Atrial Fibrillation in ACS
Case presentation

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Conflict of interest:

• Nothing to declare.
History:

- 73 y old Saudi male presented to ER with recurrent chest pain
- Past History
  - Prior CAD: S/P PCI to OM in the setting of acute STEMI 3 years ago
  - Coronary anomaly
  - CKD eGFR=58 mL/min/1.73m²
  - Dyslipidemia

Physical Exam
- Weight: 80 kg
- BMI: 24.6 kg/m²
- BP: 123/77
- PR: 66 bpm irregular
- Otherwise Negative CV Exam
PCI to LAD,
2\textsuperscript{nd} generation
DES
**Dose this patient require long term anticoagulation?**

<table>
<thead>
<tr>
<th>Death</th>
<th>% Risk (Score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In hospital</td>
<td>1.2</td>
</tr>
<tr>
<td>6 months</td>
<td>4.9–5.3 (105)</td>
</tr>
<tr>
<td>1 year</td>
<td>4.9–5.3</td>
</tr>
<tr>
<td>3 years</td>
<td>15</td>
</tr>
</tbody>
</table>

**Death/MI**
- Time: 9.4
- 1 year: 9.4

**CHA2DS2-VASc Score [AF]**
- HF/LV dysfunction: No (0) Yes (1)
- Hypertension: No (0) Yes (1)
- Age ≥ 75: No (0) Yes (2)
- Diabetes mellitus: No (0) Yes (1)
- Stroke/TIA/TE: No (0) Yes (2)
- Vascular disease: No (0) Yes (1)
- Age 65-74: No (0) Yes (1)
- Sex: Male (0) Female (1)

**Score**: 2

**HAS-BLED Score [AF]**
- Hypertension history: No (0) Yes (1)
- Abnormal RF: No (0) Yes (1)
- Abnormal LF: No (0) Yes (1)
- Stroke history: No (0) Yes (1)
- Bleeding: No (0) Yes (1)
- Labile INR: No (0) Yes (1)
- Age > 65: No (0) Yes (1)
- Medication: No (0) Yes (1)
- Alcohol or Drug Usage History: No (0) Yes (1)

**Score**: 3

**Stroke and thromboembolism event rate at 1 year follow-up (%)**
- 3.71
According to the ACC AHA guidelines, what is the best regimen for this patient?

A. Warfarin, Clopidogrel and Aspirin
B. Dabigatran, Prasugrel and Aspirin
C. Apixaban, Ticagrelor and Aspirin
D. Clopidogrel and Aspirin
In hospital course:

• The AF reverted to sinus rhythm spontaneously next day.
• His hospital course was uneventful.
• He was discharged home on Warfarin and Aspirin and Clopidogrel.
How long should dual antiplatelet with anticoagulation be continued?

- 1 month
- 3 months
- 6 months
- 12 months

A.
B.
C.
D.

VKA (INR 2-2.5) + Aspirin + Clopidogrel
VKA (INR 2-2.5) + Aspirin or Clopidogrel
VKA (INR 2-3)
• He received triple therapy for 3 months then Clopidogrel and Warfarin for 12 months
• No other documented AF within 2 years F/U including annual Holter.
• If we assume that AF episode was provoked by ACS; Can we discontinue the anticoagulation?
Diagnostic yield of different ECG screening techniques for paroxysmal or silent atrial fibrillation

- 8760/8760 hrs (100%) monitored, continuous
- 6/8760 hrs (0.06%) monitored, 365 periods
- 336/8760 hrs (4%) monitored, two periods
- 144/8760 hrs (2%) monitored, six periods
- 24/8760 hrs (0.2%) monitored, one period

- Implanted device (100%)
- Daily short-term ECG (0.06%)
- Two 7-day Holters (4%)
- Six 24h Holter ECGs (2%)
- One 24h Holter ECG (0.2%)

Time (years)
Triple Therapy

Summary and Synthesis of Guideline, Expert Consensus Documents, and Comprehensive Review Article Recommendations on the Management of Patients Treated With Triple Therapy

• Assess ischemic and bleeding risks using validated risk predictors (e.g., CHA2DS2-VASc, HAS-BLED)
• Keep triple therapy duration as short as possible; dual therapy only (oral anticoagulant and clopidogrel) may be considered in select patients
• Consider target INR 2.0–2.5 when warfarin is used
• Clopidogrel is the P2Y$_{12}$ inhibitor of choice
• Use low dose (≤100 mg daily) aspirin
• PPI Rx should be used in patients with a history of GI bleeding and are reasonable to use in patients with increased risk of GI bleeding

Thank you