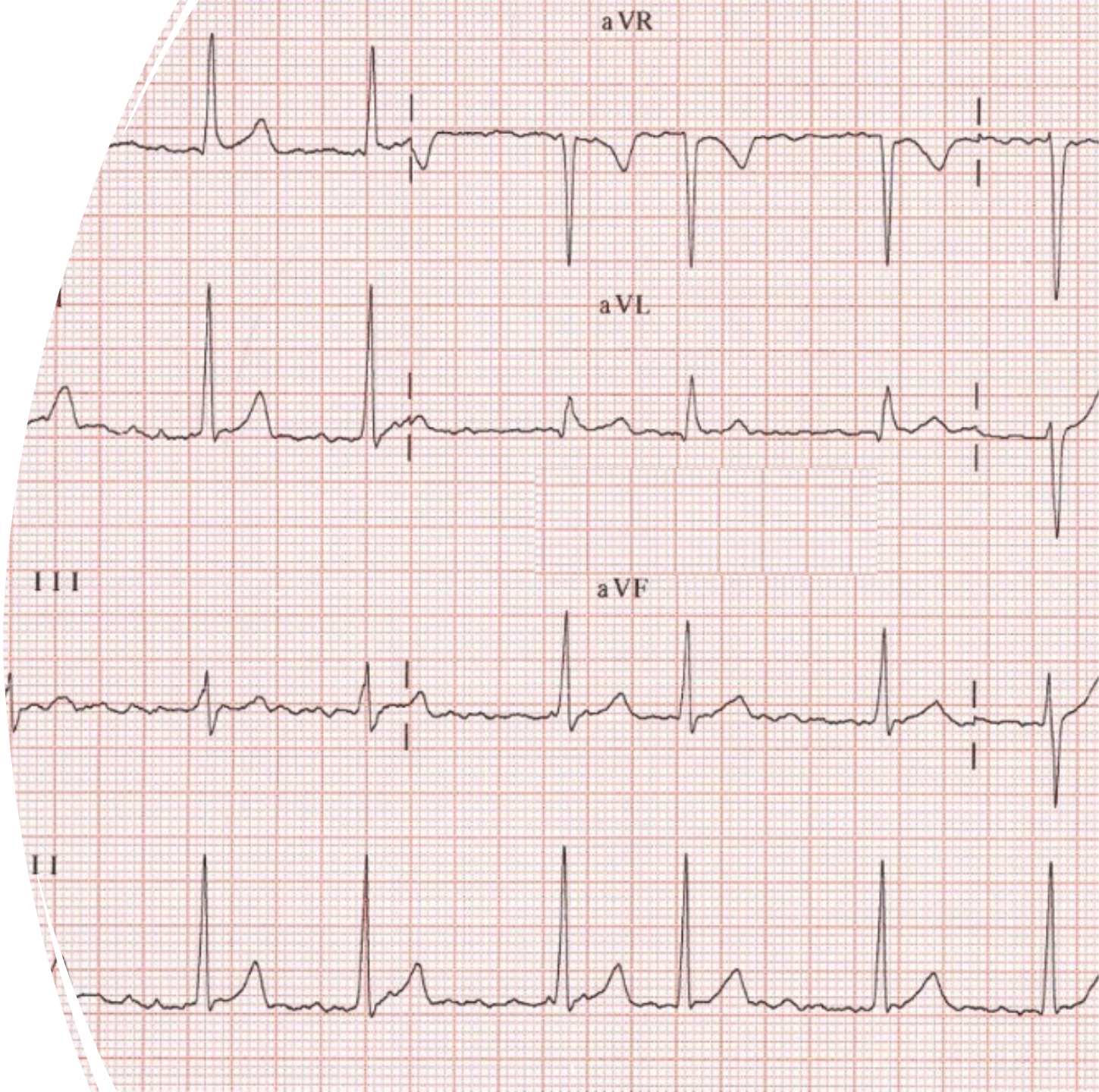
FIBRILACIÓN AURICULAR

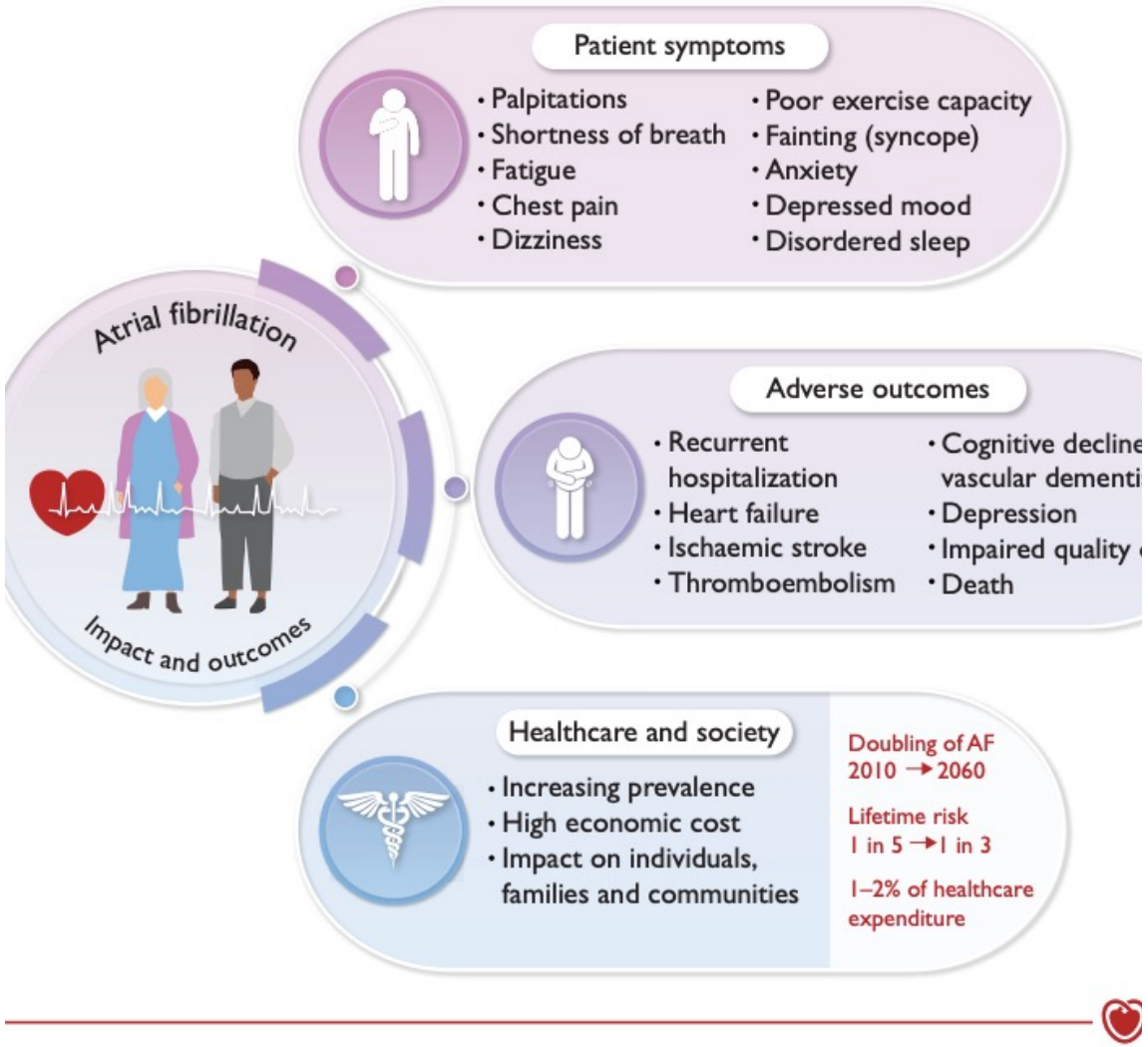


1. Introducción

- Arritmia crónica sostenida más frecuente en el mundo.
- Mecanismo: reentrada.
- ECG: ausencia de ondas P (ondas f), intervalo R-R irregular.
- <u>Tipos</u>:
  - Paroxística: <7 días.
  - Persistente: >7 días.
  - Permanente: no se cardiovierte ni se intenta hacerlo (control de FC).
- Burden: influye en riesgo de isquemia



- Factores de riesgo: edad, OH, tabaco, HTA, IC, EM, nodo sinusal enfermo, otros FRCV…
- Clínica: No específica.
- Complicaciones: Duplica riesgo de mortalidad CV y por cualquier causa.
- Prevención: manejo FRCV.



- Diagnóstico: >10 s en 12D ; >30s en 1D.
- Screening:
  - Síntomas/SmartWatch: ECG.
  - >65 a: auscultar/tomar pulso.
  - Resto: no efectivo.

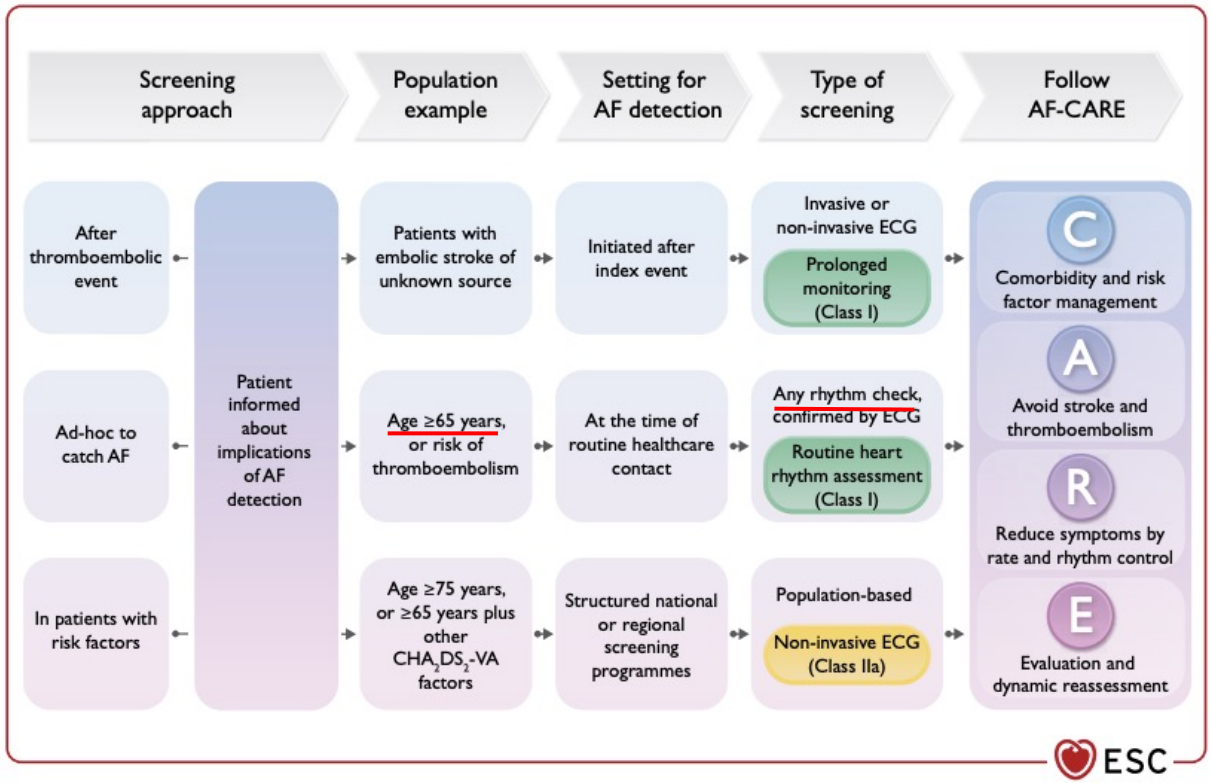


Table 6 Other clinical concepts relevant to AF

Clinical concept	Definition
Clinical AF	Symptomatic or asymptomatic AF that is clearly documented by an ECG (12-lead ECG or other ECG devices). The minimum duration to establish the diagnosis of clinical AF for ambulatory ECG is not clear and depends on the clinical context. Periods of 30 s or more may indicate clinical concern, and trigger further monitoring or risk stratification for thromboembolism.
Device-detected subclinical AF	Device-detected subclinical AF refers to asymptomatic episodes of AF detected on continuous monitoring devices. These devices include implanted cardiac electronic devices, for which most atrial high-rate episodes[a] may be AF, as well as consumer-based wearable monitors. Confirmation is needed by a competent professional reviewing intracardiac electrograms or an ECG-recorded rhythm.[5,6] Device-detected subclinical AF is a predictor of future clinical AF.[7]

Continued

2. Cambios principales

- Modelo de manejo: ABC→**AF-CARE**
- Determinación del riesgo embólico: CHA2DS2-VA**Sc**→**CHA2DS2-VA**.

ESC European Society of Cardiology
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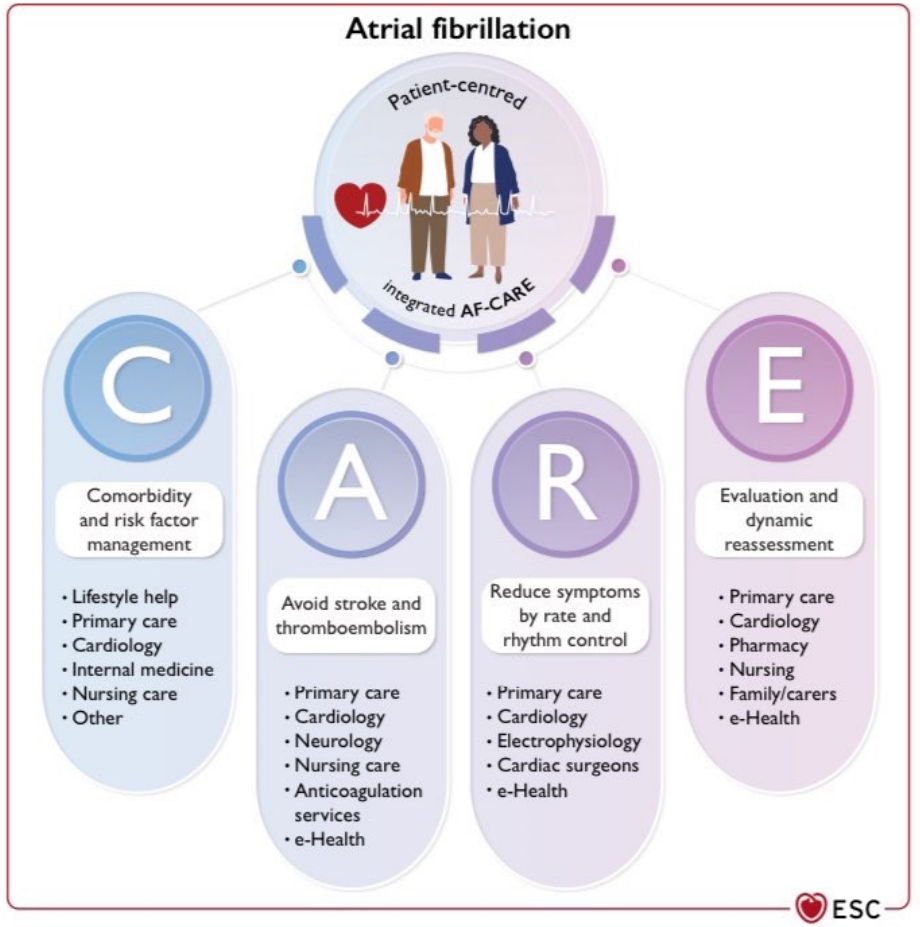
ESC GUIDELINES

2024 ESC Guidelines for the management of atrial fibrillation developed in collaboration with the European Association for Cardio-Thoracic Surgery (EACTS)

Developed by the task force for the management of atrial fibrillation of the European Society of Cardiology (ESC), with the special contribution of the European Heart Rhythm Association (EHRA) of the ESC.
Endorsed by the European Stroke Organisation (ESO)

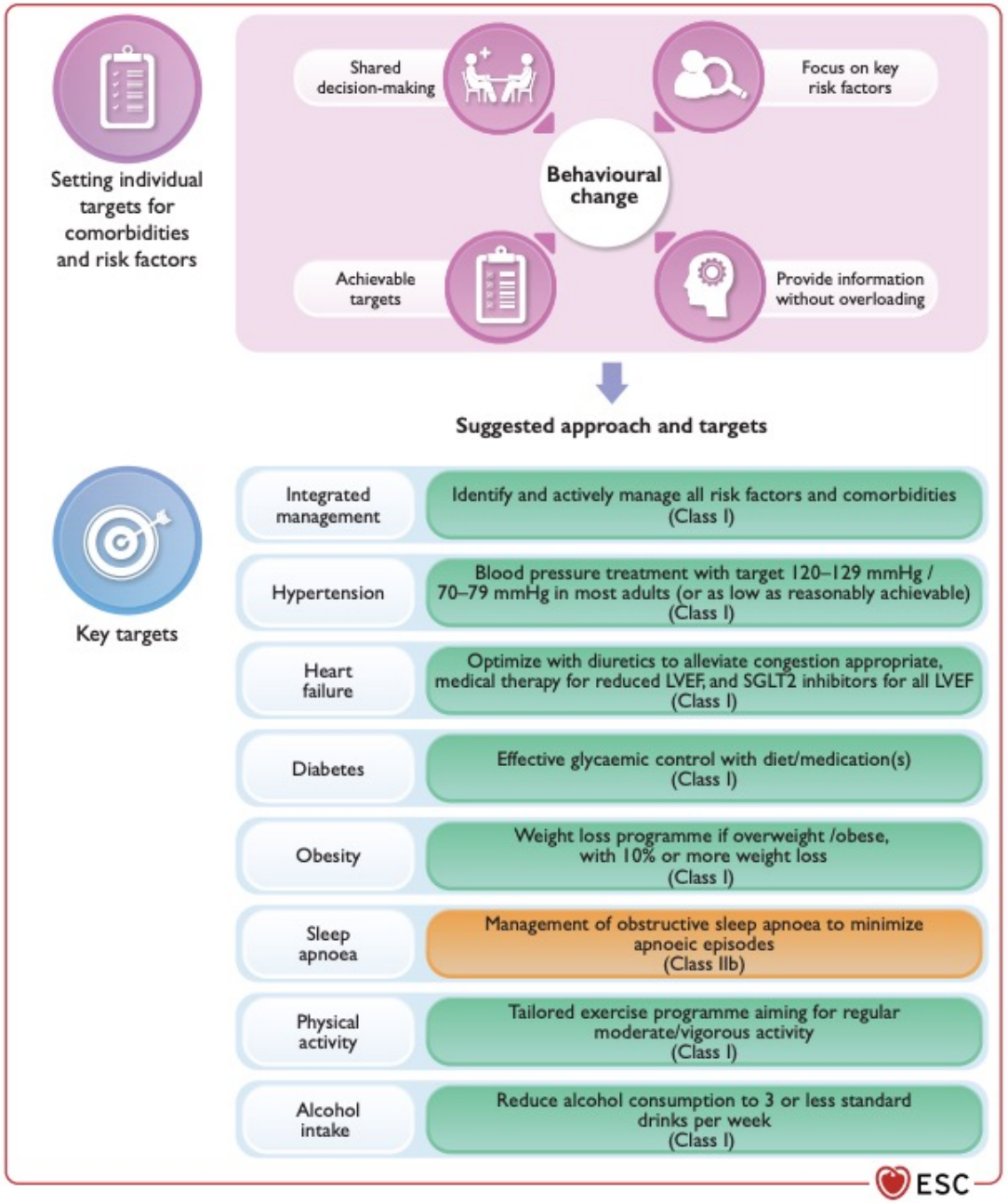
3. AF-CARE

- Enfoque más integral. Más lógica temporal.
- **C**: Comorbilidades.
- **A**: Anticoagulación.
- **R**: Reducir síntomas (estrategia ritmo vs frecuencia).
- **E**: Evaluación.
- Abordaje multidisciplinar.



AF-CARE

- Factores favorecedores que hay que identificar y sobre los que intervenir desde el primer momento.
- HTA: IECA/ARA-II para ↓ remodelado.
- IC: círculo vicioso.



AF-CARE

- Score riesgo trombótico: CHA2DS-VA (Sc)
  - Sexo femenino factor confusor.
  - Importante reevaluar el riesgo.
- Solo antiagregantes si otra indicación.

Table 10 Updated definitions for the CHA_2DS_2-VA score

CHA_2DS_2-VA component		Definition and comments	Points awarded[a]
C	Chronic heart failure	Symptoms and signs of heart failure (irrespective of LVEF, thus including HFpEF, HFmrEF, and HFrEF), or the presence of asymptomatic LVEF ≤40%.[261–263]	1
H	Hypertension	Resting blood pressure >140/90 mmHg on at least two occasions, or current antihypertensive treatment. The optimal BP target associated with lowest risk of major cardiovascular events is 120–129/70–79 mmHg (or keep as low as reasonably achievable).[162,264]	1
A	Age 75 years or above	Age is an independent determinant of ischaemic stroke risk.[265] Age-related risk is a continuum, but for reasons of practicality, two points are given for age ≥75 years.	2
D	Diabetes mellitus	Diabetes mellitus (type 1 or type 2), as defined by currently accepted criteria,[266] or treatment with glucose lowering therapy.	1
S	Prior stroke, TIA, or arterial thromboembolism	Previous thromboembolism is associated with highly elevated risk of recurrence and therefore weighted 2 points.	2
V	Vascular disease	Coronary artery disease, including prior myocardial infarction, angina, history of coronary revascularization (surgical or percutaneous), and significant CAD on angiography or cardiac imaging.[267] OR Peripheral vascular disease, including: intermittent claudication, previous revascularization for PVD, percutaneous or surgical intervention on the abdominal aorta, and complex aortic plaque on imaging (defined as features of mobility, ulceration, pedunculation, or thickness ≥4 mm).[268,269]	1
A	Age 65–74 years	1 point is given for age between 65 and 74 years.	1

¿Por qué no tener en cuenta el sexo femenino?

Key Question

Should gender be used in current clinical practice to decide which patients with atrial fibrillation (AF) need oral anticoagulation?

Key Finding

Women had a lower rate of the composite of death, stroke and embolism, and no difference compared to men for stroke/embolism or vascular dementia, after accounting for confounding factors.

Take Home Message

Removal of gender from risk stratification in AF could simplify the identification of patients who should be offered oral anticoagulation.

Impact of gender on the contemporary risk of adverse events in patients with atrial fibrillation

Study design and population

Population-based cohort study using routine healthcare records

16 587 749 primary care patients (2005–2020)

290 525 with AF aged 40–75

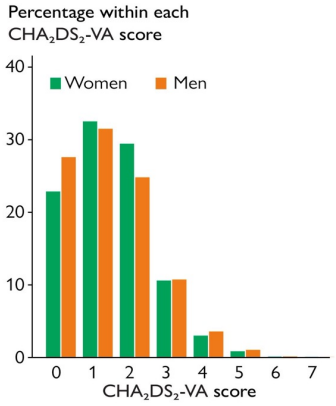
78 852 no prior stroke and not on anticoagulation

66 Median age

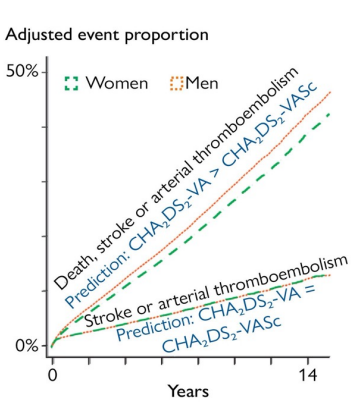
36% Women

1.38 Mean CHA_2DS_2-VA

Distribution of risk factors



Outcomes



Female sex as a risk factor for atrial fibrillation-related stroke: contemporary insights and clinical implications

Data from past decades

- Female sex was associated with 20–40% higher ischaemic stroke risk in patients with AF; hence, CHA_2DS_2-VASc score used for stroke risk stratification
- Underuse of oral anticoagulation was common particularly in women

Ischaemic stroke rate (per 1000 patient-years)

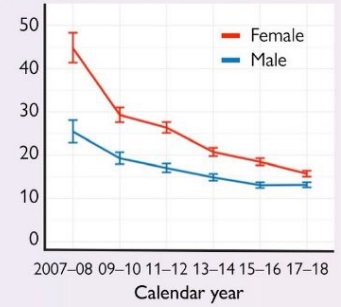
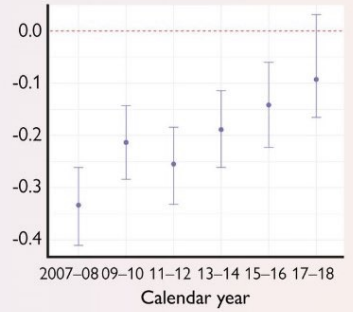


Figure showing the decline in crude stroke rates in patients with AF from 2007 to 2018 (From Teppo et al. EHJ 2024)

Contemporary data

- Overall stroke rates have decreased over time
- Female sex is now non-significantly associated with increased stroke risk in AF
- Sex disparities in the use of oral anticoagulation have decreased over time
- No significant difference in CHA_2DS_2-VASc and CHA_2DS_2-VA score for stroke risk stratification in recent years

Net reclassification index

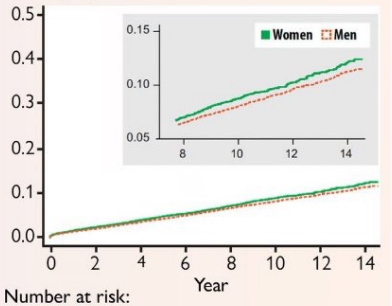


Trends of continuous net reclassification indices comparing the CHA_2DS_2-VA and CHA_2DS_2-VASc scores in predicting stroke. *Values below the red reference line favour the CHA_2DS_2-VASc score.* (From Teppo, Lip et al. Lancet Regional Health Europe 2024)

Clinical implications

- Use of the non-sex CHA_2DS_2-VASc (i.e. CHA_2DS_2-VA) score could potentially simplify the decision-making for stroke prevention in patients with AF

Event proportion



Number at risk:

♀	28 590	21 327	15 728	11 072	7408	4286	2252	1065
♂	50 262	37 035	26 926	18 796	12 374	7212	3593	1661

Kaplan-Meier curves of ischaemic stroke or arterial thromboembolism in patients with AF under 75 years without prior stroke, comparing CHD-VASc and CHD-VA scores. (From the EHJ article by Champsi et al. that forms the basis of this editorial)

Recommendation Table 6 — Recommendations to assess and manage thromboembolic risk in AF (see also Evidence Table 6)

Recommendations	Class[a]	Level[b]
Oral anticoagulation is recommended in patients with clinical AF at elevated thromboembolic risk to prevent ischaemic stroke and thromboembolism.[239,240]	I	A
A CHA_2DS_2-VA score of 2 or more is recommended as an indicator of elevated thromboembolic risk for decisions on initiating oral anticoagulation.	I	C
Oral anticoagulation is recommended in all patients with AF and hypertrophic cardiomyopathy or cardiac amyloidosis, regardless of CHA_2DS_2-VA score, to prevent ischaemic stroke and thromboembolism.[270–276]	I	B
Individualized reassessment of thromboembolic risk is recommended at periodic intervals in patients with AF to ensure anticoagulation is started in appropriate patients.[277–280]	I	B
A CHA_2DS_2-VA score of 1 should be considered an indicator of elevated thromboembolic risk for decisions on initiating oral anticoagulation.	IIa	C
Direct oral anticoagulant therapy may be considered in patients with asymptomatic device-detected subclinical AF and elevated thromboembolic risk to prevent ischaemic stroke and thromboembolism, excluding patients at high risk of bleeding.[281,282]	IIb	B
Antiplatelet therapy is not recommended as an alternative to anticoagulation in patients with AF to prevent ischaemic stroke and thromboembolism.[242,283]	III	A
Using the temporal pattern of clinical AF (paroxysmal, persistent, or permanent) is not recommended to determine the need for oral anticoagulation.[284,285]	III	B

Continued

Puntuación CHA2DS2-VA:
-2 o más: Anticoagular
-1: Considerar (++)

MCH/AA+FA: siempre
EM/VP+FA: siempre

ACOD	Antagonistas vitamina K
Preferencia si no hay CI. No inferiores o superiores a sintrom. Menor sangrado intracraneal, pero más sangrado clínicamente relevante no mayor. Sin dosis de carga.	Preferido en EM mod-severa/válvulas mecánicas. INR 2-3 (mitral mecánica 2,5-3,5). Considerar cambiar a ACOD (a no ser que >75 a con buen control).

Recommendation Table 7 — Recommendations for oral anticoagulation in AF (see also Evidence Table 7)

Recommendations	Class[a]	Level[b]
Direct oral anticoagulants are recommended in preference to VKAs to prevent ischaemic stroke and thromboembolism, except in patients with mechanical heart valves or moderate-to-severe mitral stenosis.[25–28,292–294]	I	A
A target INR of 2.0–3.0 is recommended for patients with AF prescribed a VKA for stroke prevention to ensure safety and effectiveness.[295–298]	I	B

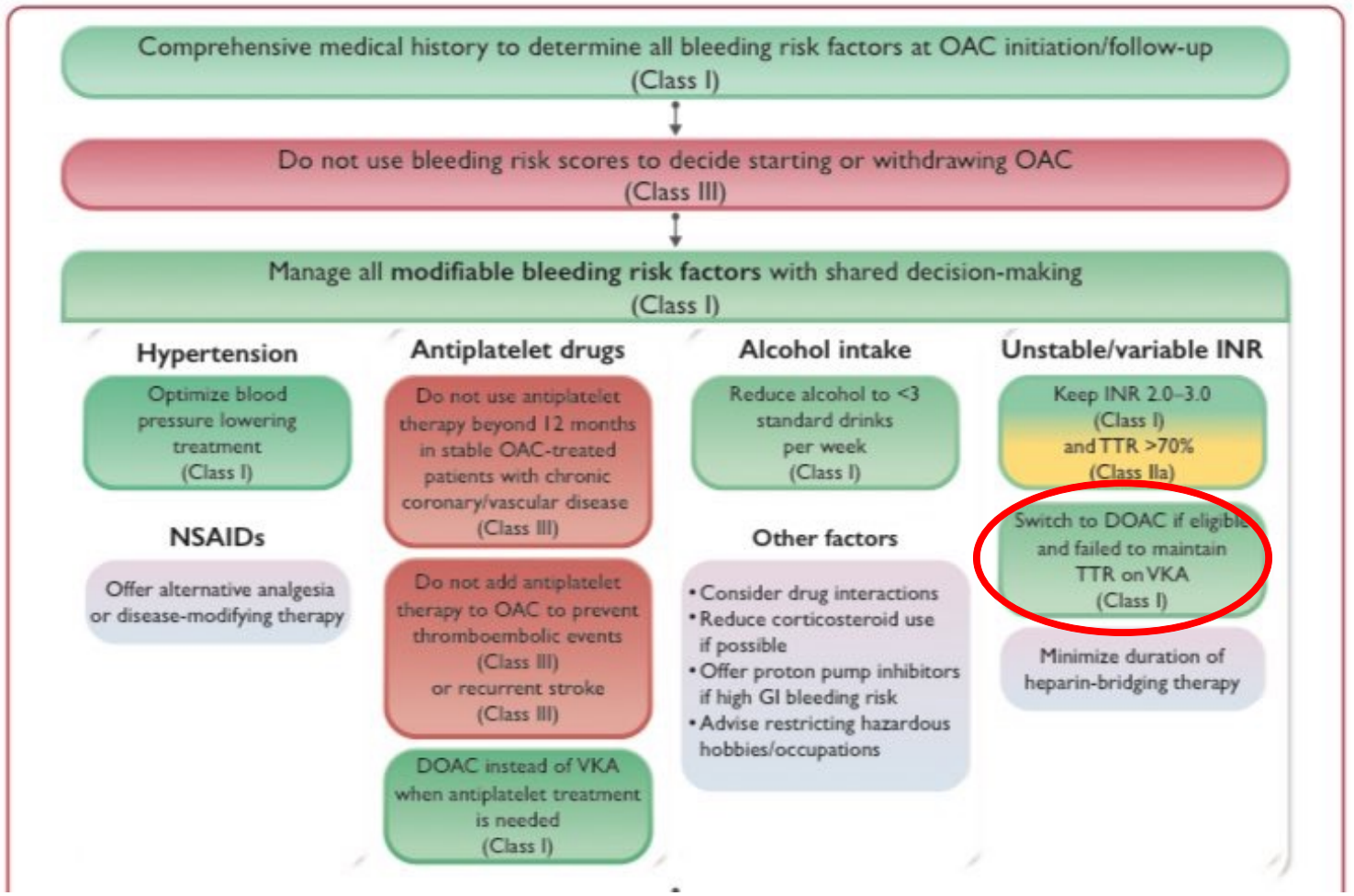
Riesgo de sangrado:

NEW

No recomendado uso de escalas (HAS-BLED).

Corregir factores de sangrado modificables.

Si contraindicación para anticoagulantes considerar cierre orejuela.



Recurrencia pese a ACO

- Solo el 20-30% de FA que sufren ACV están correctamente anticoagulados.
- NO CAMBIAR DE ACOD NI ASOCIAR ANTIAGREGANTES.
- Buscar causas secundarias: adherencia, FRCV, causas no cardioembólicas… Considerar toma de niveles.

Recommendation Table 9 — Recommendations for thromboembolism despite anticoagulation (see also Evidence Table 9)

Recommendation	Class[a]	Level[b]
A thorough diagnostic work-up should be considered in patients taking an oral anticoagulant and presenting with ischaemic stroke or thromboembolism to prevent recurrent events, including assessment of non-cardioembolic causes, vascular risk factors, dosage, and adherence.[356,357]	IIa	B
Adding antiplatelet treatment to anticoagulation is not recommended in patients with AF to prevent recurrent embolic stroke.[356,359]	III	B
Switching from one DOAC to another, or from a DOAC to a VKA, without a clear indication is not recommended in patients with AF to prevent recurrent embolic stroke.[252,356,359]	III	B

Factores que facilitan sangrado

- Dosis inapropiada: 12-40% (infradosificación>sobredosificación).
- Riesgo ictus > Riesgo sangrado.
- Pacientes frágiles→tendencia a infradosificar (TA, peso, FG).
- Dabigatrán aumenta sangrado mayor extracraneal en >80 años.
- Baja adherencia al no dar síntomas→educación sanitaria.



Table 11 **Recommended doses for direct oral anticoagulant therapy**

DOAC	Standard full dose	Criteria for dose reduction	Reduced dose only if criteria met
Apixaban	5 mg twice daily	Two out of three needed for dose reduction: (i) age ≥80 years (ii) body weight ≤60 kg (iii) serum creatinine ≥133 mmol/L.	2.5 mg twice daily
Dabigatran	150 mg twice daily	Dose reduction recommended if any apply: (i) age ≥80 years (ii) receiving concomitant verapamil. Dose reduction considered on an individual basis if any apply: (i) age 75–80 (ii) moderate renal impairment (creatinine clearance 30–50 mL/min) (iii) patients with gastritis, oesophagitis, or gastro-oesophageal reflux (iv) others at increased risk of bleeding.	110 mg twice daily
Edoxaban	60 mg once daily	Dose reduction if any apply: (i) moderate or severe renal impairment (creatinine clearance 15–50 mL/min) (ii) body weight ≤60 kg (iii) concomitant use of ciclosporin, dronedarone, erythromycin, or ketoconazole.	30 mg once daily
Rivaroxaban	20 mg once daily	Creatinine clearance 15–49 mL/min.	15 mg once daily

Pacientes frágiles

La causa principal de no tratamiento/infratratamiento: riesgo de caídas/síncope. Rara vez esto es contraindicación.

Otras razones: percepción de fragilidad, anemia.

En pacientes >75 años, mayor riesgo de ictus que de sangrado a 5 años.

El ictus implica mayor riesgo de incapacidad: el riesgo de sangrado casi nunca contraindica ACO.

AF-CARE

CONTROL DE FRECUENCIA	CONTROL DE RITMO
Objetivo: FC<110 lpm (solo inferior si síntomas o si IC→FC<80 lpm) **FEVIr**→BB ; Digoxina ; Amiodarona **FEVI>40%**→BB/CA ; Digoxina ; Amiodarona Si refractario: **ablación NAV + MCP**	**CVE**: si inestabilidad. **Antiarrítmicos**: clase IC (Flecainida, propafenona, vernakalant), sotalol. Si cardiopatía estructural (IC): amiodarona. **Ablación VVPP**: si refractario (+FA paroxística/IC FEVIr)

NO EXCLUYENTES

NO RECOMENDACIONES

Ancianos

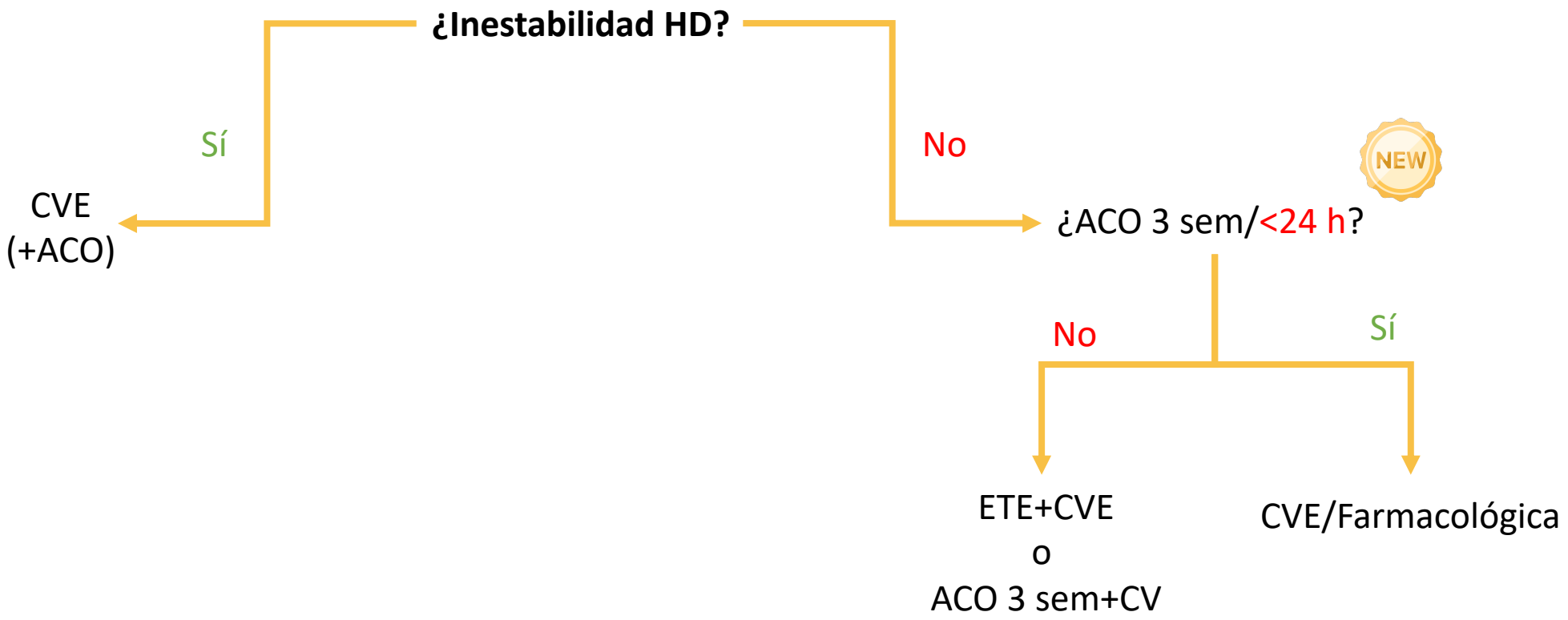
Asintomáticos

FA recién dx en jóvenes (<12 m)

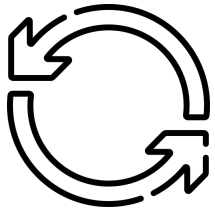
Sintomáticos

ESTRATEGIA DE CONTROL DE RITMO

Siempre asociada a control FC (no al revés)



AF-CARE



E Evaluation and dynamic reassessment

Re-evaluate when AF episodes or non-AF admissions

Regular re-evaluation: 6 months after presentation, and then at least annually or based on clinical need

ECG, blood tests, cardiac imaging, ambulatory ECG, other imaging as needed	Assess new and existing risk factors and comorbidities (Class I)	Stratify risk for stroke and thromboembolism (Class I)	Check impact of AF symptoms before and after treatment (Class I)	Assess and manage modifiable bleeding risk factors (Class I)	Continue OAC despite rhythm control if risk of thromboembolism (Class I)

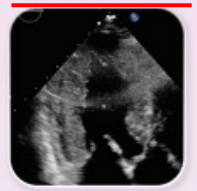
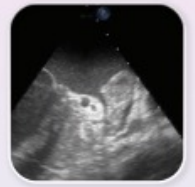
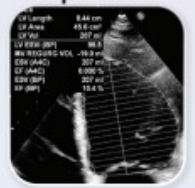
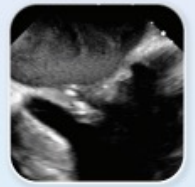
C

A

R

4. Papel del ecocardiograma

REALIZAR EN TODAS LAS FA !

AF-CARE pathway	Objective for imaging	Assessment	Example of pathology
C Comorbidity and risk factor management	To identify comorbidities which are associated with recurrence and progression of AF	Left ventricular ejection fraction, wall motion abnormalities, diastolic indices, right ventricular function and left ventricular hypertrophy to determine subtype and aetiology of heart failure Detection of pericardial fluid or pericardial disease Detection of valvular disease	Cardiac amyloid 
A Avoid stroke and thromboembolism	To determine stroke risk, choice of anticoagulant drug and ensure safety for cardioversion	Detection of heart failure for CHA_2DS_2-VA score Detection of moderate-severe mitral stenosis to determine choice of anticoagulation Transoesophageal echocardiogram for left atrial appendage assessment to exclude thrombus prior to cardioversion	Clot in LAA 
R Reduce symptoms by rate and rhythm control	To determine optimal choice of rate and rhythm control strategy and likely success of ablation	Left ventricular ejection fraction to determine choice of rate control Severity of valvular disease to determine choice of rhythm control Left ventricular size and function to determine choice of rhythm control Left atrial size and function to determine risk of arrhythmia recurrence following ablation	Severe LV impairment 
E Evaluation and dynamic reassessment	To detect changes in the patient's heart structure and function which would affect their management plan	Reassess known valve disease for increase in severity Reassess left ventricular size and function if there is a change in the patient's clinical status or symptoms	Mixed mitral valve disease 

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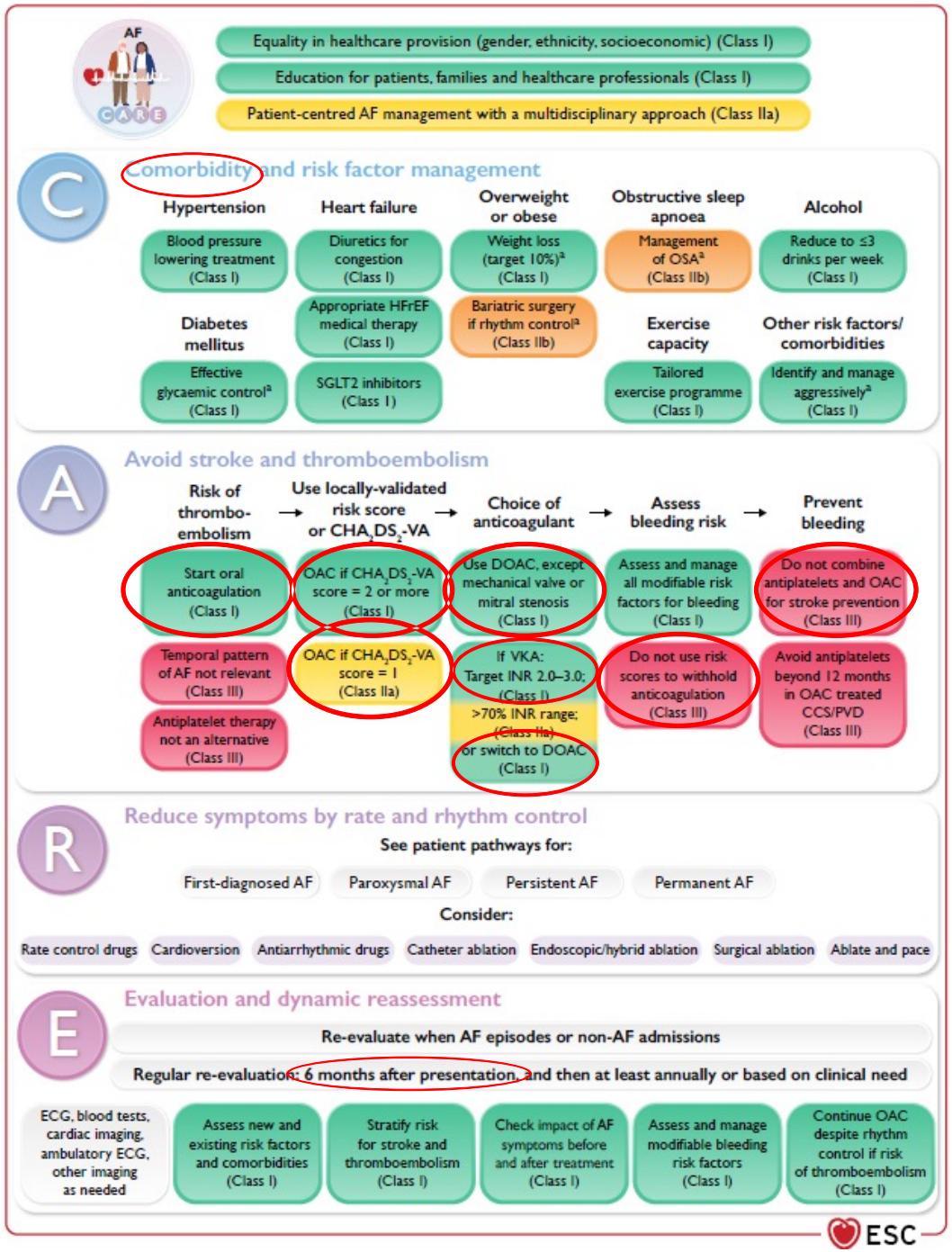
AF CARE
Equality in healthcare provision (gender, ethnicity, socioeconomic) (Class I)
Education for patients, families and healthcare professionals (Class I)
Patient-centred AF management with a multidisciplinary approach (Class IIa)
C
Comorbidity and risk factor management
Hypertension
Blood pressure lowering treatment (Class I)
Heart failure
Diuretics for congestion (Class I)
Appropriate HFrEF medical therapy (Class I)
Overweight or obese
Weight loss (target 10%)[a] (Class I)
Bariatric surgery if rhythm control[a] (Class IIb)
Obstructive sleep apnoea
Management of OSA[a] (Class IIb)
Alcohol
Reduce to ≤3 drinks per week (Class I)
Diabetes mellitus
Effective glycaemic control[a] (Class I)
SGLT2 inhibitors (Class I)
Exercise capacity
Tailored exercise programme (Class I)
Other risk factors/ comorbidities
Identify and manage aggressively[a] (Class I)
A
Avoid stroke and thromboembolism
Risk of thrombo-embolism
Use locally-validated risk score or CHA2DS2-VA
Choice of anticoagulant
Assess bleeding risk
Prevent bleeding
Start oral anticoagulation (Class I)
Temporal pattern of AF not relevant (Class III)
Antiplatelet therapy not an alternative (Class III)
OAC if CHA2DS2-VA score = 2 or more (Class I)
OAC if CHA2DS2-VA score = 1 (Class IIa)
Use DOAC, except mechanical valve or mitral stenosis (Class I)
If VKA: Target INR 2.0–3.0; (Class I)
>70% INR range; (Class IIa)
or switch to DOAC (Class I)
Assess and manage all modifiable risk factors for bleeding (Class I)
Do not use risk scores to withhold anticoagulation (Class III)
Do not combine antiplatelets and OAC for stroke prevention (Class III)
Avoid antiplatelets beyond 12 months in OAC treated CCS/PVD (Class III)
R
Reduce symptoms by rate and rhythm control
See patient pathways for:
First-diagnosed AF
Paroxysmal AF
Persistent AF
Permanent AF
Consider:
Rate control drugs
Cardioversion
Antiarrhythmic drugs
Catheter ablation
Endoscopic/hybrid ablation
Surgical ablation
Ablate and pace
E
Evaluation and dynamic reassessment
Re-evaluate when AF episodes or non-AF admissions
Regular re-evaluation: 6 months after presentation, and then at least annually or based on clinical need
ECG, blood tests, cardiac imaging, ambulatory ECG, other imaging as needed
Assess new and existing risk factors and comorbidities (Class I)
Stratify risk for stroke and thromboembolism (Class I)
Check impact of AF symptoms before and after treatment (Class I)
Assess and manage modifiable bleeding risk factors (Class I)
Continue OAC despite rhythm control if risk of thromboembolism (Class I)
ESC

5. CONCLUSIONES

La mayoría de ictus en pacientes con FA son evitables.

- Clasificación temporal: paroxística, persistente, permanente.
- Cada contacto con >65 a: pulso/auscultar.
- Nuevo enfoque: ABC→AF-**CARE** (visión integral).
- **ACOD**>Ant. Vit K (salvo CI).
- **CHA2DS2-VA**: ya no tiene en cuenta el sexo femenino.
- Si 2 o más puntos: anticoagular. Si 1 punto: valorar (+).
- No uso de escalas para valorar riesgo de sangrado.
- El riesgo de sangrado casi nunca va a cambiar indicación de ACO, por lo que no debemos evaluar el riesgo para retirar anticoagulación, sino para corregir causas tratables.
- Muchos pacientes con FA que desarrollan ACV no están correctamente anticoagulados (infradosificar aumenta los eventos CV y la mortalidad).
- La fragilidad no es un motivo para no anticoagular.
- Se recomienda ecocardiograma para guiar la toma de decisiones.

FIN

¿Preguntas?