**Update on the Management of Atrial Fibrillation**

The American College of Cardiology/American Heart Association practice guidelines were developed to assist clinicians in making the best clinical decisions by describing acceptable means for diagnosing, managing, and preventing specific diseases or conditions. Several clinical trials have become available that impacted previous guideline recommendations for the treatment of atrial fibrillation. This issue of CLIPS briefly summarizes a focused update on the management of patients with atrial fibrillation. If you need further information, please contact the Samford University Drug Information Service at (205) 726-2659.


**Guideline focus**
- 2011 update was developed to provide recommendations for strict versus lenient heart rate control; use of combination therapy with antiplatelet and anticoagulant agents; and the use of dronedarone.
- Recommendations for the use of dabigatran were not made due to lack of FDA approval at the time of organizational approval of the document. In addition, no recommendations for the Watchman device for occlusion of the left atrial appendage were included.

**New recommendations / Updated clarification**
- The following table provides new verbatim recommendations/updated clarification available in the 2011 update on the management of atrial fibrillation.

<table>
<thead>
<tr>
<th>Recommendation for rate control during atrial fibrillation</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Treatment to achieve strict rate control of heart rate (&lt;80 bpm at rest or &lt; 110 bpm during a 6-minute walk) is not beneficial compared to achieving a resting heart rate &lt;110 bpm in patients with persistent AF who have stable ventricular function (left ventricular ejection fraction &gt;0.4) and no or acceptable symptoms related to the arrhythmia, though uncontrolled tachycardia may over time be associated with a reversible decline in ventricular performance (LoE: B)</td>
<td>New recommendation</td>
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<th>Recommendation for combining anticoagulant with antiplatelet therapy</th>
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<tbody>
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<td>The addition of clopidogrel to aspirin (ASA) to reduce the risk of major vascular events, including stroke, might be considered in patients with AF in whom oral anticoagulation with warfarin is considered unsuitable due to patient preference or the physician’s assessment of the patient’s ability to safely sustain anticoagulation. (LoE: B)</td>
<td>New recommendation</td>
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</tbody>
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### Recommendations for the use of dronedarone in atrial fibrillation

- **Dronedarone is reasonable to decrease the need for hospitalization for cardiovascular events in patients with paroxysmal AF or after conversion of persistent AF.** Dronedarone can be initiated during outpatient therapy. *(LoE: B)*

- **Dronedarone should not be administered to patients with class IV heart failure or patients who have had an episode of decompensated heart failure in the past 4 weeks, especially if they have depressed left ventricular function (left ventricular ejection fraction ≤ 35%).** *(LoE: B)*

### Recommendations for maintenance of sinus rhythm

- **Catheter ablation** performed in experienced centers is useful in maintaining sinus rhythm in selected patients with significantly symptomatic, paroxysmal AF who have failed treatment with an antiarrhythmic drug and have normal or mildly dilated left atria, normal or mildly reduced LV function and no severe pulmonary disease. *(LoE: A)*

- In patients with AF without structural or coronary heart disease, initiation of propafenone or flecainide can be beneficial on an outpatient basis in patients with paroxysmal AF who are in sinus rhythm at the time of drug initiation. *(LoE: B)*

- **Catheter ablation is reasonable to treat symptomatic persistent AF.** *(LoE: A)*

- **Catheter ablation is a reasonable alternative to pharmacological therapy to prevent recurrent AF in symptomatic patients with little or no left atrium enlargement.** *(LoE: C)*

- **Catheter ablation may be reasonable to treat symptomatic paroxysmal AF in patients with significant left atrial dilation or with significant LV dysfunction.** *(LoE: A)*

### Conclusions

- New atrial fibrillation guidelines highlight the benefit of achieving a resting heart rate <110 bpm in patients with persistent AF who have stable ventricular function (left ventricular ejection fraction >0.4) and no or acceptable symptoms related to the arrhythmia.
- The combination of clopidogrel and ASA may be considered in patients with AF in whom warfarin therapy is unsuitable.
- Dronedarone may be used to decrease hospitalization in patients with paroxysmal AF or after conversion of persistent AF; however, dronedarone is not recommended in patients with class IV heart failure or those who have had an episode of decompensated heart failure in the past 4 weeks.

LoE-level of evidence; AF-atrial fibrillation; *Refers to pulmonary vein isolation with catheter ablation. An experienced center is defined as one performing >50 AF catheter ablation cases per year. LV-left ventricular

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