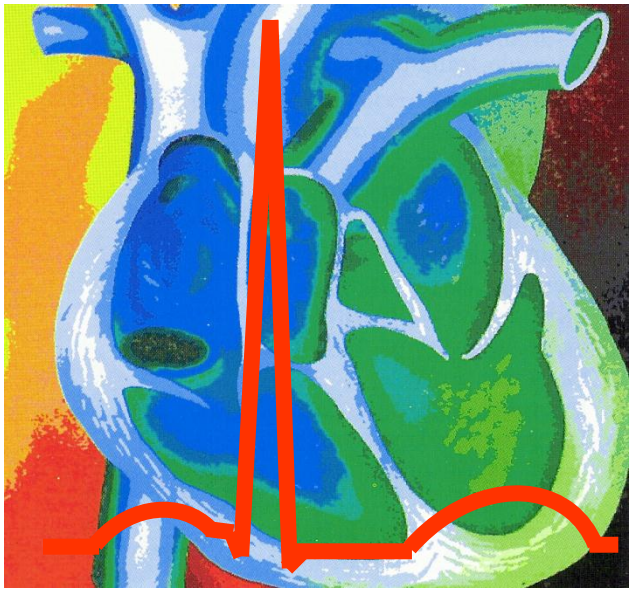
El paciente con Fibrilación Auricular del Siglo XXI



Antoni Martínez-Rubio

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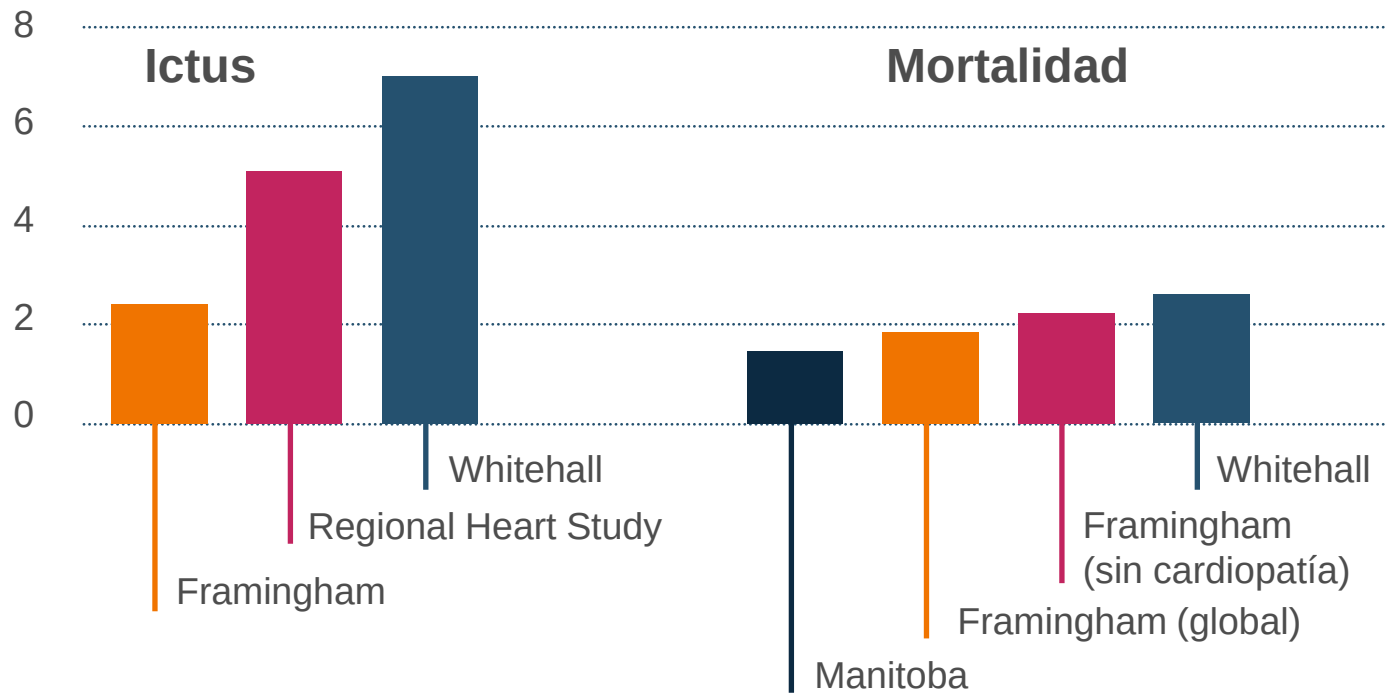
Sabadell (Barcelona)

Fibrilación auricular

Riesgo relativo en comparación con los pacientes sin FA

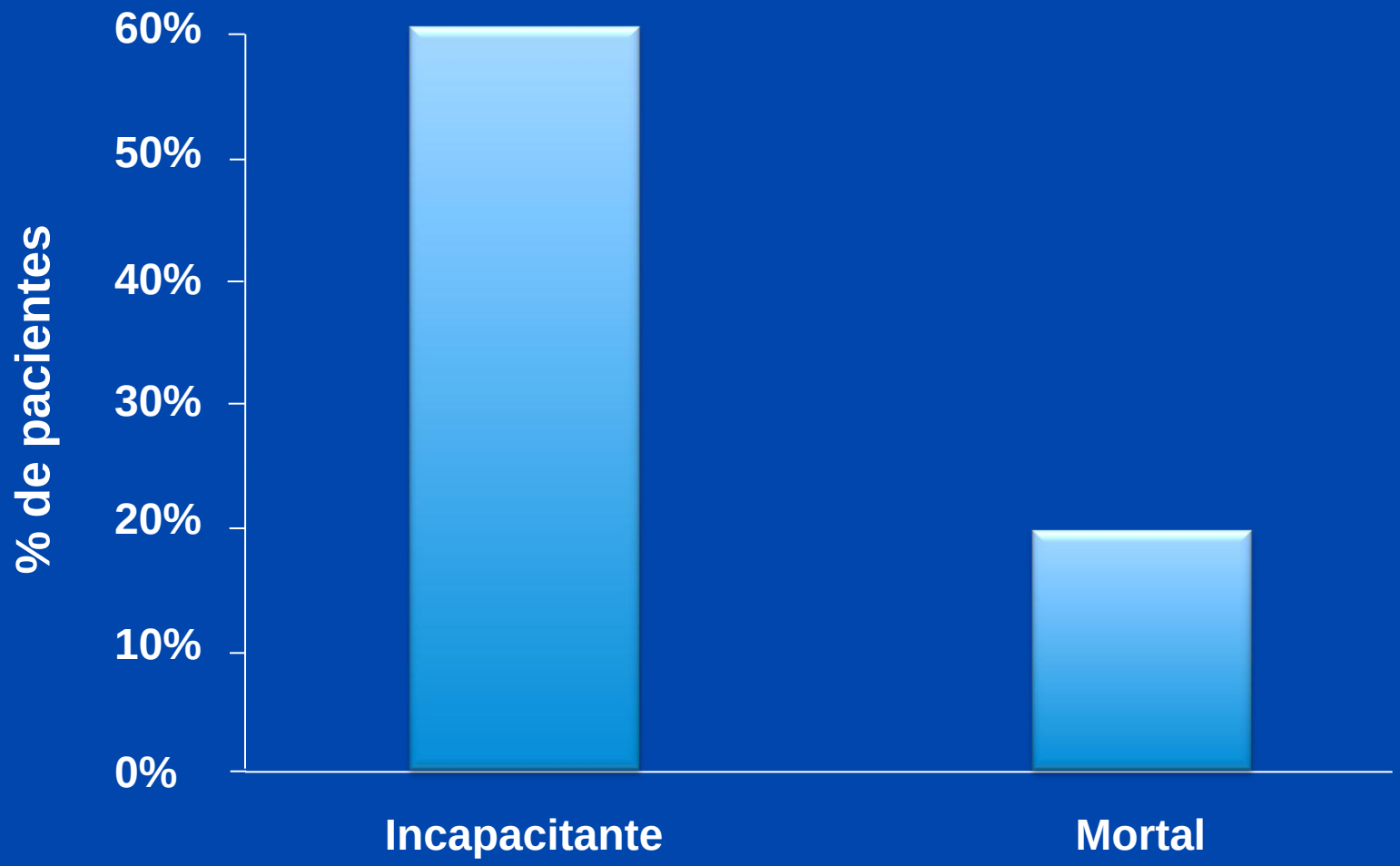


Wolf PA et al. The Framingham Study. Arch Intern Med 1987; 147: 1561-4.
Regional Heart Study.
Framingham et al. Framingham Heart Study.

Flegel KM et al. Estudio Whitehall.
Krahn AD et al. Estudio Manitoba.

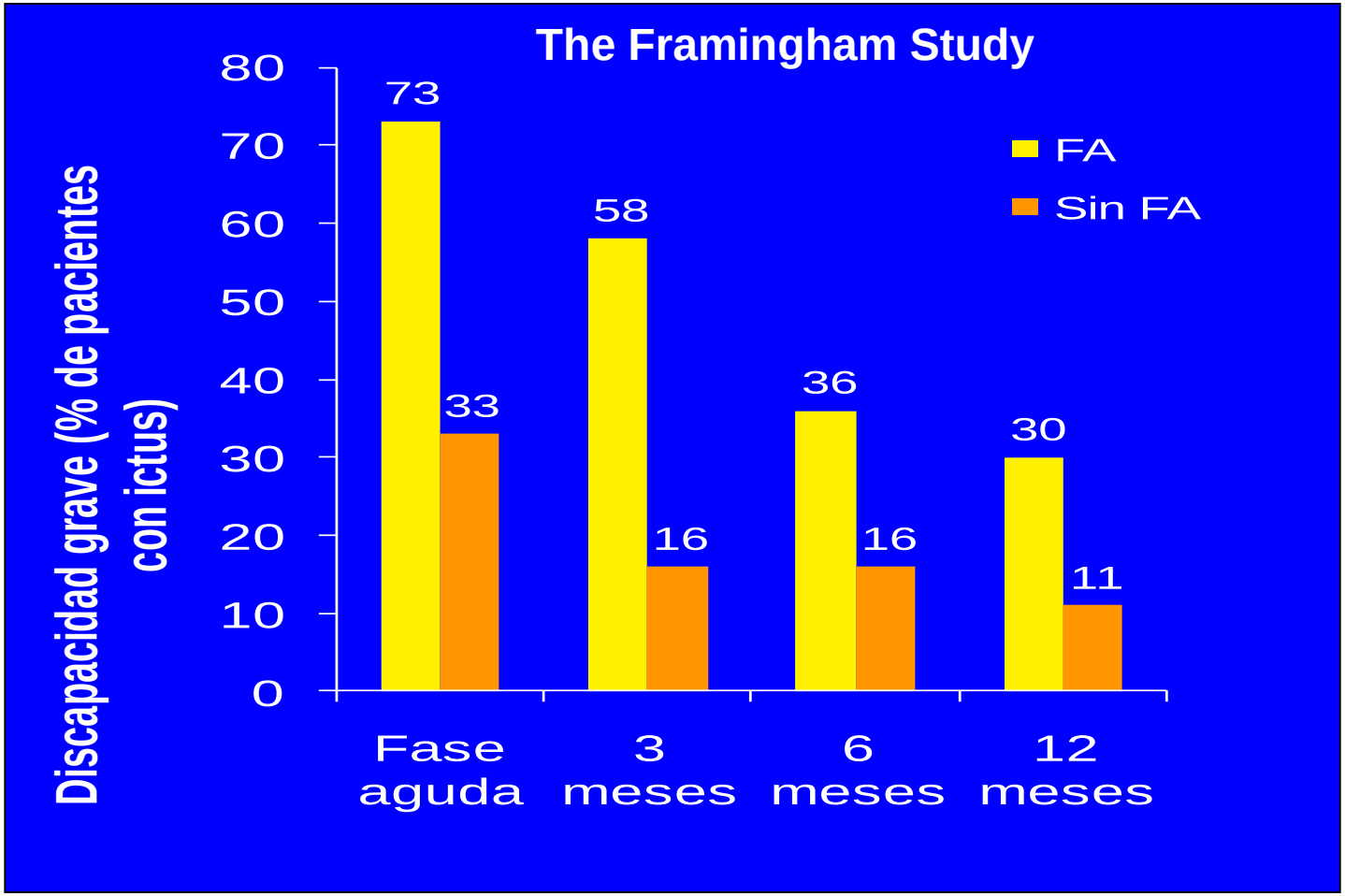
Gravedad del ictus en pacientes con FA

Efecto del primer ictus isquémico en pacientes con FA (n = 597)[1]



1. Gladstone DJ et al. *Stroke*. 2009; 40:235-240

Discapacidad grave post-ictus:
Efectos de la FA



Lin HJ *et al*. *Stroke* 1996;27:1760–1764.

Mortalidad post-ictus:
Efectos de la FA

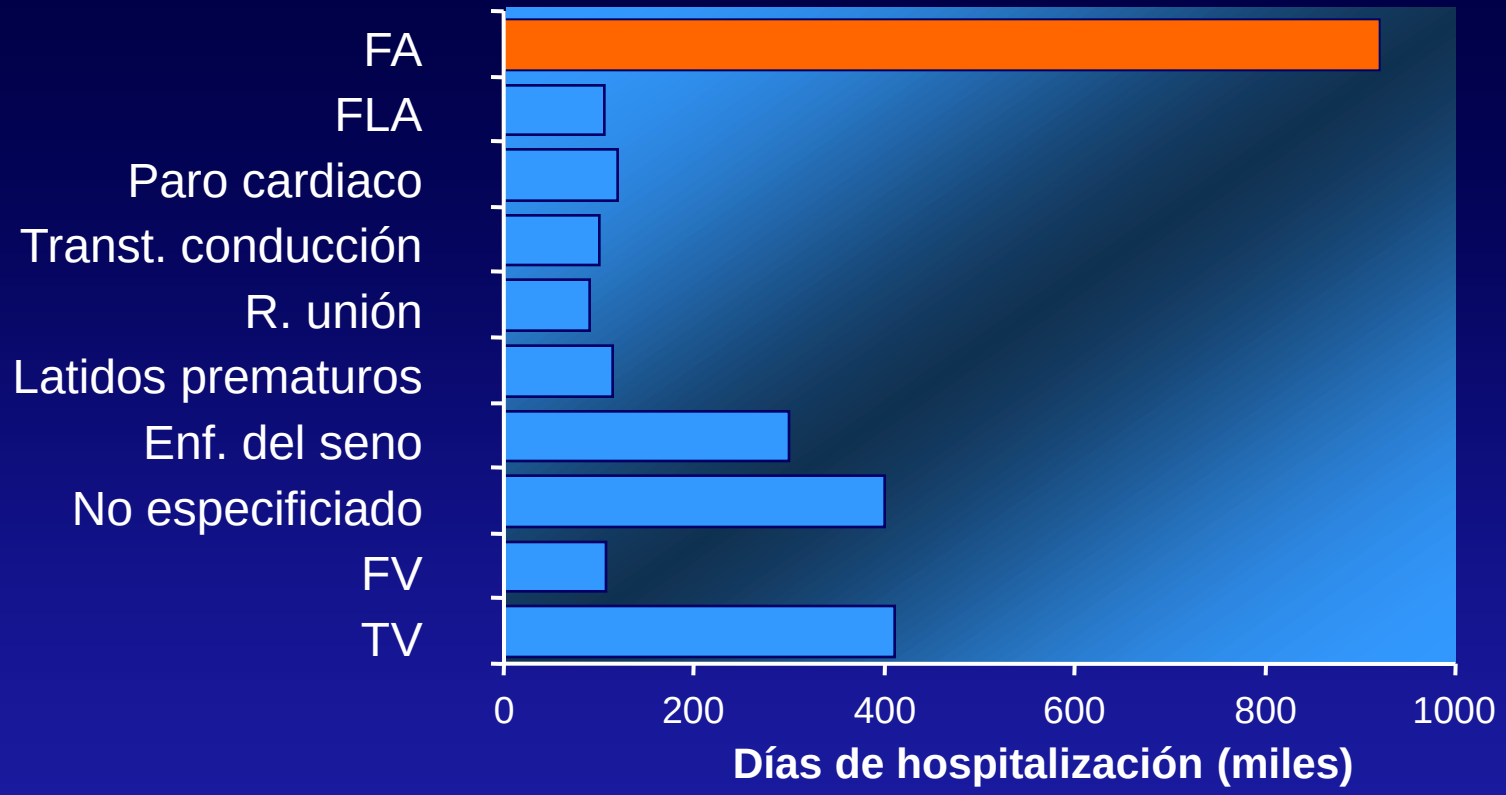
Estudio poblacional: Tasas de mortalidad

	SIN AF (N=2661)		CON AF (N=869)	
Año	**Tasa (%)**	**IC del 95%**	**Tasa (%)**	**IC del 95%**
1	27,1	25,3–28,8	49,5	46,1–52,8
2	8,2	7,1–9,4	14,1	10,8–17,5
3	6,1	4,9–7,3	13,5	10,0–17,1
4	6,0	4,8–7,2	10,1	6,8–13,5
5	5,5	4,3–6,6	11,3	7,7–14,8
6	3,4	2,4–4,4	3,6	1,3–6,0
7	3,7	2,5–4,9	5,4	2,1–8,7
8	2,5	1,3–3,6	3,8	0,3–7,4

Marini *et al*, *Ictus* 2005: 36: 1115-9

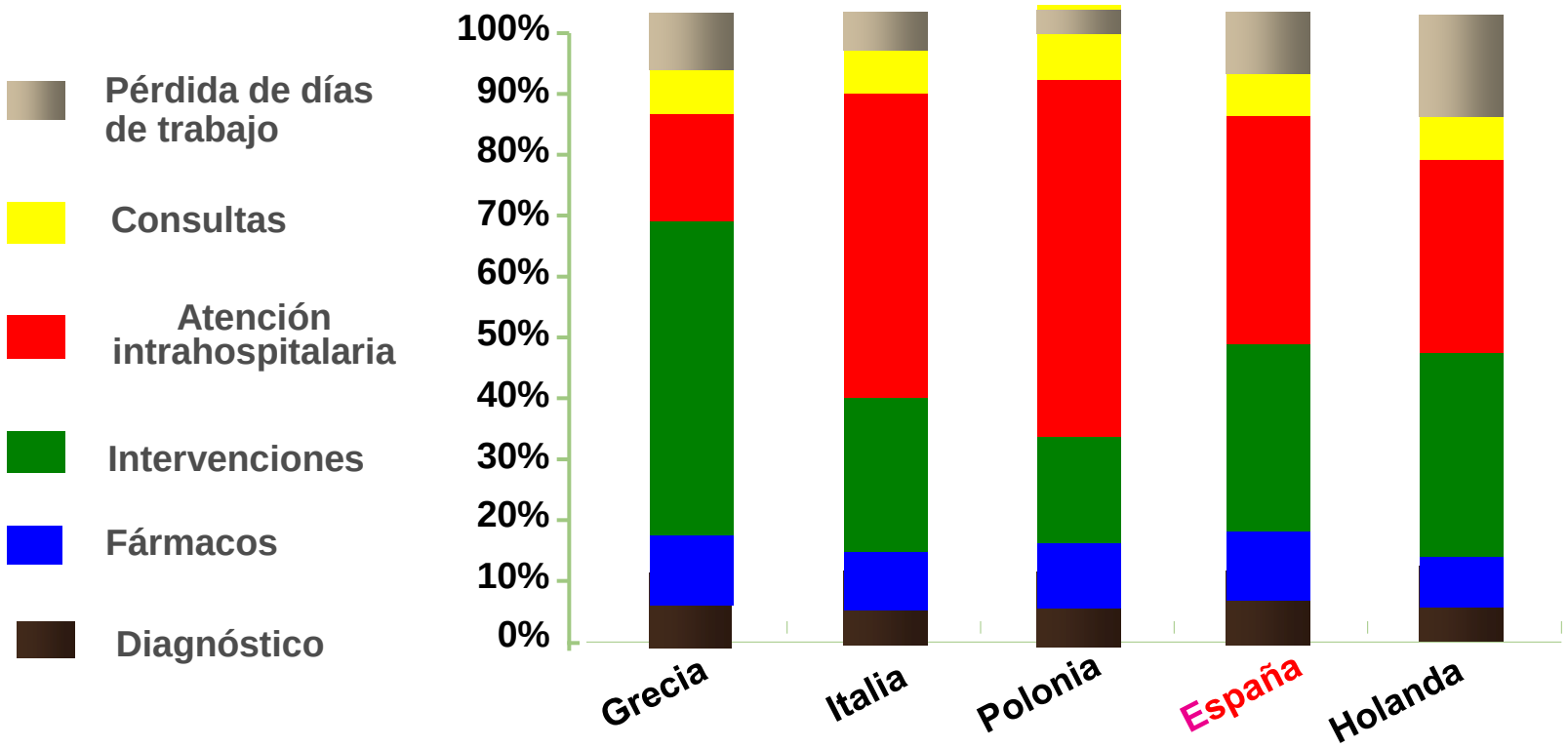
FA es la arrítmia que provoca mayor número de hospitalizaciones

n=517,699 **(10% de ingresos de causa cardiovascular)**



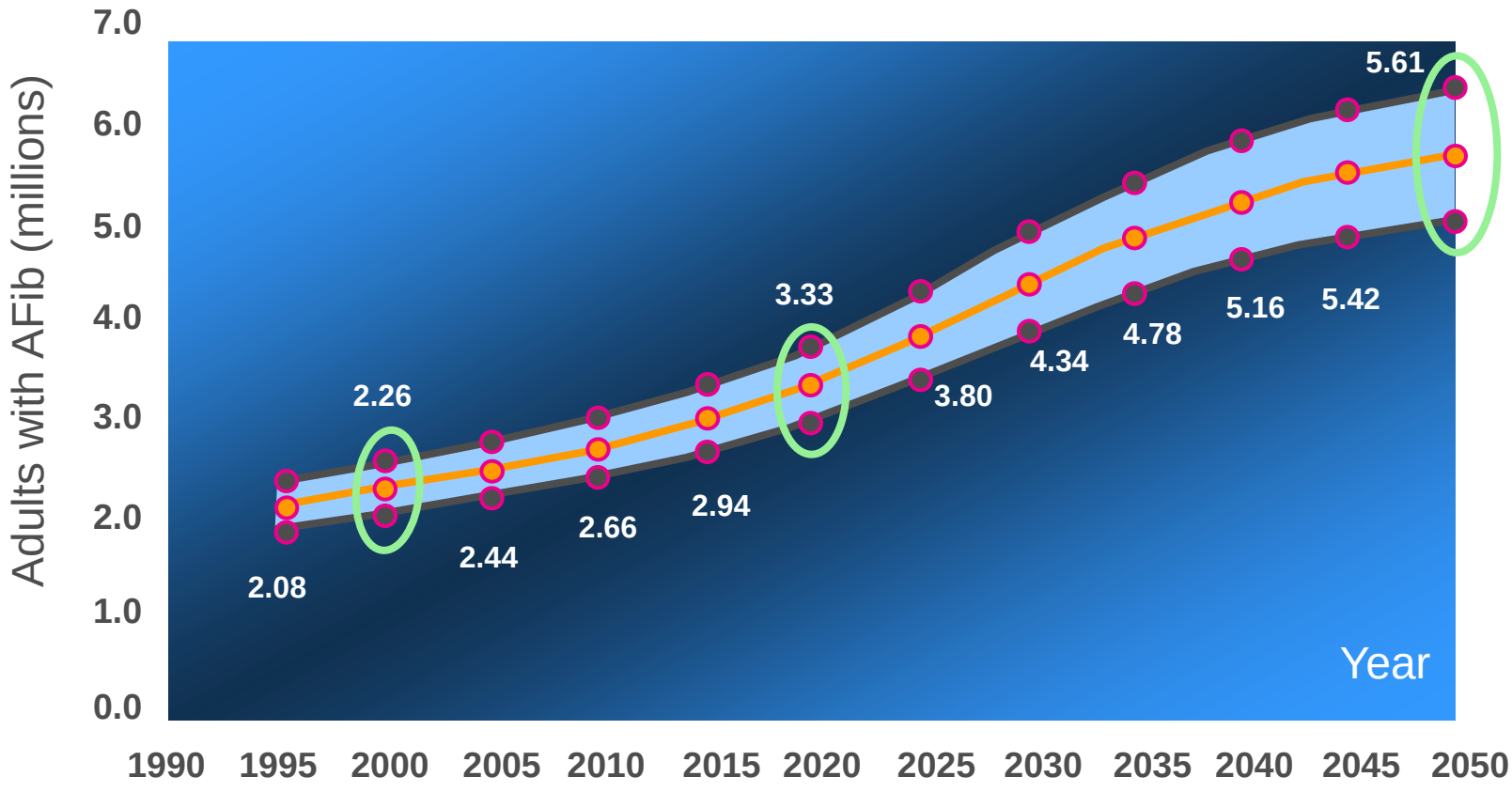
Camm AJ, Am J Cardiol 1996;78(8ª): 3-11

Coste económico de la fibrilación auricular



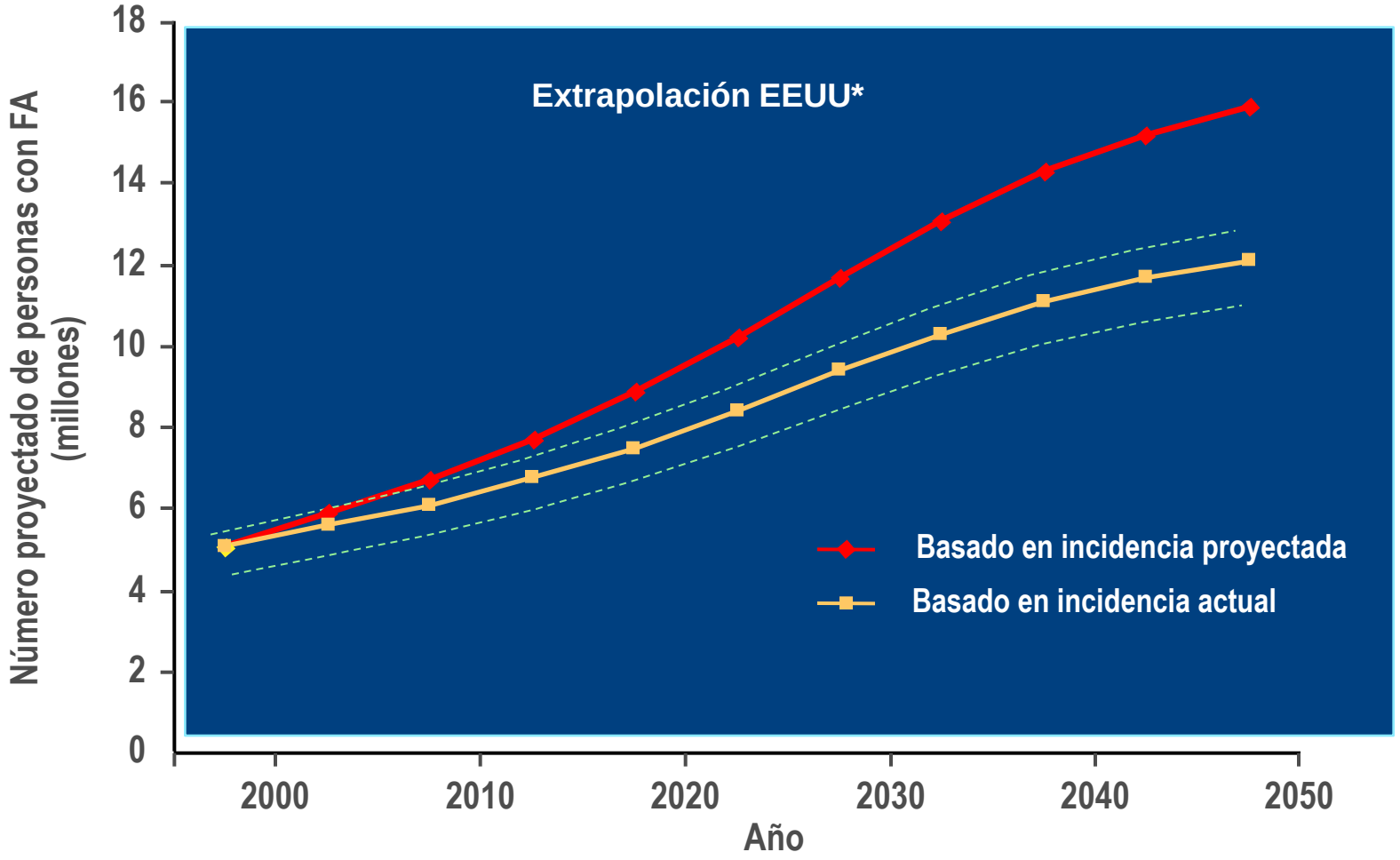
EuroHeart Survey 2004-2005. Ringborg *et al. Europace* 2008; 10:403–11.

Previsión de adultos con FA en EEUU (1995 and 2050)



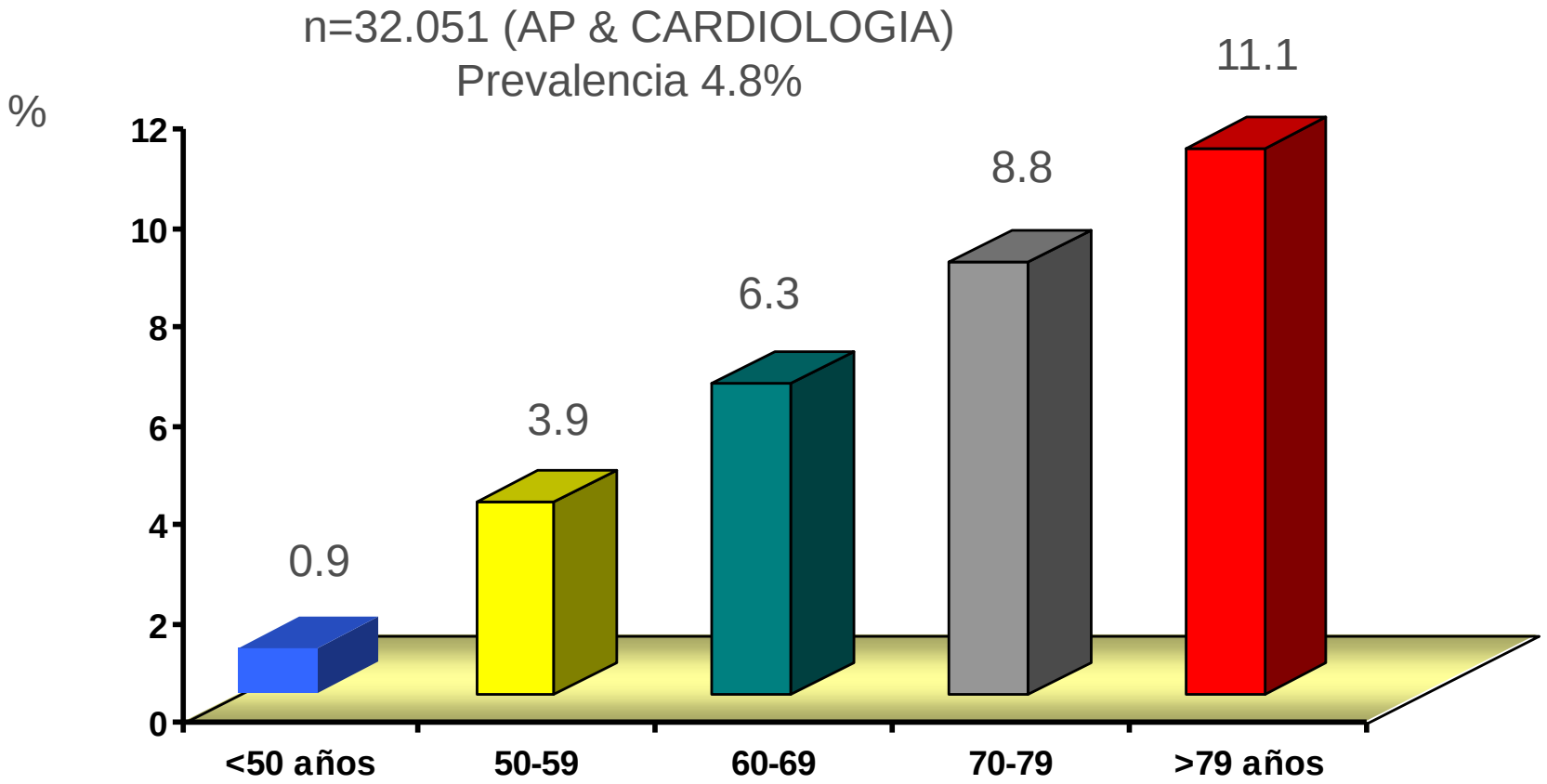
Go: JAMA, 2000

Previsión de adultos con FA en EEUU (2000 and 2050)



Miyasaka. Circulation 2006

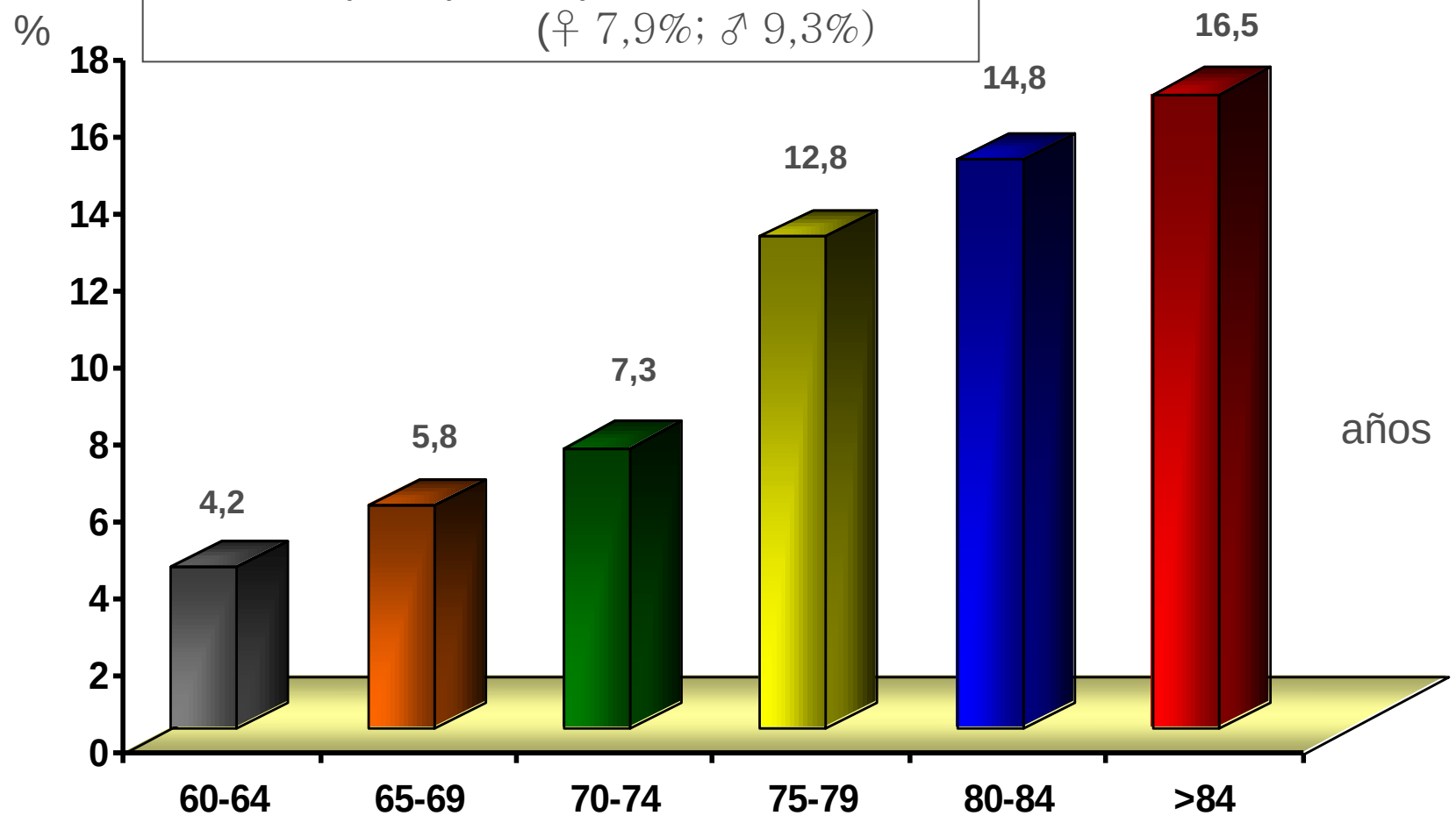
Prevalencia de fibrilación auricular en población hipertensa española



CARDIOTENS. Rev Esp Cardiol 2002; 55: 943-52

Prevalencia de FA en población general española

n=7.108 (>60a) ⟶ prevalencia FA 8.5%
(♀ 7,9%; ♂ 9,3%)



Estudio PREV-ICTUS. Rev Esp Cardiol 2007; 60: 616-24

RealiseAF: participating countries

Enrollment from October 30th, 2009 to May 3rd, 2010

Patients and AF characteristics

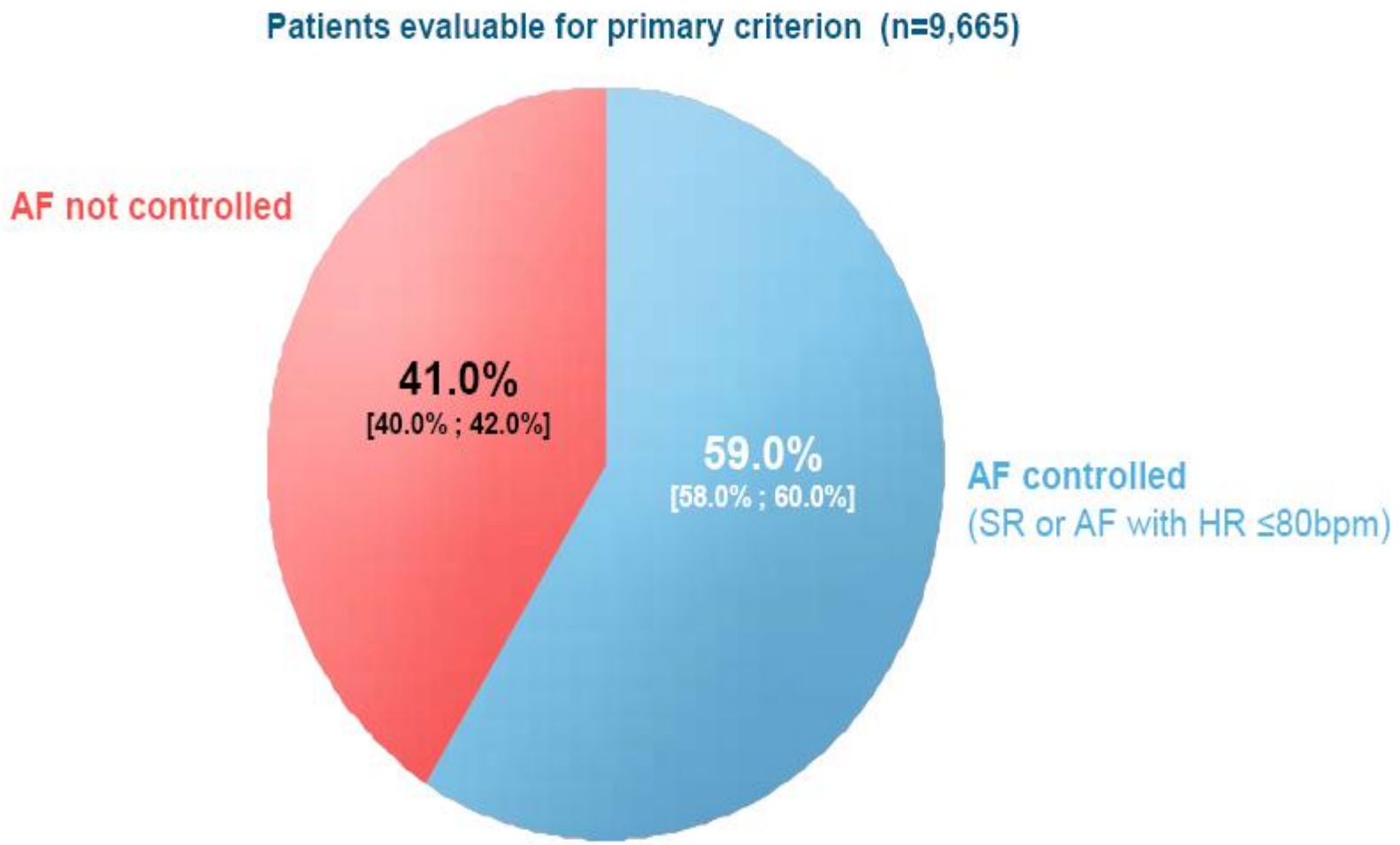
	Total N=10,523
Age ≥ 60 years (%)	73.9
Age mean (SD)	66.6 (12.2)
Males (%)	56.4
Ethnicity(%)	
Caucasian	84.2
Black	0.1
Asian	10.1
Hispanic	3.5
Other	2.1
BMI (kg/m²) mean (SD)	28.3 (5.2)
SBP (mm Hg) mean (SD)	132.8 (19.4)
DBP (mm Hg) mean (SD)	79.8 (11.4)

	Total (%)
Lone AF*	5.1
Time since AF diagnosis	
< 3 months	20.6
3 to 6 months	6.3
6 to 12 months	10.2
> 12 months	62.9
Type of AF	
Paroxysmal	24.8
Persistent	22.3
Permanent	46.4
Unable to assign (first episode)	6.4
Paroxysmal+Persistent	<0.1

* Patients aged under 60 years with no Coronary Artery Disease, no Heart Failure, no Valvular heart disease, no Chronic pulmonary disease, no VTE and no Arterial Hypertension

Primary outcome: control of AF

Sinus rhythm or AF with HR ≤ 80 bpm, on the ECG the day of the visit

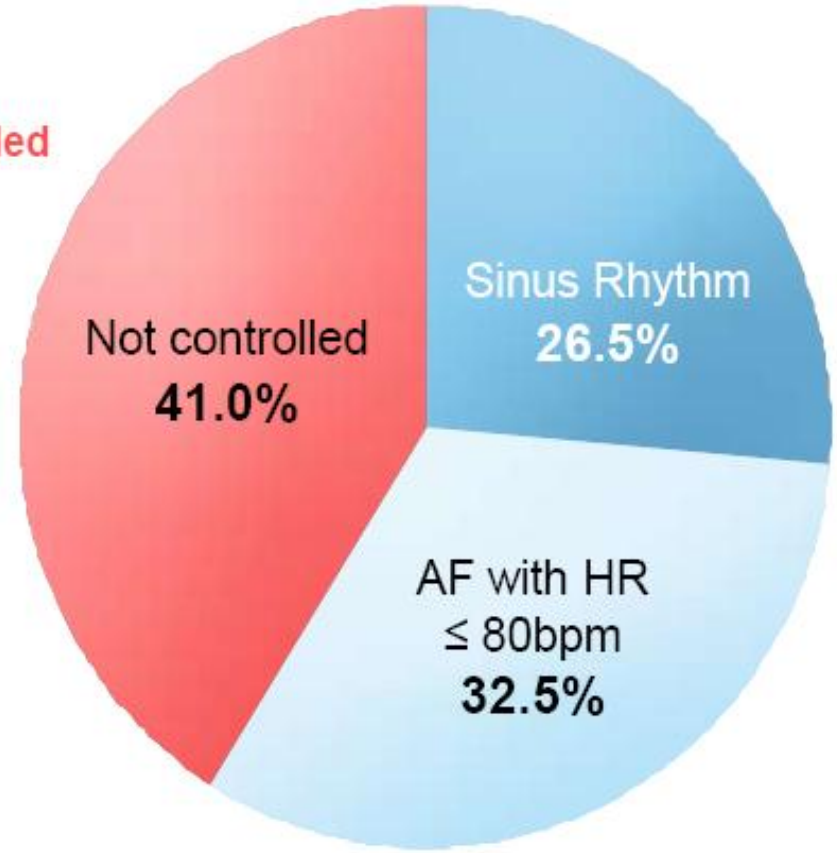


Primary outcome: control of AF

Sinus rhythm or AF with HR ≤ 80 bpm, on the ECG the day of the visit

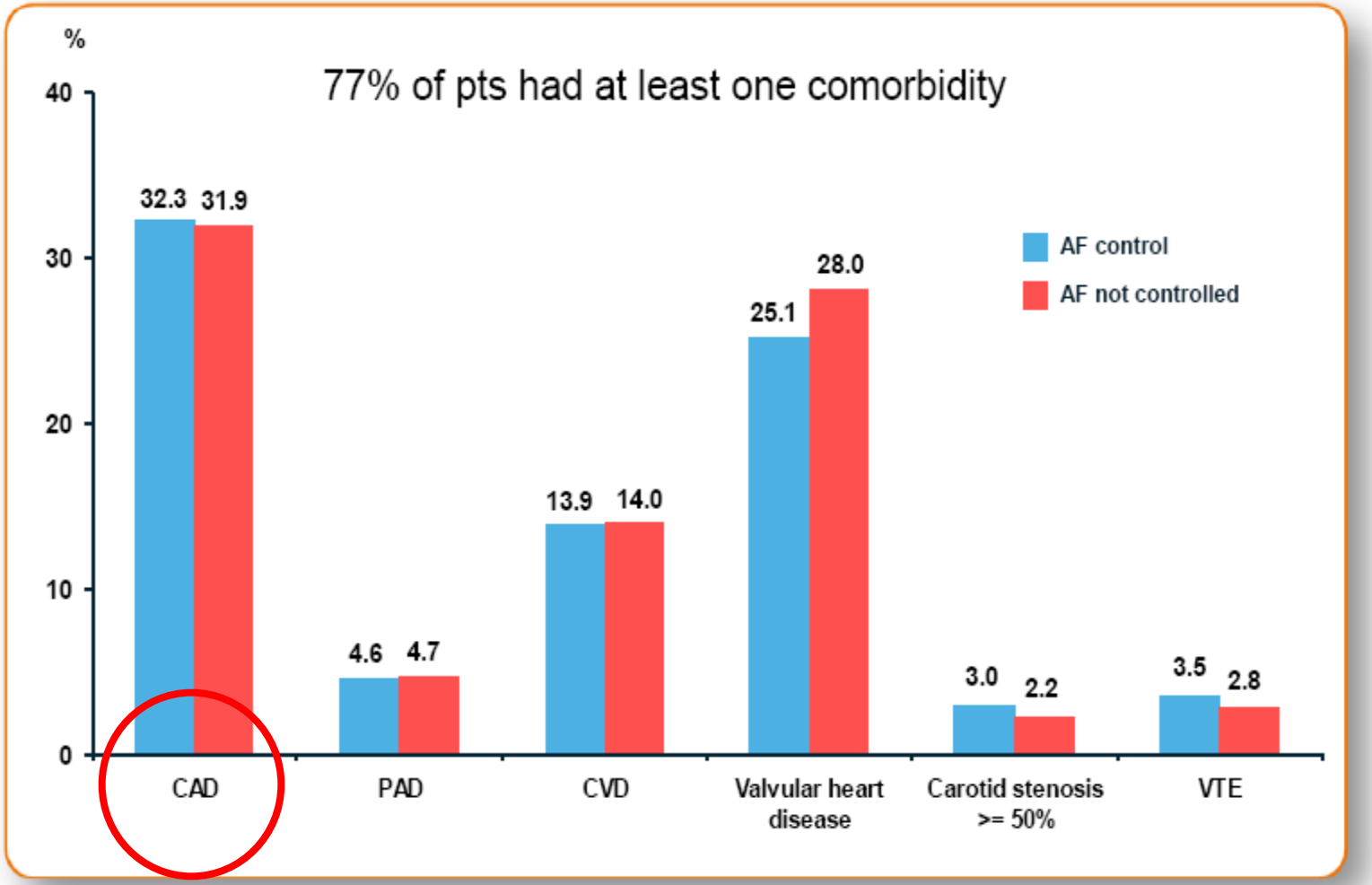
Patients evaluable for primary criterion (n=9,665)

AF not controlled
41.0%
[40.0% ; 42.0%]



AF controlled
(SR or AF with HR ≤80bpm)
59.0%
[58.0% ; 60.0%]

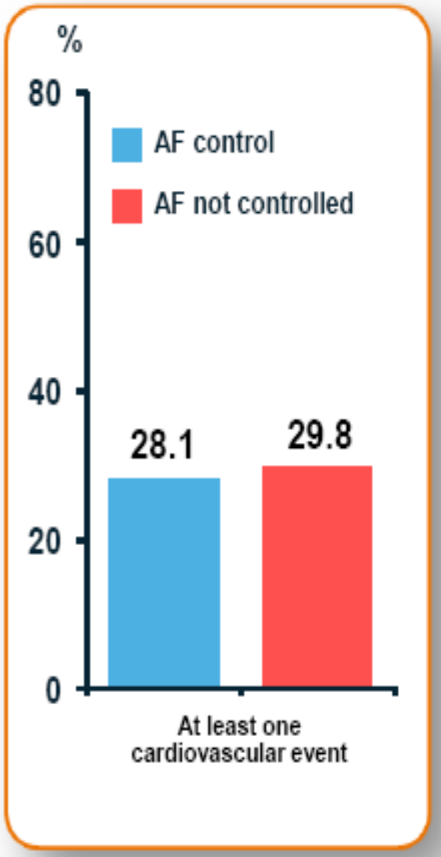
History of CV disease according to AF control

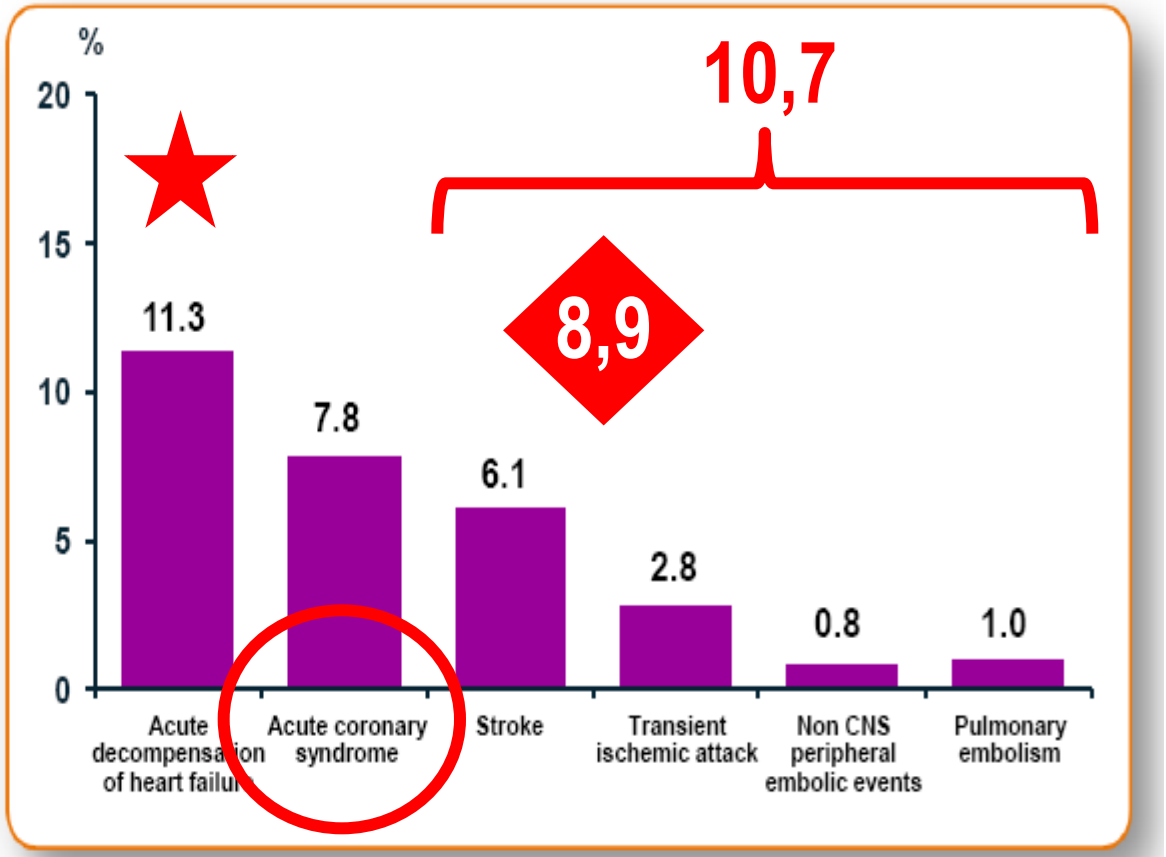


RealiseAF
real life global survey evaluating patients with Atrial Fibrillation

Frequent and severe CV events leading to unplanned hospitalisation in AF patients

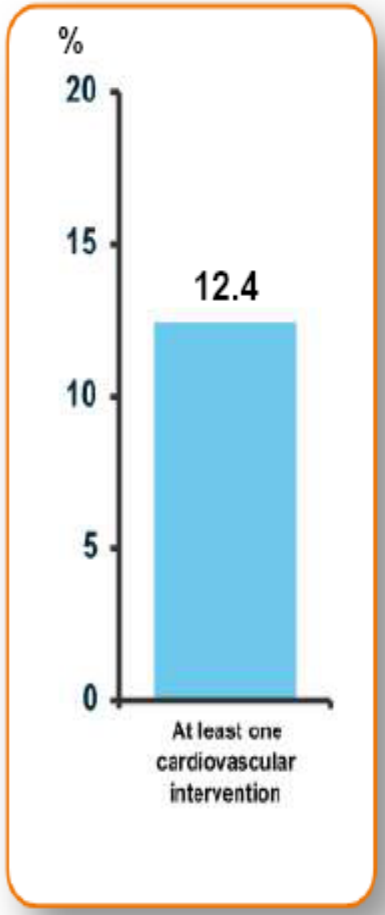
In the last 12 months

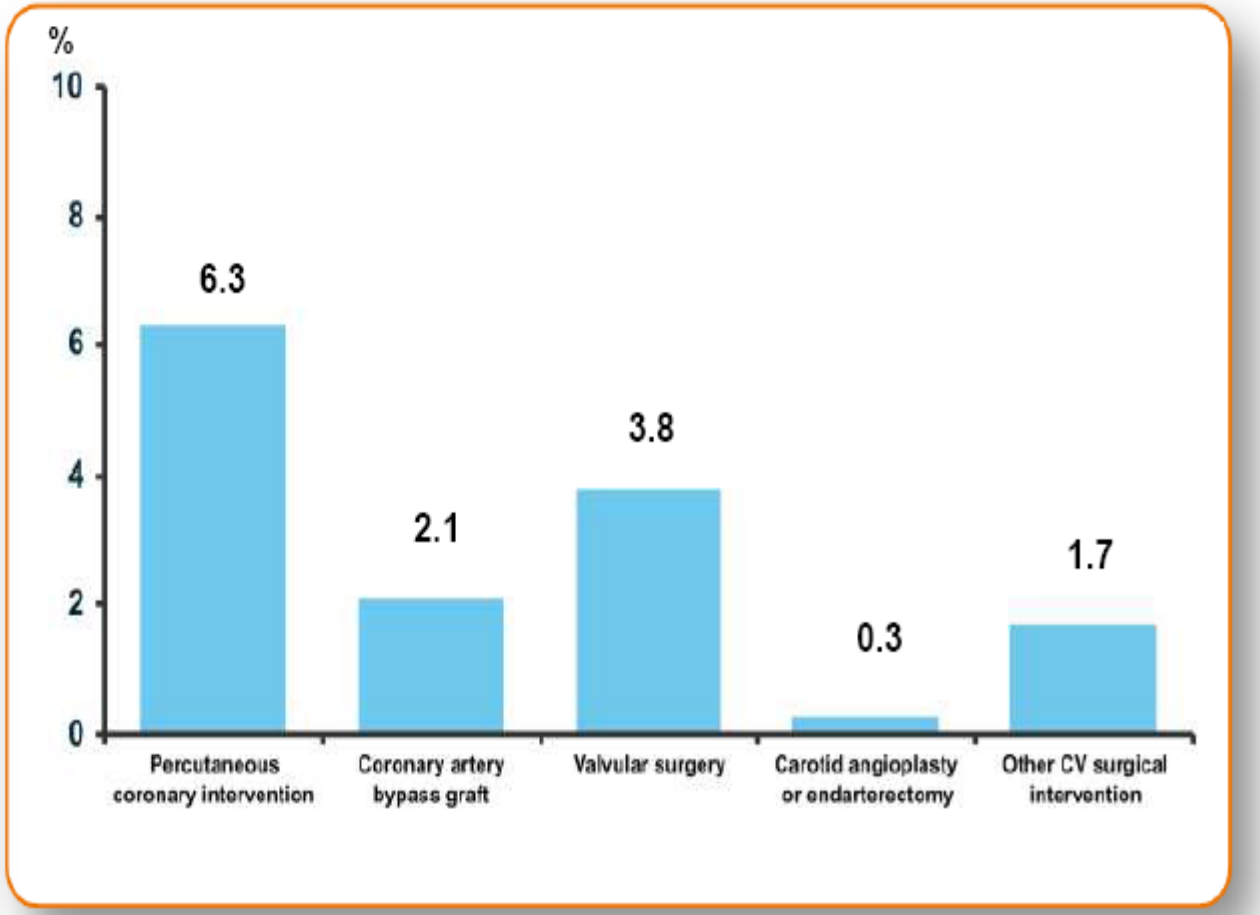




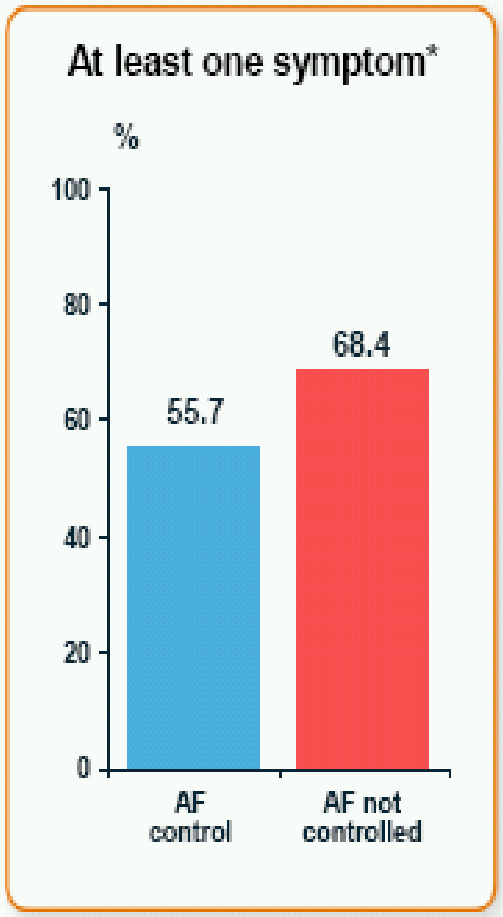
CV interventions in AF patients

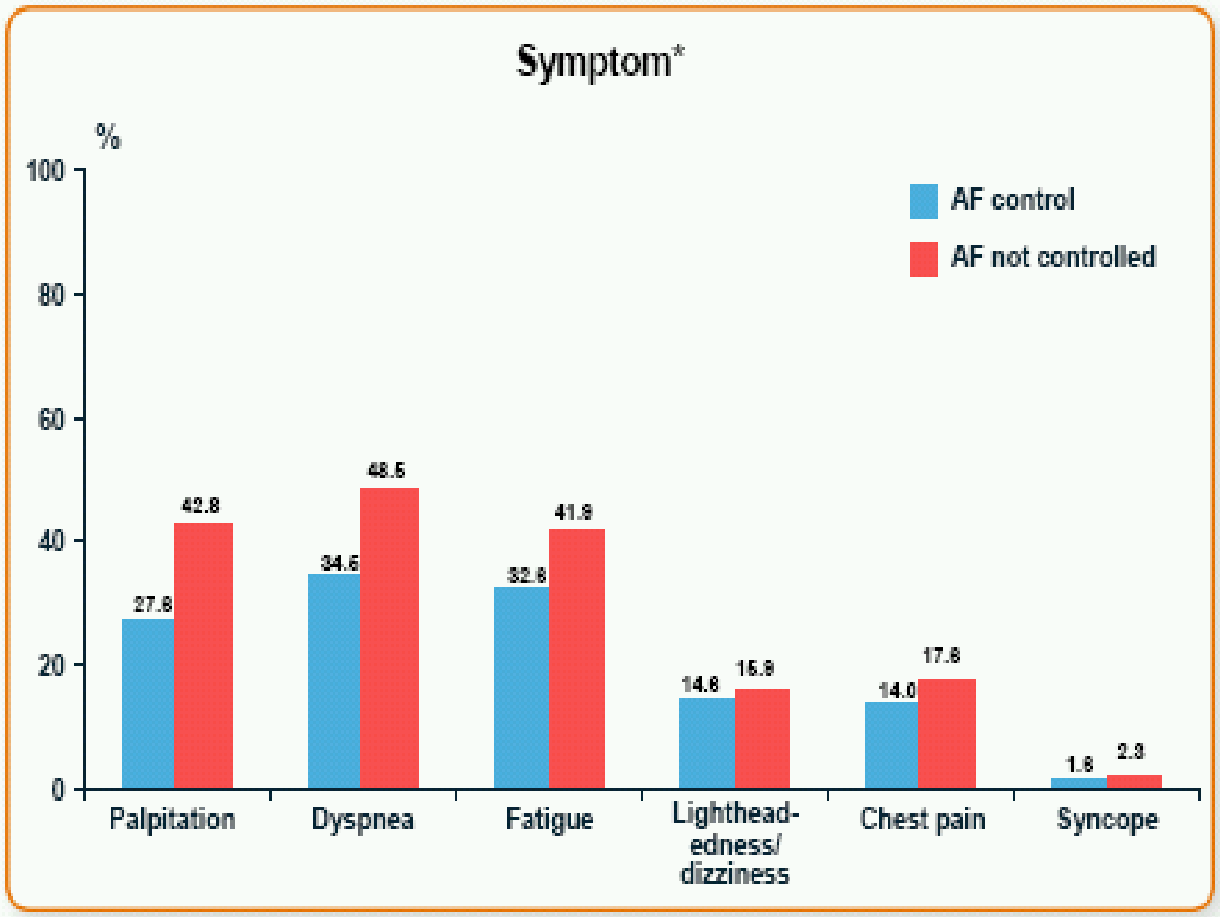
In the last 12 months



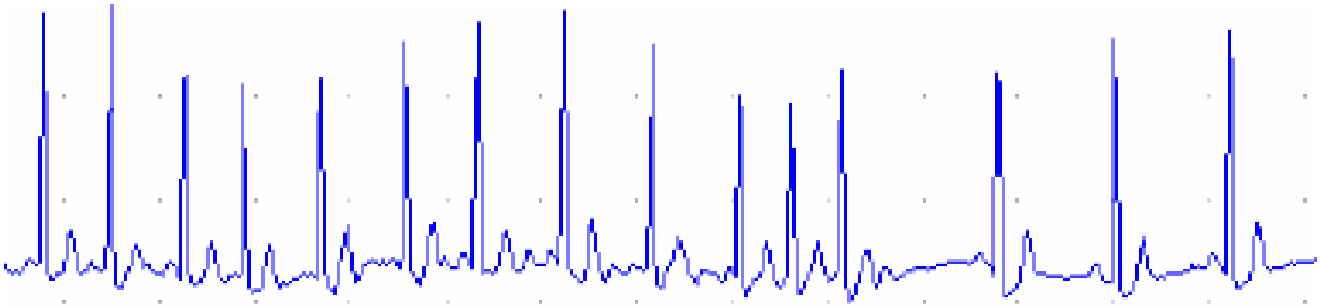


AF control was not indicative of symptom control





Asymptomatic AF detected by transtelephonic monitoring (TTM)



PAFAC (788 pts, persistent AF after CV, 12mo FU)

73% of all TTM-recorded AF recurrences were not associated with symptoms

SOPAT (1052 pts, paroxysmal AF, 12mo FU)

56% of all TTM-recorded AF recurrences were not associated with symptoms

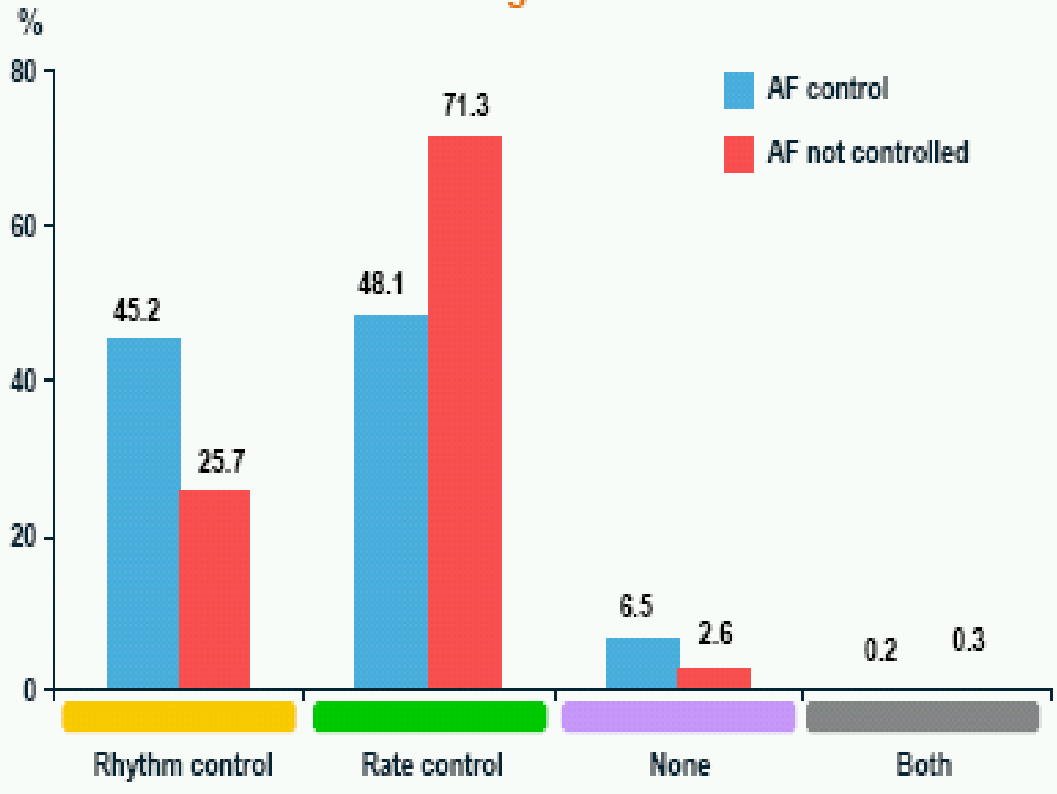
Fetsch T, et al. Eur Heart J.25: 1385-1394 (2004)
Patten M, et al. Eur Heart J.25: 1395-1404 (2004)
Kirchhof P, et al. Am Heart J.150: 899 (2005)

Rate control was the strategy most frequently chosen

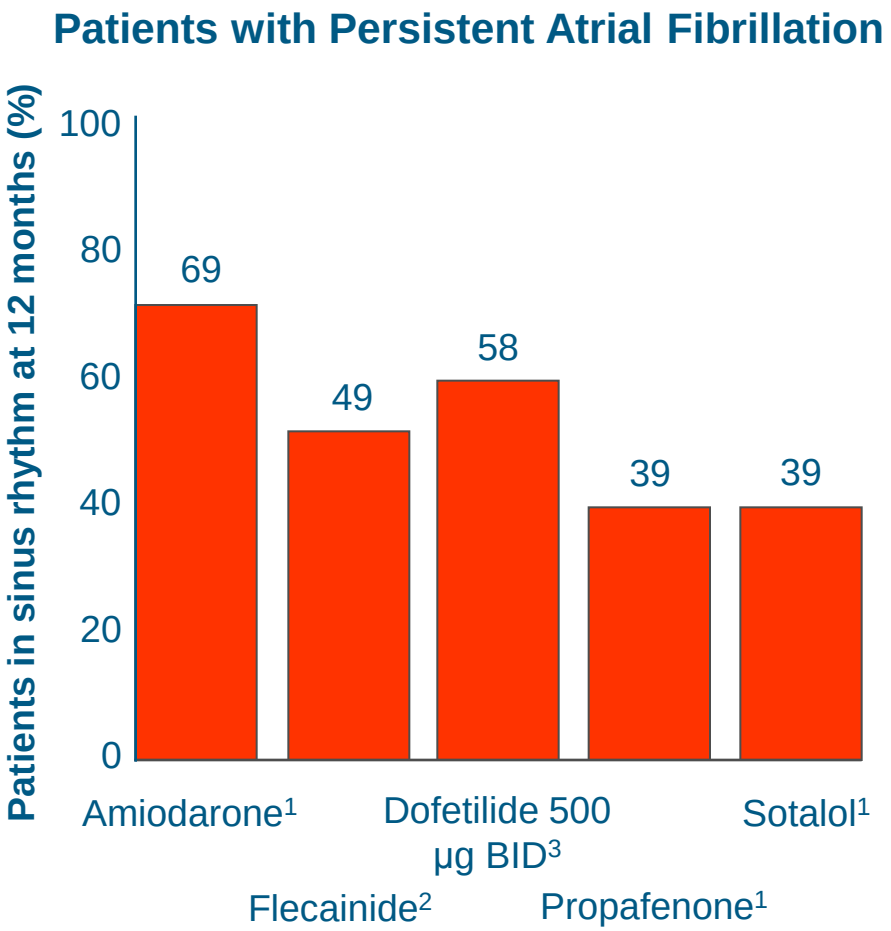
Fibrilación auricular

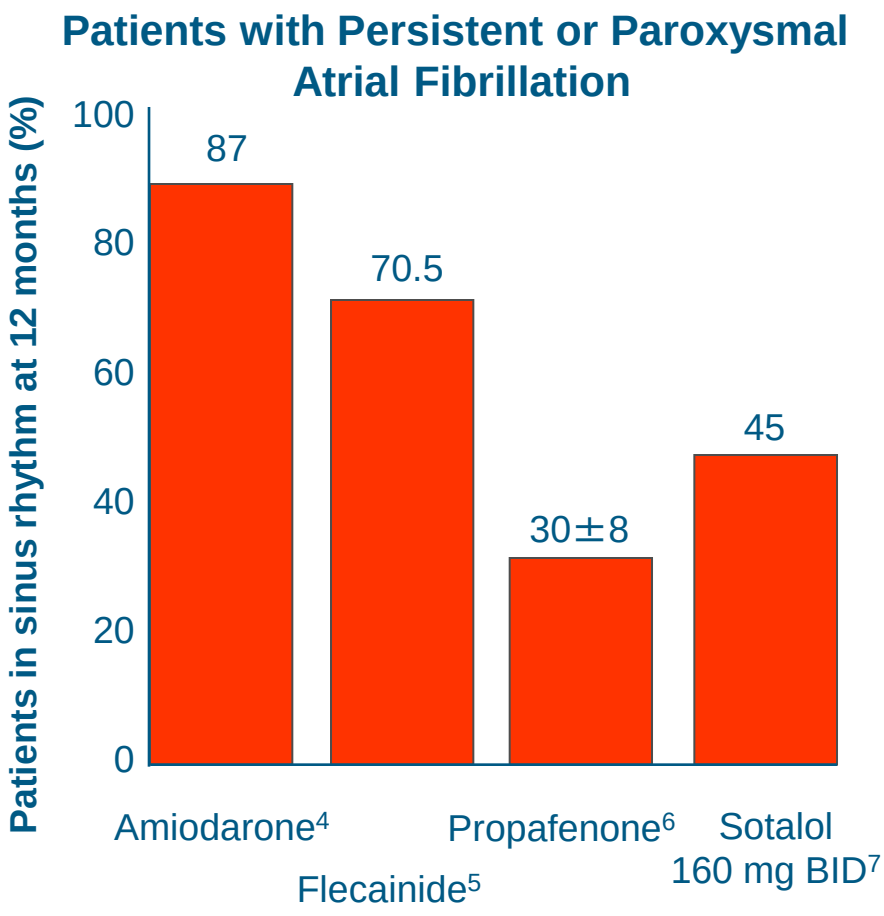
Therapeutic strategy chosen at the end of the visit

Therapeutic strategy chosen at the end of the visit - according to AF control



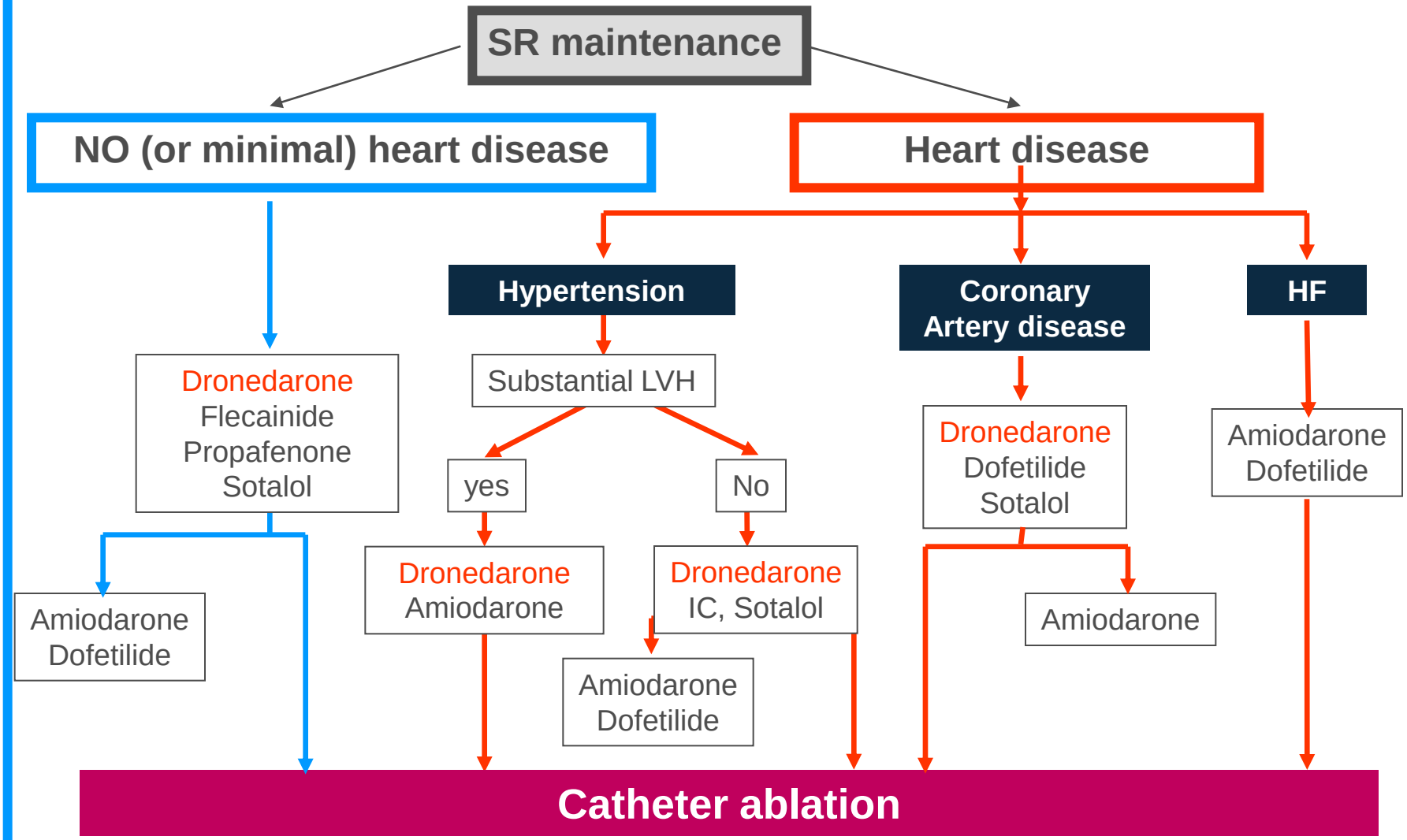
SR Maintenance at 12 Months with AADs





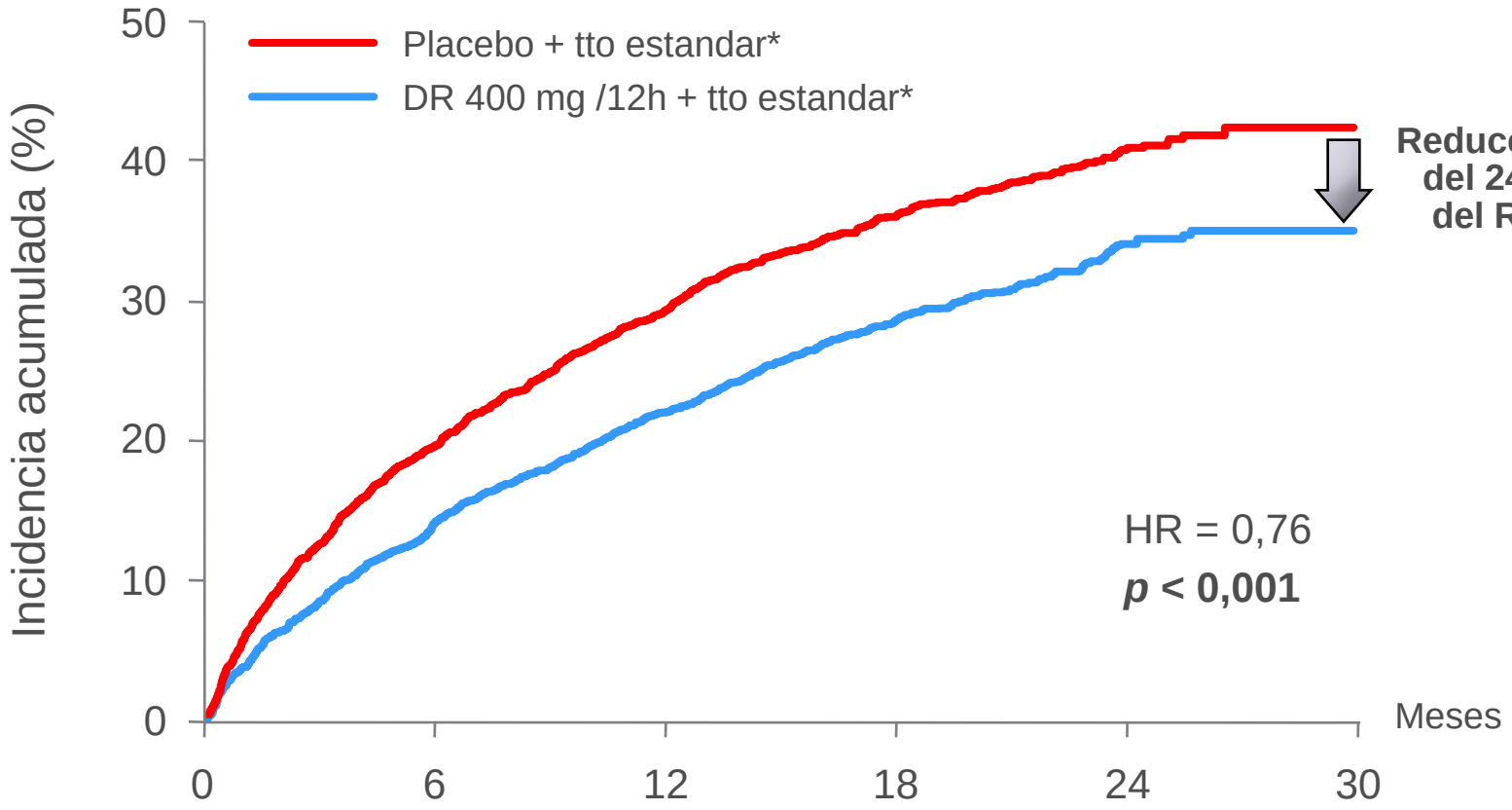
1. Roy D, *et al. N Engl J Med* 2000;**342**:913–920. 2. Van Gelder IC, *et al. Am J Cardiol* 1989;**64**:1317–1321. 3. Capucci, *et al. Int J Cardiol* 1999;**68(2):**187–196. 4. Chun Sh, *et al. Am J Cardiol* 1995;**76**:47–50. 5. Naccarelli GV, *et al. Am J Cardiol* 1996;**77**:53A–59A. 6. Reimold SC, *et al. Am J Cardiol* 1993;**71**:558–563. 7. Benditt DG, *et al. Am J Cardiol* 1999;**84**:270–277

Atrial fibrillation: management



ATHENA

Efecto de la Dronedarona en la mortalidad y hospitalización CV



Pacientes en riesgo:

Placebo	**2327**	**1858**	**1625**	**1072**	**385**	**3**
DR 400 mg /12h	**2301**	**1963**	**1776**	**1177**	**403**	**2**

Hohnloser SH *et al. N Engl J Med 2009;360:668-78.*

ATHENA

Efecto de la Dronedarona en la mortalidad

Mortalidad	Placebo n = 2327	Dronedarona n = 2301	HR	IC del 95%	*p*
Total	139	116	0.84	0.66; 1.08	0.18
Mort. NO CV	49	53	1.10	0.74; 1.62	0.65
Mort. CV	90	63	0.71	0.51; 0.98	0.03
Mort. cardiaca NO arrítmica	18	17	0.95	0.49; 1.85	0.89
Mort. cardiaca arrítmica	48	26	0.55	0.34; 0.88	0.01
Mort vasc. NO cardiaca	24	20	0.84	0.47; 1.52	0.57

Hohnloser SH *et al. N Engl J Med 2009;360:668-78.*

ATHENA

Dronedarona y hospitalización CV

Motivo de la 1ª hospitalización por causas CV	Placebo n = 2327	Dronedarona n = 2301	HR	IC del 95%	p
Cualquier motivo	859	675	0.74	0.67; 0.82	<0.001
Fibrilación auricular	510	335	0.63	0.55; 0.72	<0.001
ICC	132	112	0.86	0.67; 1.10	0.22
SCA	89	62	0.70	0.51; 0.97	0.03
Síncope	32	27	0.85	0.51; 1.42	0.54
Arritmia ventricular o PCR	12	13	1.09	0.50; 2.39	0.83

Hohnloser SH *et al. N Engl J Med 2009;360:668-78.*

Atrial fibrillation: surgery

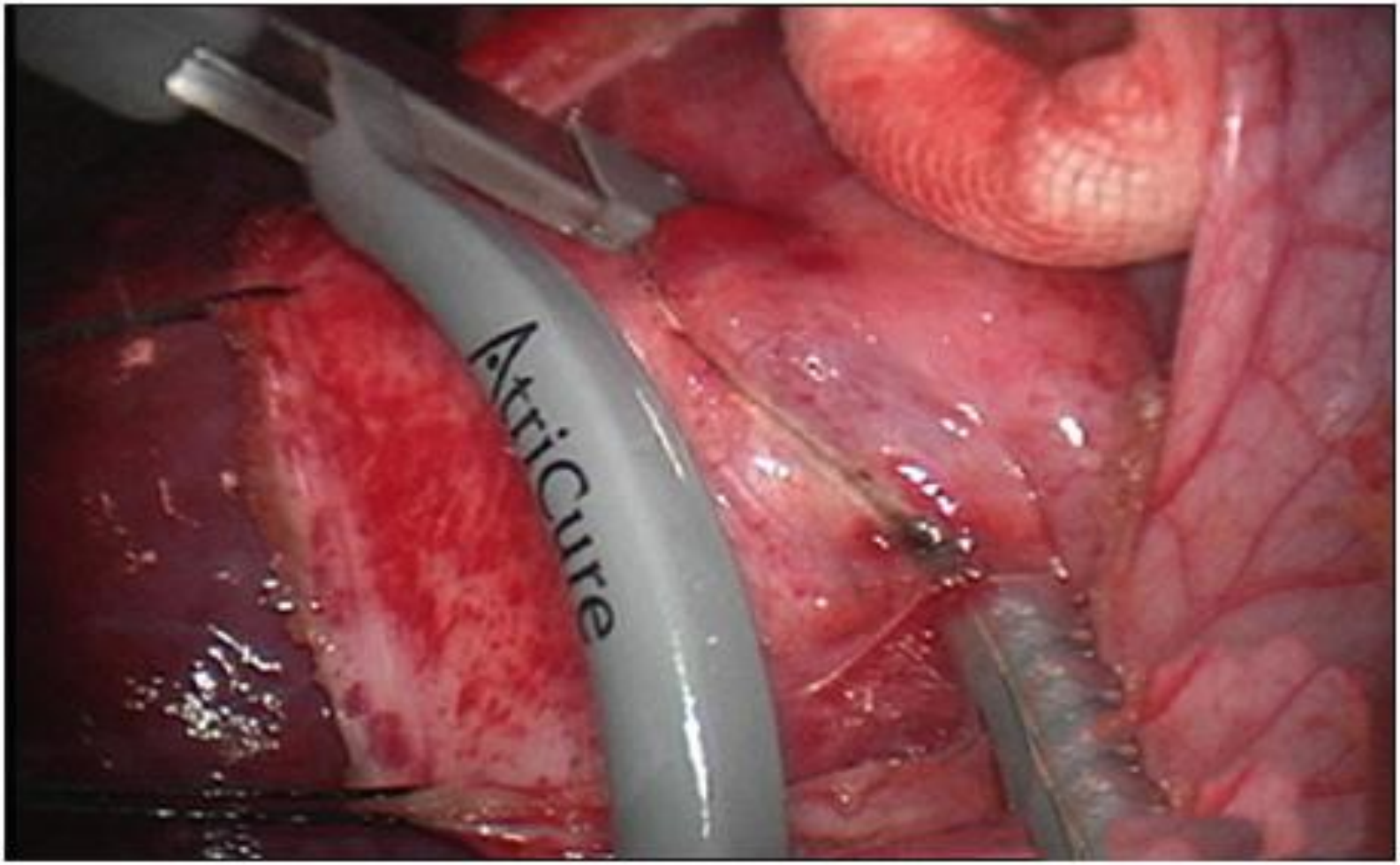
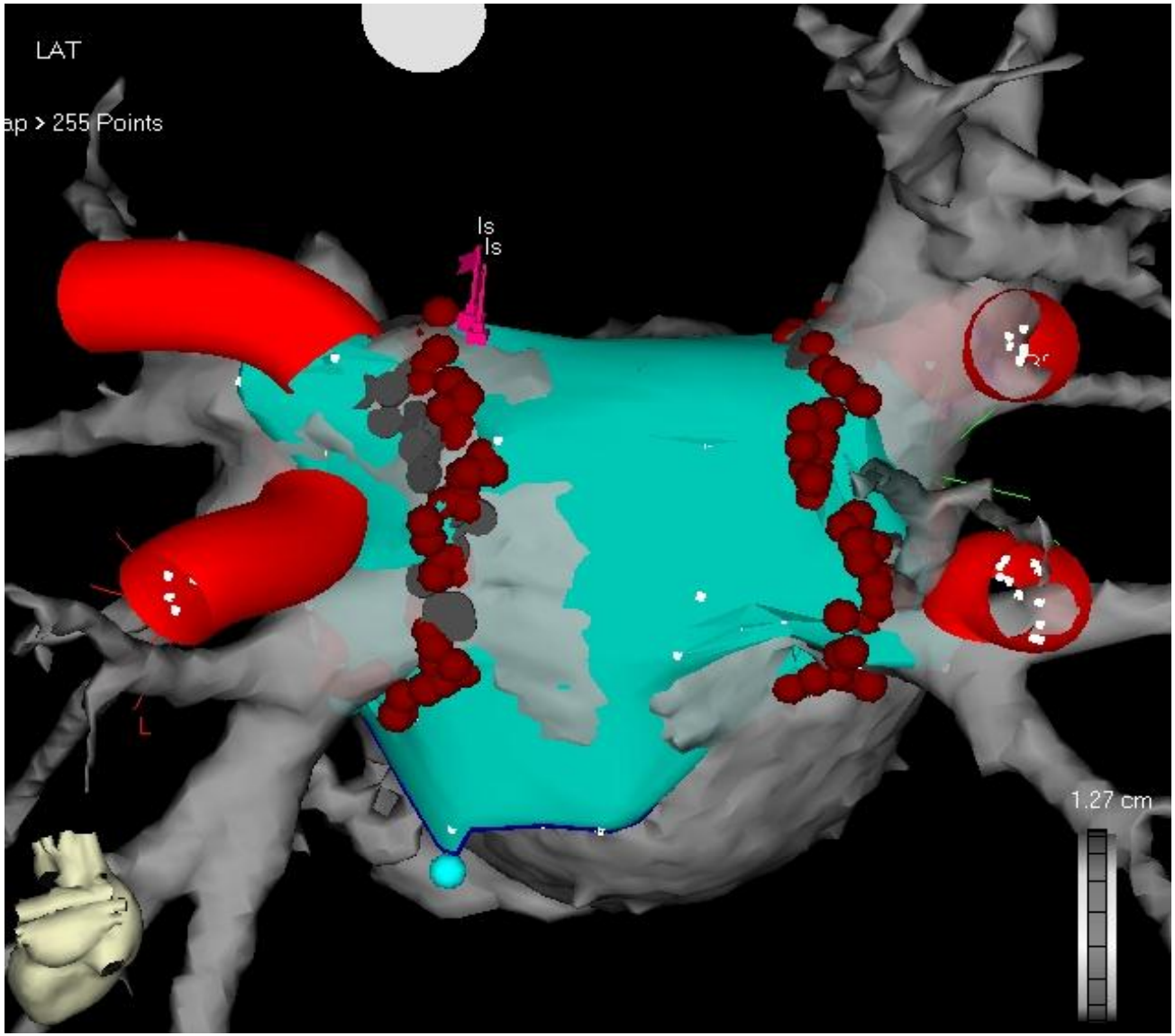
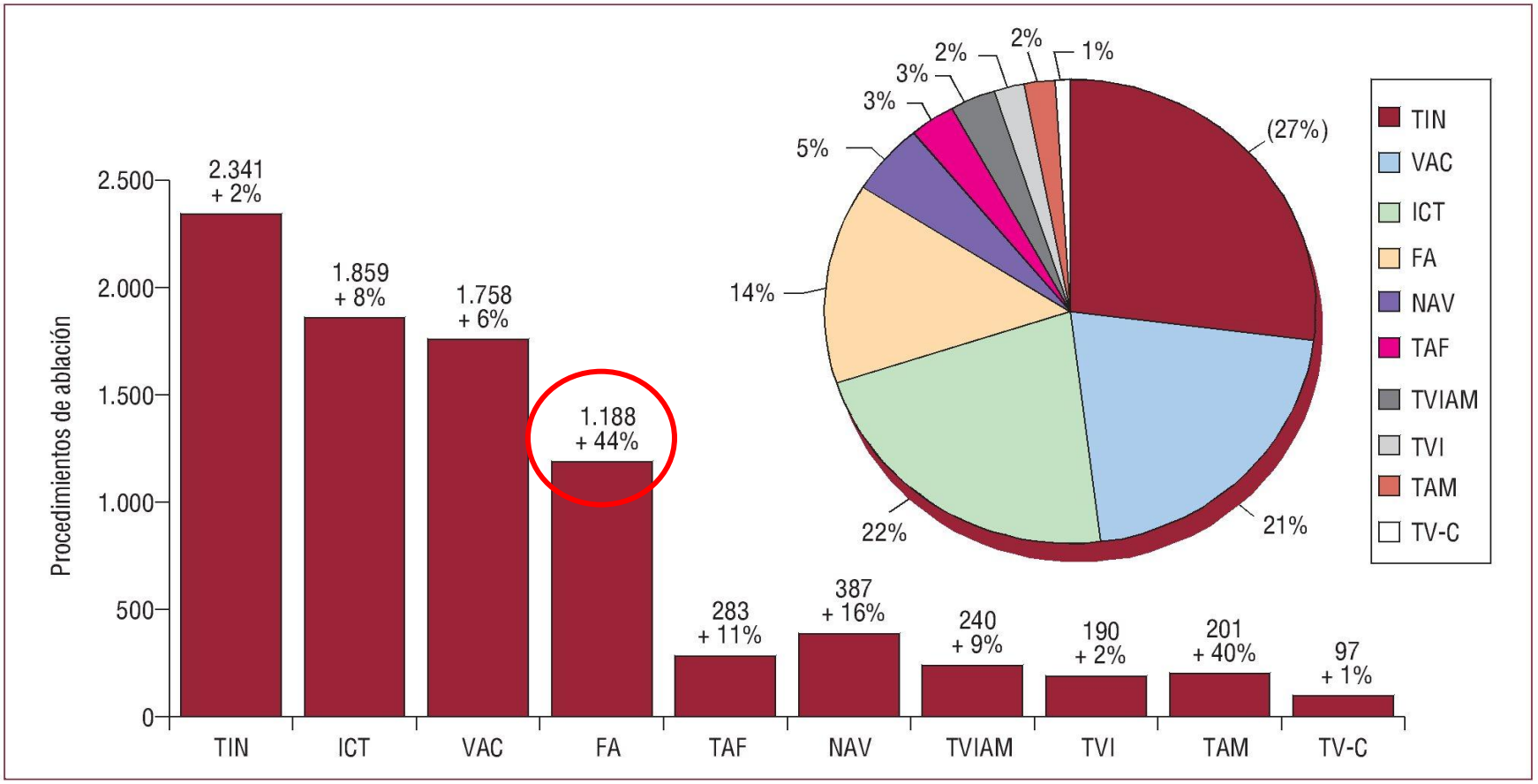


Image fusion-guided AF ablation



Registro Español de ablación transcatéter

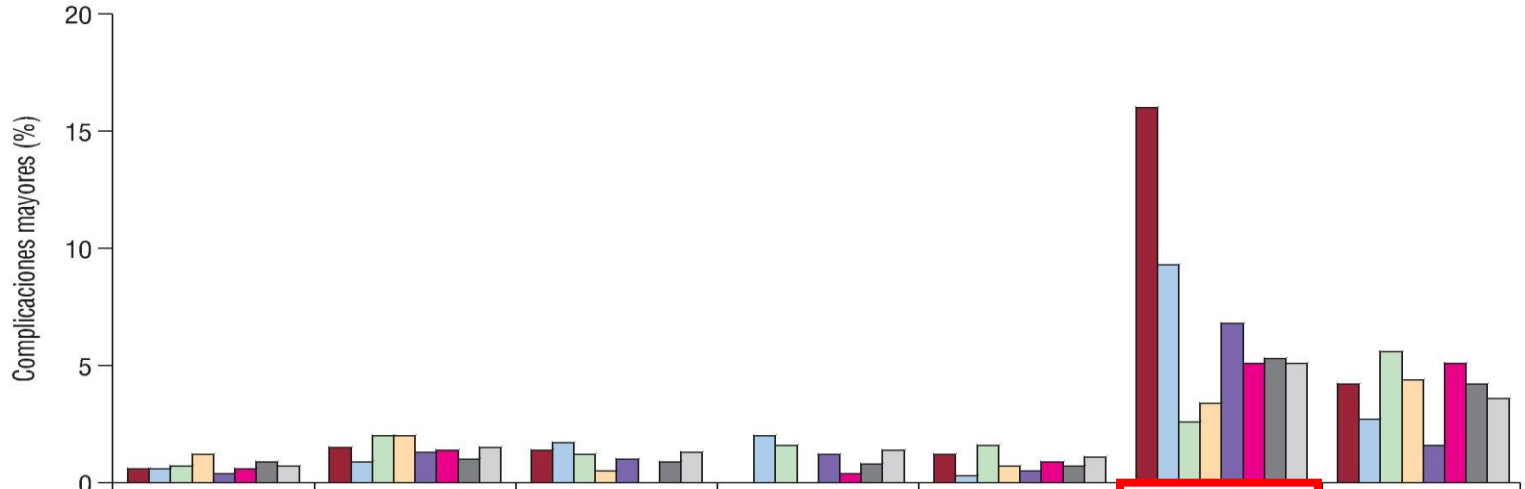
Procedimientos de ablación



Díaz-Infante E, *et al.*, Rev Esp Cardiol.2010; 63 :1329-39

Registro Español de ablación transcatéter

Complicaciones mayores (%)



	TIN	VAC	NAV	TAF	ICT	FA	TV
2002	0,6	1,5	1,4	0	1,2	16	4,2
2003	0,6	0,9	1,7	2	0,3	9,3	2,7
2004	0,7	2	1,2	1,6	1,6	2,6	5,6
2005	1,2	2	0,5	0	0,7	3,4	4,4
2006	0,4	1,3	1	1,2	0,5	6,8	1,6
2007	0,6	1,4	0	0,4	0,9	5,1	5,1
2008	0,9	1	0,9	0,8	0,7	5,3	4,2
2009	0,7	1,5	1,3	1,4	1,1	5,1	3,6

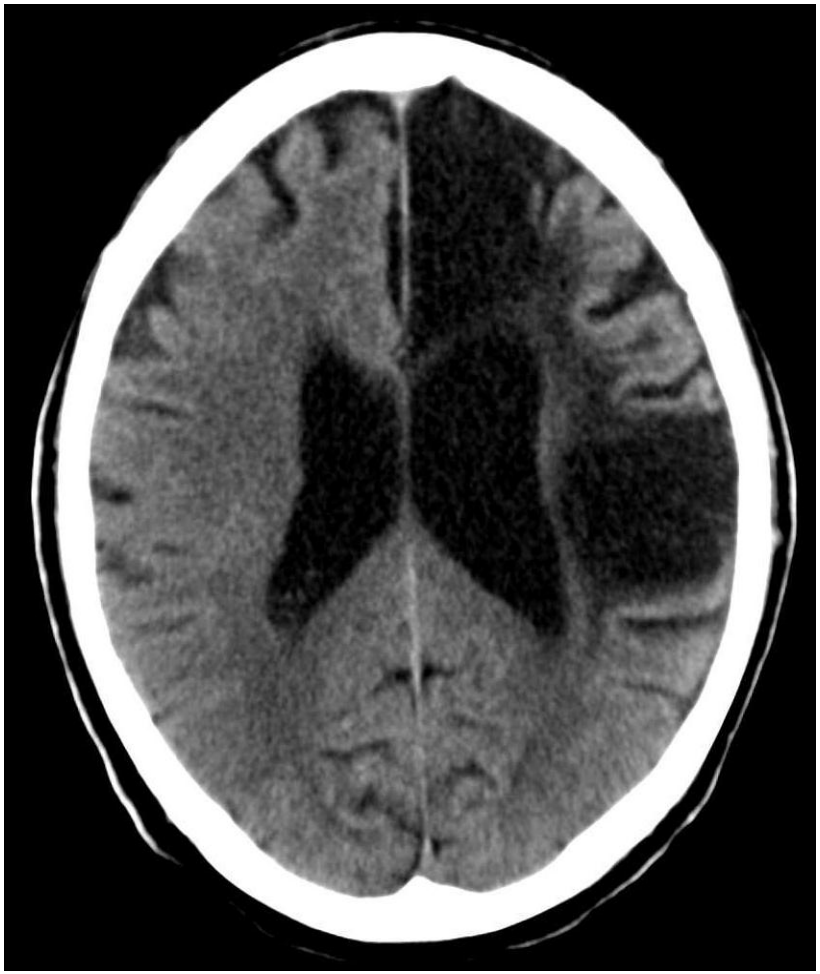
Díaz-Infante E, *et al*., Rev Esp Cardiol.2010; 63 :1329-39

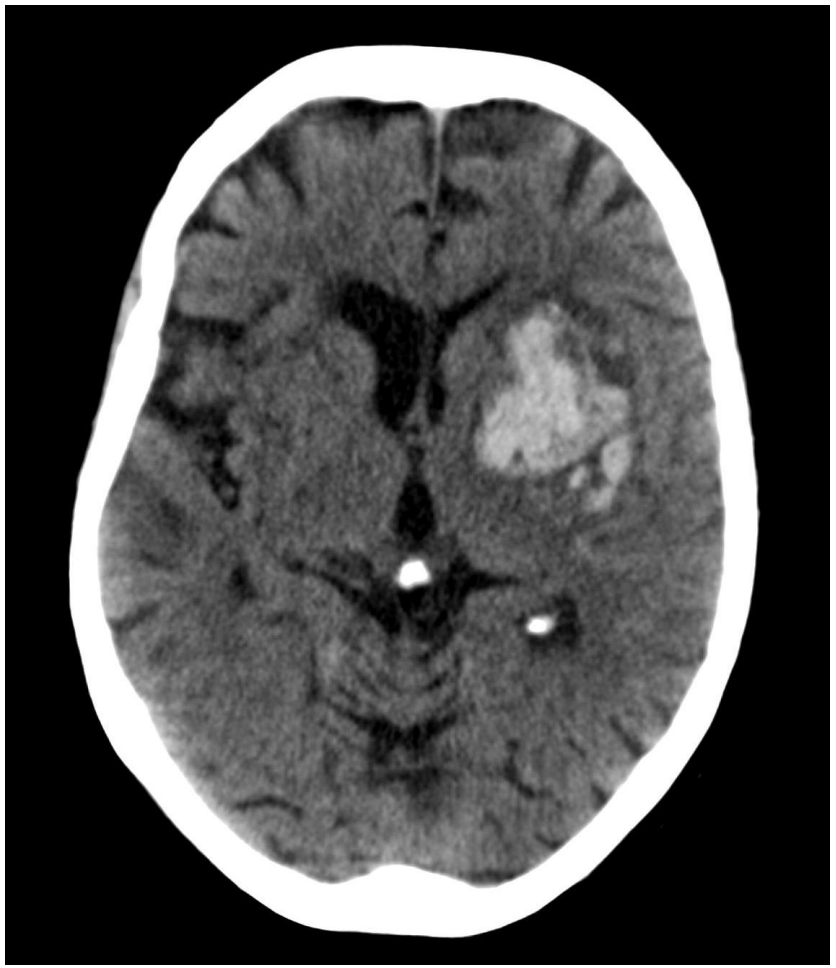
HRS/EHRA/ECAS Expert Consensus Statement on Catheter and Surgical Ablation of Atrial Fibrillation

“ Posteriormente a una ablación, NO puede recomendarse discontinuar el tratamiento con warfarina en aquellos pacientes con un índice de CHADs ≥2 ”

Calkins et al. Europace 2007. 9 (6): 335-379.

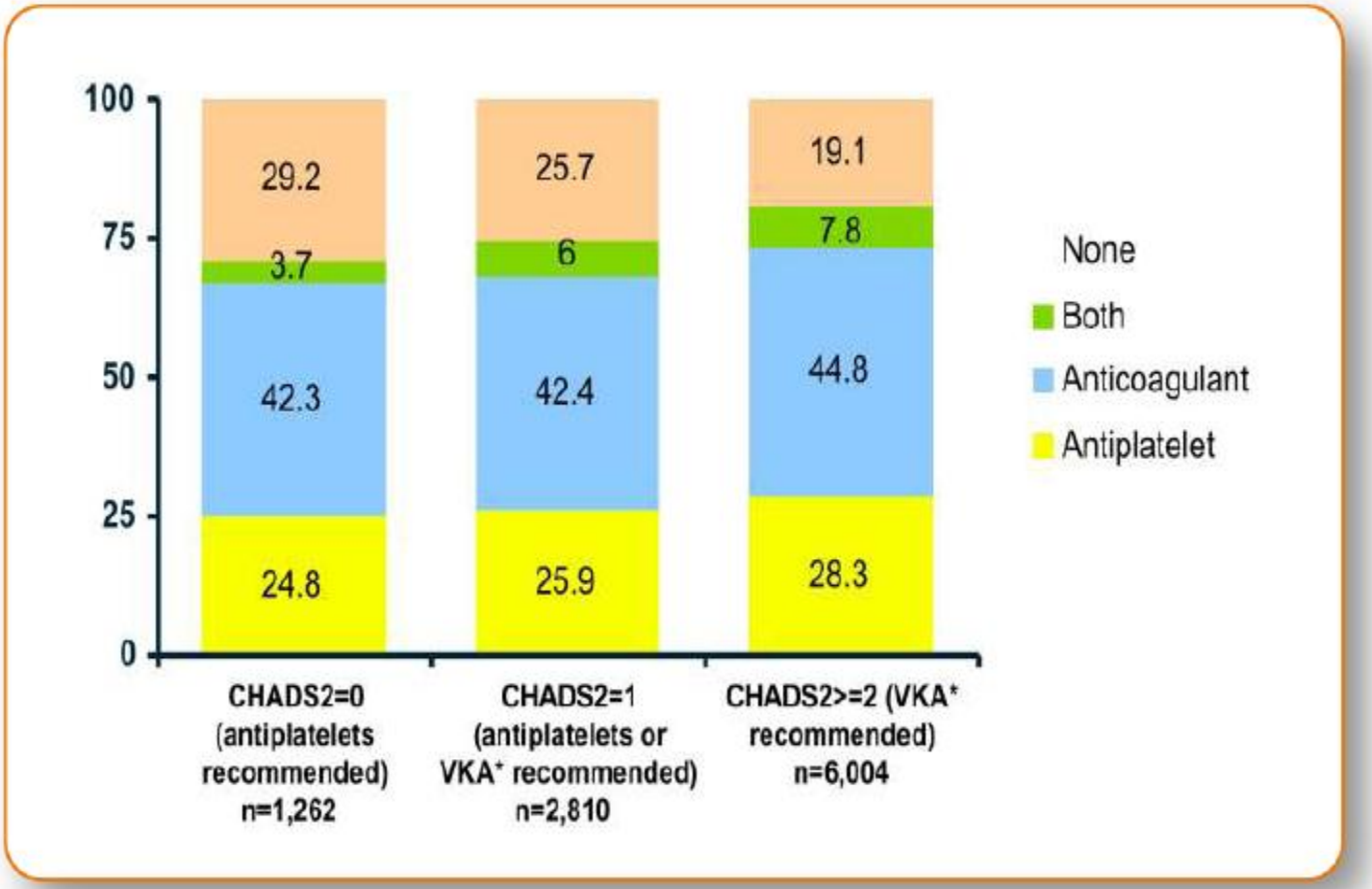
Complicaciones mayores de la FA: trombos & hemorragias





RealiseAF

Management of AF in a real life setting deviates from guidelines*



ACC/AHA/ESC guidelines

ACO en España (centros de excelencia)

Resumen

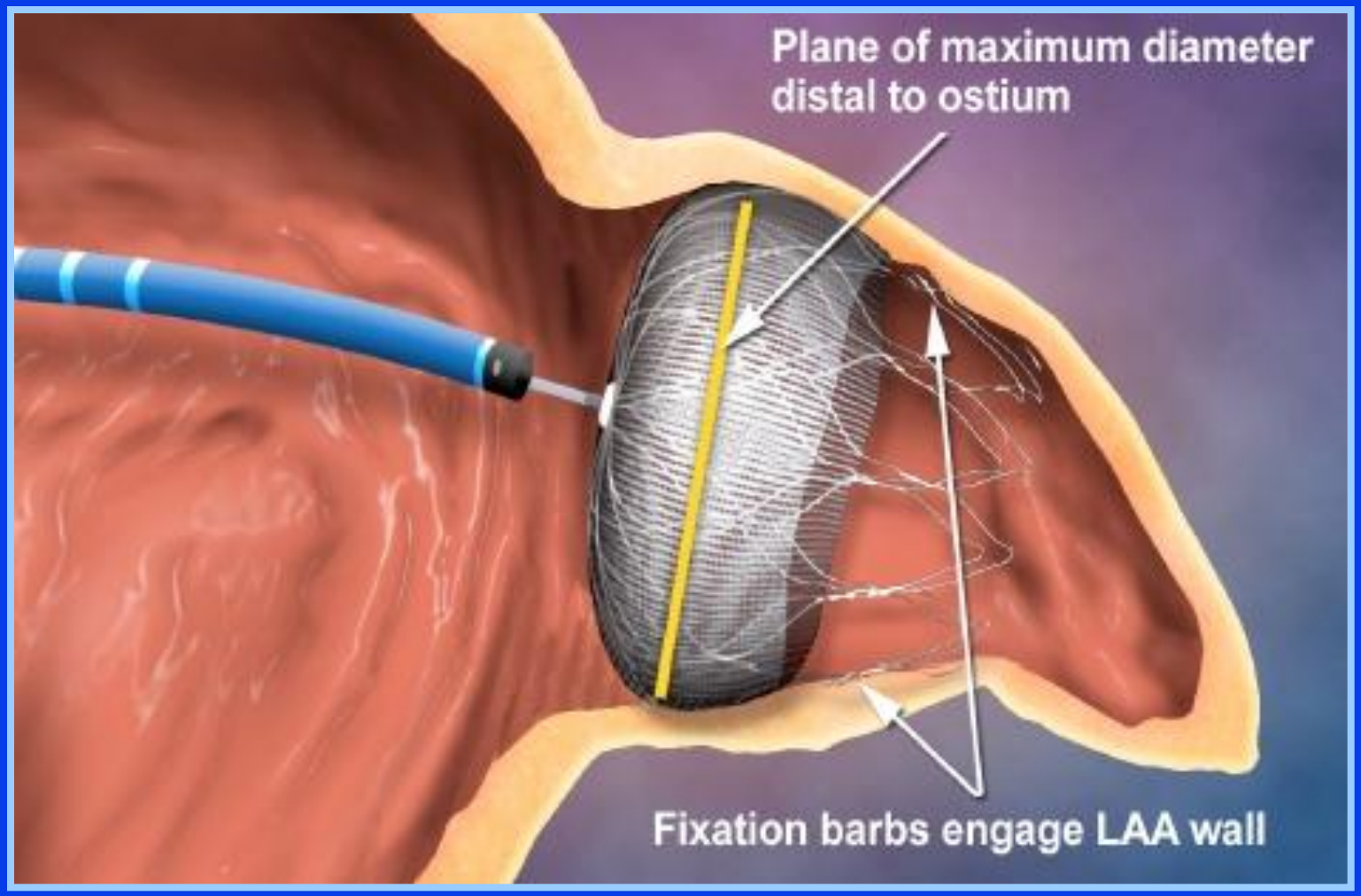
- **ACO en 1,3% de la población**
  FA en 0.8% de la población (1ª causa de ACO)

- **20.347 pacientes → 211.987 controles**

  - ✓ **Tiempo en rango terapéutico 72,1%**
  - ✓ **Hemorragias 2.369 (graves 8%)**
    (0,1 muertes/100 paciente/año)
  - ✓ **Tromboembolismo 299**
    (0,05 muertes/100 pacientes/año)
  - ✓ **Máximo riesgo prótesis valvulares**

Navarro JE, et al. Rev Esp Cardiol. 2007;60(12):1226-32

WATCHMAN LAA Closure Device in situ



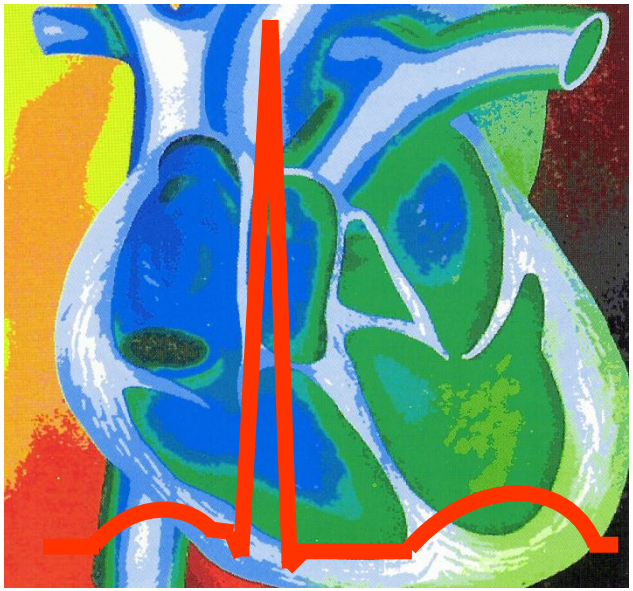
Conclusiones

FA es una creciente enfermedad CV que:

- **↑ morbilidad y mortalidad, ↓ calidad de vida y ↑ costes individuales y sociales.**
- **Opciones terapéuticas farmacológicas actuales dirigidas a mejoría de sintomas y lo logran deficitariamente.**
- **Procedimentos invasivos curativos en expansión y pueden variar el escenario, pero cobertura universal improbable en próximos años y aún muestra riesgo de complicaciones.**
- **La gran mayoría de pacientes necesitarán anticoagulación crónica. Los dicumarínicos muestran frecuentes complicaciones (incluso en centros de excelencia). Estas son potencialmente letales (hemorragia >>tromboembolismo). Los nuevos ACO son una relevante innovación terapèutica.**

El paciente con fibrilación auricular del Siglo del XXI tiene aún múltiples retos

MUCHAS GRACIAS



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