

Aktuelle ESC-Guidelines und Versorgung von Patienten mit Vorhofflimmern

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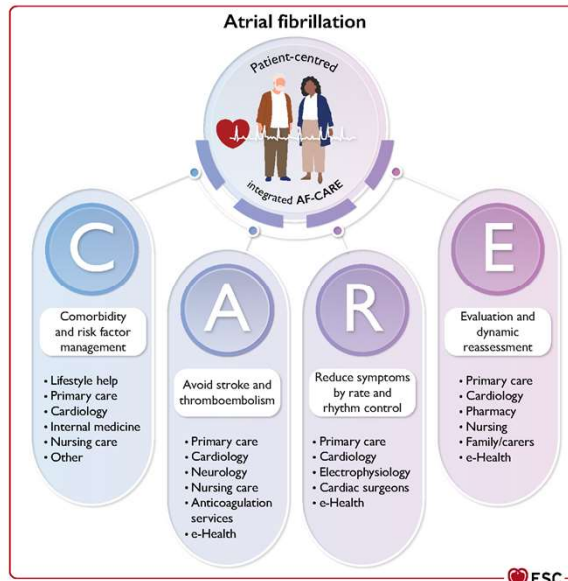
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Disclosure Statement

- Consulting / Speaker: Abbott, Astra-Zeneca, Bayer, Berlin-Chemie, Biosense Webster, Biotronik, Boehringer-Ingelheim, Boston Scientific, BMS, Daiichi Sankyo, Medscape, Medtronic, Menarini, Merck/MSD, Pfizer, Saja, Servier, and WebMD.
- Ownership CorXL, Swiss EP

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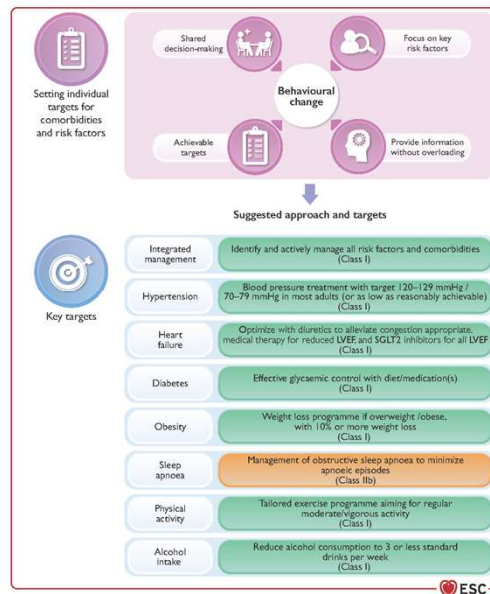
Figure 2
Multidisciplinary approach to atrial fibrillation management



2024 ESC Guidelines for the management of atrial fibrillation
(European Heart Journal: 2024 – doi: 10.1093/eurheartj/ehae176)

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Figure 8
Management of key comorbidities to reduce atrial fibrillation recurrence



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Updated definitions for the CHA₂DS₂-VA score



CHA ₂ DS ₂ -VA component	Definition and comments	Points awarded
C	Chronic heart failure Symptoms and signs of heart failure (irrespective of LVEF, thus including HFpEF, HFmrEF, and HFrEF), or the presence of asymptomatic LVEF ≤40%.	1
H	Hypertension Resting blood pressure >140/90 mmHg on at least two occasions, or current antihypertensive treatment. The optimal BP target associated with lowest risk of major cardiovascular events is 120–129/70–79 mmHg (or keep as low as reasonably achievable).	1
A	Age 75 years or above se. ^{112,256,257} The inclusion of gender complicates clinical practice both in a continuum, but for healthcare professionals and patients. ²⁵⁸ It also omits individuals who identify as non-binary, transgender, or are undergoing sex hormone therapy. Previous guidelines from the ESC (and globally) have therefore weighted 2 points.	2
D	Diabetes mellitus	1
S	Prior stroke, TIA, or arterial thromboembolism	2
V	Vascular disease Coronary artery disease, including prior myocardial infarction, angina, history of coronary revascularization (surgical or percutaneous), and significant CAD on angiography or cardiac imaging OR Peripheral vascular disease, including: intermittent claudication, previous revascularization for PVD, percutaneous or surgical intervention on the abdominal aorta, and complex aortic plaque on imaging (defined as features of mobility, ulceration, pedunculation, or thickness ≥4 mm).	1
A	Age 65–74 years 1 point is given for age between 65 and 74 years.	1

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New recommendations (3)



Recommendations	Class	Level
[C] Comorbidity and risk factor management cont.		
When screening for obstructive sleep apnoea in individuals with AF, using only symptom-based questionnaires is not recommended.	III	B
Initiating oral anticoagulation – Section 6.1		
Oral anticoagulation is recommended in patients with clinical AF at elevated thromboembolic risk to prevent ischaemic stroke and thromboembolism.	I	A
A CHA ₂ DS ₂ -VA score of 2 or more is recommended as an indicator of elevated thromboembolic risk for decisions on initiating oral anticoagulation.	I	C
A CHA ₂ DS ₂ -VA score of 1 should be considered an indicator of elevated thromboembolic risk for decisions on initiating oral anticoagulation.	IIa	C
Oral anticoagulation is recommended in all patients with AF and hypertrophic cardiomyopathy or cardiac amyloidosis, regardless of CHA ₂ DS ₂ -VA score, to prevent ischaemic stroke and thromboembolism.	I	B

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New recommendations (4)



Recommendations	Class	Level
Initiating oral anticoagulation cont.		
Individualized reassessment of thromboembolic risk is recommended at periodic intervals in patients with AF to ensure anticoagulation is started in appropriate patients.	I	B
Direct oral anticoagulant therapy may be considered in patients with asymptomatic device-detected subclinical AF and elevated thromboembolic risk to prevent ischaemic stroke and thromboembolism, excluding patients at high risk of bleeding.	IIb	B
Oral anticoagulants – Section 6.2		
A reduced dose of DOAC therapy is not recommended, unless patients meet DOAC-specific criteria, to prevent underdosing and avoidable thromboembolic events.	III	B
Maintaining VKA treatment rather than switching to a DOAC may be considered in patients aged ≥75 years on clinically stable therapeutic VKA with polypharmacy to prevent excess bleeding risk.	IIb	B
Antiplatelet drugs and combinations with anticoagulants – Section 6.3		
Adding antiplatelet treatment to oral anticoagulation is not recommended in AF patients for the goal of preventing ischaemic stroke or thromboembolism.	III	B

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Recommendations for management of post-operative atrial fibrillation



Recommendations	Class	Level
Peri-operative amiodarone therapy is recommended where drug therapy is desired to prevent post-operative AF after cardiac surgery.	I	A
Concomitant posterior peri-cardiotomy should be considered in patients undergoing cardiac surgery to prevent post-operative AF.	IIa	B
Long-term oral anticoagulation should be considered in patients with post-operative AF after cardiac and non-cardiac surgery at elevated thromboembolic risk, to prevent ischaemic stroke and thromboembolism.	IIa	B
Routine use of beta-blockers is not recommended in patients undergoing non-cardiac surgery for the prevention of post-operative AF.	III	B

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New recommendations (7)



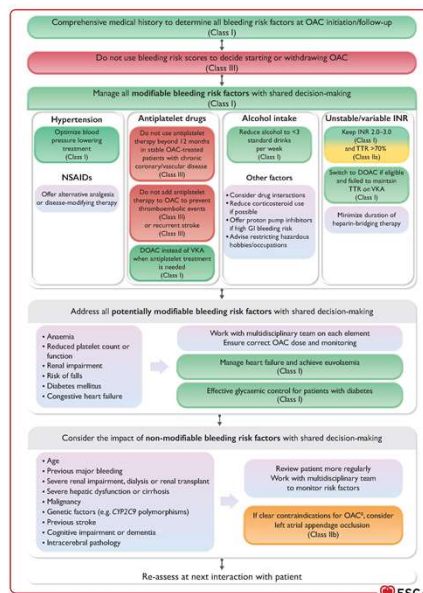
Recommendations	Class	Level
General principles and anticoagulation – Section 7.2.1		
Direct oral anticoagulants are recommended in preference to VKAs in eligible patients with AF undergoing cardioversion for thromboembolic risk reduction.	I	A
Cardioversion of AF (either electrical or pharmacological) should be considered in symptomatic patients with persistent AF as part of a rhythm control approach.	Ila	B
A wait-and-see approach for spontaneous conversion to sinus rhythm within 48 hours of AF onset should be considered in patients without haemodynamic compromise as an alternative to immediate cardioversion.	Ila	B
Implementation of a rhythm control strategy should be considered within 12 months of diagnosis in selected patients with AF at risk of thromboembolic events to reduce the risk of cardiovascular death or hospitalization.	Ila	B
Early cardioversion is not recommended without appropriate anticoagulation or transoesophageal echocardiography if AF duration is longer than 24 hours, or there is scope to wait for spontaneous cardioversion.	III	C

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Figure 10

Modifying the risk of bleeding associated with OAC

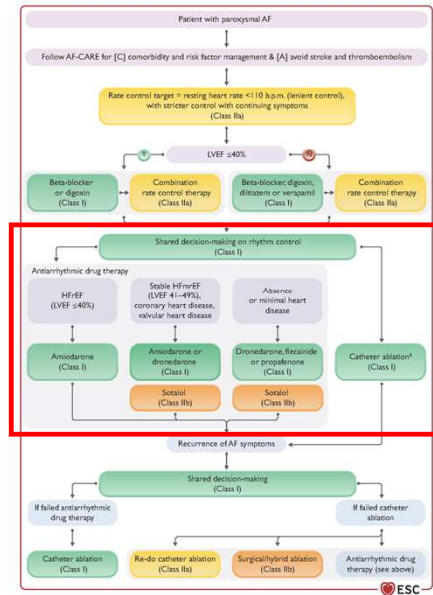


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Figure 5

[R] Pathway for patients with paroxysmal atrial fibrillation

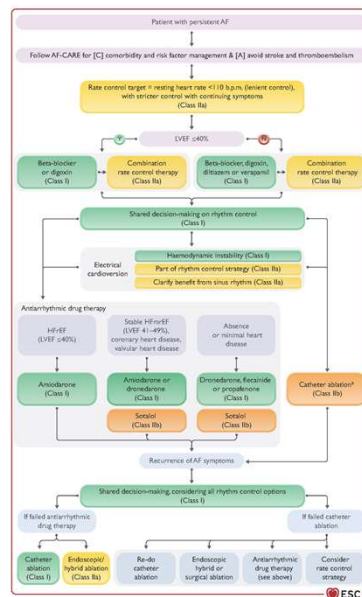


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Figure 6

[R] Pathway for patients with persistent atrial fibrillation



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Recommendations for catheter ablation of atrial fibrillation (1) ESC

Recommendations	Class	Level
Shared decision-making		
Shared decision-making is recommended when considering catheter ablation for AF, taking into account procedural risks, likely benefits, and risk factors for AF recurrence.	I	C
Atrial fibrillation patients resistant or intolerant to antiarrhythmic drug therapy		
Catheter ablation is recommended in patients with paroxysmal or persistent AF resistant or intolerant to antiarrhythmic drug therapy to reduce symptoms, recurrence, and progression of AF.	I	A
First-line rhythm control therapy		
Catheter ablation is recommended as a first-line option within a shared decision-making rhythm control strategy in patients with paroxysmal AF, to reduce symptoms, recurrence, and progression of AF.	I	A
Catheter ablation may be considered as a first-line option within a shared decision-making rhythm control strategy in selected patients with persistent AF to reduce symptoms, recurrence, and progression of AF.	IIb	C

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New recommendations (8) ESC

Recommendations	Class	Level
Electrical cardioversion – Section 7.2.2		
Electrical cardioversion as a diagnostic tool should be considered in patients with persistent AF where there is uncertainty about the value of sinus rhythm restoration on symptoms, or to assess improvement in left ventricular function.	IIa	C
Antiarrhythmic drugs – Section 7.2.4		
Antiarrhythmic drug therapy is not recommended in patients with advanced conduction disturbances unless antibradycardia pacing is provided.	III	C
Catheter ablation – Section 7.2.5		
Sinus node disease/tachycardia–bradycardia syndrome		
Atrial fibrillation catheter ablation should be considered in patients with AF-related bradycardia or sinus pauses on AF termination to improve symptoms and avoid pacemaker implantation.	IIa	C

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New recommendations (9)



Recommendations	Class	Level
Catheter ablation cont.		
Recurrence after catheter ablation		
Repeat AF catheter ablation should be considered in patients with AF recurrence after initial catheter ablation, provided the patient's symptoms were improved after the initial PVI or after failed initial PVI, to reduce symptoms, recurrence, and progression of AF.	Ila	B
Anticoagulation in patients undergoing catheter ablation – Section 7.2.6		
Uninterrupted oral anticoagulation is recommended in patients undergoing AF catheter ablation to prevent peri-procedural ischaemic stroke and thromboembolism.	I	A
Endoscopic and hybrid atrial fibrillation ablation – Section 7.2.7		
Continuation of oral anticoagulation is recommended in patients with AF at elevated thromboembolic risk after concomitant, endoscopic, or hybrid AF ablation, independent of rhythm outcome or LAA exclusion, to prevent ischaemic stroke and thromboembolism.	I	C
Endoscopic and hybrid ablation procedures should be considered in patients with symptomatic persistent AF refractory to AAD therapy to prevent symptoms, recurrence, and progression of AF, within a shared decision-making rhythm control team of electrophysiologists and surgeons.	Ila	A

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Recommendations for screening for atrial fibrillation



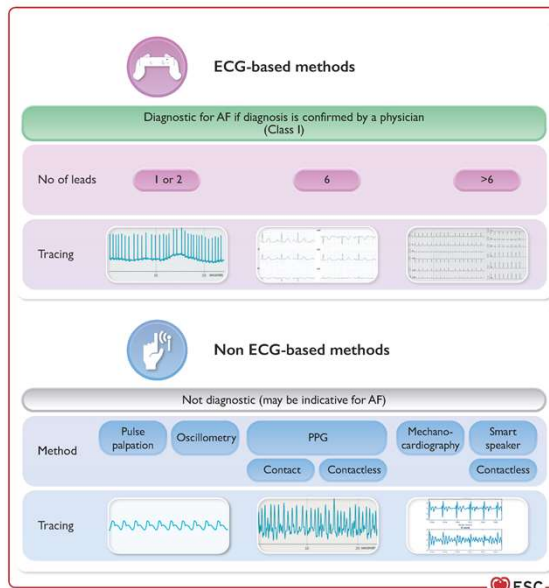
Recommendations	Class	Level
Review of an ECG (12-lead, single, or multiple leads) by a physician is recommended to provide a definite diagnosis of AF and commence appropriate management.	I	B
Routine heart rhythm assessment during healthcare contact is recommended in all individuals aged ≥ 65 years for earlier detection of AF.	I	C
Population-based screening for AF using a prolonged non-invasive ECG-based approach should be considered in individuals aged ≥ 75 years, or ≥ 65 years with additional CHA ₂ DS ₂ -VA risk factors to ensure earlier detection of AF.	Ila	B

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Figure 15

Non-invasive diagnostic methods for atrial fibrillation screening

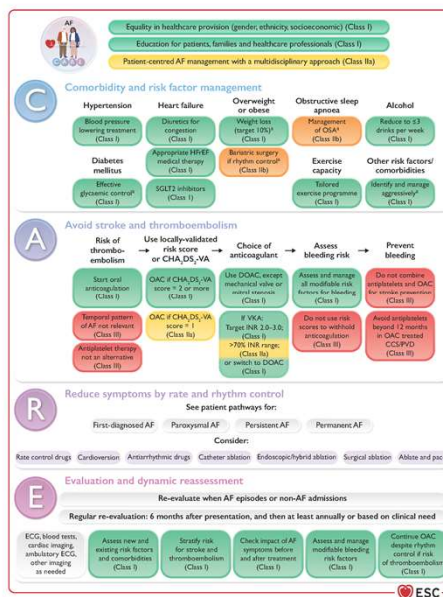


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Figure 3

Central illustration. Patient pathway for AF-CARE



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