Guidelines atrial fibrillation esc

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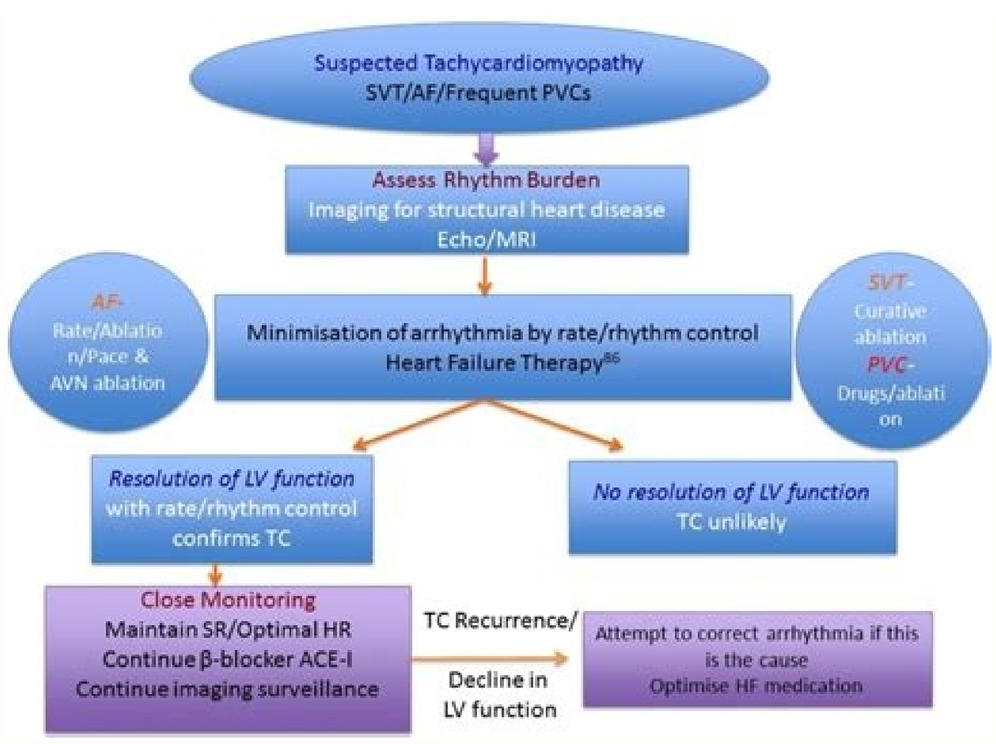
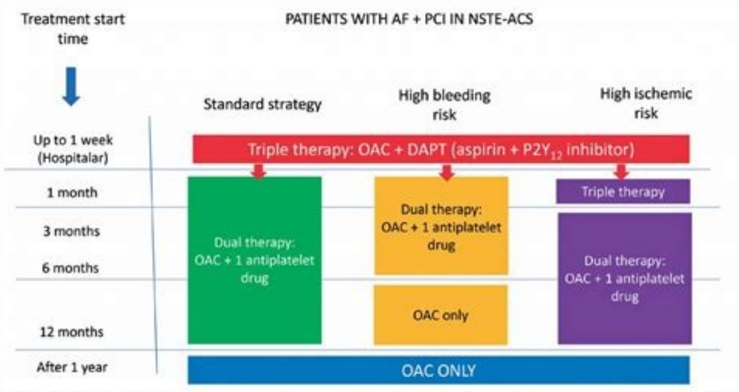




AF: atrial fibrillation; PCI: percutaneous coronary intervention; NSTE-ACS: non-ST segment elevation acute coronary syndrome; OAC: oral anticoagulation; DAPT: dual antiplatelet therapy.

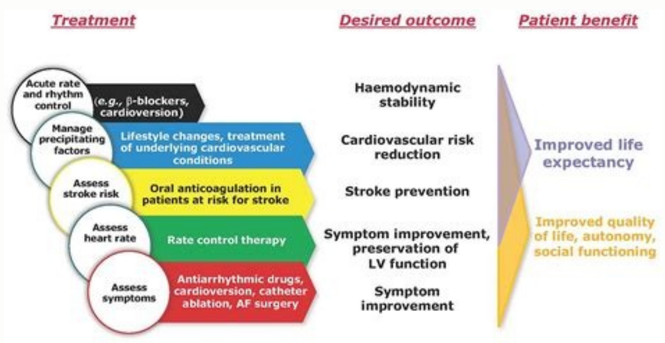


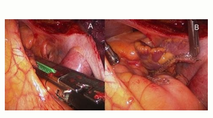
Table 1. Dose-Reduction Criteria Among Patients Randomized to Apixaban or Warfarin in the ARISTOTLE Trial[a]

No. of Dose-Reduction Criteria		No. (%) of Patients (n = 17 370)
None		13 356 (76.9)
1		3966 (22.8)
	Age ≥80 y	1636 (41.3)
	Weight ≤60 kg only	1426 (36.0)
	Creatinine ≥1.5 mg/dL only	904 (22.8)
2		48 (0.3)

Abbreviation: ARISTOTLE, Apixaban for Reduction of Stroke and Other Thromboembolic Complications in Atrial Fibrillation.

SI conversion factor: To convert creatinine to micromoles per liter, multiply by 88.4.

[a] Includes patients randomized to apixaban 5 mg twice daily (standard dose).



Esc atrial fibrillation guidelines 2020 pdf. Acc/aha/esc guidelines atrial fibrillation. Esc pocket guidelines atrial fibrillation. Esc guidelines for the management of atrial fibrillation developed in collaboration with eacts. 2020 esc guidelines for the diagnosis and management of atrial fibrillation. Acc/aha/esc 2006 guidelines for the management of patients with atrial fibrillation. 2020 esc guidelines for atrial fibrillation key points. Acc/aha/esc guidelines for the management of patients with atrial fibrillation.

Aug 30, 2020 | Thomas C. Crawford, MD, FACC Authors: Hindricks G, Potpara T, Dagres N, et. al. Citation: 2020 ESC Guidelines for the Diagnosis and Management of Atrial Fibrillation Developed in Collaboration With the European Association of Cardio-Thoracic Surgery (EACTS): The Task Force for the Diagnosis and Management of Atrial Fibrillation of the European Society of Cardiology (ESC) Developed With the Special Contribution of the European Heart Rhythm Association (EHRA) of the ESC. Eur Heart J 2020;Aug 29:[Epub ahead of print]. The following are key points to remember from the 2020 European Society of Cardiology (ESC) and European Association of Cardio-Thoracic Surgery (EACTS) guidelines for the diagnosis and management of atrial fibrillation (AF): “Clinical AF” is defined as symptomatic or asymptomatic AF that is documented by surface electrocardiogram (ECG) (at least seconds on ambulatory monitor, including wearable-recorded ECG or a 12-lead ECG). “Subclinical AF” refers to individuals without symptoms, whose pacemaker or implantable cardioverter-defibrillator (ICD) interrogation reveals “atrial high rate episode (AHRE)," and in whom AF has not been detected on surface ECG. While there is a significant amount of data on the management of “clinical AF,” data on optimal management of AHRE and subclinical AF are lacking. Opportunistic screening for AF is recommended in patients ≥65 years old, hypertensive patients, and in patients with obstructive sleep apnea. Systematic ECG screening should be considered to detect AF in patients aged ≥75 years, or those at high risk of stroke. All patients diagnosed with AF should undergo a “structured characterization,” which includes stroke risk, symptom severity, AF burden, and AF substrate assessment. Patient values should be considered, and an assessment of “patient-reported outcome” measures is recommended. Integrated, patient-centered AF management may be accomplished through the coordination of a cardiologist, AF nurse, general practitioner, and pharmacist. The introduction of tools to measure quality of care and identify opportunities for improved treatment quality and AF patient outcome should be considered by practitioners and institutions. CHA2DS2-VASc clinical stroke risk score should be used to identify patients at “low risk” (CHA2DS2-VASc score = 0 in men, or 1 in women), who should not be offered antithrombotic therapy. Antiplatelet therapy alone is not recommended for stroke prevention in AF (Class III). Oral anticoagulation (OAC) is recommended for stroke prevention in AF patients with CHA2DS2-VASc score ≥2 in men or ≥3 in women, and it should be considered in patients with a CHA2DS2-VASc score of 1 in men or 2 in women, with treatment individualized based on net clinical benefit and patient values/preferences. A risk score-based bleeding risk assessment (HAS-BLED) is recommended to help identify patients at high risk of bleeding who should be scheduled for more frequent clinical follow-up. Estimated bleeding risk, in the absence of absolute contraindications to OAC, should not in itself guide treatment decisions to avoid using OAC. Nonvitamin K antagonist oral anticoagulants (NOACs) are recommended in preference to VKAs (excluding patients with mechanical heart valves or moderate-to-severe mitral stenosis). In AF patients with acute coronary syndrome (ACS) undergoing an uncomplicated percutaneous coronary intervention, early cessation (≤1 week) of aspirin and continuation of dual therapy with an OAC and a P2Y12 inhibitor (preferably clopidogrel) for up to 12 months is recommended. Triple therapy with aspirin, clopidogrel, and an OAC for longer than 1 week after an ACS should be considered when risk of stent thrombosis outweighs the bleeding risk, with the total duration (≤1 month). Long-term OAC therapy to prevent thromboembolic events should be considered in patients at risk for stroke with postoperative AF after noncardiac surgery, considering the anticipated net clinical benefit of OAC and informed patient preferences. Beta-blockers should not be used routinely for the prevention of postoperative AF in patients undergoing noncardiac surgery (Class III). Lenient rate control (heart rate In patients with AF and normal left ventricular function, catheter ablation has not been shown to reduce total mortality or stroke; in patients with tachycardia-induced cardiomyopathy, catheter ablation reverses left ventricular dysfunction in most cases. Obesity and obstructive sleep apnea are major risk factors for AF. Weight loss improves outcomes in patients with AF. Aggressive risk factor reduction programs focusing on weight management, hyperlipidemia, obstructive sleep apnea, hypertension, diabetes, smoking cessation, and alcohol intake reduction significantly reduced AF burden after ablation. Clinical Topics: Acute Coronary Syndromes, Anticoagulation Management, Arrhythmias and Clinical EP, Dyslipidemia, Heart Failure and Cardiomyopathies, Prevention, Valvular Heart Disease, Anticoagulation Management and ACS, Anticoagulation Management and Atrial Fibrillation, Implantable Devices, EP Basic Science, SCD/Ventricular Arrhythmias, Atrial Fibrillation/Supraventricular Arrhythmias, Sleep Apnea Keywords: ESC Congress, ESC20, Acute Coronary Syndrome, Anti-Arrhythmia Agents, Anticoagulants, Arrhythmias, Cardiac, Aspirin, Atrial Fibrillation, Cardiomyopathies, Catheter Ablation, Defibrillators, Implantable, Electrocardiography, Hyperlipidemias, Mitral Valve Stenosis, Pacemaker, Artificial, Platelet Aggregation Inhibitors, Quality of Life, Risk Assessment, Risk Factors, Secondary Prevention, Sleep Apnea, Obstructive, Smoking Cessation, Stroke, Ventricular Function, Left, Weight Loss < Back to Listings AF has major clinical implications on patients’ quality of life, morbidity with ischaemic stroke and heart failure, and mortality when compared with the general population.1 AF is the most common sustained arrhythmia and it has been calculated that it will affect 17.9 million adults in the EU and the UK by 2060.2 The increasing prevalence of AF is driven mainly by the ageing population and the high burden of risk factors and comorbidities, which raises significant issues about the use of healthcare systems and economic costs.2–4 The 2020 European Society of Cardiology (ESC) Clinical Practice Guidelines for AF summarise and evaluate the available evidence from 1,492 references to provide an overview of contemporary AF diagnosis, management and research.3 Given the complexity of AF and its poorly understood mechanisms, the management of AF patients requires a holistic, multidisciplinary approach, including individual assessment, patient preferences and active involvement in decision-making. The guidelines introduce a novel, simplified, holistic approach to care for patients with AF (Figure 1), incorporating screening, diagnosis and treatment for effective, integrated management.3 These AF guidelines should consider the clinical evaluation and the choice of the best treatment strategies for each individual patient with AF.3 To accompany the guidelines, the ESC published quality indicators (17 main and 17 secondary indicators from six domains of care) to help improve and allow comparisons of the overall quality of care among AF patients at various levels, by looking at data at patient, centre or international level.3,5 Detection of AF In recent years, substantial progress has been made in detecting AF, including asymptomatic AF. Increasing data on the identification and monitoring of AF are available for the use of wearable technology or implantable loop recorders to detect and record AF episodes.6–9 Novel tools and technologies for digital ECG analysis, in the form of wearables, machine learning and artificial intelligence, have brought potentially significant opportunities for the detection and diagnosis of AF and may be used for long-term AF screening, especially in high-risk cohorts.10 However, the diagnosis of clinical AF needs to be confirmed and documented by a conventional 12-lead ECG tracing or rhythm strip showing a typical AF pattern for ≥30 seconds. Nonetheless, a gap in data exists which raises the question of the management of patients with shorter AF duration (

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