ESC guidelines förmaksflimmer 2016-kommentarer från HRG

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

Denna rekommendation är olycklig då det krävs högre poäng för kvinnor än män vilket riskerar leda till underbehandling av kvinnor. I nuläget rekommenderas att vi i Sverige behåller rekommendationen att behandling ska övervägas vid CHA_2DS_2-VASc 1 om inte kvinnligt kön är den enda riskfaktorn.

Recommendations	Class	Level
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
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
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
In male or female AF patients without additional stroke risk factors, anticoagulant or antiplatelet therapy is not recommended for stroke prevention.	III (harm)	B
Antiplatelet monotherapy is not recommended for stroke prevention in AF patients, regardless of stroke risk.	III (harm)	A
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

IIb – rekommendationen för byte från warfarin till NOAK hos warfarinbehandlade patienter med dåligt kontrollerat INR trots god compliance är förhållandevis svag (kan ha en starkare rekommendation).

Management of bleeding

Recommendations	Class	Level
Blood pressure control in anticoagulated patients with hypertension should be considered to reduce the risk of bleeding.	IIa	B
When dabigatran is used, a reduced dose (110 mg twice daily) may be considered in patients >75 years to reduce the risk of bleeding.	IIb	B
In patients at high-risk of gastrointestinal bleeding, a VKA or another NOAC preparation should be preferred over dabigatran 150 mg twice daily, rivaroxaban 20 mg once daily, or edoxaban 60 mg once daily.	IIa	B
Advice and treatment to avoid alcohol excess should be considered in all AF patients considered for OAC.	IIa	C
Genetic testing before the initiation of VKA therapy is not recommended.	III (no benefit)	B
Reinitiation of OAC after a bleeding event should be considered in all eligible patients by a multidisciplinary AF team, considering different anticoagulants and stroke prevention interventions, improved management of factors that contributed to bleeding, and stroke risk.	IIa	B
In AF patients with severe active bleeding events, it is recommended to interrupt OAC therapy until the cause of bleeding is resolved.	I	C

Med klass II a rekommenderas annan NOAK än dabigatran, edoxaban eller rivaroxaban till patienter med hög risk för gastrointestinal blödning.

Då det inte finns några head-to-head jämförelser mellan de olika NOAK är en sådan rekommendation tveksam då den baseras på studier med olika patientpopulationer, blödningsförekomst, olika definitioner av blödning. Data från real life studier talar mot en sådan generell rekommendation

Stroke prevention in patients designated for cardioversion of AF			
Anticoagulation with heparin or a NOAC should be initiated as soon as possible before every cardioversion of AF or atrial flutter.	IIa	B	708,709
For cardioversion of AF/atrial flutter, effective anticoagulation is recommended for a minimum of 3 weeks before cardioversion.	I	B	648,708
Transoesophageal echocardiography (TOE) is recommended to exclude cardiac thrombus as an alternative to preprocedural anticoagulation when early cardioversion is planned.	I	B	648,708
Early cardioversion can be performed without TOE in patients with a definite duration of AF <48 hours.	IIa	B	648
In patients at risk for stroke, anticoagulant therapy should be continued long-term after cardioversion according to the long-term anticoagulation recommendations, irrespective of the method of cardioversion or the apparent maintenance of sinus rhythm. In patients without stroke risk factors, anticoagulation is recommended for 4 weeks after cardioversion.	I	B	353,710
In patients where thrombus is identified on TOE, effective anticoagulation is recommended for at least 3 weeks.	I	C	
A repeat TOE to ensure thrombus resolution should be considered before cardioversion.	IIa	C	

Rekommendationerna för **Stroke prevention in patients designated for cardioversion of AF** kan uppfattas vara oklara. Därför behöver man i de situationerna också väga in om det handlar om flimmerduration <48 timmar och riskfaktorer enligt CHA_2DS_2-VASc.

“ Anticoagulation with heparin or a NOAC should be initiated as soon as possible *before every cardioversion* of AF or atrial flutter. ” Oklart om det också avses alla patienter med CHA_2DS_2-VASc 0 och flimmerduration mindre än 48 timmar.

"For cardioversion of AF/atrial flutter, effective anticoagulation is recommended for a minimum of *3 weeks before cardioversion*." Avses här patienter med CHA_2DS_2-VASc 0 och flimmerduration mindre än 48 timmar? Vi tolkar det som om det bara syftar på de med riskfaktorer och indikation för antikoagulantia.

"In patients at risk for stroke, anticoagulant therapy should be continued long-term after cardioversion according to the long-term anticoagulation recommendations, irrespective of the method of cardioversion or the apparent maintenance of sinus rhythm. *In patients without stroke risk factors, anticoagulation is recommended for* ***4 weeks after cardioversion****."*
Kan uppfattas som oklart om det i den andra lydelsen avses flimmerduration mindre än 48 timmar? Vi anser att detta inte gäller vid flimmerduration <48 timmar. Vi bedömer att det inte finns skäl att ändra nuvarande praxis i Sverige.

AAD for the long-term maintenance of sinus rhythm/prevention of recurrent AF		
The choice of AAD needs to be carefully evaluated, taking into account the presence of comorbidities, cardiovascular risk and potential for serious proarrhythmia, extracardiac toxic effects, patient preferences, and symptom burden.	I	A
Dronedarone, flecainide, propafenone, or sotalol are recommended for prevention of recurrent symptomatic AF in patients with normal left ventricular function and without pathological left ventricular hypertrophy.	I	A
Dronedarone is recommended for prevention of recurrent symptomatic AF in patients with stable coronary artery disease, and without heart failure.	I	A
Amiodarone is recommended for prevention of recurrent symptomatic AF in patients with heart failure.	I	B
Amiodarone is more effective in preventing AF recurrences than other AAD, but extracardiac toxic effects are common and increase with time. For this reason, other AAD should be considered first.	IIa	C
Patients on AAD therapy should be periodically evaluated to confirm their eligibility for treatment.	IIa	C

Enligt Cochranerapporten om proarytmier och antiarytmika hos förmaksflimmerpatienter noterades högre dödlighet till följd av proarytmier för sotalol medan dronedarone var det säkraste antiarytmiska läkemedlet. ESCs riktlinjer gör ingen skillnad mellan dessa preparat vilket dock bör beaktas vid val av antiarytmika. SoS prioriteringslista har förtjänstfullt noterat detta och rekommenderar dronedarone i första hand och sotalol i sista hand.