XIII CONGRESO INTERNACIONAL DE CARDIOLOGIA
CARDIOLOGIA INTERVENCIONISTA - LII JORNADA ACCI-SOLACI
DE LA PREVENCIÓN A LA INTERVENCIÓN

Fibrilación auricular manejo actual (AF CARE), manejo de la anticoagulación en el paciente frágil, FA+IC con FE reducida: cuándo priorizar ritmo.

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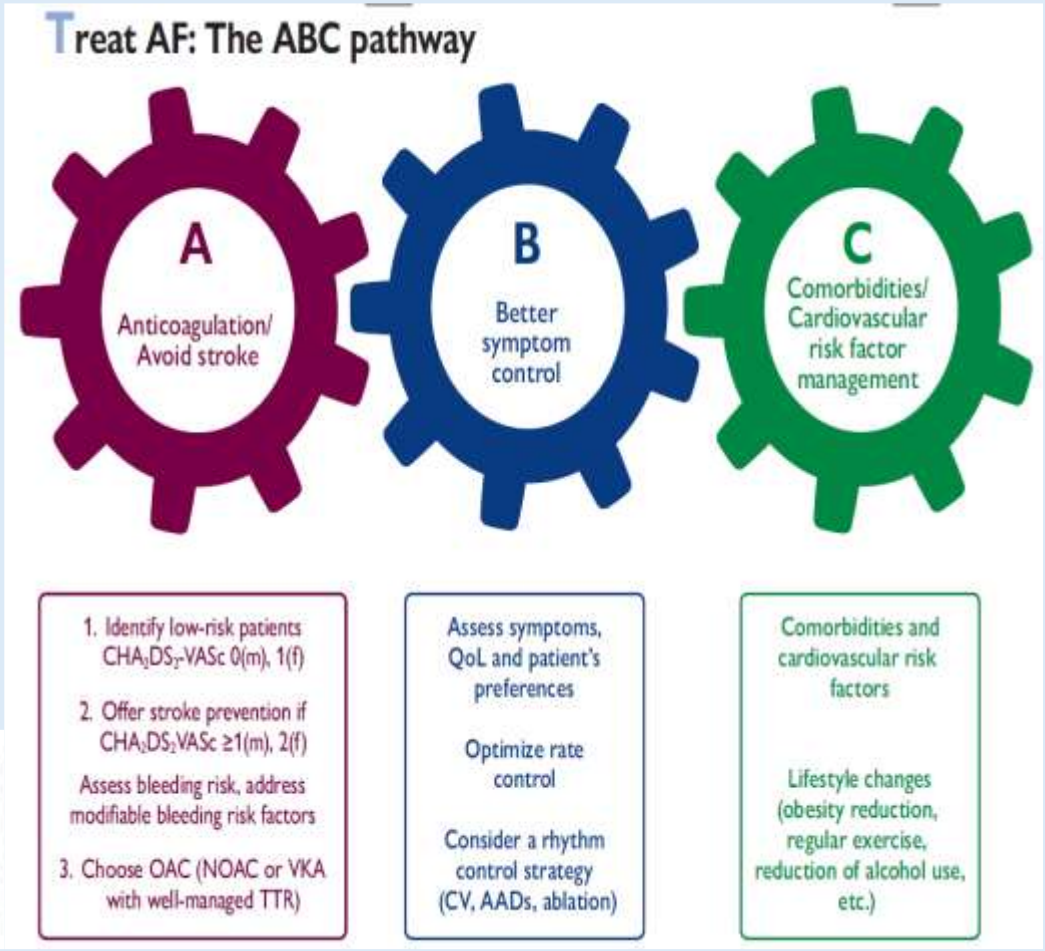
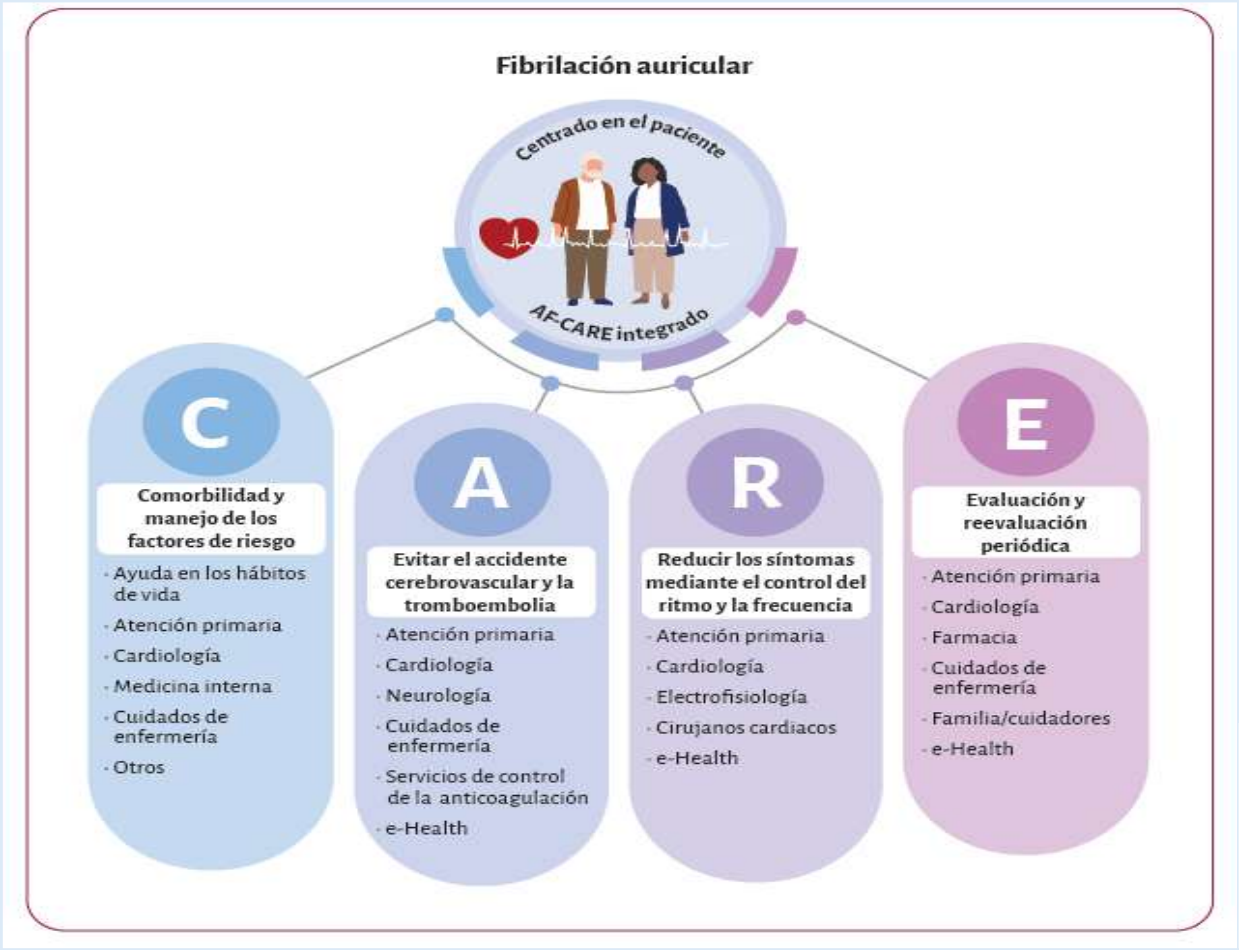
ASOCAR Asociación Costarricense de Cardiología
ASOCAR Capítulo de Enfermería
ACCI
JORNADAS SOLACI

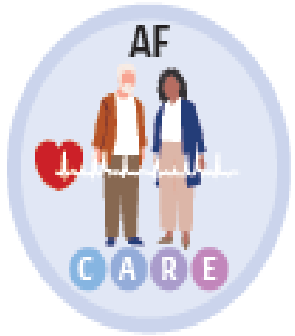
CONFLICTOS DE INTERES

No tengo conflictos de interés

Fibrilación auricular manejo actual (AF CARE)







Equidad en la prestación de los servicios sanitarios (género, etnia, nivel socioeconómico) (Clase I)

Educación dirigida a pacientes, familiares y profesionales sanitarios (Clase I)

Manejo de la FA centrado en el paciente con un enfoque de equipo multidisciplinario (Clase IIa)

C — Comorbilidad y manejo de los factores de riesgo

Hipertensión	Insuficiencia cardiaca	Sobrepeso u obesidad	Síndrome de apnea obstructiva del sueño	Alcohol
Tratamiento antihipertensivo (Clase I)	Diuréticos para la congestión (Clase I)	Pérdida de peso (objetivo de 10%)[a] (Clase I)	Manejo de la apnea obstructiva del sueño[a] (Clase IIb)	Reducir a ≤3 unidades de bebida estándar semanales (Clase I)
Diabetes mellitus	Tratamiento médico adecuado para la ICFEr (Clase I)	Cirugía bariátrica si hay control del ritmo[a] (Clase IIb)	**Capacidad de esfuerzo/ejercicio**	**Otros factores de riesgo /comorbilidades**
Control glucémico eficaz[a] (Clase I)	Inhibidores SGLT2 (Clase I)		Programa de ejercicios personalizado (Clase I)	Identificar y manejar intensivamente[a] (Clase I)

Guía ESC 2024

A Evitar el accidente cerebrovascular y la tromboembolia

Riesgo de tromboembolia	Utilizar una escala de riesgo validada localmente o CHA2DS2-VA	Elección del anticoagulante	Evaluar el riesgo hemorrágico	Prevenir el sangrado
Iniciar anticoagulación oral (Clase I)	ACO si puntuación CHA2DS2-VA =2 o más (Clase I)	Usar ACOD, excepto si válvula mecánica o estenosis mitral (Clase I)	Evaluar y manejar todos los factores de riesgo hemorrágico modificables (Clase I)	No combinar fármacos antiplaquetarios y ACO para la prevención del accidente cerebrovascular (Clase III)
Patrón temporal de FA no relevante (Clase III)	ACO si puntuación CHA2DS2-VA =1 (Clase IIa)	Si AVK: objetivo INR 2,0-3.0; (Clase I) >70% rango INR; (Clase IIa) o cambiar a ACOD (Clase I)	No usar escalas de riesgo para interrumpir la anticoagulación (Clase III)	Evitar fármacos antiplaquetarios después de 12 meses en SCC/EVP tratados con ACO (Clase III)
El tratamiento antiplaquetario no es una alternativa (Clase III)				

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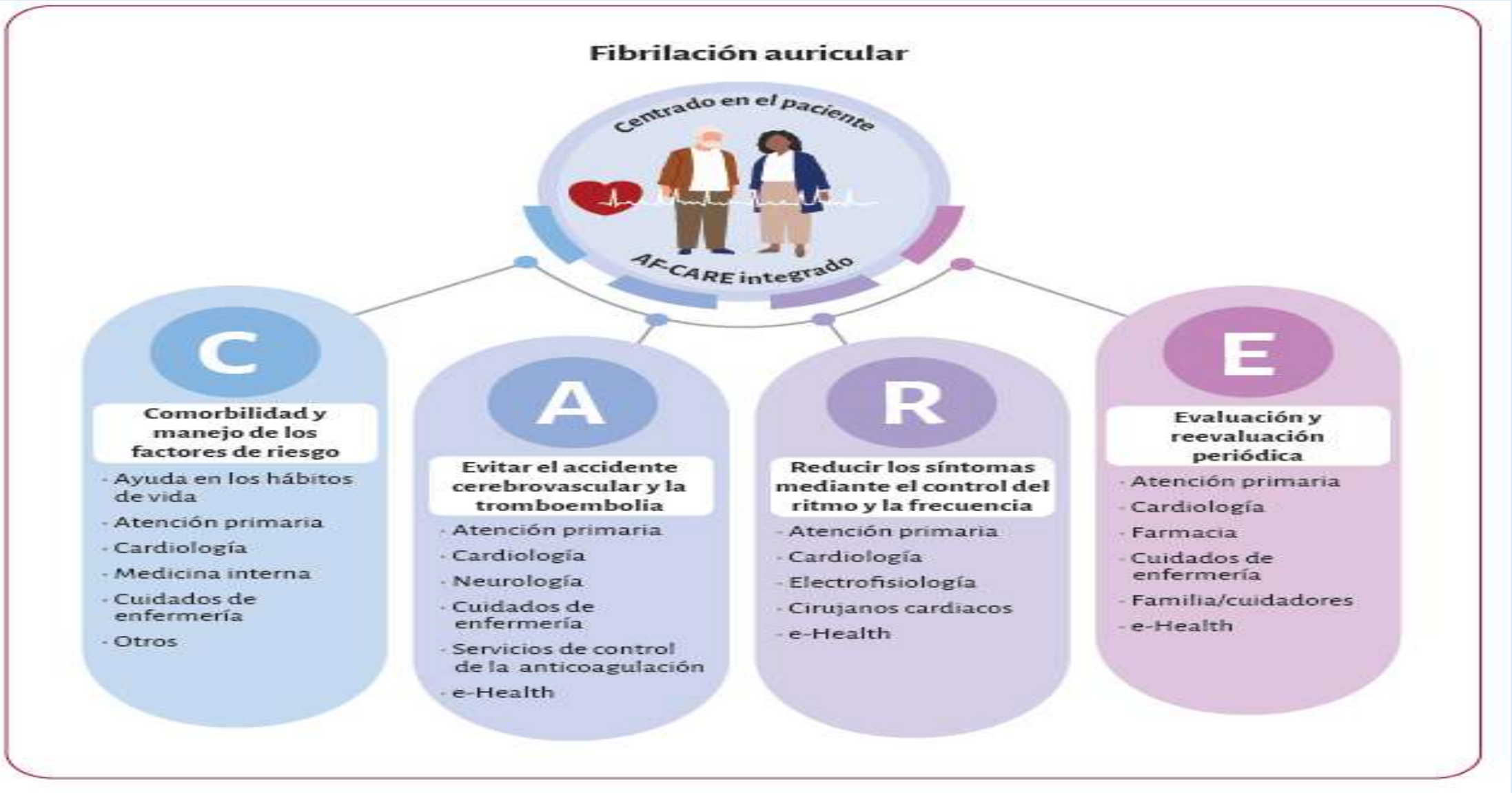
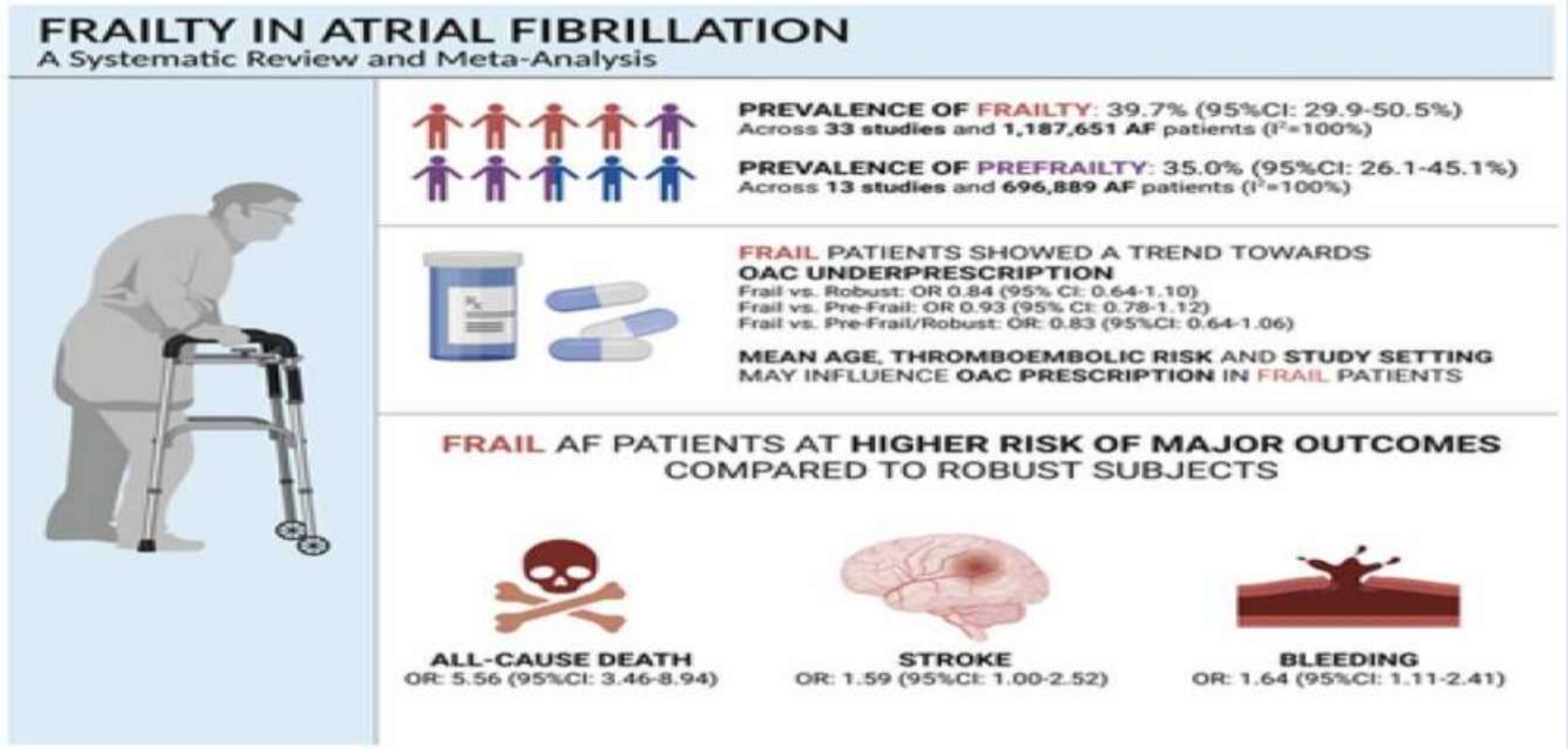


Guía ESC 2024

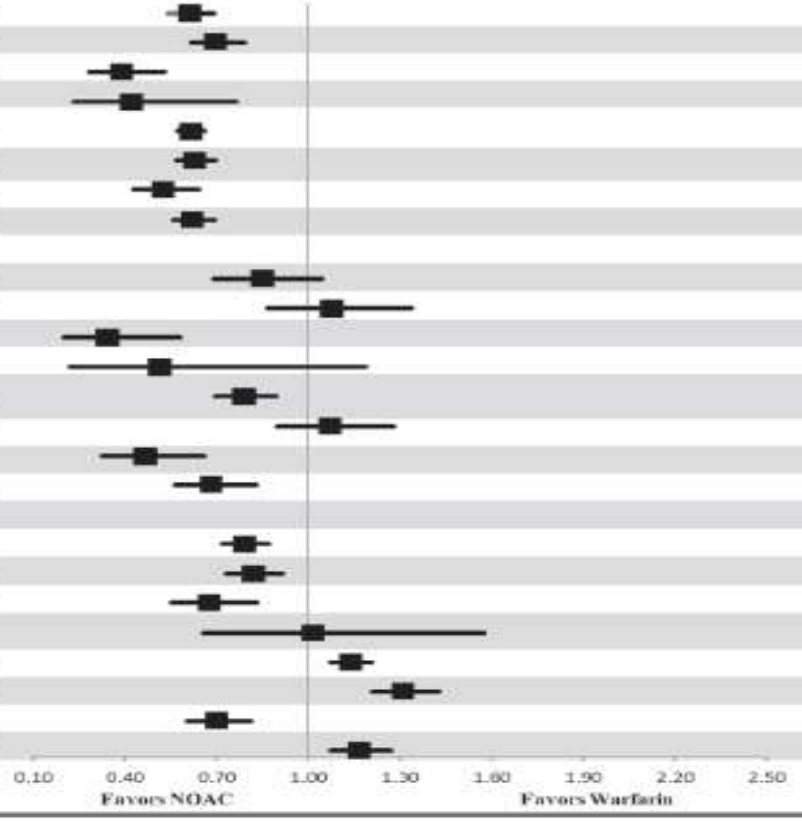
Manejo de la anticoagulación en el paciente frágil.



Oral anticoagulants for nonvalvular atrial fibrillation in frail elderly patients: insights from the ARISTOPHANES study

(a)

		NOAC	Warfarin	Hazard Ratio (95% CI)	*P*-value
		No. of events (incidence per 100 person-years)			
Apixaban vs. Warfarin					
	Stroke/SE	381 (2.18)	731 (3.30)	0.61 (0.55-0.69)	<0.001
	Ischemic	310 (1.77)	521 (2.35)	0.70 (0.62-0.79)	<0.001
	Hemorrhagic	59 (0.34)	179 (0.80)	0.39 (0.29-0.53)	<0.001
	SE	13 (0.07)	36 (0.16)	0.42 (0.23-0.76)	0.004
	Major Bleeding	1,050 (6.05)	1,978 (9.04)	0.62 (0.57-0.66)	<0.001
	GI Bleeding	501 (2.87)	921 (4.16)	0.63 (0.57-0.70)	<0.001
	ICH	146 (0.83)	333 (1.49)	0.53 (0.43-0.64)	<0.001
	Other Bleeding	463 (2.65)	863 (3.90)	0.62 (0.56-0.69)	<0.001
Dabigatran vs. Warfarin					
	Stroke/SE	150 (2.60)	184 (3.06)	0.85 (0.69-1.04)	0.119
	Ischemic	127 (2.20)	123 (2.04)	1.08 (0.87-1.34)	0.508
	Hemorrhagic	16 (0.28)	49 (0.81)	0.34 (0.20-0.58)	<0.001
	SE	<11 (0.12)	14 (0.23)	0.51 (0.22-1.19)	0.119
	Major Bleeding	405 (7.07)	531 (8.98)	0.79 (0.70-0.89)	<0.001
	GI Bleeding	247 (4.29)	239 (3.99)	1.07 (0.90-1.28)	0.438
	ICH	38 (0.65)	86 (1.42)	0.46 (0.33-0.66)	<0.001
	Other Bleeding	155 (2.68)	234 (3.91)	0.68 (0.57-0.83)	<0.001
Rivaroxaban vs. Warfarin					
	Stroke/SE	608 (2.50)	806 (3.13)	0.79 (0.72-0.87)	<0.001
	Ischemic	449 (1.85)	574 (2.22)	0.82 (0.73-0.92)	<0.001
	Hemorrhagic	130 (0.53)	202 (0.78)	0.68 (0.55-0.83)	<0.001
	SE	32 (0.13)	33 (0.13)	1.02 (0.66-1.58)	0.938
	Major Bleeding	2,451 (10.24)	2,258 (8.88)	1.14 (1.08-1.21)	<0.001
	GI Bleeding	1,358 (5.63)	1,085 (4.22)	1.31 (1.21-1.43)	<0.001
	ICH	250 (1.03)	377 (1.45)	0.70 (0.61-0.81)	<0.001
	Other Bleeding	1,055 (4.36)	948 (3.68)	1.17 (1.08-1.27)	<0.001

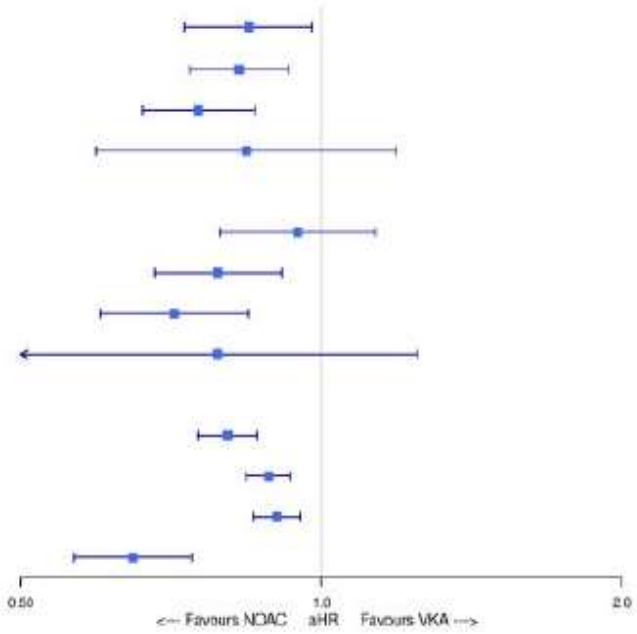


Journal of Internal Medicine, 2021, 289; 42–52

Impact of frailty on the effectiveness and safety of non-vitamin K antagonist oral anticoagulants (NOACs) in patients with atrial fibrillation: a nationwide cohort study

(A)

Outcome	Comparison	NOAC n	NOAC Events (/100PY)	VKA n	VKA Events (/100PY)	aHR (95%CI)	p-value
Stroke/SE							
	Dabigatran vs.VKA	6009	335 (3.74)	12686	502 (4.67)	0.84 (0.73-0.98)	0.025
	Rivaroxaban vs.VKA	19604	905 (3.45)	12438	475 (4.46)	0.83 (0.74-0.93)	<0.001
	Apixaban vs.VKA	22685	837 (3.38)	9683	368 (4.62)	0.75 (0.66-0.86)	<0.001
	Edoxaban vs.VKA	6294	156 (3.82)	2015	45 (4.62)	0.84 (0.60-1.19)	0.324
Ischemic stroke							
	Dabigatran vs.VKA	6009	227 (2.52)	12686	308 (2.84)	0.95 (0.79-1.13)	0.550
	Rivaroxaban vs.VKA	19604	521 (1.97)	12438	291 (2.71)	0.79 (0.68-0.91)	0.002
	Apixaban vs.VKA	22685	470 (1.88)	9683	224 (2.78)	0.71 (0.60-0.85)	<0.001
	Edoxaban vs.VKA	6294	85 (2.07)	2015	27 (2.74)	0.79 (0.50-1.25)	0.308
All-cause mortality							
	Dabigatran vs.VKA	6009	1583 (17.17)	12686	2435 (22.10)	0.81 (0.75-0.86)	<0.001
	Rivaroxaban vs.VKA	19604	5068 (18.91)	12438	2447 (22.42)	0.88 (0.84-0.93)	<0.001
	Apixaban vs.VKA	22685	5386 (21.20)	9683	1951 (23.89)	0.90 (0.85-0.95)	<0.001
	Edoxaban vs.VKA	6294	901 (21.72)	2015	334 (33.94)	0.65 (0.57-0.74)	<0.001



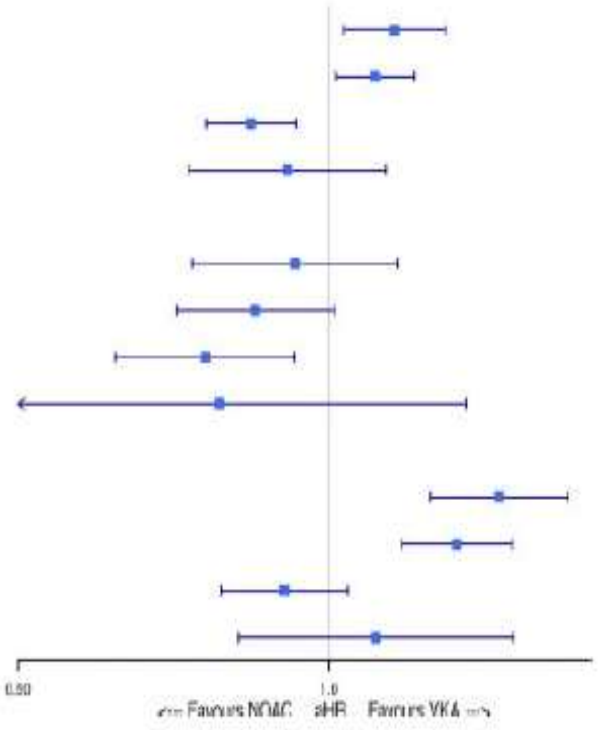
(B)

European Heart Journal - Quality of Care and Clinical Outcomes (2024) **10**, 55–65

Impact of frailty on the effectiveness and safety of non-vitamin K antagonist oral anticoagulants (NOACs) in patients with atrial fibrillation: a nationwide cohort study

(B)

Outcome	Comparison	NOAC n	NOAC Events (/100PY)	VKA n	VKA Events (/100PY)	aHR (95%CI)	p-value
Major bleeding							
	Dabigatran vs.VKA	6009	698 (7.93)	12686	763 (7.24)	1.16 (1.03-1.30)	0.012
	Rivaroxaban vs.VKA	19604	1916 (7.51)	12438	751 (7.19)	1.11 (1.02-1.21)	0.020
	Apixaban vs.VKA	22685	1491 (6.09)	9683	582 (7.43)	0.84 (0.76-0.93)	<0.001
	Edoxaban vs.VKA	6294	414 (10.36)	2015	114 (11.95)	0.91 (0.73-1.14)	0.412
Intracranial bleeding							
	Dabigatran vs.VKA	6009	156 (1.72)	12686	212 (1.96)	0.93 (0.74-1.17)	0.517
	Rivaroxaban vs.VKA	19604	399 (1.51)	12438	205 (1.91)	0.85 (0.71-1.01)	0.068
	Apixaban vs.VKA	22685	351 (1.40)	9683	151 (1.88)	0.76 (0.62-0.93)	0.007
	Edoxaban vs.VKA	6294	60 (1.45)	2015	19 (1.97)	0.78 (0.45-1.36)	0.385
Gastrointestinal bleeding							
	Dabigatran vs.VKA	6009	420 (4.66)	12686	365 (3.37)	1.46 (1.25-1.71)	<0.001
	Rivaroxaban vs.VKA	19604	1107 (4.24)	12438	362 (3.38)	1.33 (1.18-1.50)	<0.001
	Apixaban vs.VKA	22685	769 (3.09)	9683	281 (3.50)	0.91 (0.79-1.04)	0.174
	Edoxaban vs.VKA	6294	252 (6.21)	2015	57 (5.86)	1.11 (0.82-1.51)	0.500

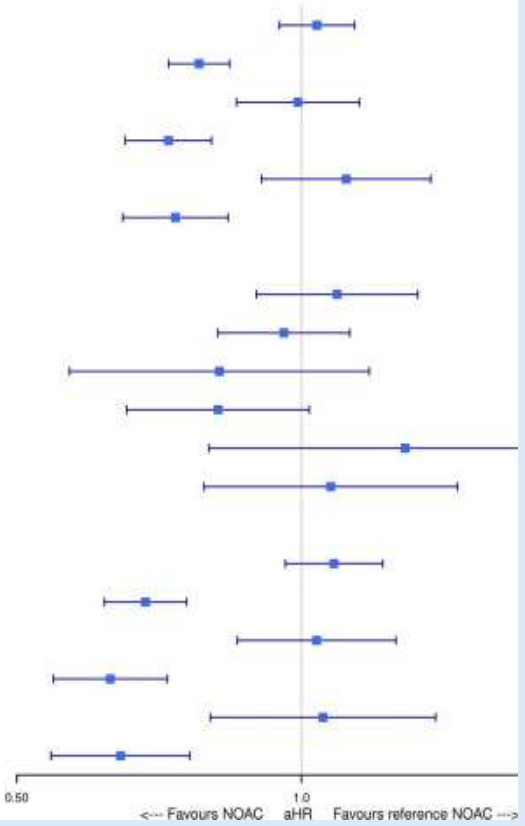


European Heart Journal - Quality of Care and Clinical Outcomes (2024) **10**, 55–65

Impact of frailty on the effectiveness and safety of non-vitamin K antagonist oral anticoagulants (NOACs) in patients with atrial fibrillation: a nationwide cohort study

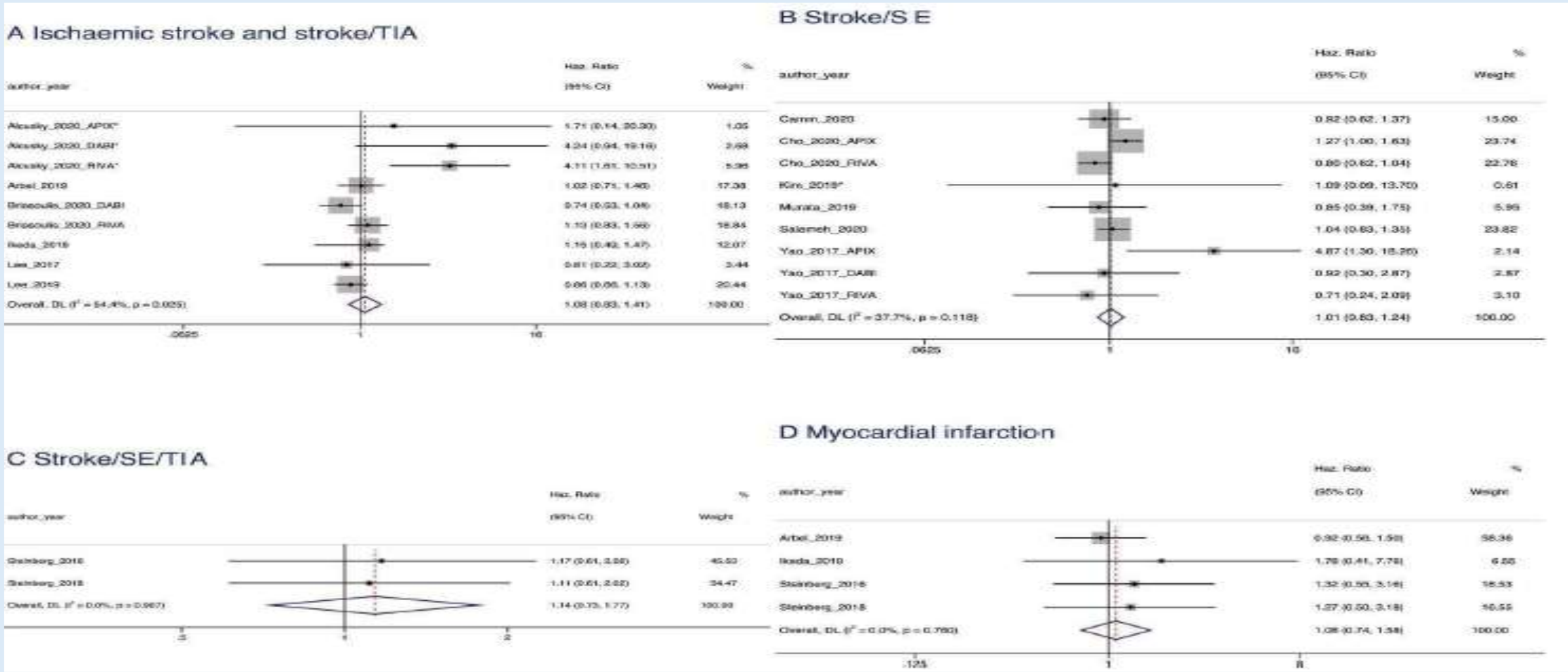
(B)

Outcome	Comparison	NOAC n	NOAC Events (/100PY)	Reference NOAC n	Reference NOAC Events (/100PY)	aHR (95%CI)	p-value
Major bleeding							
	Dabigatran vs. Rivaroxaban (ref)	7022	671 (7.37)	20285	1850 (7.02)	1.04 (0.95-1.14)	0.417
	Apixaban vs. Rivaroxaban (ref)	22903	1466 (5.89)	16211	1457 (7.36)	0.78 (0.72-0.84)	<0.001
	Edoxaban vs. Rivaroxaban (ref)	6404	401 (9.89)	4864	326 (9.46)	0.99 (0.85-1.15)	0.914
	Apixaban vs. Dabigatran (ref)	23152	1456 (5.79)	5411	524 (7.90)	0.72 (0.65-0.80)	<0.001
	Dabigatran vs. Edoxaban (ref)	1803	150 (10.83)	6404	410 (10.06)	1.12 (0.91-1.37)	0.299
	Apixaban vs. Edoxaban (ref)	11583	587 (7.44)	6289	416 (10.44)	0.74 (0.65-0.84)	<0.001
Intracranial bleeding							
	Dabigatran vs. Rivaroxaban (ref)	7022	148 (1.58)	20285	389 (1.43)	1.09 (0.90-1.33)	0.385
	Apixaban vs. Rivaroxaban (ref)	22903	346 (1.35)	16211	282 (1.37)	0.96 (0.82-1.13)	0.604
	Edoxaban vs. Rivaroxaban (ref)	6404	62 (1.49)	4864	60 (1.68)	0.82 (0.57-1.18)	0.284
	Apixaban vs. Dabigatran (ref)	23152	349 (1.35)	5411	112 (1.64)	0.82 (0.65-1.02)	0.074
	Dabigatran vs. Edoxaban (ref)	1803	26 (1.82)	6404	63 (1.50)	1.29 (0.80-2.08)	0.300
	Apixaban vs. Edoxaban (ref)	11583	130 (1.61)	6289	64 (1.56)	1.07 (0.79-1.46)	0.649
Gastrointestinal bleeding							
	Dabigatran vs. Rivaroxaban (ref)	7022	403 (4.33)	20285	1066 (3.95)	1.08 (0.96-1.22)	0.189
	Apixaban vs. Rivaroxaban (ref)	22903	758 (2.99)	16211	860 (4.25)	0.68 (0.62-0.76)	<0.001
	Edoxaban vs. Rivaroxaban (ref)	6404	244 (5.92)	4864	191 (5.46)	1.04 (0.86-1.26)	0.706
	Apixaban vs. Dabigatran (ref)	23152	748 (2.93)	5411	311 (4.60)	0.63 (0.55-0.72)	<0.001
	Dabigatran vs. Edoxaban (ref)	1803	87 (6.18)	6404	250 (6.03)	1.05 (0.80-1.39)	0.706
	Apixaban vs. Edoxaban (ref)	11583	309 (3.85)	6289	249 (6.17)	0.64 (0.54-0.76)	<0.001



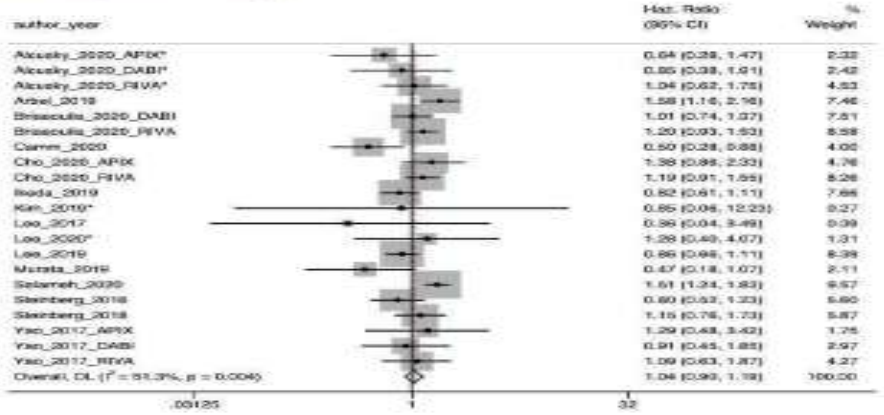
European Heart Journal - Quality of Care and Clinical Outcomes (2024) 10, 55–65

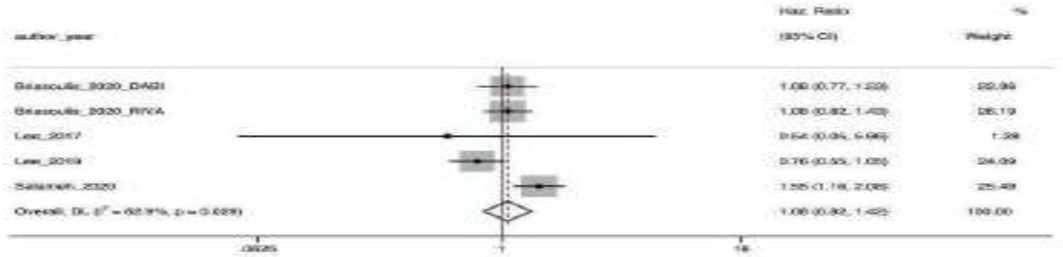
Outcomes and drivers of inappropriate dosing of non-vitamin K antagonist oral anticoagulants (NOACs) in patients with atrial fibrillation: a systematic review and meta-analysis

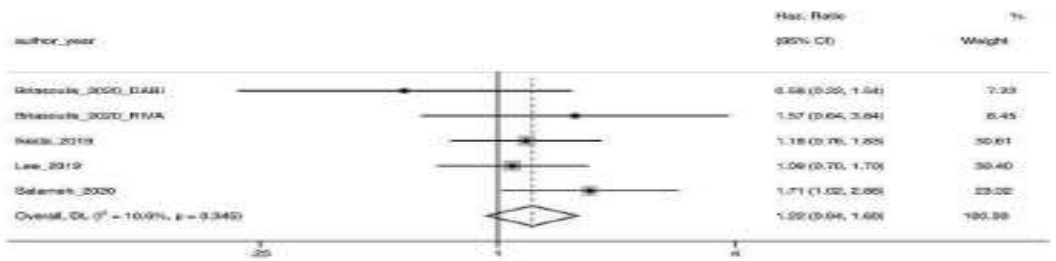


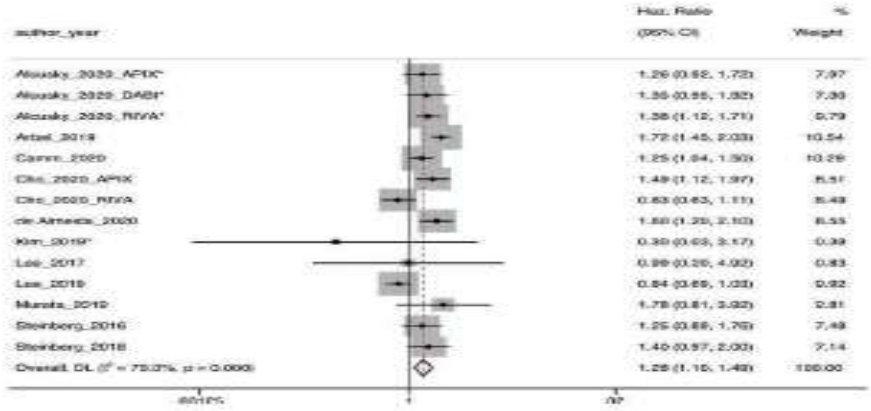
Caso V, *et al*. *Heart* 2023;**109**:178–185. doi:10.1136/heartjnl-2022-321114

Outcomes and drivers of inappropriate dosing of non-vitamin K antagonist oral anticoagulants (NOACs) in patients with atrial fibrillation: a systematic review and meta-analysis









Caso V, *et al*. *Heart* 2023;**109**:178–185. doi:10.1136/heartjnl-2022-321114

Table 1 Dose reduction criteria of NOACs[18]

NOAC	Dose reduction criteria	Reduced dose
Dabigatran	Creatinine clearance: 50 mL/min	Variable doses below full 110 mg dose recommended in ESC guidelines
Rivaroxaban	Creatinine clearance: 50 mL/min	15 mg once a day
Apixaban	2 of 3 criteria: age ≥80 years, weight ≤60 kg, creatinine ≥1.5 mg/dL	2.5 mg two times a day
Edoxaban	Creatinine clearance: ≤50 mL/min	30 mg once a day

NOAC, non-vitamin K antagonist oral anticoagulant.

FA+IC con FE reducida: cuándo priorizar ritmo.

RELACION ICC Y FA

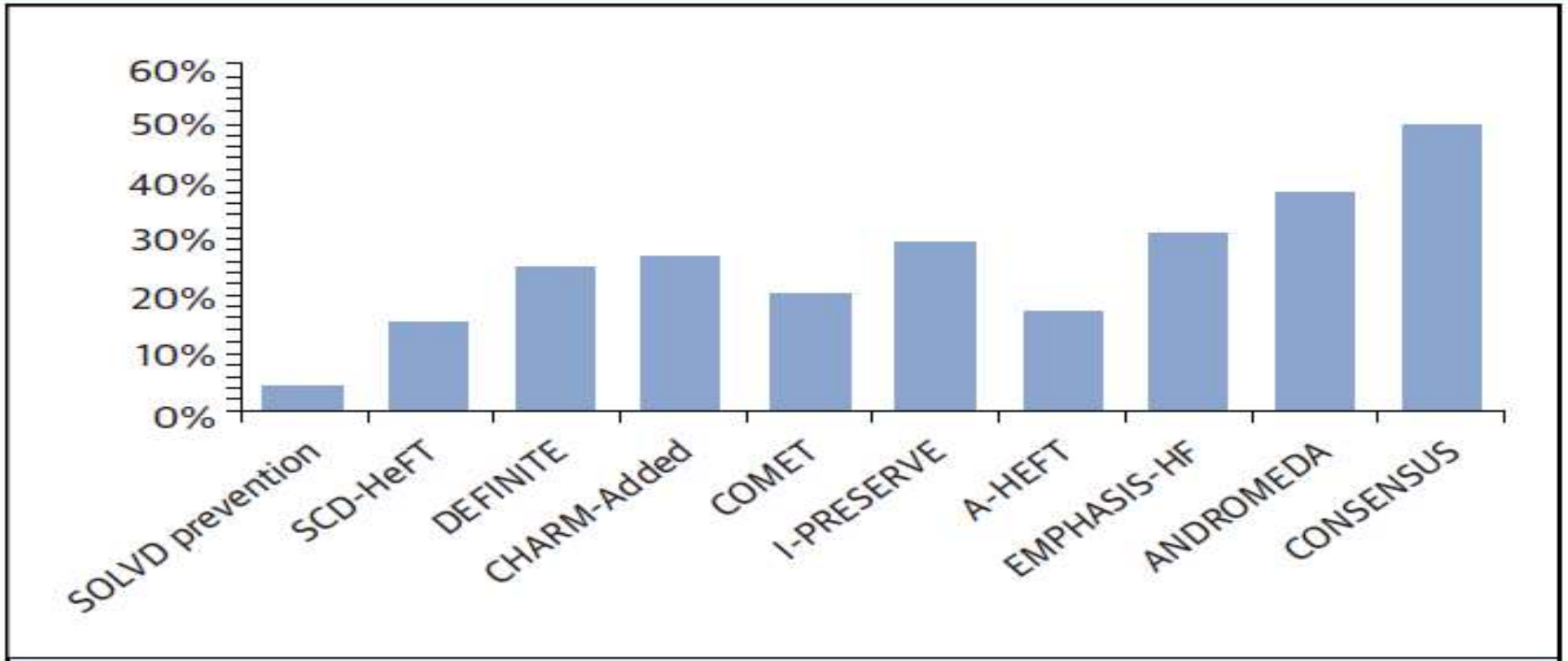


FIGURE 2 Prevalence of AF in Patients Enrolled in HF Studies

Trulock KM, et al. JACC 2014;64:710-21.

RELACION ICC Y FA

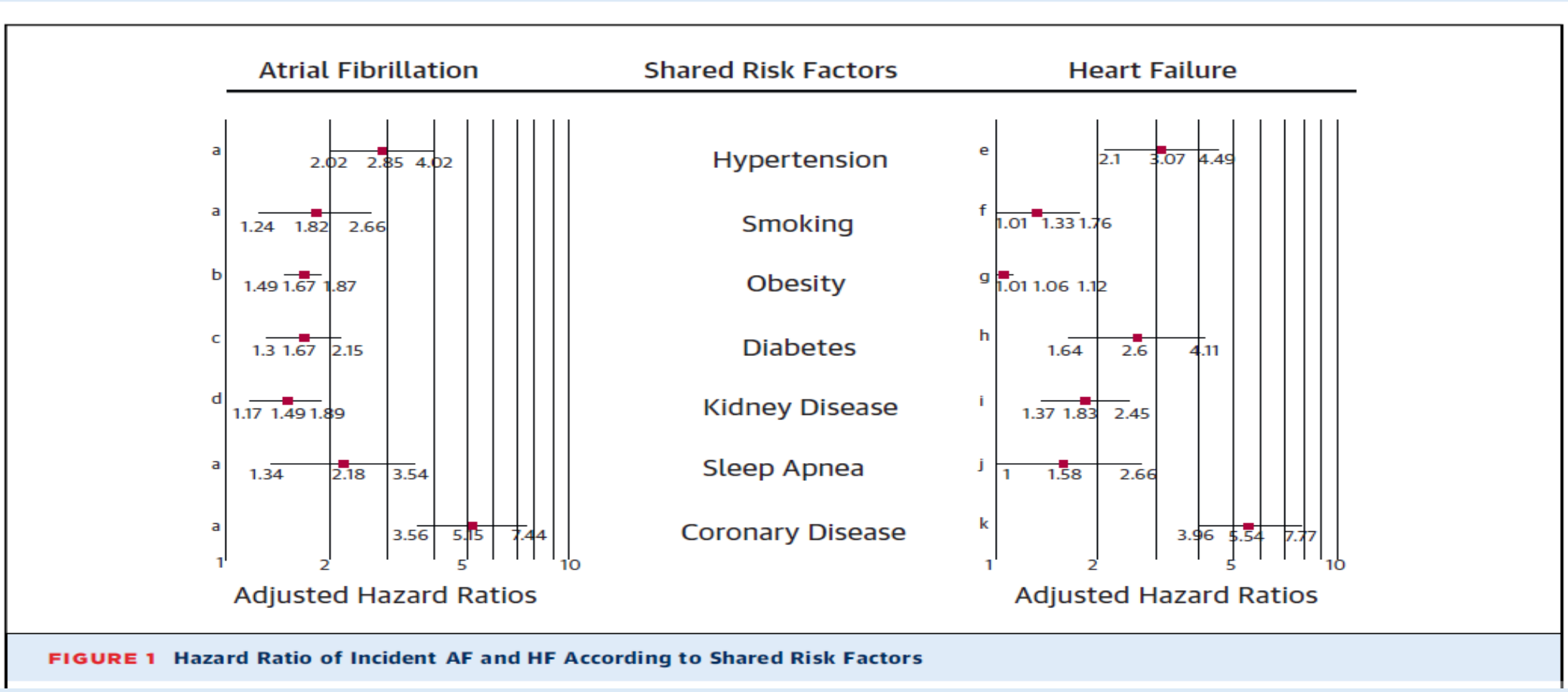
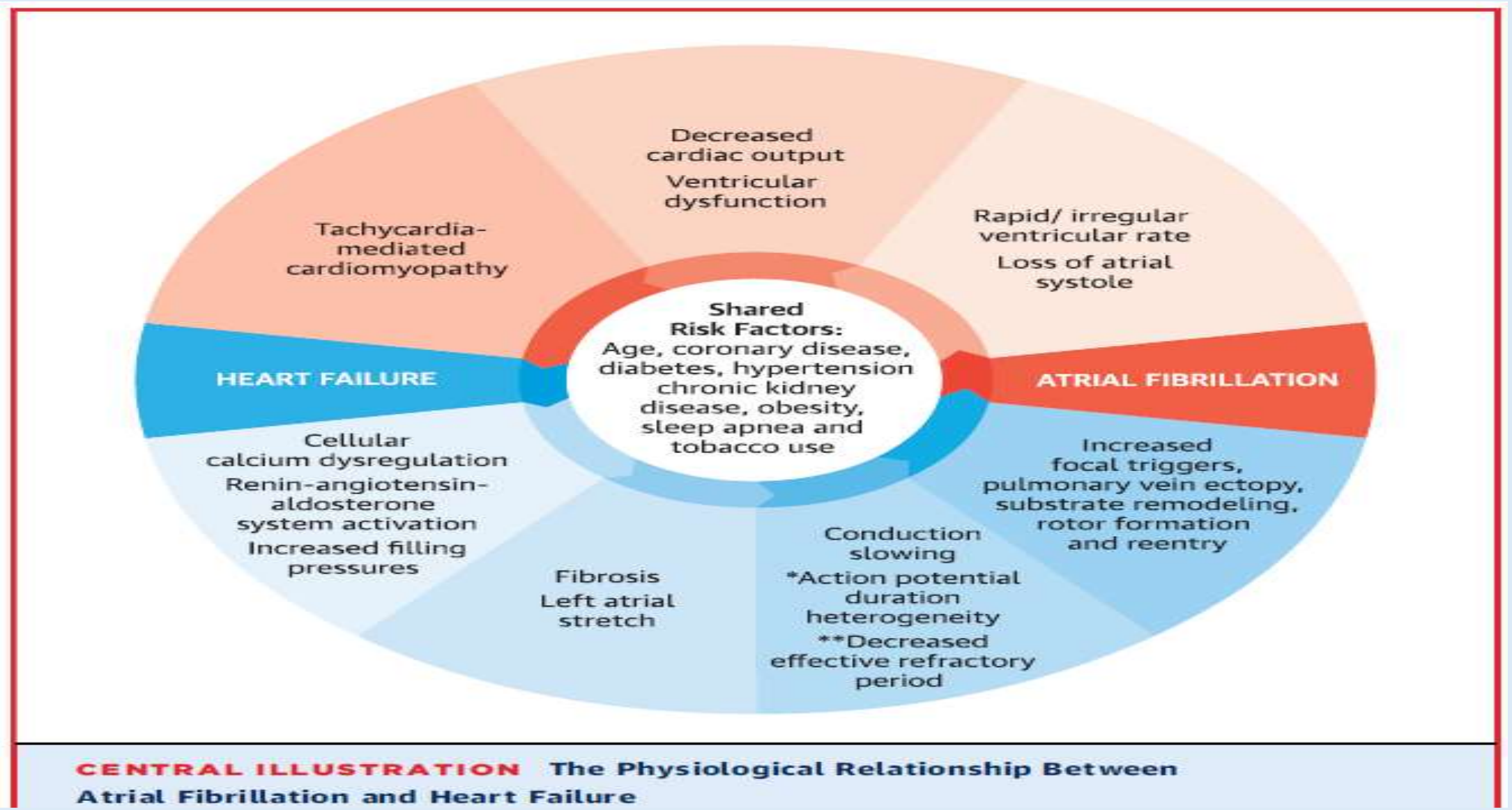


FIGURE 1 Hazard Ratio of Incident AF and HF According to Shared Risk Factors

Trulock KM, et al. JACC 2014;64:710-21.



CENTRAL ILLUSTRATION **The Physiological Relationship Between Atrial Fibrillation and Heart Failure**

Trulock KM, et al. JACC 2014;64:710-21.

Efficacy of β blockers in patients with heart failure plus atrial fibrillation: an individual-patient data meta-analysis

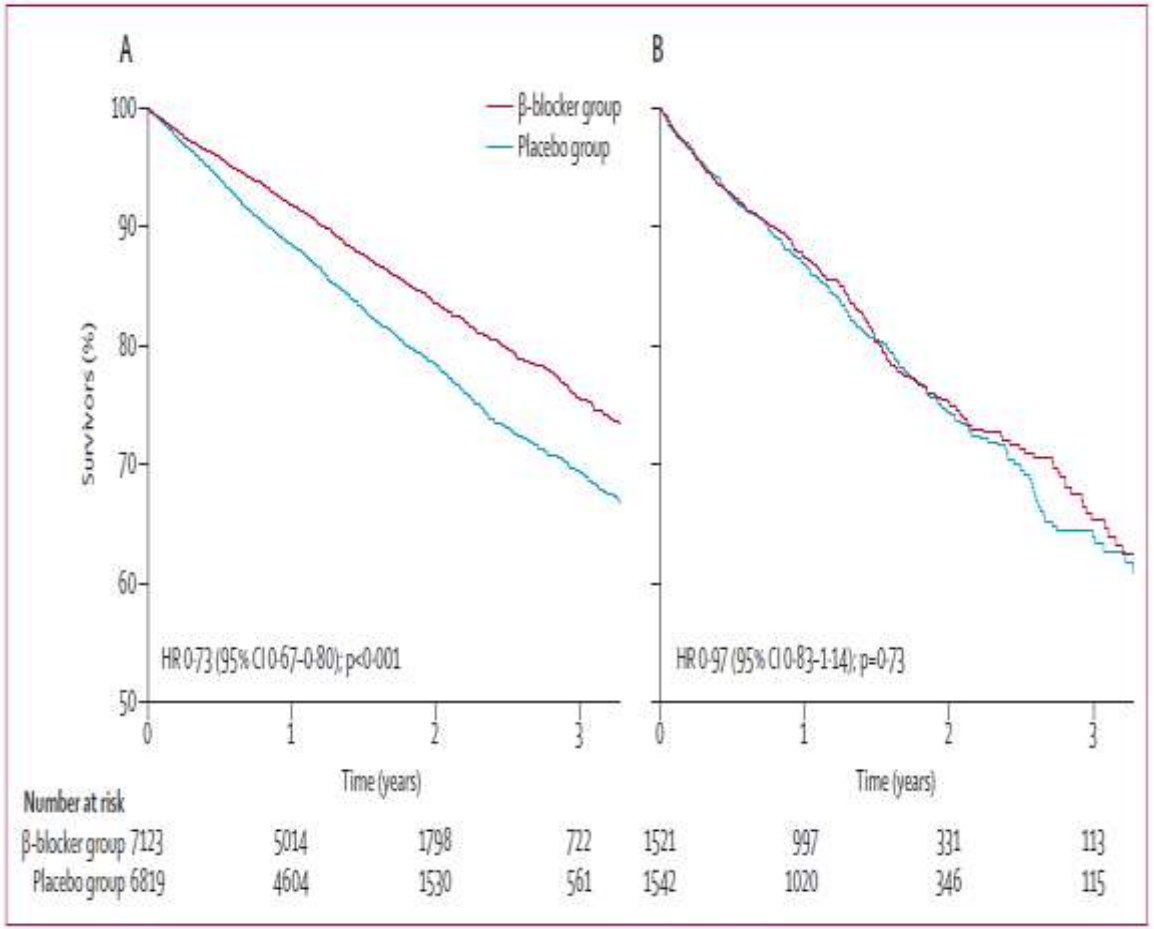
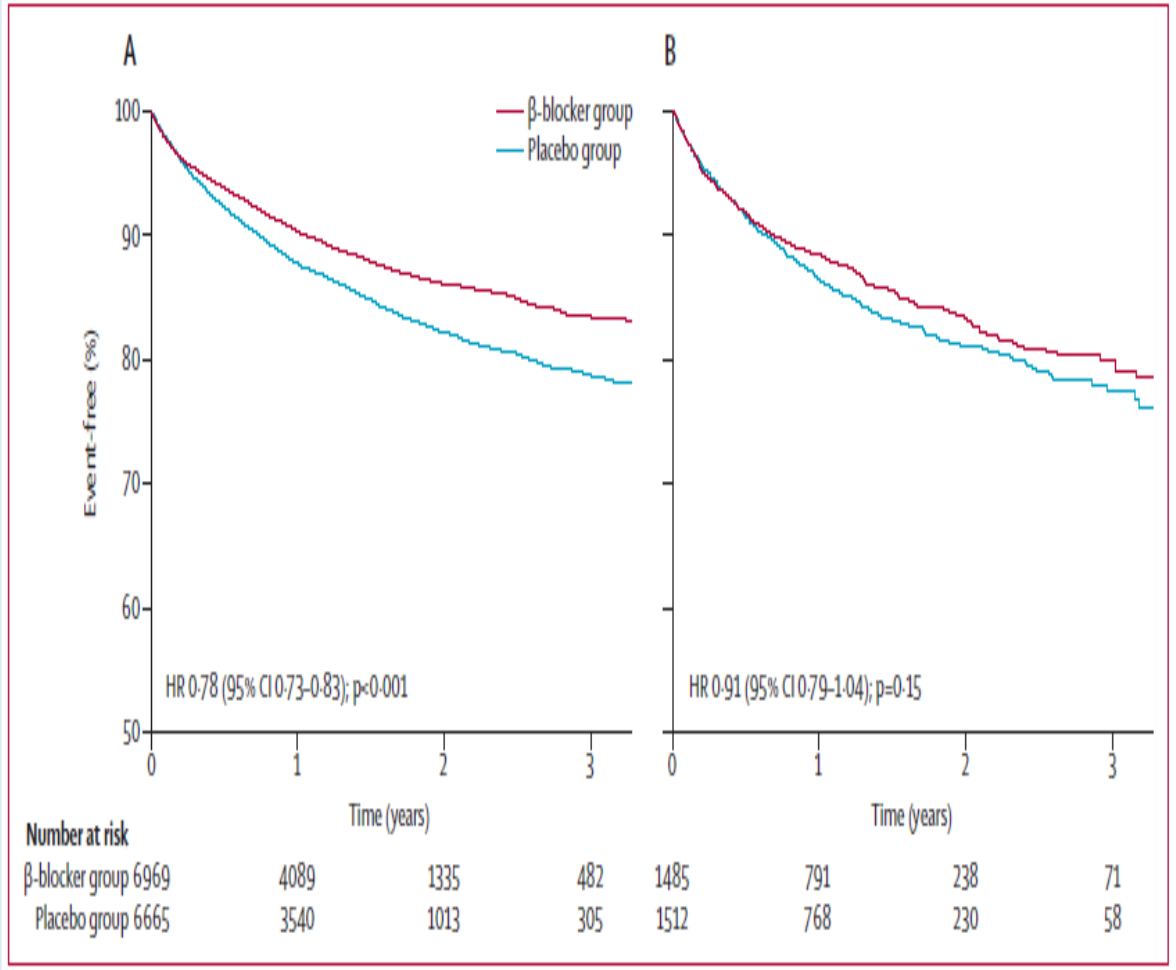


Figure 1: Kaplan-Meier survival curve for patients with sinus rhythm (A) and atrial fibrillation (B) in the β-blocker and placebo groups
Data are unadjusted survival curves for all reported deaths. HRs are derived from the adjusted one-stage Cox regression model and stratified by study. HR=hazard ratio.



www.thelancet.com Published online September 2, 2014

EVIDENCIA EN IC

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Catheter Ablation for Atrial Fibrillation with Heart Failure

Nassir F. Marrouche, M.D., Johannes Brachmann, M.D., Dietrich Andresen, M.D., Jürgen Siebels, M.D., Lucas Boersma, M.D., Luc Jordaens, M.D., Béla Merkely, M.D., Evgeny Pokushalov, M.D., Prashanthan Sanders, M.D., Jochen Proff, B.S., Heribert Schunkert, M.D., Hildegard Christ, M.D., Jürgen Vogt, M.D., and Dietmar Bänsch, M.D., for the CASTLE-AF Investigators*

Catheter Ablation for Atrial Fibrillation with Heart Failure

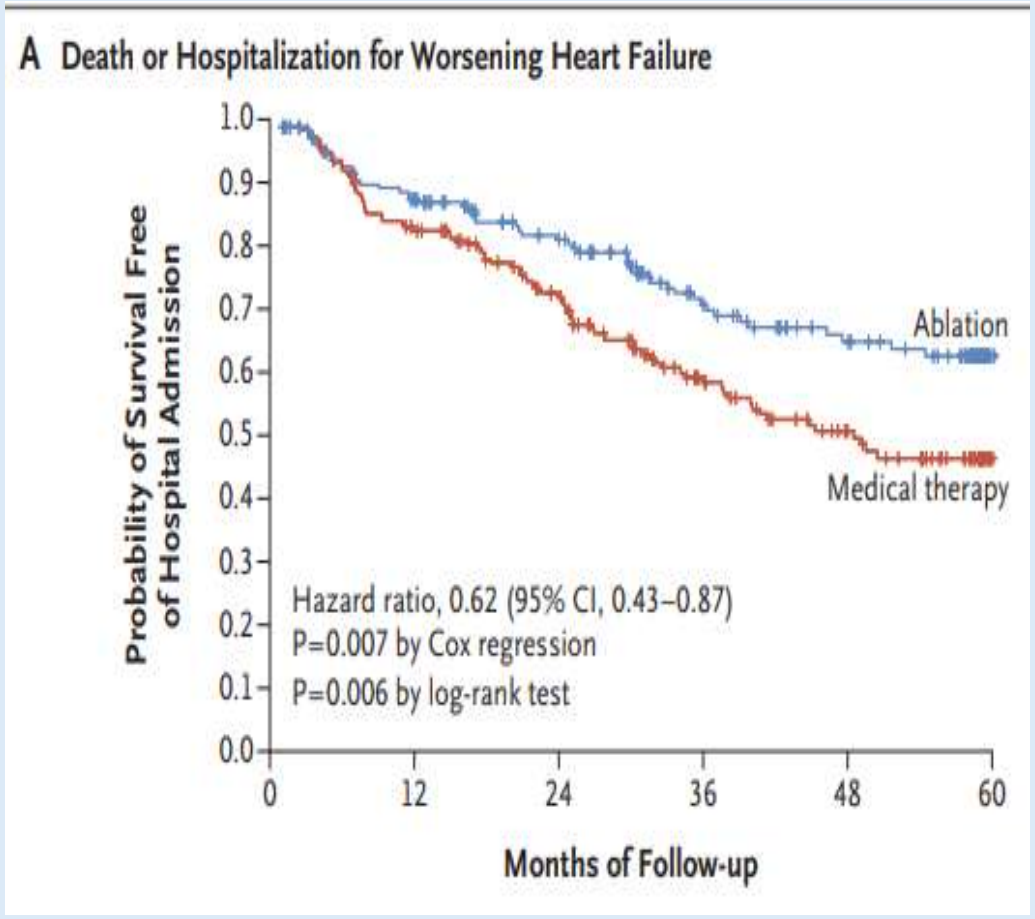
- Ablación vs terapia médica (control del ritmo o de frecuencia) en paciente con FA e insuficiencia cardiaca
- Aleatorizaron en total 363 pacientes, 174 en ablación y 184 en terapia médica
- Seguimiento promedio 37 meses (3 años)
- ICC, FE ≤ 35%, NYHA 2 -3-4, FA paroxística o persistente

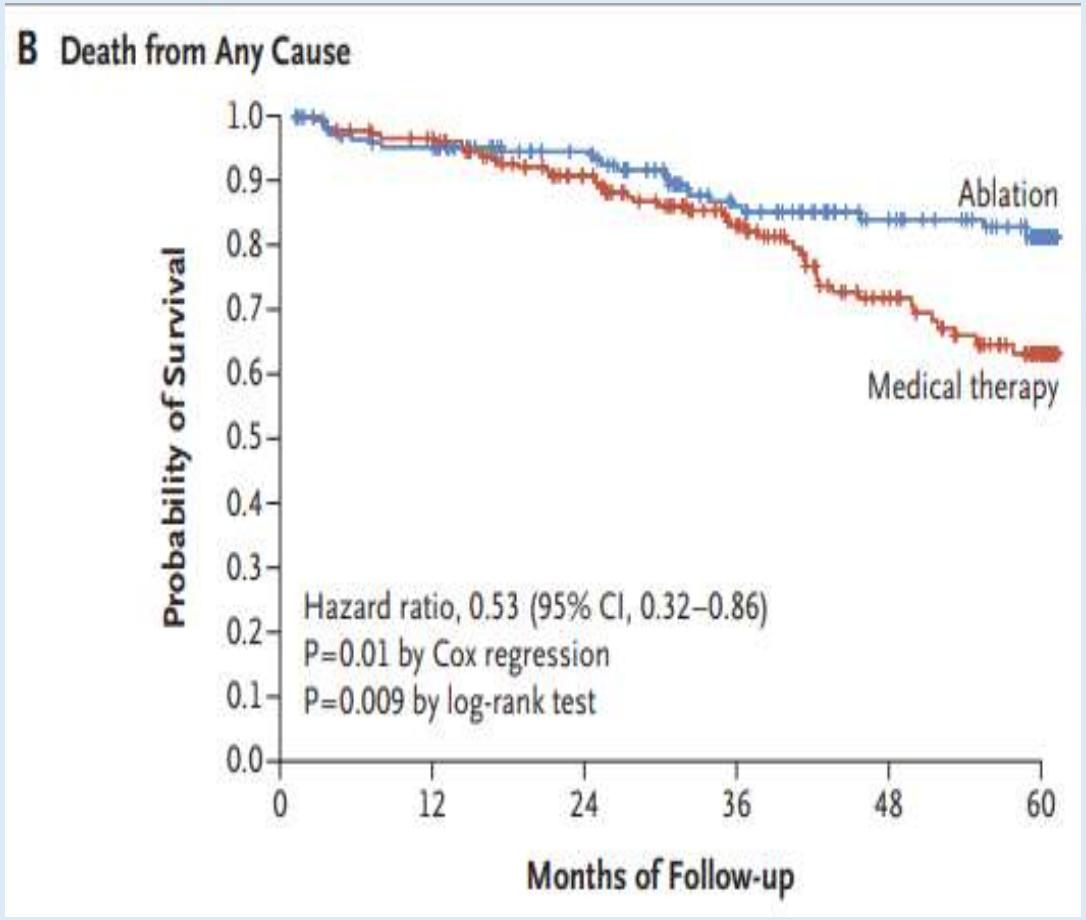
- Resultado primario: compuesto de muerte por cualquier causa y hospitalizaciones por ICC
- Resultados secundarios: muerte cardiovascular, hospitalizaciones y ECV
- Edad promedio 64 años

CASTLE-AF Investigators*

FEBRUARY 1, 2018

Catheter Ablation for Atrial Fibrillation with Heart Failure





CASTLE-AF Investigators*

FEBRUARY 1, 2018

Rhythm control for patients with atrial fibrillation complicated with heart failure in the contemporary era of catheter ablation: a stratified pooled analysis of randomized data

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European Heart Journal (2020) **41**, 2863–2873
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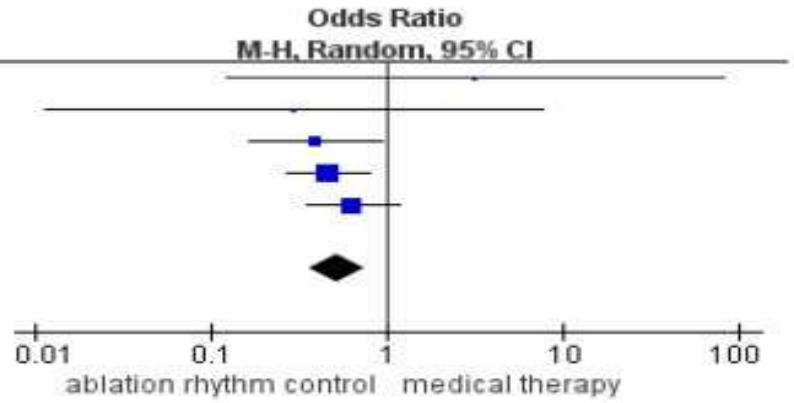
A catheter ablation rhythm control vs. medical therapy for all-cause mortality

Study or Subgroup	ablation rhythm control Events	Total	medical therapy Events	Total	Weight	Odds Ratio M-H, Random, 95% CI
2. ARC-HF 2013	1	26	0	26	1.3%	3.12 [0.12, 80.12]
3. CAMTAF 2014	0	26	1	24	1.3%	0.30 [0.01, 7.61]
4. AATAC 2016	8	102	18	101	17.0%	0.39 [0.16, 0.95]
6. CASTLE-AF 2018	24	179	46	184	44.7%	0.46 [0.27, 0.80]
7. CABANA HF-subgroup 2019	21	174	29	163	35.9%	0.63 [0.35, 1.16]
Total (95% CI)		**507**		**498**	**100.0%**	**0.51 [0.36, 0.74]**
Total events	54		94			

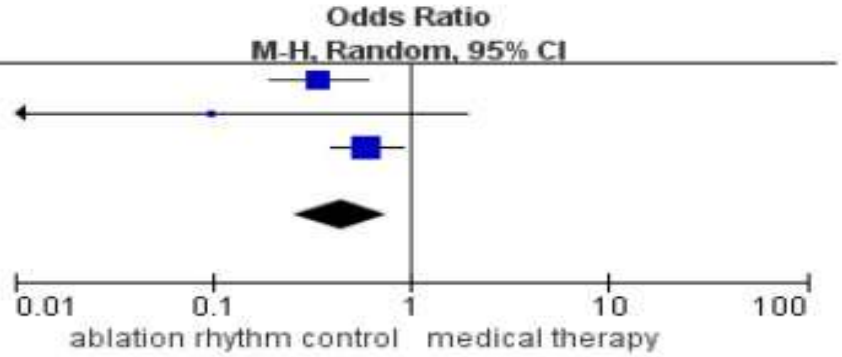
Heterogeneity: Tau² = 0.00; Chi² = 2.25, df = 4 (P = 0.69); I² = 0%
Test for overall effect: Z = 3.59 (P = 0.0003)



B catheter ablation rhythm control vs. medical therapy for re-hospitalization

Study or Subgroup	ablation rhythm control Events	Total	medical therapy Events	Total	Weight	Odds Ratio M-H, Random, 95% CI
4. AATAC 2016	32	102	58	101	42.4%	0.34 [0.19, 0.60]
5. CAMERA-MRI 2017	0	33	4	33	3.2%	0.10 [0.01, 1.89]
6. CASTLE-AF 2018	64	179	89	184	54.4%	0.59 [0.39, 0.90]
Total (95% CI)		**314**		**318**	**100.0%**	**0.44 [0.26, 0.76]**
Total events	96		151			

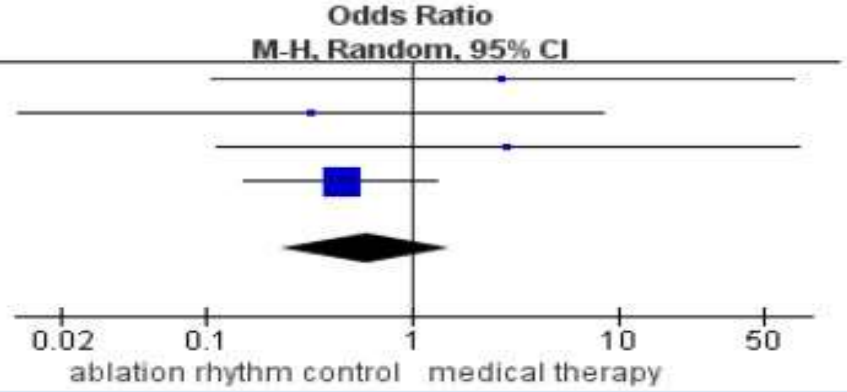
Heterogeneity: Tau² = 0.10; Chi² = 3.51, df = 2 (P = 0.17); I² = 43%
Test for overall effect: Z = 2.95 (P = 0.003)



C catheter ablation rhythm control vs. medical therapy for stroke

Study or Subgroup	ablation rhythm control Events	Total	medical therapy Events	Total	Weight	Odds Ratio M-H, Random, 95% CI
1. MacDonald 2011	1	22	0	19	8.2%	2.72 [0.10, 70.79]
2. ARC-HF 2013	0	26	1	26	8.3%	0.32 [0.01, 8.24]
3. CAMTAF 2014	1	26	0	24	8.3%	2.88 [0.11, 74.21]
6. CASTLE-AF 2018	5	179	11	184	75.2%	0.45 [0.15, 1.33]
Total (95% CI)		**253**		**253**	**100.0%**	**0.59 [0.23, 1.51]**
Total events	7		12			

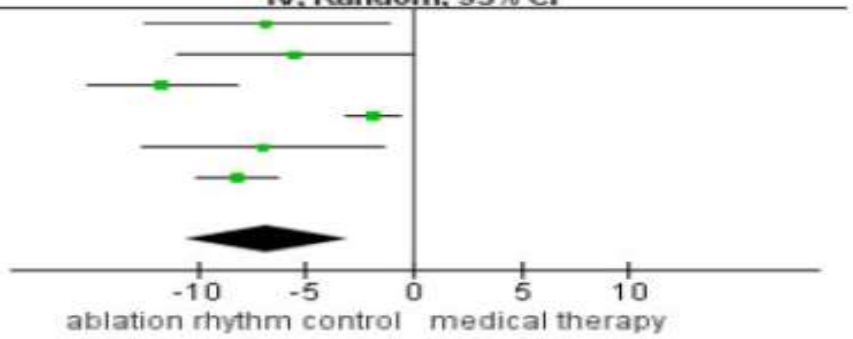
Heterogeneity: Tau² = 0.00; Chi² = 2.14, df = 3 (P = 0.54); I² = 0%
Test for overall effect: Z = 1.09 (P = 0.27)



A catheter ablation rhythm control vs. medical therapy for LVEF improvement

Study or Subgroup	ablation rhythm control Mean	SD	Total	medical therapy Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
1. MacDonald 2011	-8.2	12	22	-1.4	5.9	19	14.1%	-6.80 [-12.47, -1.13]
2. ARC-HF 2013	-10.9	11.5	26	-5.4	8.5	26	14.3%	-5.50 [-11.00, -0.00]
3. CAMTAF 2014	-8.1	8	26	3.6	4	24	17.6%	-11.70 [-15.17, -8.23]
4. AATAC 2016	-8.1	4	102	-6.2	5	101	20.2%	-1.90 [-3.15, -0.65]
5. CAMERA-MRI 2017	-9.2	14	33	-2.2	8.5	33	14.2%	-7.00 [-12.59, -1.41]
6. CASTLE-AF 2018	-8	8.5	179	0.2	9.6	184	19.7%	-8.20 [-10.06, -6.34]
Total (95% CI)			**388**			**387**	**100.0%**	**-6.79 [-10.55, -3.03]**

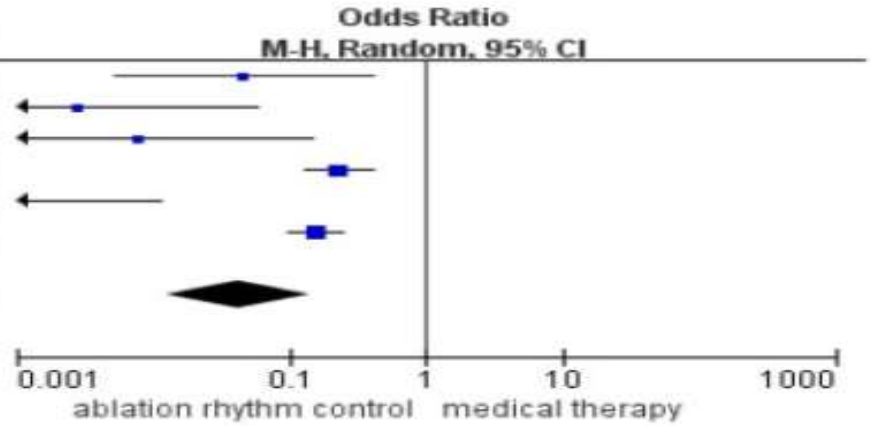
Heterogeneity: Tau² = 17.84; Chi² = 49.85, df = 5 (P < 0.00001); I² = 90%
Test for overall effect: Z = 3.54 (P = 0.0004)



B catheter ablation rhythm control vs. medical therapy for AF/AT recurrence

Study or Subgroup	ablation rhythm control Events	Total	medical therapy Events	Total	Weight	Odds Ratio M-H, Random, 95% CI
1. MacDonald 2011	10	22	18	19	15.2%	0.05 [0.01, 0.41]
2. ARC-HF 2013	3	26	26	26	10.5%	0.00 [0.00, 0.06]
3. CAMTAF 2014	7	26	24	24	10.9%	0.01 [0.00, 0.15]
4. AATAC 2016	29	102	64	101	27.7%	0.23 [0.13, 0.41]
5. CAMERA-MRI 2017	0	33	33	33	7.2%	0.00 [0.00, 0.01]
6. CASTLE-AF 2018	66	179	145	184	28.4%	0.16 [0.10, 0.25]
Total (95% CI)		**388**		**387**	**100.0%**	**0.04 [0.01, 0.14]**
Total events	115		310			

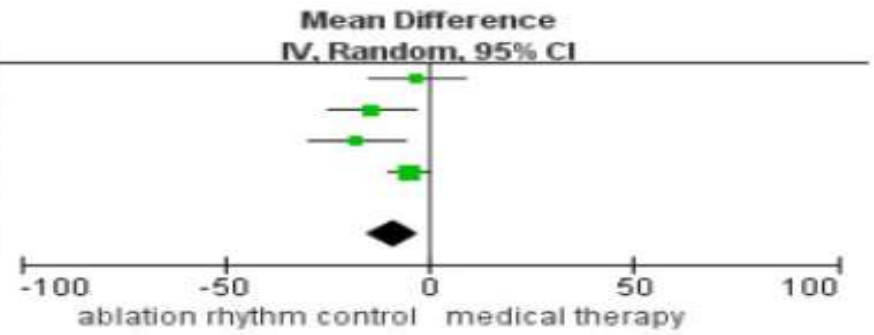
Heterogeneity: Tau² = 1.30; Chi² = 26.32, df = 5 (P < 0.0001); I² = 81%
Test for overall effect: Z = 5.08 (P < 0.00001)



C catheter ablation rhythm control vs. medical therapy for Quality of Life (MLHFQ score)

Study or Subgroup	ablation rhythm control Mean	SD	Total	medical therapy Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
1. MacDonald 2011	-5.7	19.7	20	-2.8	17.9	18	19.3%	-2.90 [-14.85, 9.05]
2. ARC-HF 2013	-19.58	22.32	24	-5.35	15.71	26	22.0%	-14.23 [-25.01, -3.45]
3. CAMTAF 2014	-18	21.99	26	-0.2	21.47	24	19.1%	-17.80 [-29.85, -5.75]
4. AATAC 2016	-11	19	94	-6	17	83	39.6%	-5.00 [-10.30, 0.30]
Total (95% CI)			**164**			**151**	**100.0%**	**-9.07 [-15.66, -2.48]**

Heterogeneity: Tau² = 21.26; Chi² = 5.72, df = 3 (P = 0.13); I² = 48%
Test for overall effect: Z = 2.70 (P = 0.007)



Study or Subgroup	ablation rhythm control Events	Total	medical therapy Events	Total	Weight	Odds Ratio M-H, Random, 95% CI
1. MacDonald 2011	6	22	0	19	4.8%	15.36 [0.80, 293.60]
2. ARC-HF 2013	4	26	1	26	7.4%	4.55 [0.47, 43.78]
3. CAMTAF 2014	2	26	2	24	8.7%	0.92 [0.12, 7.07]
4. AATAC 2016	9	102	18	101	22.5%	0.45 [0.19, 1.05]
5. CAMERA-MRI 2017	0	33	0	33		Not estimable
6. CASTLE-AF 2018	86	179	137	184	29.7%	0.32 [0.20, 0.49]
7. CABANA HF-subgroup 2019	21	174	29	163	26.9%	0.63 [0.35, 1.16]
Total (95% CI)		**562**		**550**	**100.0%**	**0.66 [0.33, 1.34]**
Total events	128		187			

Heterogeneity: $Tau^2 = 0.38$; $Chi^2 = 13.85$, df = 5 (P = 0.02); $I^2 = 64\%$
Test for overall effect: Z = 1.14 (P = 0.25)

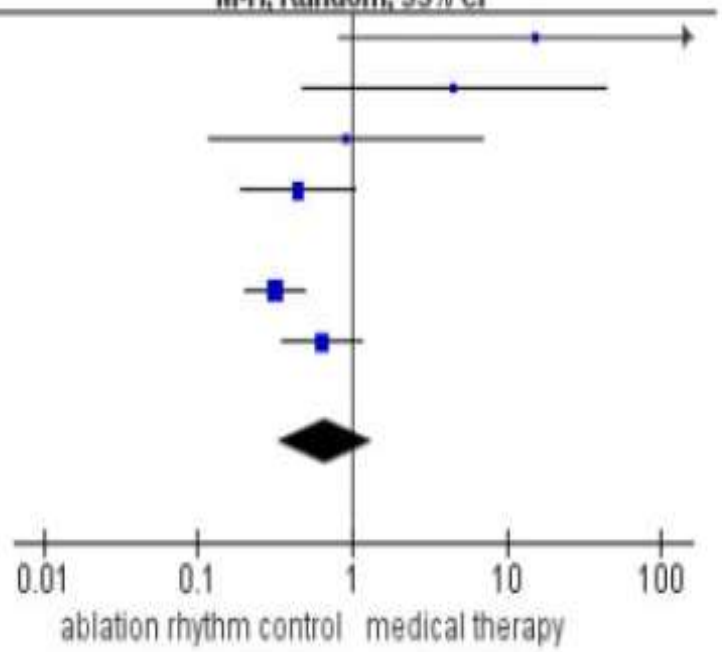


Figure 4 Composite adverse events (catheter ablation rhythm control vs. medical therapy).

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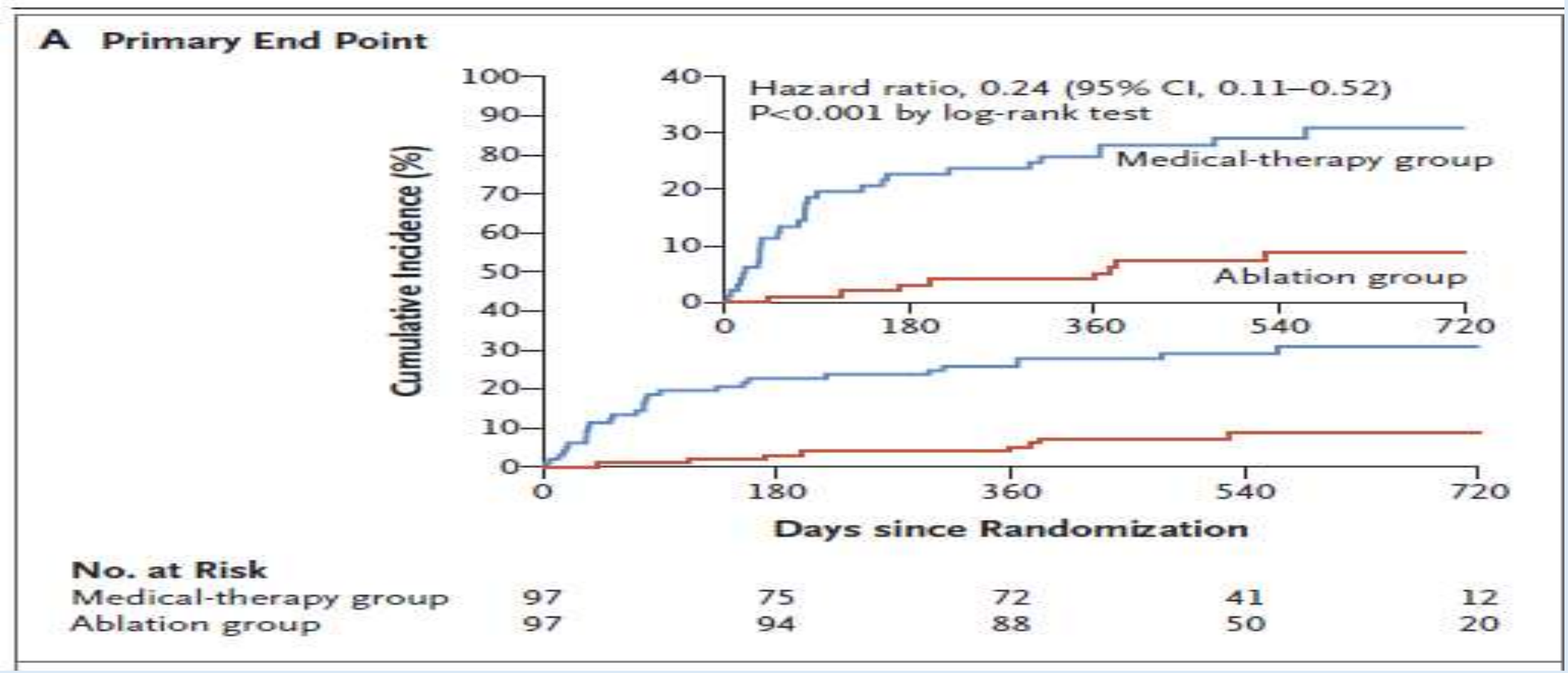
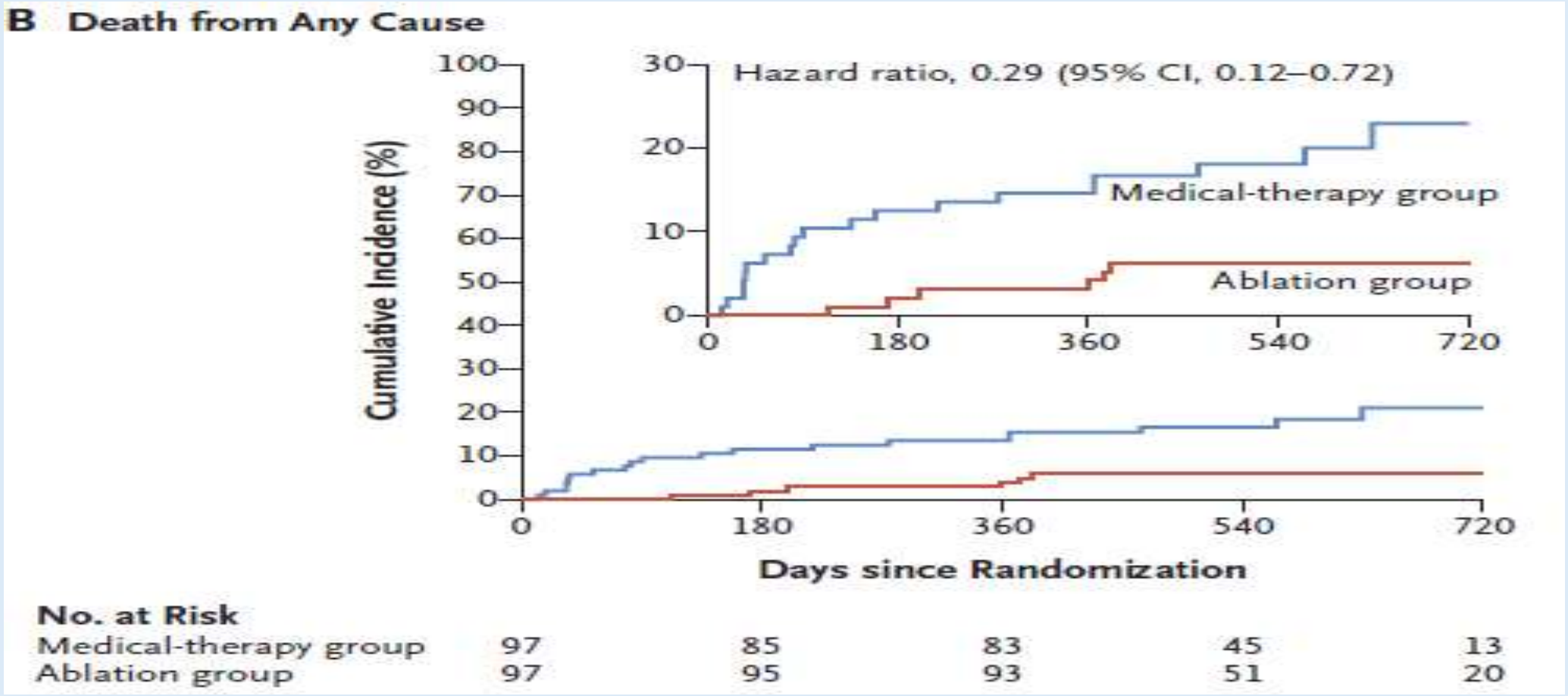
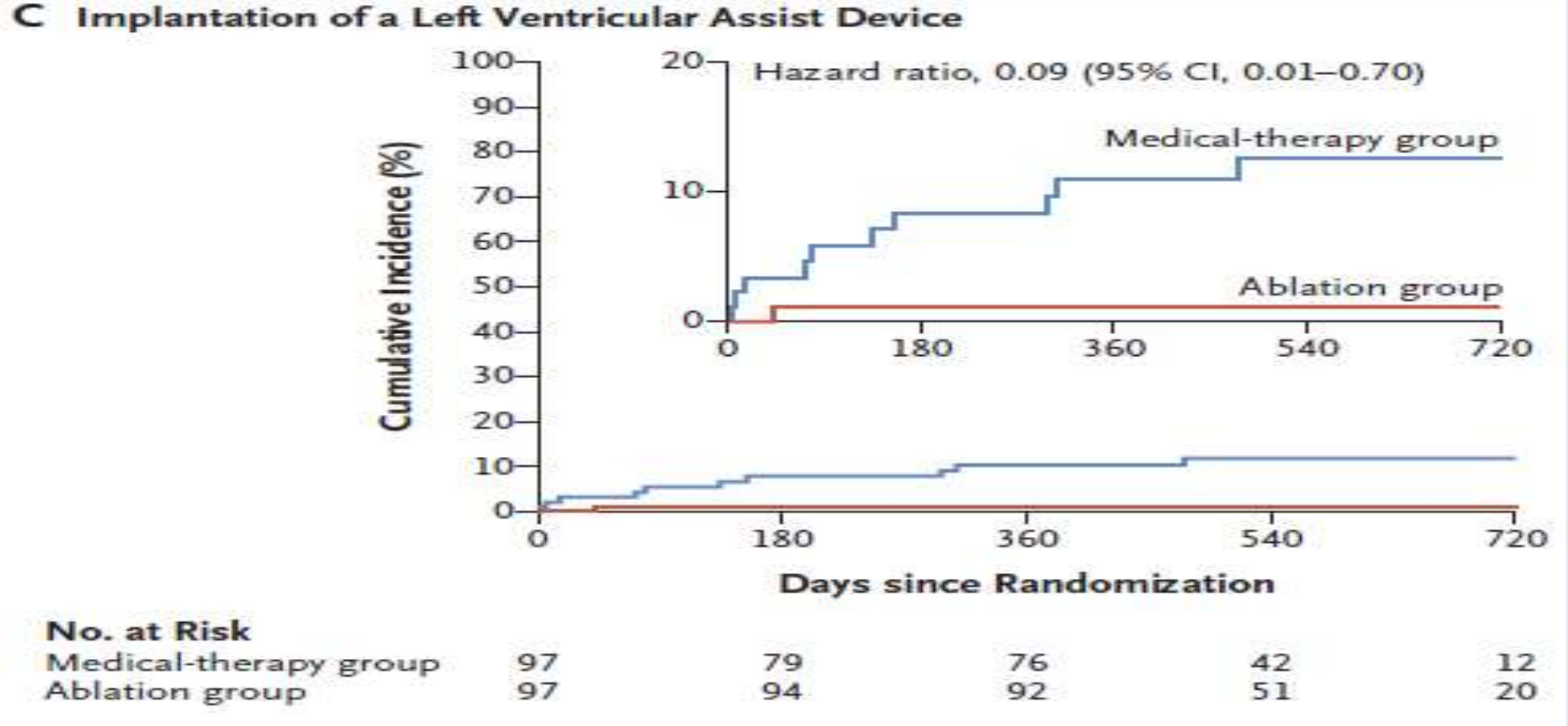
CASTLE HTX


A Primary End Point
Hazard ratio, 0.24 (95% CI, 0.11–0.52)
P<0.001 by log-rank test
Medical-therapy group
Ablation group
Cumulative Incidence (%)
Days since Randomization
No. at Risk
Medical-therapy group 97 75 72 41 12
Ablation group 97 94 88 50 20

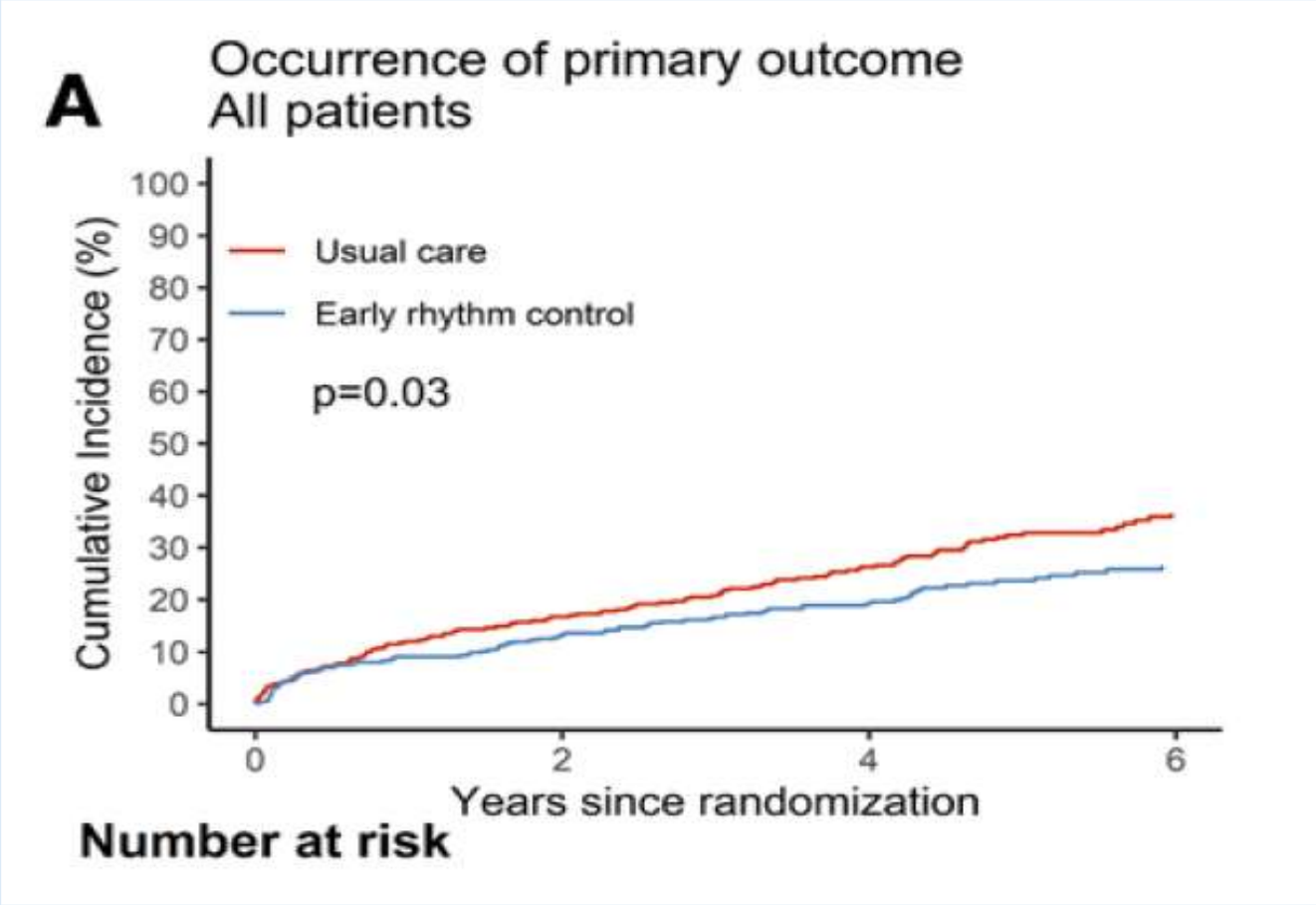
CASTLE HTX


B Death from Any Cause
Cumulative Incidence (%)
100
90
80
70
60
50
40
30
20
10
0
30
20
10
0
Hazard ratio, 0.29 (95% CI, 0.12–0.72)
Medical-therapy group
Ablation group
0
180
360
540
720
Days since Randomization
No. at Risk
Medical-therapy group 97 85 83 45 13
Ablation group 97 95 93 51 20

CASTLE HTX


C Implantation of a Left Ventricular Assist Device
Hazard ratio, 0.09 (95% CI, 0.01–0.70)
Medical-therapy group
Ablation group
Cumulative Incidence (%)
100
90
80
70
60
50
40
30
20
10
0
20
10
0
0
180
360
540
720
Days since Randomization
No. at Risk
Medical-therapy group 97 79 76 42 12
Ablation group 97 94 92 51 20

Early Rhythm Control Therapy in Patients With Atrial Fibrillation and Heart Failure



Circulation. 2021;144:845–858. DOI: 10.1161/CIRCULATIONAHA.121.056323

CONCLUSIONES

- Manejo interdisciplinario centrado en el paciente
- Control estricto de factores de riesgo
- Anticoagular cuando se requiera y a la dosis adecuada
- Paciente frágil anticoagular con DOAC (idealmente apixaban)
- Patología crónica de seguimiento periódico.
- Priorizar ritmo, de forma temprana en pacientes con ICFER + FA.

XIII CONGRESO INTERNACIONAL DE CARDIOLOGIA

CARDIOLOGIA INTERVENCIONISTA - LII JORNADA ACCI-SOLACI

DE LA PREVENCIÓN A LA INTERVENCIÓN

ASOCAR
Asociación Costarricense de Cardiología

ASOCAR
Capítulo de Enfermería

ACCI

JORNADAS SOLACI