Nonpermanent atrial fibrillation in the new European Society of Cardiology guidelines. Response

La fibrilación auricular no permanente en la nueva guía de la Sociedad Europea de Cardiología. Respuesta

To the Editor,

We are grateful for the critical analysis by Vázquez Ruiz de Castroviejo et al., which raises the important question of thromboembolic risk stratification in patients with atrial fibrillation (AF). Analysis of arrhythmia burden is probably one of the most important factors of those which, in recent years, have entered clinical practice. The new AF guidelines also cover this concept, highlighting its relevance.1,2

However, we must also consider the limitations inherent to this approach. Firstly, the incidence of thromboembolic events in paroxysmal AF is significant, which is an argument for starting anticoagulant therapy independently of whether it shows a greater benefit in other forms of the disease. No study to date has demonstrated that a thromboembolic risk-prevention strategy guided by AF classification pattern improves the risk profile, therapeutic benefit or safety of anticoagulant therapy. Recent cautious attempts observed no benefit from anticoagulant treatment guided by individual patients’ arrhythmia burden at any time.3 Nonetheless, each patient’s arrhythmia burden is directly related to their cardiovascular and thromboembolic risk profile. Therefore, any attempt to differentiate the therapeutic benefits of anticoagulant treatment should involve a combined analysis of the arrhythmia burden and the profile of cardiovascular risk factors. Their independence has not been demonstrated in prospective studies, and AF holds increasing weight as a marker of risk, in conflict or accordance with its nature as a primary causative factor.1

We disagree about the supposed lack of advances in anticoagulant treatment; these have been substantial in terms of the consolidation of direct-acting anticoagulants as a preferred treatment,1 but we agree with Vázquez Ruiz de Castroviejo et al. that the arrhythmia burden will, in the near future, become a key factor in embolic risk stratification. Although the available evidence at present does not allow its translation to management, it certainly ensures this important area of clinical research remains active.

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AUTHORS’ CONTRIBUTIONS

D. Calvo and E. Arbelo contributed equally to the writing and review of this manuscript. Both have approved the final version and accept responsibility for the content.

CONFLICTS OF INTEREST

No conflicts of interest.

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