SOCIETAT CATALANA DE Cardiologia

CURS DE FORMACIÓ CONTINUADA

Fibril.lació Auricular

UN PROCÉS TRANSVERSAL:
DES D'ATENCIÓ PRIMÀRIA AL "SUPER ESPECIALISTA"

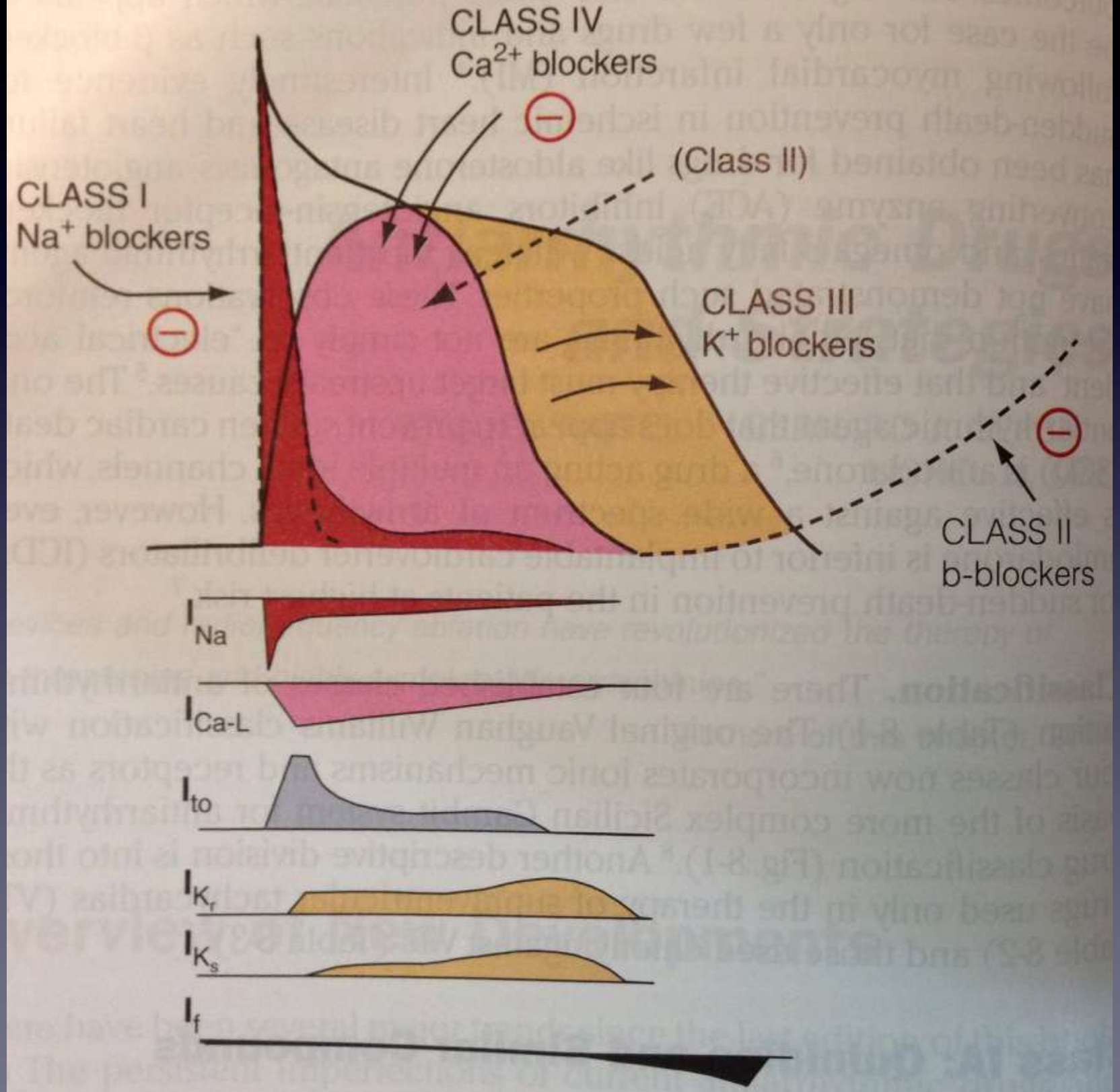
HOSPITAL ARNAU DE VILANOVA
LLEIDA, NOVIEMBRE 2014

ORIENTACIÓN DEL MANEJO ARRÍTMICO DE LA FIBRILACIÓN AURICULAR

- **TRATAMIENTO FARMACOLÓGICO**
- **TRATAMIENTO NO FARMACOLÓGICO**

CLASSES OF ANTIARRYTHMIC DRUGS

Opie 2012



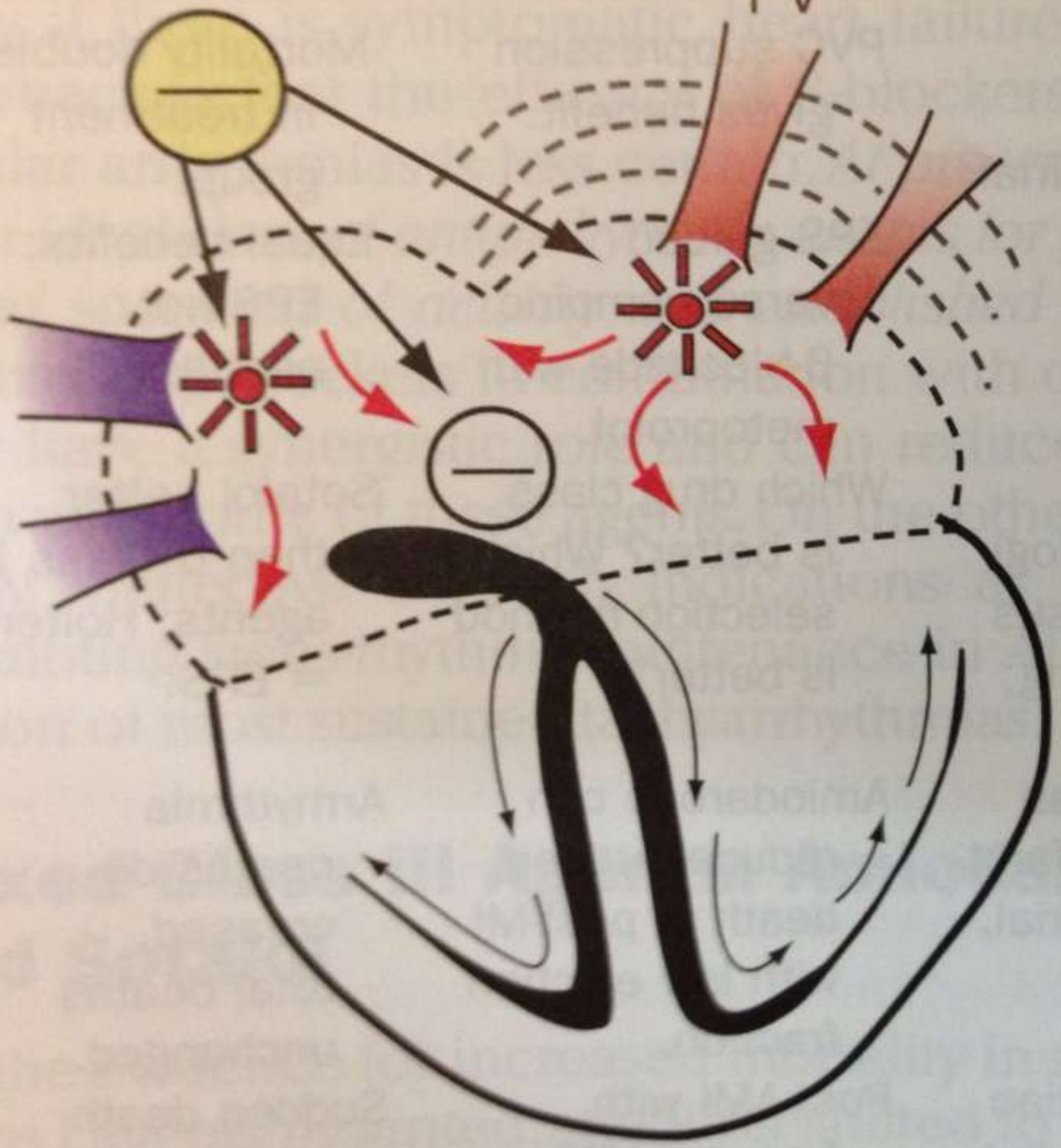
Tratamiento Farmacológico
Antiarrítmicos de uso actual más frecuente

- **FLECAINIDA: Tipo IC. Inhibición potente de canales de Na+. Contraindicación si cardiopatía estructural. Asociar fármaco bloqueo nodo AV**
- **AMIODARONA: Tipo III Inhibición corrientes repolarizantes K (también actividad tipo I, II y IV) Distribución lenta y extensa en tejido adiposo, hígado, pulmón (vida media hasta 6 meses)**
- **DRONEDARONA: Bloqueante multicanal como amiodarona. No molécula de Iodo**
- **OTROS: SOTALOL: Betabloqueante no selectivo + clase III**

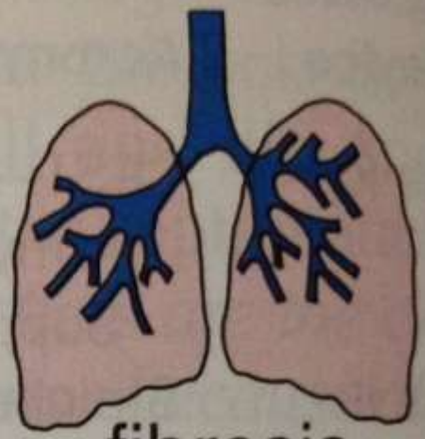
AMIODARONE FOR ATRIAL FIBRILLATION

Opie 2012

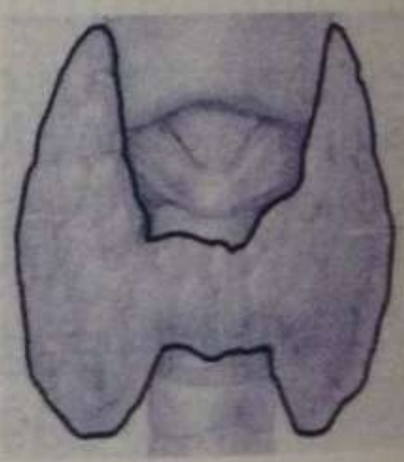
AMIODARONE
INHIBITION



SIDE EFFECTS



fibrosis

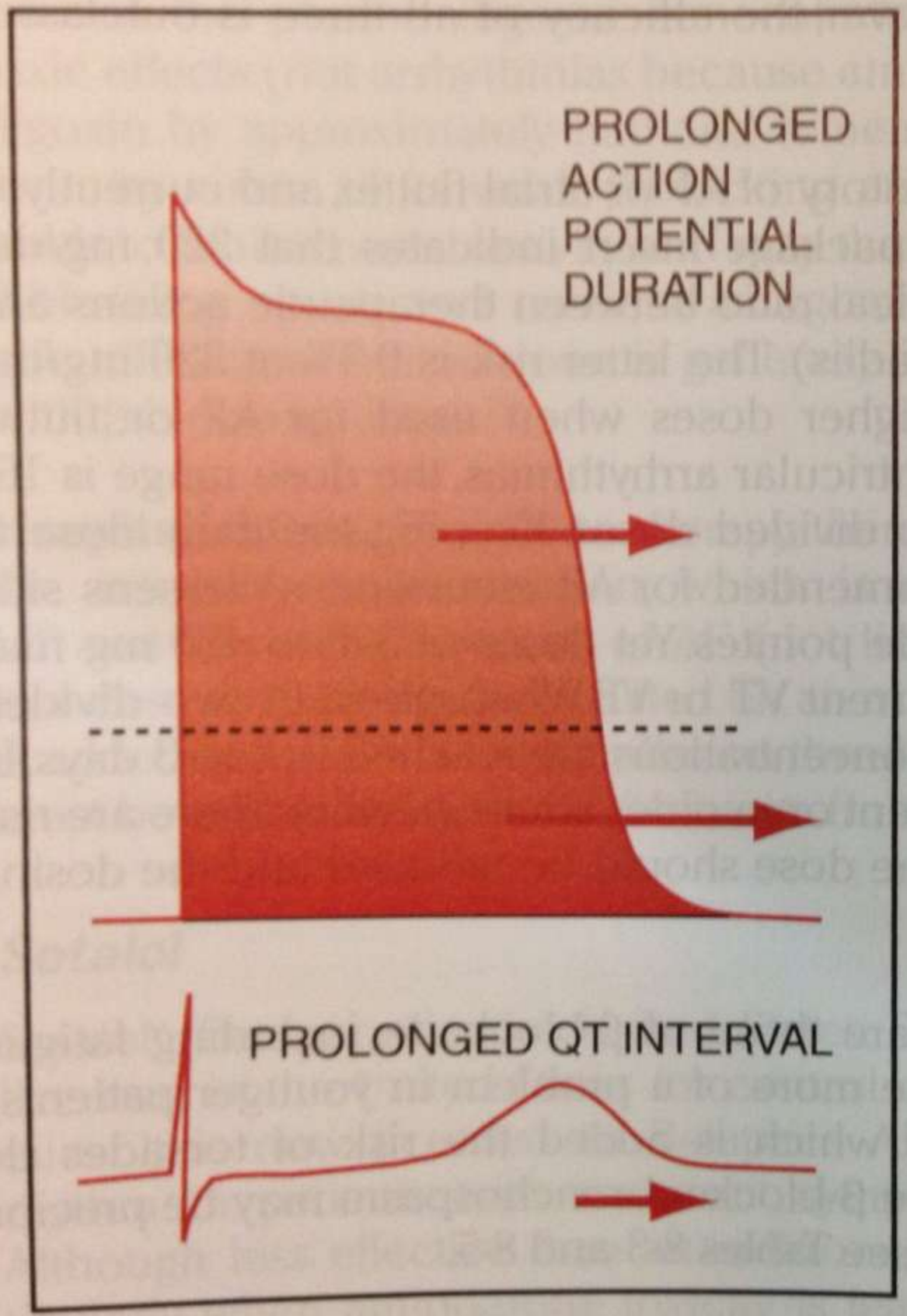


thyroid
dysfunction

Liver toxicity

LONG QT WITH RISK OF TORSADE

Opie 2012

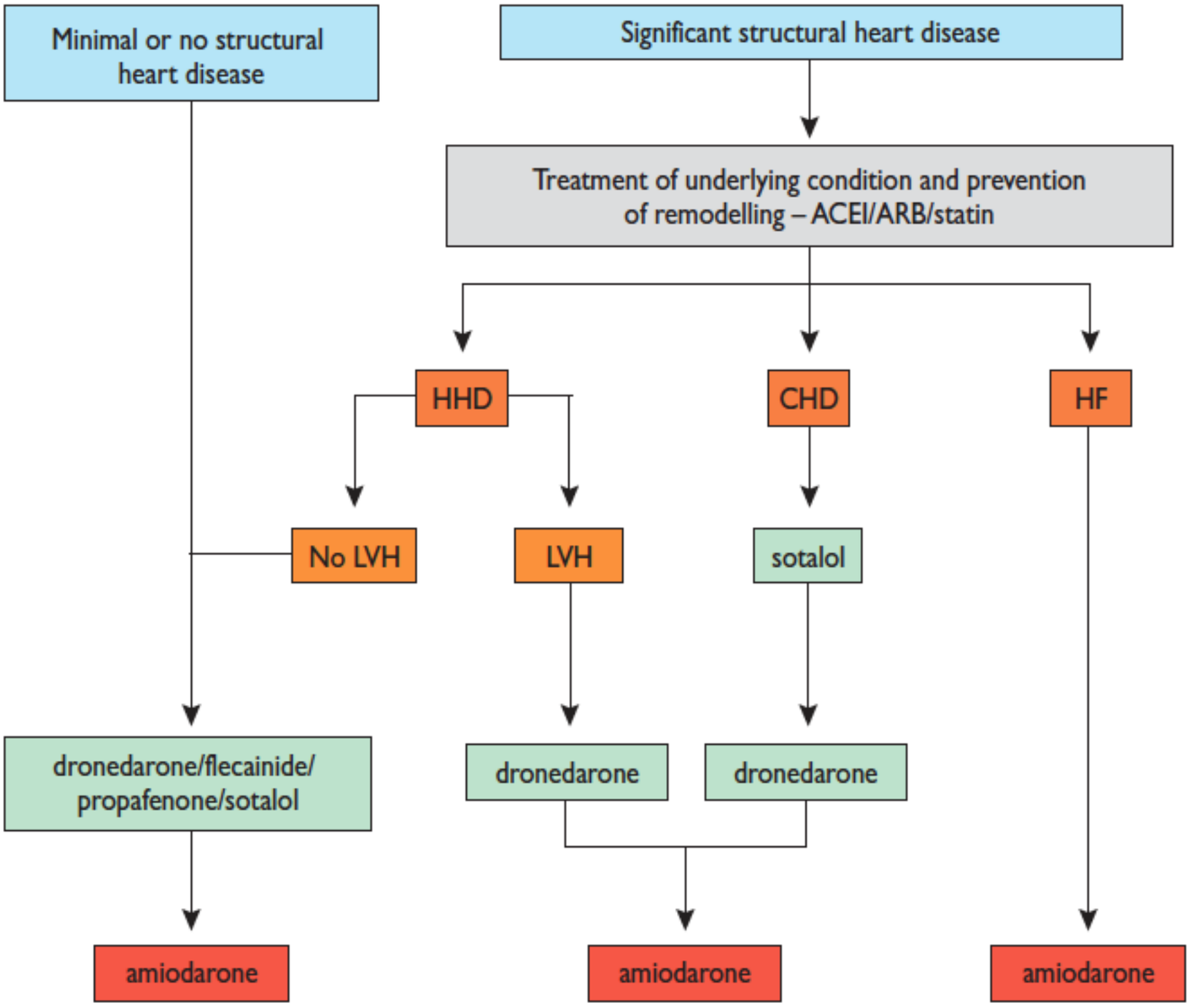


- *DISOPYRAMIDE*
  QUINIDINE
- *IBUTILIDE*
  DOFETILIDE
- *SOTALOL*
  (AMIODARONE)
- *TRICYCLICS*
  HALOPERIDOL
- *ANTIPSYCHOTICS*
- *PHENOTHIAZINES*
- *IV ERYTHROMYCIN*
  QUINOLONES (SOME)
- *ANTIHISTAMINICS*
  - *astemizole*
  - *terfenadine*
- *KETOCONAZOLE*
- *Prolonged QTU:*
  Low K^+ , Mg^{2+}
  (THIAZIDES)

European Heart Journal (2012) **33**, 2719–2747
doi:10.1093/eurheartj/ehs253

ESC GUIDELINES

2012 focused update of the ESC Guidelines for the management of atrial fibrillation



ACEI = angiotensin-converting enzyme inhibitor; ARB = angiotensin-receptor blocker; HHD = hypertensive heart disease; CHD = coronary heart disease; HF = heart failure; LVH = left ventricular hypertrophy, NYHA = New York Heart Association. Antiarrhythmic agents are listed in alphabetical order within each treatment box.

Apuntes sobre Vernakalant

- Nuevo antiarrítmico, bloqueo multicanal
- Cardioversión farmacológica FA < 7 días o < 3 días FA post cirugía cardíaca
- Contraindicación si: TAs< 100 mmHg, insuficiencia cardíaca clase III-IV NYHA, estenosis aórtica severa, QT > 440 ms (no corregido)
- 3 mg/kg ev 10 min. Si no efectividad 15 min, nueva administración 2 mg/kg
- 50% pacientes cardioversión efectiva 90 min (tiempo medio cardioversión: 8-14 min)

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2012 focused update of the ESC Guidelines for the management of atrial fibrillation

Recommendations for pharmacological cardioversion of recent-onset AF

Recommendations	Class[a]	Level[b]	Ref[c]
When pharmacological cardioversion is preferred and there is no or minimal structural heart disease, intravenous flecainide, propafenone, ibutilide, or vernakalant are recommended.	I	A	120, 121, 123, 124, 126, 127, 131–134
In patients with AF ≤7 days and moderate structural heart disease [but without hypotension <100 mm Hg, NYHA class III or IV heart failure, recent (<30 days) ACS, or severe aortic stenosis], intravenous vernakalant may be considered. Vernakalant should be used with caution in patients with NYHA class I–II heart failure.	IIb	B	120, 121, 124, 128
Intravenous vernakalant may be considered for cardioversion of postoperative AF ≤3 days in patients after cardiac surgery.	IIb	B	122

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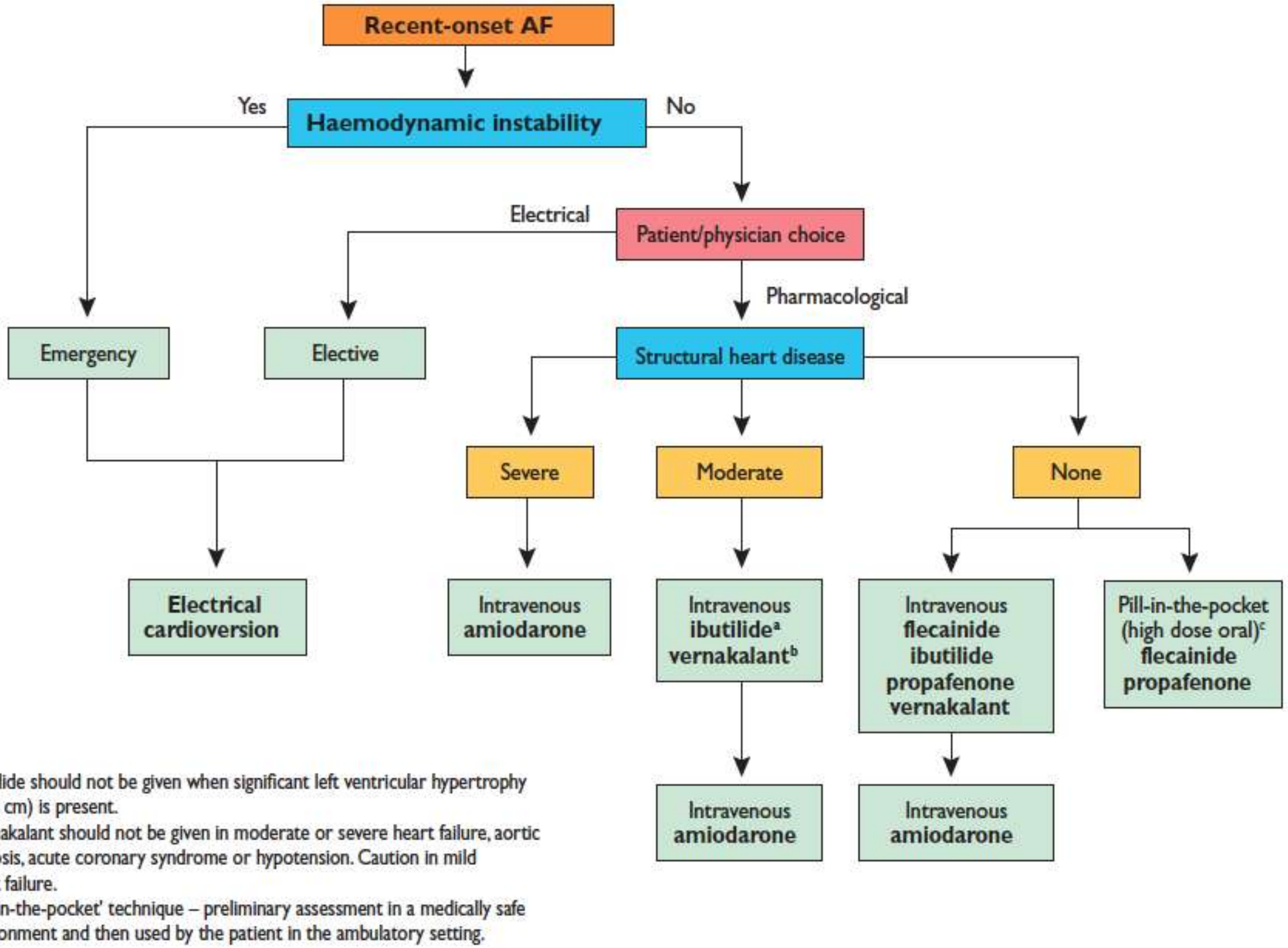

[a]Ibutilide should not be given when significant left ventricular hypertrophy (≥1.4 cm) is present.
[b]Vernakalant should not be given in moderate or severe heart failure, aortic stenosis, acute coronary syndrome or hypotension. Caution in mild heart failure.
[c]'Pill-in-the-pocket' technique – preliminary assessment in a medically safe environment and then used by the patient in the ambulatory setting.

Tratamiento No Farmacológico

- **Ablación de VVPP con catéter (RF o crioablación)**
- **Ablación Quirúrgica (Maze)**
- **Ablación de nodo AV e implantación de MCP**

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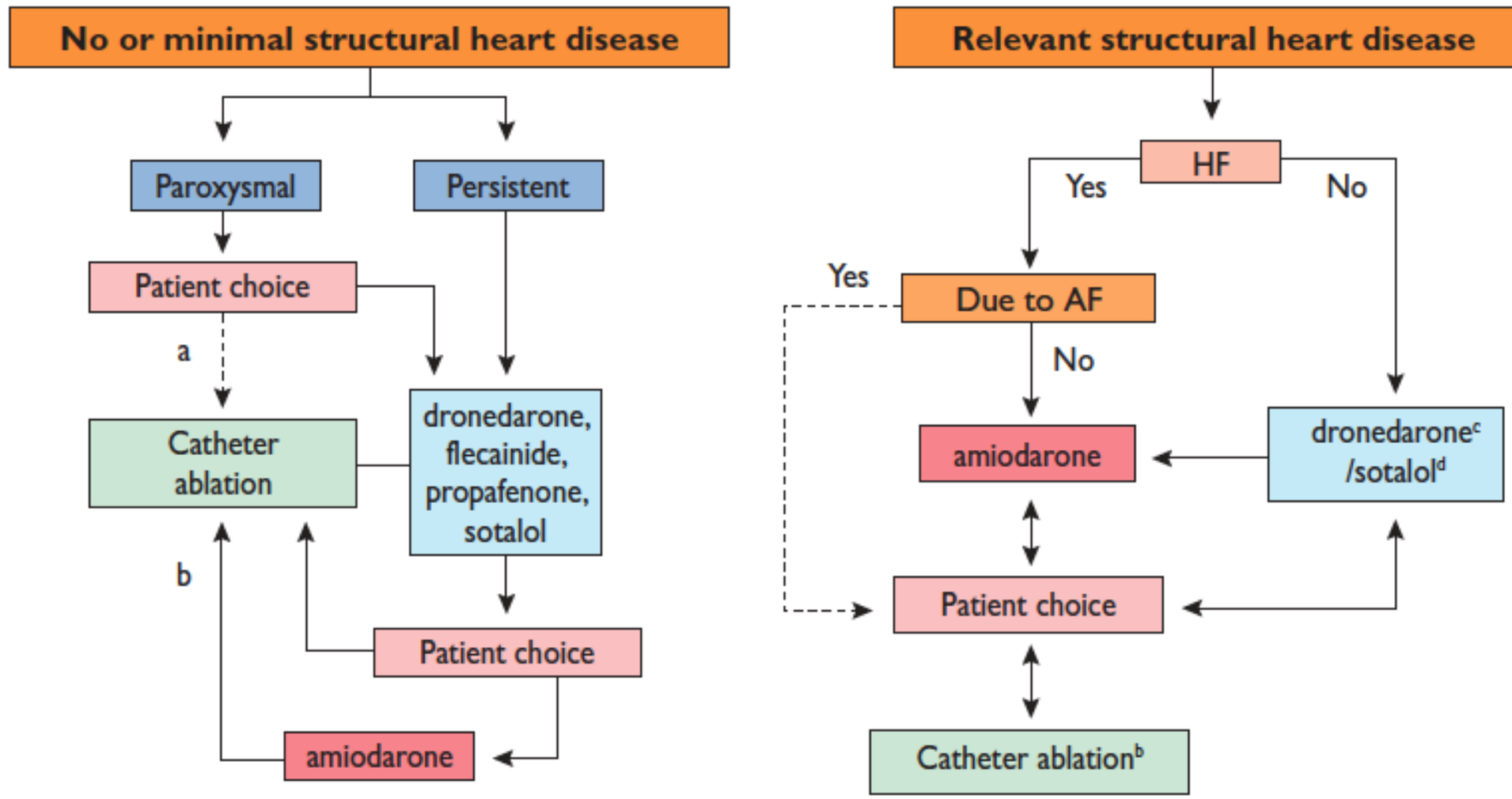

AF = atrial fibrillation; HF = heart failure. [a]Usually pulmonary vein isolation is appropriate. [b]More extensive left atrial ablation may be needed. [c]Caution with coronary heart disease. [d]Not recommended with left ventricular hypertrophy. Heart failure due to AF = tachycardiomyopathy.

Figure 5 Antiarrhythmic drugs and/or left atrial ablation for rhythm control in AF.

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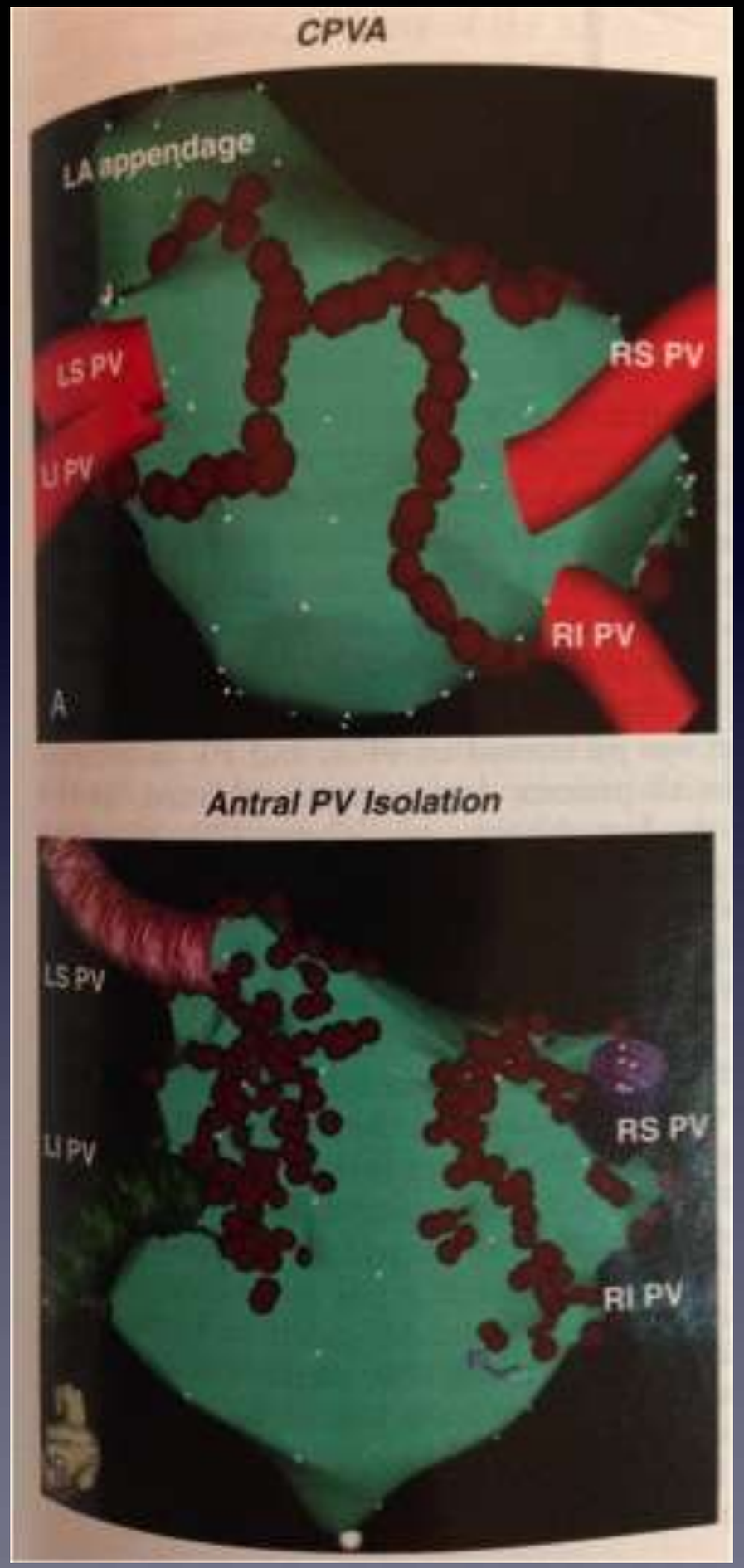
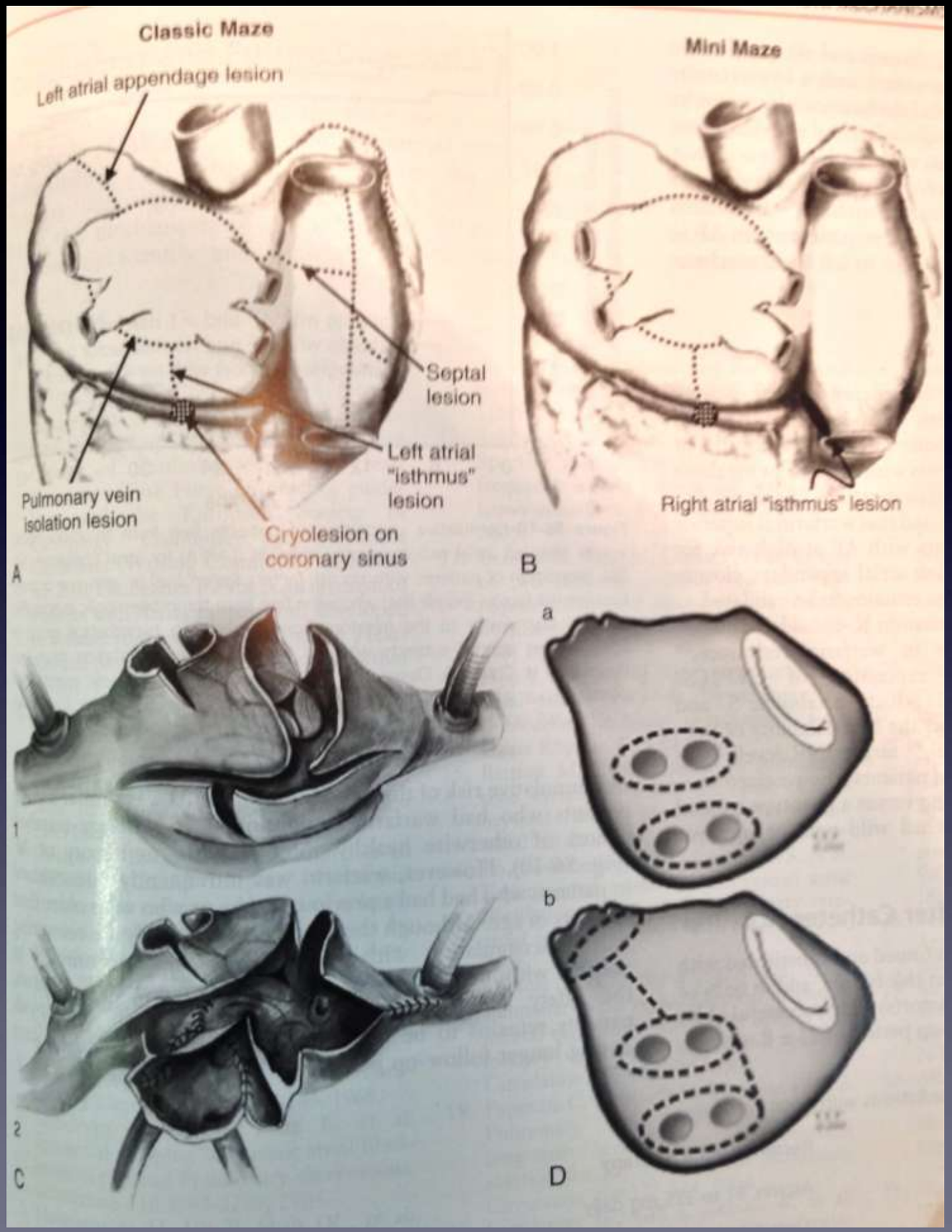
2012 focused update of the ESC Guidelines for the management of atrial fibrillation

Recommendations for left atrial ablation

Recommendations	Class[a]	Level[b]	Ref[c]
Catheter ablation of symptomatic paroxysmal AF is recommended in patients who have symptomatic recurrences of AF on antiarrhythmic drug therapy (amiodarone, dronedarone, flecainide, propafenone, sotalol) and who prefer further rhythm control therapy, when performed by an electrophysiologist who has received appropriate training and is performing the procedure in an experienced centre.	I	A	192, 193
Catheter ablation of AF should target isolation of the pulmonary veins.	IIa	A	170, 172, 192, 194
Catheter ablation of AF should be considered as first-line therapy in selected patients with symptomatic paroxysmal AF as an alternative to antiarrhythmic drug therapy, considering patient choice, benefit, and risk.	IIa	B	156–158
When catheter ablation of AF is planned, continuation of oral anticoagulation with a VKA should be considered during the procedure, maintaining an INR close to 2.0.	IIa	B	170, 181–184
When AF recurs within the first 6 weeks after catheter ablation, a watch-and-wait rhythm control therapy should be considered.	IIa	B	195


CPVA
LA appendage
LS PV
LI PV
RS PV
RI PV
A
Antral PV Isolation
LS PV
LI PV
RS PV
RI PV


Classic Maze
Left atrial appendage lesion
Septal lesion
Left atrial "isthmus" lesion
Pulmonary vein isolation lesion
Cryolesion on coronary sinus
A
Mini Maze
Right atrial "isthmus" lesion
B
1
2
C
a
b
D

¡Muchas Gracias!