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ACC 2024: What's Really New in Electrophysiology That Will Change My Practice?

Announcer:
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Dr. Patel:
Hi, this is Manesh Patel. I'm a cardiologist at Duke and thanks for joining us for this Duke Heart On The Go Conference Updates from the ACC 2024 meeting. You know, a lot's going on with atrial fibrillation and a lot in management of our patients that have that. And it was really exciting not just to manage and understand atrial fibrillation, but there's a session at ACC called, *What's Really New in Electrophysiology That Will Change My Practice?* It was a joint symposium from the Heart Rhythm Society and the American College of Cardiology. And I thought this was a really great session because they had a lot of great panelists and speakers, and they went through a broad range of topics that I hope to cover in the next 5 minutes.

The first was, you know, genetics and arrhythmias, how can this change my practice? And I won't go deeply into the conversation except to say that, you know, our understanding of how we have to manage our antiarrhythmics and how we have to manage ablation or the risk of our patients with genetic evaluation has really changed. Not just the sort of board questions of patients with long QT and VT, but there are a whole set of evolving markers for our patients, both genetic and otherwise, that have ARVC, or arrhythmogenic right ventricular cardiomyopathy, or importantly, arrhythmogenic right ventricles in a variety of patients that might be high risk for VT [ventricular tachycardia]. So I thought that session was important.

Maybe the most highlighted session or the middle of that session right off the bat was what's new with the Afib guidelines. And there were several sort of key messages and updates from that session, and I wanted to just to go over them with you guys because I do think it adds a lot for us.

First, it's just that the global burden of atrial fibrillation continues to grow and we can see that it goes up by age and obviously as you age, there's a higher likelihood that you'll have atrial fibrillation, and men seem to have more atrial fibrillation per age and through the years than women. But still, it's a global pandemic or epidemic – I don't want to call it a pandemic – in atrial fibrillation.

The other thing that was very evident at the ACC/AHA Guideline session on atrial fibrillation was all aspects of care for atrial fibrillation can be broken down into sort of 3 big areas, and there's even a little pneumonic: SOS. So Stroke risk, that's assess and treat; Optimize all the modifiable risk factors for that patient; and then Symptom management, Afib burden, rhythm control, or rate control. So I'm going to go through all 3 sort of areas and what's new in them.

So stroke risk, assess and treat. Well, there were no real new risk factors identified. We have a variety of those including the CHADS VASC and others. But what the guidelines really highlighted was to make sure that we do assess the risk, and as they were before for people with the CHADS VASC of 2, men or greater for either sex, was to consider and treat with anticoagulants with a preference for DOACS. For patients that have a CHADS VASC of 1, understanding their shared decision-making and other risk factors might be important. There was actually additional areas for thinking about how to better define that risk.

For optimizing all the modifiable risk factors, including heart failure, exercise, hypertension, diabetes, tobacco, maybe one of the biggest ones was obesity. Clear recommendations, Class 1 recommendations to discuss weight reduction and the benefit of weight reduction on patients with atrial fibrillation. Obviously obstructive sleep apnea and sleep play a role, and that was again highlighted in the guidelines.

And then symptom burden management. Maybe one of the bigger new changes in symptom burden management for our patients with atrial fibrillation from the guidelines was to recognize that the guidelines have now moved from always thinking, or at least previously thinking, about antiarrhythmics to moving Afib ablation much higher to a Class 1 in the recommendations, especially for patients that may have LV [left ventricular] dysfunction or may have chronic symptomatic atrial fibrillation that's not been managed previously.

They do also recommend some antiarrhythmics, but they're a lower recommendation. And the way to think about those is if people have a normal LV function with no prior MI [myocardial infarction] or significant structural heart disease, so no real heart structural disease, then a variety of agents, including dofetilide, dronedarone, flecainide and propafenone, are all 2A recommendations. But if they have a prior MI or significant structural heart disease, including a reduced ejection fraction, then amiodarone or dofetilide are 2A. And those that actually have heart failure III or IV, or recent decompensated heart failure, then I think it's important to recognize, if that's true, then dronedarone might be harmful.

So I think the guidelines break that down nicely. The message from the Guidelines and from this session was, recognize atrial fibrillation, treat atrial fibrillation risks with anticoagulation, reduce burden.

Thank you for listening to me as I give you an update from the ACC.

Announcer:
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