Arrhythmias and EP
Contemporary Management and Anticoagulant Therapy

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Conflict of interest

Nothing To Declare
Imagine if **YOU** have asymptomatic permanent AF with a CHA\textsubscript{2}DS\textsubscript{2}VASc: (male 0 or female 1)

Which **ANTITHROMBOTIC** would you take??

- Nothing
- NOAC
- Warfarin
- Aspirin
- None of them
Clinical Case

65-year-old-male with new onset (<2h) chest pain, palpitations, dyspnea. BP 92/78mmHg
Which one is your next step

- Urgent catheterization and intervention
- Urgent electrical cardioversion
- Rate control with Beta-blockers, initiate anticoagulation
- Transesophageal echocardiogram
- None of them
DISCUSSION

Which of the following is correct?

- Every patient with AF_ACS has an indication to receive anticoagulants unless there is a contraindication.
- Developing AF during an ACS increases by 5 the in-hospital mortality vs no AF.
- Dual therapy anticoagulants + antiplatelet increase the bleeding risk.
- All of the above.
~2-21% of SCA patients $^{1,2}$

ACS + AF = 5 x more in hospital mortality

IN practice .....what to do?

1. Personalize antithrombotic therapy according to:

- Stroke risk (CHA$_2$DS$_2$-VASc)
- Bleeding risk (HAS BLED)
- Clinical setting (ACS vs elective)
- Stent type (DES vs BMS)
- Time from PCI/ACS
IN practice .....what to do?

2. Prefer

- The lower test dose for stroke prevention in AF (that is, Dabigatran 110mg BID, Rivaroxaban 15mg OD, or Apixaban 2.5mg BID) to minimize the risk of bleeding

- Clopidrogel instead of the more potent ticagrelor and prasugrel

- New generation DES (or BMS) over first generation DES

- Use of radial approach, thus minimizing the risk of access site bleeding
Treating AF with Concomitant ACS Is a Balancing Act

Thromboembolic risk
Patients with ACS and AF are at risk of both a second myocardial infarction\(^1\) and a stroke\(^2\)

Bleeding risk
Risk of bleeding increases with the number of antithrombotic agents\(^3\)

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Even in the controlled setting of a clinical trial, warfarin management is not ideal. According to the ORBIT-AF registry, if patients had 100% of their international normalized ratios (INRs) in therapeutic range at 6 months, what proportion of them would have INRs well outside therapeutic range (<1.5 or >4.0) over the next 12 months?

- < 5%
- 10 %
- 20 %
- > 30 %
Five Commandments, Guidelines for Management of AF

1. ECG screening and monitoring whenever AF might be suspected
2. Physician-patient relationship are critical in decision making
3. CHA$_2$DS$_2$-VASc score. With a score $\geq 2$ in male and $\geq 1$ in female patients, AC is clearly recommended, while in a score of 1 in males and 2 in females, AC should be considered.
4. Bleeding risks should be minimized, hypertension controlled, antiplatelet or NSAID therapy should be short duration, alcohol use moderated, and anemia treated and normalized.
5. Use perioperative oral beta-blockers for the prevention of postoperative AF, and restore SR by CV in postoperative AF.

Valentin Fuster. EHJ 2016
Thank you @mencardio