Adjunctive Therapy* and Post-Procedural Monitoring (Including Tools, Duration, Documentation) **

*(Anti-Platelet, Anti-Coagulant, Anti-Arrhythmic) **(Clinical, Rhythm, Laboratory)
Background:
Overview of the Importance of the Issue Under Discussion
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• **AF ablation is not always successful:**
  
  – AF recurrences are common
    
    ▪ Symptomatic -- some requiring antiarrhythmic intervention
    ▪ Asymptomatic -- with implications for rate control and anticoagulation
    ▪ What defines procedural success? How should it be assessed? How should recurrences be treated?
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- **AF ablation may be associated with clot formation and/or prothrombotic initiators/sites:**
  - Anticoagulation is necessary following ablation
    - How, if at all, should we / can we risk stratify?
    - How long should we treat acutely? Who requires it chronically? Does it matter if an arrhythmia recurs post ablation and which one it is?
    - Which drug(s) are reasonable/do we have data for: warfarin, anti-platelet agents, Xa / thrombin inhibitors?
    - Should ablation be coupled with LAA occlusion?
What Works Well Today?

- Assessing Recurrence:
  - Patient symptoms, patient pulse self-assessment
  - Intermittent monitoring: HM, TSED, memory loop recorders, auto-triggered memory loop recorders
  - Mobile Cardiac Outpatient Telemetry – the most thorough
  - *Should one method be standard? How often should we monitor? For how long? Should we use implanted monitors?*
  - *If need for AAD is just for symptom control, then no monitoring is needed.*
  - *If AAD is for any recurrence (To stop anticoagulation), then intensive monitoring is needed.*
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• Handling Anticoagulation:
  – Parenteral regimens (pre/post) and oral warfarin
  – Are traditional “high-risk” markers adequate / appropriate as a guide to utilizing chronic anticoagulation?
  – Are there lab parameters that might be followed to indicate chronic risk (hematologic, echocardiographic)?
What is Missing, Broken, or Does Not Work Well Today?

• Arrhythmia Recurrence:
  – Defining success
    ▪ Absence of a standardized monitoring protocol
  – Absence of adequate mechanistic studies re: recurrence
  – Absence of scientific-quality data regarding post-ablation antiarrhythmic drug therapy
    ▪ What works? What doesn’t?
    ▪ How should we select an agent? Is there any relationship to arrhythmic mechanism? Is there any relationship to prior success or failure?
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- Anticoagulation:
  - Absence of objective determination for the duration of treatment
  - Absence of a standardized algorithm
  - Is there a safe and effective regimen when warfarin cannot be used?
    - e.g., NPO, the rare warfarin AE, non-compliance, etc.
  - What should we do when anti-platelet agents are required for concomitant conditions?
  - *Is a significant bleeding history a contraindication to ablation of AF?*
What is the Highest Priority Short Term (1-3 yrs)?

- Arrhythmia Recurrence:
  - Standard post-ablation monitoring protocols
  - Standard definition of success
  - Prospective, randomized AAD trials
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- **Arrhythmia Recurrence:**
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  - Standard definition of success
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- **Anticoagulation:**
  - Standard post-ablation anticoagulation protocols
  - Standard post-ablation monitoring protocols re: embolic events
    - *Clinical (?), Imaging (?), Other?*
  - Prospective, randomized trials of oral anticoagulants
What is the Highest Priority Long Term (3-5 yrs)?

- Reassessment of thromboembolism concerns with evolutionary approaches to ablation.
- Reassessment of AAD selection with evolutionary approaches to ablation.
- Determining the natural history of asymptomatic recurrences post-ablation.
- Determining the long-term course of patients with initial post-ablation “success.”
Final Thought

• Given the ATHENA results of clinically meaningful outcomes with dronedarone, other than AF reduction, what role will the anticipated release of this agent play in:
  – The place for AF ablation?
  – The role of AAD (dronedarone) discontinuation post ablation?
  – The anticoagulation question?